

Dr. Stephen Holt: Hello and welcome. Thanks for tuning in to today's episode. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host for today's episode, Dr. Stephen Holt, and I'm thrilled to be joined by two distinguished experts and friends, Drs. Carolyn Chan and Shawn Cohen.

Dr. Carolyn Chan: Hey, everybody. I'm Dr. Carolyn Chan. I'm an internist and an addiction medicine specialist.

Dr. Shawn Cohen: And hey there, I'm Shawn Cohen. This is officially the first time I've ever been called distinguished, but I'm also an addiction medicine doctor over at Yale and a general medicine doc.

Dr. Stephen Holt: Today's episode is part of our Advanced Buprenorphine Education series where we discuss common buprenorphine implementation challenges in both hospital and clinic settings. We're diving into a topic that's critical for improving patient care, and that is overcoming barriers to MOUD at the time of discharge and ensuring patients have a smooth transition to and from skilled nursing facilities. Transitions like these, as we all know, can be incredibly challenging, and it's really a vulnerable time for patients. But it also gives providers an opportunity to make a significant difference. So, let's kick things off with a case example to frame our conversation.

Today, we are considering a 64-year-old man with a history of newly diagnosed opioid use disorder and chronic pain who is recovering from a hip fracture he sustained when he stumbled going up the stairs to his apartment. After nearly a week on the orthopedic service, he is successfully initiated on buprenorphine, and he's slated to go to short-term rehab in a day or two.

However, discharge planning hits a major roadblock. The short-term rehab doesn't actually carry buprenorphine, and they require that an outside prescriber continue this medication. His outpatient provider, who had been prescribing nearly 180 mg of oxycodone to our patient daily, is unwilling to take on the buprenorphine prescription. And even more, the preferred pharmacies that we would use don't even stock buprenorphine. His family is growing frustrated, and without a clear plan in place, the patient is at risk of being discharged without access to this essential medication.

So, in this situation, what could be done differently to ensure patients like him have uninterrupted access to medications for opioid use disorder? And that is exactly what we, with my colleagues, will be unpacking today.

So, first off, Dr. Chan, Dr. Cohen, thinking about the big picture here, stepping outside of this particular case, you guys do a lot more inpatient medicine than I do; what are, in your minds, the

most common barriers to ensuring continuity of care for our MOUD patients at the time of discharge when they're going to skilled nursing facilities or things of that nature?

Dr. Shawn Cohen: Yeah, I mean, I always think about it's worth taking a step back at the bigger picture. I think that a lot of the issues that this patient was having, and particularly, probably with the skilled nursing facility as well, come back to this stigma that we see. One: in society, but I think two: often in healthcare settings around substance use disorders, and around treatment of substance use disorders.

And I think that a lot of it, I think, comes back to the stigma, and the medications become this easy marker to be able to identify people with substance use disorders for people to be able to decline care, not want to take care of. I think there are, truthfully, for nursing facilities there are other logistical issues that I think are more relevant honestly to methadone often than to buprenorphine of, like, how do you coordinate with an OTP?

How do you ensure things like chain of custody where the methadone can get from the OTP to the nursing facility and things like that, that just don't exist with buprenorphine. I think a lot of it is lack of education and stigma that comes down to it. It's always worth taking a step back and saying declining someone care at any type of medical facility, including a nursing facility because they have a substance use disorder or because they're on treatment for substance use disorder is illegal under the Americans with Disabilities Act and so there's lots of avenues to try to address this from the legal aspect of getting lawyers involved, talking with your local attorneys. But, I think, from the partnership-building aspect, I think a lot of the reasons nursing facilities often decline these patients is because they have this idea that they're going to be quote unquote 'difficult' that's based on these often, I think, stigmatizing ideas that they have in their head about substance use disorders.

And so, starting to talk to local nursing facilities, building relationships with them, making sure whether you're the outpatient or the inpatient doc is helping out with the addiction thing, they know that you're a resource to them that can talk through the buprenorphine, that's willing to prescribe the buprenorphine and other meds while they're in the nursing facility, and kind of troubleshoot whatever the things are is a step, but I think often to address this requires multiple steps from multiple different avenues too.

Dr. Carolyn Chan: Along that line, same thing. Building that relationship with the intake coordinator, I feel like, is often one of the key things. I have a number of nursing homes that I know will often accept my patients and those intake coordinators, I have their phone numbers. They have my number. I make it as easy as possible, to let them know that they can call me if there's any issues. They don't have to page me.

They have my personal number, and I think that goes a long way as a physician who gives out their number at these scenarios. I's not like I get flooded with phone calls, it's just like a really nice way to sort of ensure number one continuity of care for patients to make sure that they're getting evidence-based care and to like, "Hey, I wasn't trained well in addiction medicine, you know, I felt like I received a lot of my knowledge during fellowship."

So, sort of like thoughtful that like, hey, sometimes people just feel like they need that extra support. You know, oftentimes, the nursing home physician will take it over, and in my experience, if they know who they can reach out to if something happens. And, it's challenging, right? Because the systemic and structural issues, Shawn, that you're describing, it takes a long time to do those things. So, it's like, what am I going to do right here and right now, for that patient? I've noticed as well that, sometimes, depending on who you talk to, on the day of who's doing the intakes, somebody will say no, and you're like, I know that facility will take my patients.

So again, just like knowing the local facilities well and how to sort of like advocate and making sure that, policies that the nursing home have are implemented in an equitable manner is important.

Dr. Stephen Holt: It's interesting to me, I hear some of the things you're saying, and they sound like advocacy, right?

You know, a lot of times we think of advocacy as like going to Washington D.C., or it's writing op-eds or, you know, it's doing those kinds of big picture things. But advocacy is just knowing the names and contact information of someone who works at a short-term rehab or nursing home who you're advocating for this patient for.

You're calling, and you're saying, "Hey, look, you know, me, my friend is your friend." And you know, this is a patient who really needs this medication needs to be placed at the center, it's that extra work against those phone calls that I think can really transform things for our patients.

Dr. Shawn Cohen: Speaking to what Carolyn said, too, of like, there's this huge gap in education around effective addiction treatments and buprenorphine and methadone, and so I do think there's this huge education barrier where I've definitely spoken with people at nursing facility to say "Oh, we don't have a physician or a clinician like an APP that can prescribe buprenorphine and having to do that education of there's no such thing as an x-waiver anymore. If you have a DEA, which you definitely have a DEA if you're working probably at a nursing facility, you can prescribe this. And even if they're still not comfortable, saying I'll send a 30-day script. You can call me in a month, just taking away whatever barriers pop up too.

Dr. Stephen Holt: That dovetails nicely with my next question, which is, we were just focusing on getting to a place and figuring out, what the stigma and other barriers are to getting a patient

from the time of discharge to an STR or what have you. I do a little bit of time on the inpatient side for this, and one of the things that comes up is you write a prescription for, maybe it's XR-BUP, maybe it's Suboxone films or tablets and the patients now left the hospital, and some prior authorization issue comes up. It's kind of hard to anticipate even those things. How do you guys deal with that? Can you deal with it? Is it sort of up to the outpatient provider? Like, how do you handle issues with prior authorizations when they arise in those situations?

Dr. Shawn Cohen: Yeah, especially with things around methadone and bup, I tend to double-check things. I mean, this is true for going to a nursing facility, but also often if I'm sending bup to a pharmacy I've never sent it before, I call the pharmacy and I'm like, "Did you get this prescription? Are you able to fill it? Do you have enough for the month? Cause I've had it where people show up to a pharmacy and either one, they don't stock it or two, they're like, "Well, we have three days. We can fill that. "And then the patient has no way to contact, too. And so, I am very much in the mode of, I think transitions of care are the places where people get lost, or things happen in a bad way the most. And so those are the times where I really try to double-check things.

Dr. Carolyn Chan: When possible, I like to send the prescription to the hospital discharge pharmacy just because I know if there is an issue, I'm going to get contacted. I do have a sense of common challenges that happen for patients who are on Medicaid or I provide care in a city that borders on three states that have different rules. Over time, I do think we learned some of these and, you know, if you're supervising learners, you really should be thoughtful and sort of coach them through some of these things. Cause I do think after a while we're like, "Hey, we know that we're going to have X problem with combination product or model product with this insurance."

So, sort of trying to keep track of that and confirming, again, that things go through when possible is key. And also, even when we're thinking about discharges to nursing homes, there can be some details that are really important, right? Like, "Hey, if it's the nursing home doctor who is going to take it over, but they only come in on Wednesdays, how long should I send the prescription before that doctor comes in?" Some field facilities say, "Hey, no, we always just use X pharmacy for everything. We don't want any bridge scripts. It's going to be sent, you know, here, and this is how we do it because this is how we deliver it, et cetera." So, I think really working closely with the case manager to clarify the details of prescription delivery, to the nursing homes and how that process works is important.

Dr. Stephen Holt: And how does that change when you're talking about methadone and trying to continue that, and you're discharging a patient on a Friday to an STR? Like, how do you guys get around those particular challenges?

Dr. Shawn Cohen: Methadone comes with its own bag of regulations that do make it harder, definitely, for nursing facilities to take people with methadone. But I think some of that is [that]

they make it easier for them to say, "We can't provide methadone because there's too many barriers to it."

And so, there's lots of steps, I think, that nursing and relationships like nursing facilities need to know the OTP, be able to get methadone delivered, or there are situations where nursing facilities can open up a satellite OTP location within the nursing facility and just provide methadone that way.

So there are ways to do it, but I think it relies on not only building relationships, but a lot of coordination between the nursing facility and an OTP eventually. But for the specific on the Friday discharge, I think there was a period of time where we would just wait till Monday because we just didn't have an avenue.

But there is now the 72-hour rule, which is a way that hospitals and, in some cases, outpatient clinics can dispense but not prescribe. And so that's like fill methadone for up to three days from like an inpatient pharmacy through the Pyxis or through the inpatient pharmacy that you can then hand to a patient to leave with, whether that's to a nursing facility or to the community. There's a couple of good papers that we can maybe link in, show notes and stuff like that, let's talk through how to actually implement that in your care setting too.

Dr. Carolyn Chan: And I want to pause and actually just do a high-level overview in case some folks may be working in places that have really low-level access to methadone. So, just to sort of remind everybody that methadone for opioid use disorder cannot be prescribed via a prescription.

You can prescribe methadone for pain, but not for opioid use disorder. So, methadone for OUD has to come from an OTP, which stands for an Opioid Treatment Program. So, what this means is if a patient is going to be discharged, they have to essentially be able to start methadone at an OTP the next day of discharge and get it often delivered to their nursing home.

So, often what this means, if it's a patient who has newly started methadone. So, I think it can vary a little bit if somebody's already been established at a methadone clinic and it's more continuation of care, but if it's a brand new start, they have to be discharged on a day in which the methadone clinic can do their intake often, not always, but like the next day. Different methadone clinics have different hours for intakes, just in the same way that different clinics have different hours for which they can see patients.

So, you often have to coordinate with the clinic to say, "Hey, when can this person come and do their assessment and their physical exam and start the methadone?" And then the second piece is nursing homes very rarely. Actually, I don't know of any in my area. They don't actually bring the patient every day to get dosed for methadone.

What they do is something called chain of custody, which is what you referenced, Shawn. So, essentially, either the nursing home on the first day will send somebody with the patient and they'll sign forms and then seven days of methadone is often handed to the healthcare facility worker and then they dispense it at the methadone clinic rather than having them come dose every day.

And I think that methadone clinics, you said, Shawn, too, in your area, they'll deliver it to nursing homes?

Dr. Shawn Cohen: Some of them. Yeah, there's a couple of different ways to do this. And so, I think some deliver it. Some of the patients have to go. There's one methadone clinic that basically has an office in one of the nursing facilities, and so they can actually see patients there and dispense the methadone there. So, there's different avenues that have different amounts of barriers too.

But there is more leeway in the newer updates to the methadone regulations in terms of clinics being able to, if you have a relationship with a clinic, them being able to use your physical exam and some of your information to be able to dose someone for a couple of weeks before they do a full formal intake at the OTP, but everything in addiction med, because the process is a little complicated and there are so many barriers often, so much of this is knowing your resources, having relationships with your OTPs, with your nursing facility administrators, with your intake people so that you can help kind of connect people together and, figure out a plan to try to help the person in front of you.

Dr. Stephen Holt: Thanks for that. Let's talk about, you know, there's an increasing prevalence or increasing access to extended-release buprenorphine options at the time of discharge.

So, for you guys, when you decide that, you know, getting a person on XR bupe on the day of discharge is something you want to do. It's good for the patient. You know, it's going to keep them safe for whatever stretch of time. Do you always make sure that you have a follow-up plan and that you have somebody 30 days from now who's going to take over? And how do you guys manage that? What's sort of your approach to XR-BUP on the day of discharge?

Dr. Shawn Cohen: Yeah. I mean, I feel plus and minus about this because it's much easier, I think, for a nursing facility to be able to continue a med, they can prescribe, but I think like if XR-BUP is what this patient wants and what they feel like is best for them and we feel like it's best for them, I think they should get it before discharge.

But I think a lot of it is knowing your community the clinic that they're going to follow up in and I think we often like turf a lot of follow-up care when someone's at a SNF to figure out after the fact, but I think this is one of those times where you're like you have to be proactive and either

make sure they already have a follow-up appointment that the nursing facility is aware of that is considered like a specialty appointment with an addiction provider so it's not primary care that the nursing facility covers and that that clinic is willing to either get an appointment a couple weeks before so they can order the next bup shot or they're willing to pre-order it on essentially your words if this patient's going to show up And then I, and again, like as you can tell I'm probably a little neurotic, but I, in these cases where I'm worried about transitions, I will send myself an EPIC message, like four weeks from now to remind myself that this is going to fall through the cracks. And so please double-check that it didn't fall through the cracks.

Dr. Carolyn Chan: Similar, I will offer to pre-order it, especially if the patient's going to come to a clinic in our system, just because I know that it often has to go to a specialty pharmacy, so it's not quite like sublingual be aware of the expectation is, many pharmacies have it and if one doesn't, you can usually find another one pretty quickly to get the same day, but it will often take like one to three days to get shipped, assuming that there's no holiday and you know, nothing crazy going on. So I really think about that I really agree that I try and schedule them ahead of time and Let the nursing home know what the appointment is for so they don't think that it's like, "Oh, this is a random primary care appointment that I can just cancel because we already have somebody managing that."

Being very clear on what the purpose is because sometimes stuff happens, right? And people, for whatever reason, aren't able to get to their appointments when they go to a nursing home. I also think that if I'm starting it on discharge for the first time, it's pretty common for people to need additional sublingual buprenorphine during that first month.

So in my practice, I definitely counsel patients on that expectation, will encourage, and actually usually prescribe like eight milligrams as needed, PRN daily for patients on top, just to sort of help manage any cravings that may happen until that medication gets to steady state, which can also be confusing to the nursing facility, right?

Dr. Stephen Holt: Yeah, I was just thinking that. I mean, it's, it's tricky enough sometimes for us to give that out, even though I think we're more and more often doing that, but I could just imagine, like, so here's a PRN medication that maybe they won't need for about two weeks, and then all of a sudden they'll want to use it on a daily basis, and by the fourth week they might ask for it twice a day, and that is tricky, especially if you don't even know how long they'll stay, you know, how long they'll be at STR, you know. Well, I wanted to pivot a little bit to change gears and talk about, to what extent do you see providers engaging with family members or caregivers or other people in this patient support system, as important to, ensuring a good transition of care.

Like, do you ever touch base with, obviously in a HIPAA-appropriate way, your patients' significant others or family members, support systems, et cetera, to help this?

Dr. Shawn Cohen: I mean, I leave it up to the patient always. One, I think we have to, based on 42CFR and all that stuff, but two is I'm never going to try to engage a family member, caregiver, whoever, someone important to this patient behind their back to try to push something that I want or the family member wants, and so I would say if the patient feels like, for us to build a plan that works for them, whether that's at the nursing facility or just an outpatient plan where we're trying to help with a transition of care and they know that like, I'm going to be around this person a lot and they can kind of help ensure that I remember my follow-up appointments and that kind of thing then yeah, I'm definitely going to call that person or have them come into the hospital and sit down and kind of talk through things and write things out for them too.

I think we underestimate how confusing hospitalization and transitions of care when they're here for cellulitis and they also have a new diagnosis of diabetes and they just got started on bup and there's 15 different new medications that are at 3 different pharmacies and clinics at 3 different sites and how are they going to remember which clinic is the buprenorphine clinic, right?

And so, I think as much as they're interested in and engaging people to help make sure the plan works out, I think is important.

Dr. Stephen Holt: Yeah, that makes a lot of sense. Especially like you said, those patients who have to see a cardiologist, an infectious disease doctor, a cardiothoracic surgeon, God forbid, the addiction medicine provider having another party, helping with that, with the patient's consent, it makes a lot of sense.

Returning back to your comments earlier about stigma and nursing homes or short-term rehab places being somewhat resistant to accept our patients with substance use disorders. Do you see a role at all for staff education, at nursing facilities? And to what extent can educating other providers, be they nurses or other staff at nursing facilities, can that help to grease the wheels, so to speak, so that they're a little bit more willing to accept patients with substance use disorders? Any thoughts on that or an experience in that space?

Dr. Shawn Cohen: I have been, like, a very small part in a bigger movement towards getting some nursing facilities in the area I work to start accepting people, but I think the bigger reason that things change was because there was a person within a nursing facility that became a champion for this type of thing and part of their being a champion was making all the relationships with one, consult services, but two, OTPs people in the nursing facilities and them internally I think doing education starting to take these patients and showing that the world isn't going to end. These are just normal human beings that need help. And so, I do think someone within the system to change, it goes a lot more than the external someone wagging their finger. But that being said, I think that pressure to change things, and I don't want to paint all nursing facilities as these terrible, stigmatizing places.

I think it's more of a societal thing that we often stigmatize substance use disorders and that pervades all these institutions we work at. But I do think that to really change things, you often have to go from multiple avenues. And so that's internal change agents, pressure from regulatory authorities that this is clear discrimination if it's needed, like, pressure from the legal aspect to say, like, this is illegal that you're doing, and I think in Massachusetts, there have been a ton of settlements with nursing facilities that were declining people on MOUD because of that, and I think all those things, I think, together, eventually changed the system.

Dr. Carolyn Chan: And for people who are trying to do that locally, be patient. Don't be frustrated. It takes time. Similar to harm reduction, right? We talk about any positive change, you know, and acknowledging that, like, sometimes things get better, like smaller incremental ways, and that is still really valuable.

And those efforts are worthwhile. So, it can be really frustrating to work in this space and to be an advocate in this space. I think many of us here have experienced that, right? But keep at it, be flexible, build relationships, and just be persistent, you know, and work with people. And if they're going to give you a movement on something small, take it and just start there. And just kind of try and keep moving forward, one step at a time.

Dr. Stephen Holt: So, can you think of a success story, you know, for like a challenging situation, much like the one that I just outlined at the beginning of this episode. You know, an example of effective MOUD discharge planning, despite all odds, that could potentially inspire some of our listeners.

Dr. Shawn Cohen: Fortunately, I will say I think some of the MOUD discharge from planning that goes well as an inpatient doc, like the ones that go well, I never hear about, which is probably good because I don't see them again. Right.

Dr. Stephen Holt: That's true. Yeah.

Dr. Shawn Cohen: The ones that I like that always come back to me are the ones where, like all those layers of Swiss cheese, like one of the layers caught somebody. And so it winds up working out of like patient who went to a nursing facility, leaves the nursing facility, but wound up having the consult service phone number and so calls the consults because we have like a landline I know very weird, but we have a landline in our office and calls the consult service phone number. We give them a bridge script, I messaged Steve, he gets them in two weeks, and then like, you know, happy story. Those are the stories that stick with me, is like, the patient trusted us, found a way to, with all the kind of extra layers we tried to add, found a way to make it work.

Dr. Stephen Holt: I love that. Like somehow at least the patient held on to that little, you know, little business card with y'all's number on it. And that was a sufficient little bit of safety net. Carolyn, I don't know if you had a similar type of situation you wanted to describe.

Dr. Carolyn Chan: I want to describe a scenario, just to remind people that there are places that have methadone clinics associated with their healthcare system. So, we had just a challenging scenario where a patient, just due to medical conditions, was just like unable due to acute medical process to actually, like, get even in a wheelchair into the OTP.

So, they're essentially bed-bound again due to ongoing medical issues. So, we just did the intake in the hospital. I'm lucky that we have a healthcare system that has a methadone clinic. So, we actually developed a process where we just did everything in the hospital for them as a new patient, which is very unusual. Though, again, looking at ways to be creative, that was kind of cool. And again, to sort of align with what Shawn says, like this idea, the biggest gap I see is what happens after the nursing home? There's just so much that has gone on for that patient. So much time has passed. Like, really, anytime a patient shows up after a nursing home to my clinic, I'm, like, ecstatic.

I'm like, yes, you made it here. Like, they're all successes. but like trying, sometimes what I'll do is like our office also has cards, like we'll encourage people to take a photo of it on their phone. And, if they lose all their paperwork, hopefully they can, like, pull up the number and their phone really to care re strategize.

So sometimes again, we'll get calls as well and can help a patient be like, "Where was I supposed to go again? You know, like, "By the way, now I'm like two hours from where I thought I was going to be. What do I do?" Like, where are you staying, sir? Like, that is very different than the last plan.

Dr. Stephen Holt: Nice. So, let's start to close out here, and we'll get some key takeaways. Let's first revisit our case that we started with.

So again, we had a 64-year-old gentleman, newly diagnosed OUD with chronic pain. He had fallen down the stairs and sustained a hip fracture. And now, after having had his ORIF of his hip, he is getting ready to go to short-term rehab and is experiencing some barriers, and vis a vis, some limitations on buprenorphine access at the facility that it was going to and outpatient prescribers who aren't game with prescribing it.

So, take home points here, just to summarize on things that we have gone over during our talk today, Shawn, can you give me sort of your first key point on what we've talked about and how it applies to the patient that we've introduced?

Dr. Shawn Cohen: Yeah. I mean, I think about like, I mean, one, and I think you brought this up, Steve, is like embrace your role as, not a big, big time advocate and going to Washington D.C., but as this like local advocate that can build relationships, get to know your local nursing facility administrators, intake people, buprenorphine clinics so that you're able to be that person that can talk to everybody and kind of help smooth the road for this patient and plug the holes where they wind up coming or provide the prescriptions where they're needed.

Dr. Carolyn Chan: I feel like that summarizes it up so well. Also, be familiar with the details of your health system and plan, right? Think about the specifics of the buprenorphine. Where is it going to go? Is it going to need a prior auth? Is there a way I can call and confirm if there's any uncertainty in terms of whether a patient is actually going to be able to fill it when they show up.

Dr. Stephen Holt: Awesome. All right, well, thank you all for tuning in to ASAM Practice Pearls. I again want to thank our distinguished experts, Drs. Carolyn Chan and Dr. Shawn Cohen for sharing their invaluable insights on overcoming these common barriers that we see with our patients with MOUD at the time of discharge.

For more information on buprenorphine implementation, check out ASAM's new Advanced Buprenorphine Education Series, which focuses on addressing common challenges in hospital and clinic settings. Remember to subscribe and share this episode with colleagues who may find this information helpful. We'd also love to hear your thoughts.

What challenges have you faced in ensuring continuity of care during patient transitions? And what solutions have worked for you? Be sure to comment and join the conversation. Otherwise, thanks for listening, and we will see you next time on ASAM Practice Pearls.