

Strategies to Support Direct Admissions from Hospitals to OTPs

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Presenters



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POLL

Session Objectives

By the end of this session, participants will be able to:

1. Describe how direct admission processes work within the presenting organization's model.
 2. Identify the roles of hospital staff and OTP staff in supporting an efficient and coordinated direct admission process.
 3. Outline the steps involved in direct admissions, including communication workflows, documentation needs, and the systems used to support coordination.
 4. Identify ways to maintain ongoing collaboration and professional relationships between hospitals and OTPs beyond individual patient admissions.
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Lowell General Hospital

Services:

- Medication management for SUD
- Recovery coaching
- Social work support
- Referrals & resources
- Transportation to detox
- Connection to inpatient and outpatient treatment
- Addiction consult services (hospital wide)

Bridge to Recovery Program

978-934-8494

Hours: 8AM-5PM

33 Bartlett St, Suite 108

2 Hospital Dr, Saab Building
Lowell, MA, 01852

Acadia Healthcare

General Services:

- State Opioid Response (SOR) grantee
- Community Liaison on staff
- Traditional OTP services
- Medication management for SUD
- Counseling

SOR Funded Services:

- Outreach
- Food
- Housing
- SOR room
- Uber Health for transportation
- Enhanced clinical services (yoga, art therapy, animal therapy, gardening etc)

Discharge is a High-Risk Moment

- Overdose risk is highest in first 2 weeks post-discharge.
- Patients started on MOUD inpatient may risk destabilization if connection to care not streamlined.

Failure of the system, not of the patient

Direct Admission is Allowed and Encouraged

- No regulatory barriers in Massachusetts or federally
- Governed by 42 CFR Part 8

Admissions	<p>The final rule eliminates the 1-year opioid addiction history requirement and promotes priority treatment for pregnant individuals. It also removes the requirement for two documented instances of unsuccessful treatment for people under age 18. Allows consent to be obtained electronically. In addition, medication access is no longer contingent on receipt of counseling.</p> <p>The final rule also allows screening examinations to be performed by practitioners external to the OTP under certain conditions.</p>	Removes unnecessary barriers to medication access by focusing on individual patient needs. Adds protections for vulnerable groups.
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April 4, 2024, Revised on July 24, 2024, Revised on July 31, 2025
<https://www.mass.gov/doc/dph-bsas-revised-waiver-from-certain-regulatory-requirements-and-guidance-42-cfr-part-8-and-105-cmr-164000-1/download>




42 CFR Part 8- 164.305 (C): Assessment and (D): Initial Medical Exam

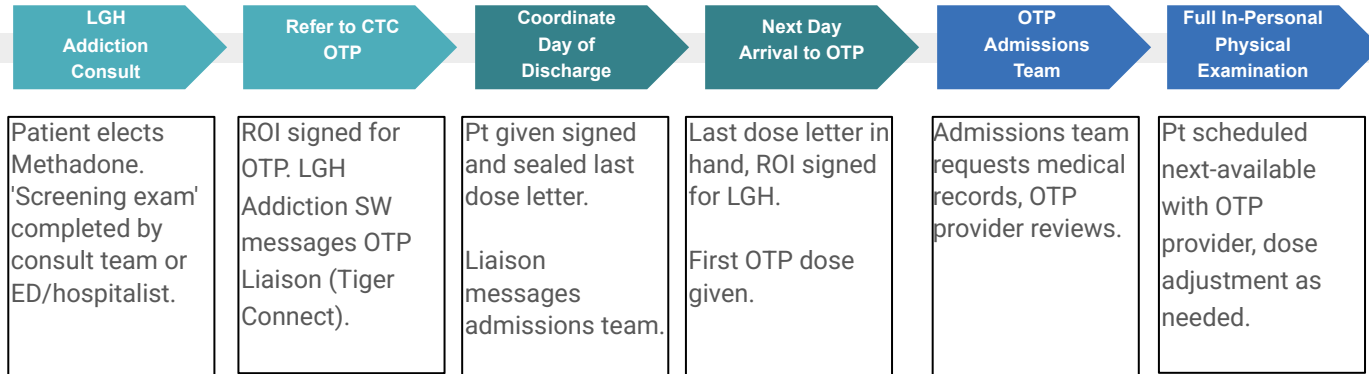
- In accordance with the new federal OTP regulations 42 CFR § 8.12 (f)(2), **it is the Department's expectation that OTPs shall require each patient to undergo an initial medical examination.** The initial medical examination is comprised of two parts:
 1. A **screening examination** to ensure that the patient meets the criteria for admission and that there are no contraindications to treatment with MOUD; and
 2. A **full history and examination**, to determine the patient's broader health status, with lab testing as determined to be required by an appropriately licensed practitioner. A patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to treatment, provided such refusal does not have the potential to negatively impact treatment with medications.
- **Assuming no contraindications, a patient may commence treatment with MOUD after the screening examination has been completed.** Both the **screening examination** and full examination must be completed by an appropriately licensed practitioner as defined in 42 CFR § 8.2 and 164.005.

If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner.
- A **full in-person physical examination**, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP.

Clinical and Regulatory Minimums

- DSM-5 OUD diagnosis
 - Evidence of opioid tolerance
 - Medical evaluation (may rely on hospital H&P or consult)
 - Informed consent and treatment plan
 - PDMP review (MassPAT)
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Lowell General OTP Workflow



Benefits of a Community Liaison

Sharing hospital feedback with CTC

- E.g. dose confirmation after hours – Now after-hours line for medical staff 24/7

Ease of admissions, communication prior to the direct admission, scheduling

- Advocated for Mon-Fri same day intakes

A direct contact, "go-to" staff to address barriers in accessing care

- Mental health concerns, social needs, medical complexities etc.
- Making OTP aware of possible transportation barriers ahead of time
- Health needs to be utilized prior to PT-1 transport being active/ available to the patient

A partner to brainstorm ideas with to continue improving processes



Current CTC Locations with SOR Funding/ Liaison Role

Each liaison role may operate slightly differently based on area, clinic goals, patient needs, and function. We encourage you to reach out to your local CTC to learn more!

- Springfield
 - Fitchburg
 - Lynn
 - Lawrence
 - Lowell
 - New Bedford (Gifford St)
 - Fall River
 - Yarmouth
 - Wareham
 - Taunton
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Maintaining Ongoing Collaboration

- **Attending community meetings**
- Local methadone clinic having **LGH ROIs completed during their intake process** to make dosing verification and ongoing collaboration during patient hospitalizations simple/ quick
- **Providing updates** to our liaison if something could've gone smoother
- **Tiger-texting** if there is a complex patient that may benefit from an in-person liaison visit or support call
- Support with **arranging guest dosing** from Lowell General to a receiving facility (like an STR, CSS etc)

Addressing Barriers: No Liaison?

- Identify other roles within your local OTP that could have a similar function
- Request a care coordination meeting to discuss possibilities of collaboration

- Care Navigator
- Case manager
- Intake coordinator
- Admissions coordinator
- Nurse Manager
- Recovery coach
- Clinician of the day

Addressing Barriers: Workflow Optimization

Workflow Barriers

- Communication gaps from discharging hospital
- Intake scheduling constraints
- Insurance authorizations

Improvements to Consider

- Rely on strong partnerships with local hospitals and OTPs
- Educate hospitals to counsel patients
 - What to bring (last dose letter, ID, insurance card)
- Create availability of warm handoff for complex patients
- Create standardized plan for intake by OTP prescriber (e.g. appts reserved weekly for direct admits)

Addressing Barriers: Clinical Risk Mitigation

Clinical risks to consider

- QTc concerns, polysubstance use, overdose risk
- Possible lack of addiction medicine expertise at local hospitals
- 'Medical Complexity' and lack of communication

Consider standardized “hospital transfer packet”

- Discharge summary
- Last methadone dose (mg, time/date)
- Toxicology results
- EKG if available
- Contact information for prescriber (hospitalist, ED doc, or addiction consult team)

Discussion Topics

Does anyone use a similar process, or have alternative approaches that work well for your team?

What barriers are currently preventing you from implementing a more streamlined process?

Thank you!

Questions?

