Tip 6: Transitions of Care

Description

Care transitions are when a patient or resident moves from one health care provider or setting to another.[239,240] To have a safe, successful transition of care, providers must share good and timely communication of clinical information so that the downstream clinicians can assume responsibility for resident care. By fostering an atmosphere of clear communication between health care providers or settings, improvement can be seen in resident outcomes, resident satisfaction, and decreased cost.[241] This communication can be crucial for those residents with OUD and StUD. Coordinated care for complex chronic conditions has repeatedly shown a positive influence on disease progress; treatment of OUD is no different.[242] This section will discuss the steps needed to facilitate a successful transition of care for a resident with OUD and StUD while highlighting the key documentation needed between health care providers and settings.

Goal

This section aims to help LTCFs establish thoughtful and safe transitions from the hospital to the LTCF while maintaining communication with the resident's physician or other health care provider, OTP or OBOT/OBAT, as well as safe transitions from the LTCF after discharge.

Aftercare programs and community support groups are crucial in helping those with SUD manage their addictions while striving to make essential life changes. Thus, another goal of this section is to ensure that LTCFs are facilitating connections with community resources for those in need of behavioral therapy.

Objectives

At the end of this section, participants will be able to:

- Identify key steps in discharging persons on MOUD or behavioral therapy for StUD from the hospital to a LTCF.
- Identify key steps for discharging these residents from a LTCF.
- Establish processes to communicate with key partners in caring for residents on MOUD, including OTPs, OBOTs/OBATs, hospitals, and community-wide services.
- Provide examples of forms and templates that your LTCF can utilize during the transition process.

Policies

- Incorporate safe transitions of care from hospital to LTCF, with connection to OTP or OBOT/OBAT into your policies.
- Incorporate safe transitions of care from the LTCF to a facility or community, with connection to OTP or OBOT/OBAT into your policies.
- Incorporate safe transitions of care for residents with StUD from LTCF with connections to community resources for behavioral health therapy into your policies.

Process

Process for Transitions of Care from Hospital to LTCF for Residents Treated with Medication for Opioid Use Disorder

The links below bring you to the flow diagrams for each of the following treatments.

- Appendix 4 Resident is on methadone maintenance (*only for residents on methadone maintenance*)
- Appendix 5 Resident is newly inducted on methadone (*only for residents newly inducted on methadone*)
    - Note: Residents newly inducted on methadone will require more coordinated efforts between LTCFs and the OTP. Be sure to reach out to your community OTP regarding their admission process. You must transport patients to OTP morning after they're discharged from hospital.
- Appendix 6 Resident is on buprenorphine (only for residents on buprenorphine or Vivitrol, newly inducted or maintenance)

Key Steps in Transition Process for Residents Treated with Medication for Opioid Use Disorder

Developing Qualified Service Organization Agreement

A QSOA is a two-way agreement between a SUD program (OTP or OBOT/OBAT) and an entity that provides services to the resident (LTCF). It authorizes communication between the parties and restricts the information they may disclose or re-disclose. The QSOA is used only by SUD programs that are subject to Federal Regulation 42 CFR Part 2. [243]

- QSOAs should be completed before admission to LTCF.
- QSOAs should include types of services QSO provides, medical services (counseling services, on-site call coverage, treatment plan, etc.).
- Discussions with LTCF and OTP/OBOT administrators should occur before admitting residents on MOUD.

Obtaining Release of Information

- Obtain a release of information (ROI) before discharge from the hospital.
- Forms must include resident signatures authorizing treating health entities to release protected health information (PHI) to other health entities. These forms help designate what information can be released. It may be helpful to include as part of the QSOA with the hospital, so forms are on hand.
- Hospital presents ROI for both LTCF and OTP or OBOT/OBAT to sign; LTCF confirms ROI receipt with OTP or OBOT/OBAT.
- Communication: case management or social worker at hospital connects with liaison/social worker at LTCF and OTP or OBOT/OBAT.

Opioid Use Disorder Agreement, If Applicable to Long-Term Care Facility

- Obtain the OUD agreement at the hospital discharge or upon admission to the LTCF.
- Obtain resident's written consent to share protected records with family or other caregivers. 42 CFR Part 2 requires resident's written consent before disclosing of protected records. Always obtain written consent and include specific information about the recipient of records and exactly what to share.
- Communication: case management or social work at the hospital connects with LTCF liaison.

Arranging Transportation of Person to Opioid Treatment Program

The following only applies to those residents on methadone and if no take-home waiver is in place.

- If requesting Prescription for Transportation (PT-1) services:
  - Note PT-1 services are available only to MassHealth beneficiaries.
  - Mass Health Medical Necessity Form needs to be completed. If possible, start at admission before discharge from the hospital (2-4 days to get approval). Hospital may request transportation if there is an area on the form for an alternate address.
  - Physician/clinician to request PT-1 transportation before hospital discharge, if possible (need to confirm approval to allow a provider to request a destination that is not the same as their own).
  - Notes: turnaround time for PT-1 approval is between 2-4 days; must be transporting within a 25-mile radius; if not within 25 miles, need to have justification; client/resident may be in the car with other individuals. Therefore, it may not be a quick roundtrip; LTCF must be an enrolled Medicaid provider and have Provider ID.
- Coordinate with OTP for best time for residents to arrive at OTP (look at synchronizing if multiple residents need to go to OTP).
- Other potential transportation options
  - Public transportation
  - Some are using UberHealth as a temporary measure while MassHealth approves resident's PT-1
  - LTCF own transportation (i.e., van)
- Communication: OTP/LTCF to communicate best time to pick up medication; LTCF Registered Nurse (RN)/Licensed Practical Nurse (LPN), OTP RN/LPN, and resident need to sign chain of custody form.

Arranging Transportation of Methadone to the Long-Term Care Facility

The following only applies to those residents on methadone with take-home waiver.

- Opioid Treatment Exception Request: Eligible residents may receive take-home medication from OTP, must submit for this at discharge from hospital.
- Process should be started at the time of admission.
- Diversion trained RN/LPN picks up the methadone with a locked container(s).
- Coordinate with OTP for best time, typically at the end of dispensing at the OTP, after the first pick-up, LPN/RN to bring back empties (look at synchronizing pick-up times if multiple residents have pick-ups).
- Once LTCF nurse arrives at OTP, OTP nurse will verify with LTCF contents before locking and confirm on chain of custody form.
- Once LTCF nurse is back at facility, document and confirm with resident that medications are in the box.
- Chain of custody form should stay with medicine and have initials that LTCF/OTP confirmed the medications count in the box; chain of custody should also go back with empty boxes.
- OTP/LTCF to communicate best time to pick-up medication; chain of custody form needs to be signed by LTCF RN/LPN, OTP RN/LPN, and resident.
- Notes:
  - LTCF should provide protocol training to diversion RN/LPN as to the full process.
  - Only for residents that can self-administer – per the OTP (medical take-home waivered residents).
  - As part of exception, request the destruction of unused methadone according to destruction policy. When resident leaves AMA or LTCF, work with OTP for diversion control, investigation, and sharing information.
  - Lock box for each resident, either resident's own lock box or one the LTCF provides.

Managing Pre-Poured Methadone

- LTCF to create an area to manage methadone within a double locked area, potentially locked in medication room; cabinet within the medication room locked; resident locked box inside. The management of pre-poured methadone at the LTCF needs to meet DEA criteria in that it must be stored under a double lock (e.g., door and safe), and separately from all other medications (on a separate shelf).
- Set-time for staff to give medications; locked box taken out of the med room brought to the resident room; resident unlocks and self-administers and relocks box; nurse to take lock box back to med room, relock in the med cabinet.
- Communication between nurse and resident; resident signs MOUD administration affidavit sheet.
- Notes:
    - LTCF may want to buy a lock box and training staff on what to look for regarding diversion.
    - Our recommendation: two nurses every shift would need to have the authority to open lock box.
    - Follow facility's recommendations on including in narcotics book.
    - If resident leaves AMA, alert OTP and destroy medications as mandated by federal regulations.
    - Naloxone: LTCFs must have a supply of naloxone on hand; know the signs of an overdose and how to administer. (See Tip 1 for directions.)

Self-Administration

- Should be completed at admission to LTCF and per policy (quarterly or per change in status).
- LTCF would need the self-administration form/assessment from the hospital before admitted; liaison or case Manager from the LTCF could do this at the hospital.
- LTCF does a self-administration assessment on admission and quarterly per guidelines/changes in status.
- For residents on MOUD at end-of-life, pain doctor can take over care and prescribe medications. Pain doctor would need to write an order for comfort. Methadone would come from pharmacy for pain.
- Communicate with hospital during the discharge process.
- Notes: educate staff on self-administration.

Discharge Planning

- Proceed with normal discharge process.
- Alert OTP or OBOT/OBAT of planned discharge and location.
- For buprenorphine: appointment scheduled at OBOT/OBAT day after discharge or plan for patient to have a script ready until appointment.
- For methadone: alert OTP with last dose letter.
- Connect resident with additional behavioral therapy services as needed, counseling, support services, etc.

Key Steps in the Transition Process for Residents Treated Through Behavioral Health Programs for Stimulant Use Disorder.

Arranging Connections to Behavioral Health Programs

- Determine what level of care is most appropriate for resident.
- Intensive Outpatient Programs (IOPs) are treatment programs for addictions that do not need detoxification or 24/7 supervision.
    - IOPs generally offer 10-hours of group and individual therapy weekly for roughly three months.
    - Connect resident with IOP prior to discharge and with input from resident, secure an outpatient appointment at a date and time the patient can attend.
    - IOPs Treatment Centers in Massachusetts
- Connect residents with support for substance use treatment and recovery prior to discharge. Provide resources and available options for treatment in their community.
    - The Massachusetts Substance Use Helpline[244]
    - National Alliance on Mental Illness[245]
    - Massachusetts Behavioral Health Access (MABHA)[246]
    - New England Region of Narcotics Anonymous[247]
    - SMART Recovery New England[248]
    - Peer Recovery Support Centers[249]

Education and Resources

- Institute for Healthcare Improvement: Situation-Background-Assessment-Recommendation (SBAR)[250]
- Healthcentric Advisors: Best Practices for Safe Transitions[251]
- Healthcentric Advisors: Project RED Video[252] and After Care Plan[253]
- DEA Office of Diversion Control: Drug Disposal Act LTCF Fact Sheet[254]
- Appendix 13: Additional Resources

Implementation: Key Points

Tip 6:	Transitions of Care
Policies	1. Incorporate the following into your policies: ▪ Ensuring safe transitions of care from hospital to LTCF with connection to OTP or OBOT/OBAT. ▪ Ensuring safe transitions of care from LTCF to community with continued treatment. ▪ Ensuring safe transitions of care from hospital to LTCF with connections to behavioral health programs for residents with StUD. ▪ Ensuring safe transitions of care from LTCF to the community with continued treatment.
Interventions	***Topic and Potential Staff***
QSOA	☐ **Administrators or Directors** ▪ Complete QSOAs prior to admission to LTCF and include types of services QSO provides and medical services (e.g., counseling services, on-site call coverage, and treatment plan). ▪ Discussions between LTCF and OTP or OBOT/OBAT administrators should occur prior to admission of residents on MOUD. ▪ Discussions between LTCF and behavioral health programs should occur for residents receiving or in need of treatment for StUD. ▪ See QSOA example: Appendix 7.
Obtaining ROI	☐ **Case Management or Hospital's Social Worker** ▪ ROI should be obtained prior to discharge from hospital. ▪ Hospital presents ROI for LTCF, OTP or OBOT/OBAT for resident with OUD, and behavioral health program for resident with StUD to sign; LTCF reaches out to OTP or OBOT/OBAT, and behavioral health program to confirm ROI receipt. ▪ Hospital's case management or social worker connects with LTCF's liaison or social worker for OTP, OBOT/OBAT, or behavioral health program for resident with OUD or StUD. ▪ See ROI Example Appendix 8.
Arranging Transportation of Person to OTP	☐ **Clinician (if requesting PT-1), Case Management, or Social Work** ▪ The following only applies to residents on methadone and if no take-home waiver is in place: o Determine type of transportation: PT1, UberHealth, LTCF's own van, etc. o OTP/LTCF to communicate best time to pick up medication. The chain of custody form needs to be signed by LTCF and OTP's nurse or licensed practical nurse as well as the resident. ▪ View the PT-1 Request Form. ▪ View the Medical Necessity Form for non-ambulatory residents (Appendix 9).
Arranging transportation of methadone to LTCF	☐ **Diversion-Trained Nurse or Licensed Practical Nurse at LTCF and OTP** ▪ The following only applies to those residents on methadone with take-home waiver o Coordinate with OTP for best time (either at end of OTP's dispensing). Nurse brings back empties. Coordinate pick-up times with multiple residents. o Once LTCF nurse arrives at the OTP, OTP nurse will verify with LTCF nurse the contents prior to locking and confirm on chain of custody form. o Once LTCF nurse is back at facility, document and confirm with residents that medications are in the box. o Chain of custody form stays with medicine and have initials that LTCF/OTP confirmed the medications count of box. Chain of custody goes back with empty boxes. o OTP/LTCF to communicate best time to pick-up medication. Chain of custody form needs to be signed by LTCF and OTP nurse or licensed practical nurse and resident. ▪ View Chain of Custody Form (Appendix 10) and Chain of Custody Record (Appendix 11).

Tip 6:	Transitions of Care
Managing Pre-Poured Methadone	☐ **Medication Nurse and Resident** ▪ LTCF to create an area to manage methadone within a double locked area. ▪ Set-time for staff to give medications; locked box taken out of the med room brought to the resident room; resident unlocks and self-administers and relocks box; nurse to take lock box back to med room, relock in the med cabinet. ▪ Resident signs MOUD Administration Affidavit Sheet. ▪ Naloxone: LTCFs must have a supply of naloxone on hand. ▪ View MOUD Administration Affidavit Sheet.
Self-Administration of Methadone	☐ **Liaison or Case Management** ▪ Should be completed at admission to LTCF and per policy (quarterly or per change in status). ☐ **Clinician at Admission** ▪ LTCF would need the self-administration form/assessment from the hospital before admitted; liaison or case Manager from the LTCF could do this at the hospital. ▪ LTCF does a self-administration assessment on admission and quarterly or per guidelines/change in status. ▪ Communicate with hospital during the discharge process. ▪ View the Facilities Self-Administration Assessment (Appendix 12).
Discharge Planning	☐ **Case Management, Social Work, or Discharge Planner** ▪ Proceed with normal discharge process. ▪ Alert OTP or OBOT/OBAT of planned discharge and location. ▪ For buprenorphine: appointment scheduled at OBOT/OBAT day after discharge or plan for patient to have a script ready until appointment. ▪ For methadone: alert OTP that a last dose letter is needed. • Connect resident with additional behavioral therapy services/ IOP, as needed, counseling, support services, etc.
Regulatory Information	Federal and state regulations require facilities to assess for self-administration of MOUD. Federal and state regulations require double locking. **Federal regulations at 42 CFR 8.12:** Federal opioid treatment standards[255] Unsupervised or take-home use, which identifies the following eight-point criteria: 1. Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol 2. Regularity of clinic attendance 3. Absence of serious behavioral problems at the clinic 4. Absence of known recent criminal activity, e.g., drug dealing 5. Stability of the patient's home environment and social relationships 6. Length of time in comprehensive maintenance treatment 7. Assurance that take-home medication can be safely stored within the patient's home 8. Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion