Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Learning Session:
Supporting the needs of long term care residents receiving medication for opioid use disorder

SAMHSA

Abt

Healthcentric Advisors

MOUD IN LONG TERM CARE

Continuing Education

- This nursing continuing professional development activity was approved by Northeast Multistate Division, an accredited approver of the American Nurses Credentialing Center's Commission on Accreditation for 4.50 contact hours.

- This live activity, Medication for Opioid Use Disorder in Long Term Care Facilities Learning Session (01/21/2020 - 01/30/2020), has been reviewed and are acceptable for up to 4.50 prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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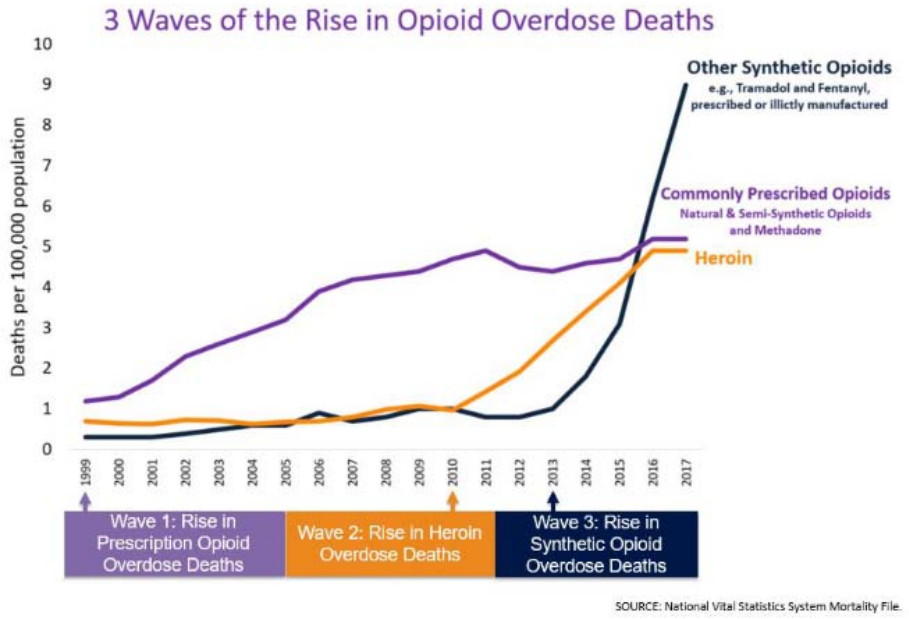
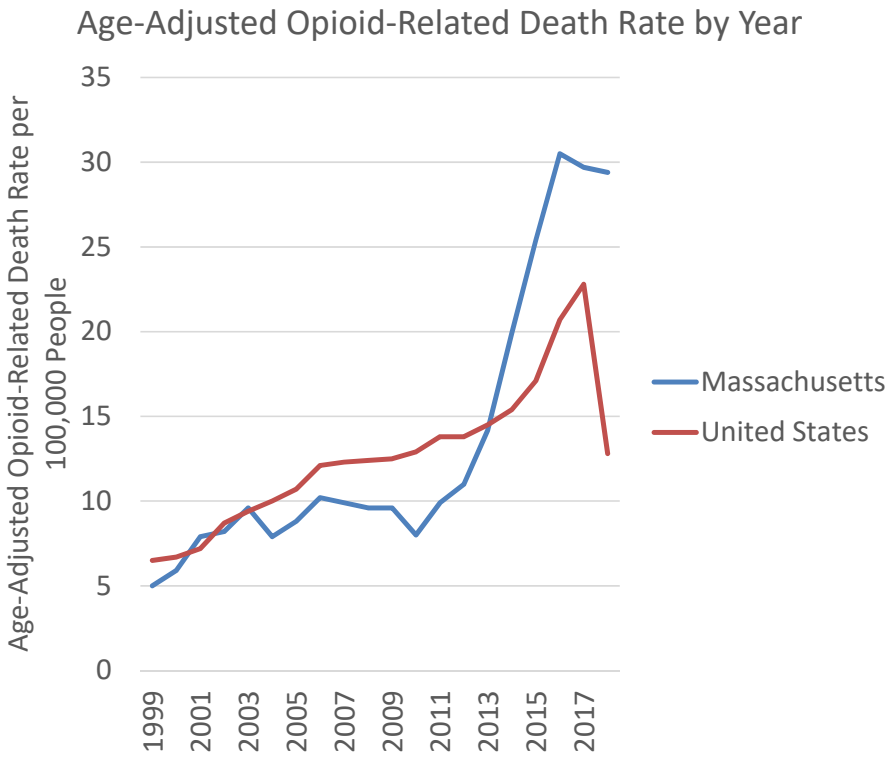
Call to Action

Marybeth McCabe, BA

Department of Public Health, Bureau of Health Care Safety and Quality

The Opioid Epidemic: Nationally and Locally

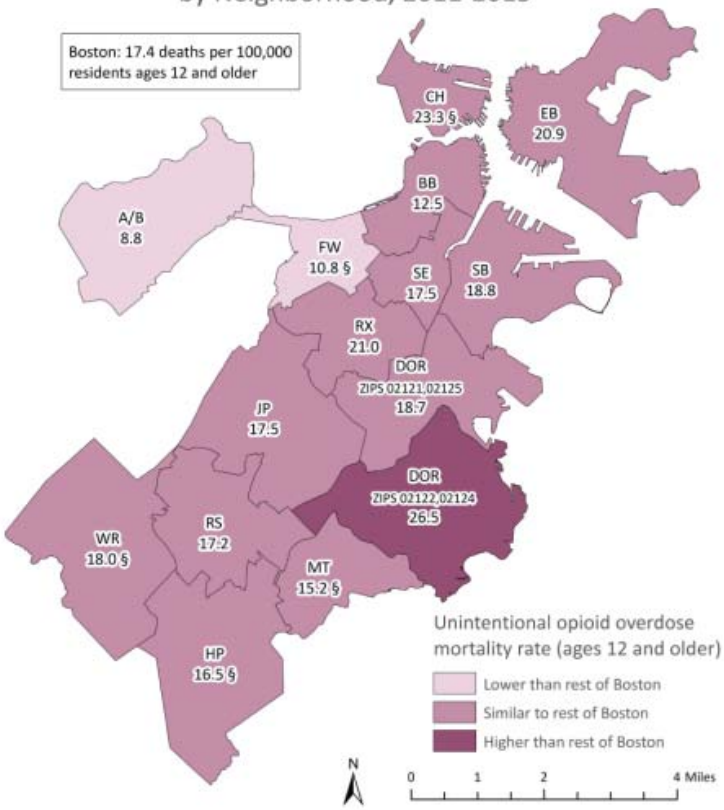




MA statistics from https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-november-2019/download; U.S statistics from CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Dec 26, 2019

Boston Community of Practice

Figure 14.21 Unintentional Opioid Overdose Mortality† by Neighborhood, 2011-2015



Mortality Rates from 2011-2015

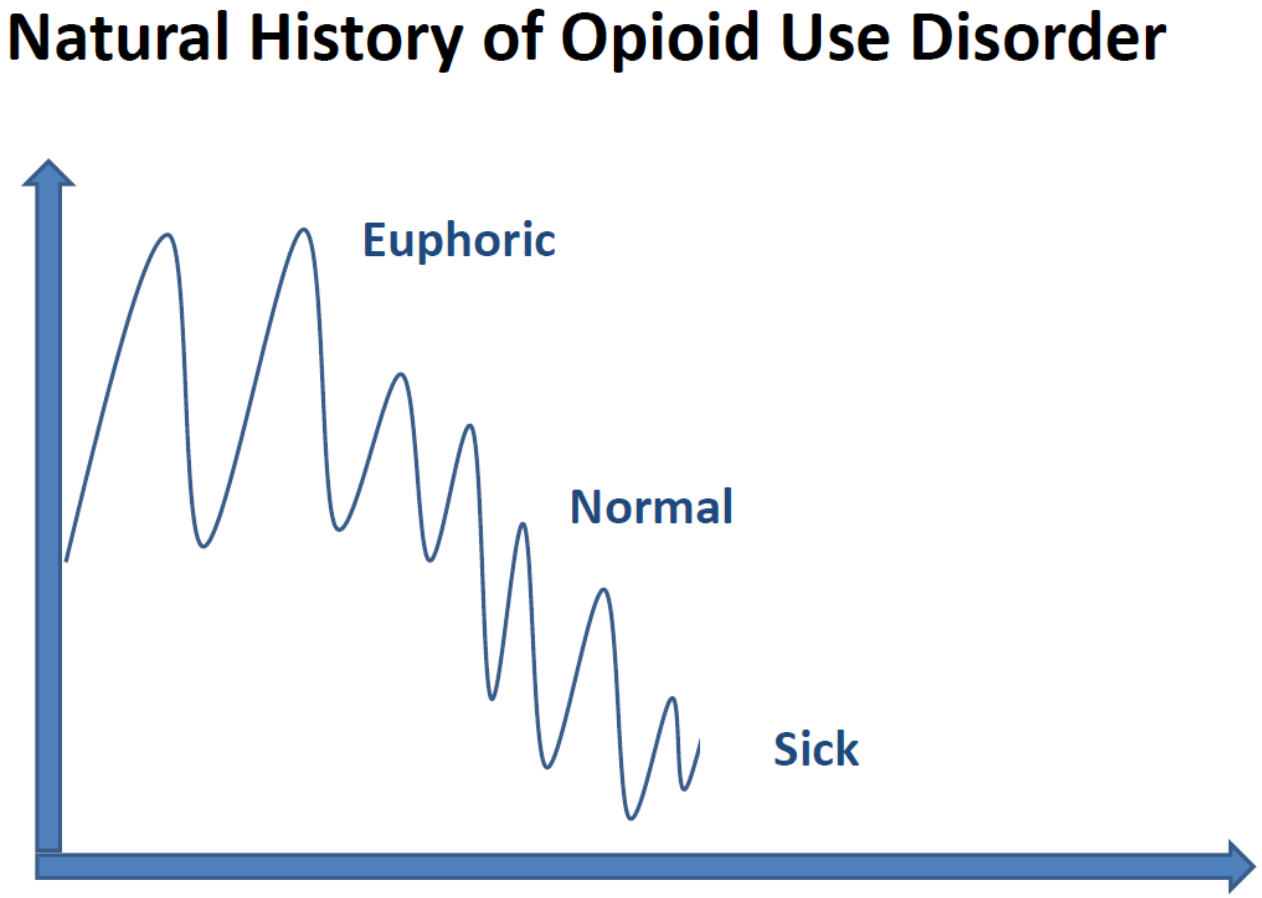
† 5-year average annual age-adjusted rates per 100,000 residents ages 12 and older
§ Rates are based on 20 or fewer cases and should be interpreted with caution.

NOTE: "BB" includes the Back Bay, Beacon Hill, Downtown, the North End, and the West End. "SE" includes the South End and Chinatown. Unintentional overdose includes overdose with undetermined intent. Unintentional overdose death totals for 2015 are likely an undercount due to deaths awaiting causal determinations. For more information see "Cause of Death Undercount" in the Technical Notes.

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health (data as of December 2016). Data may be updated as more information becomes available.

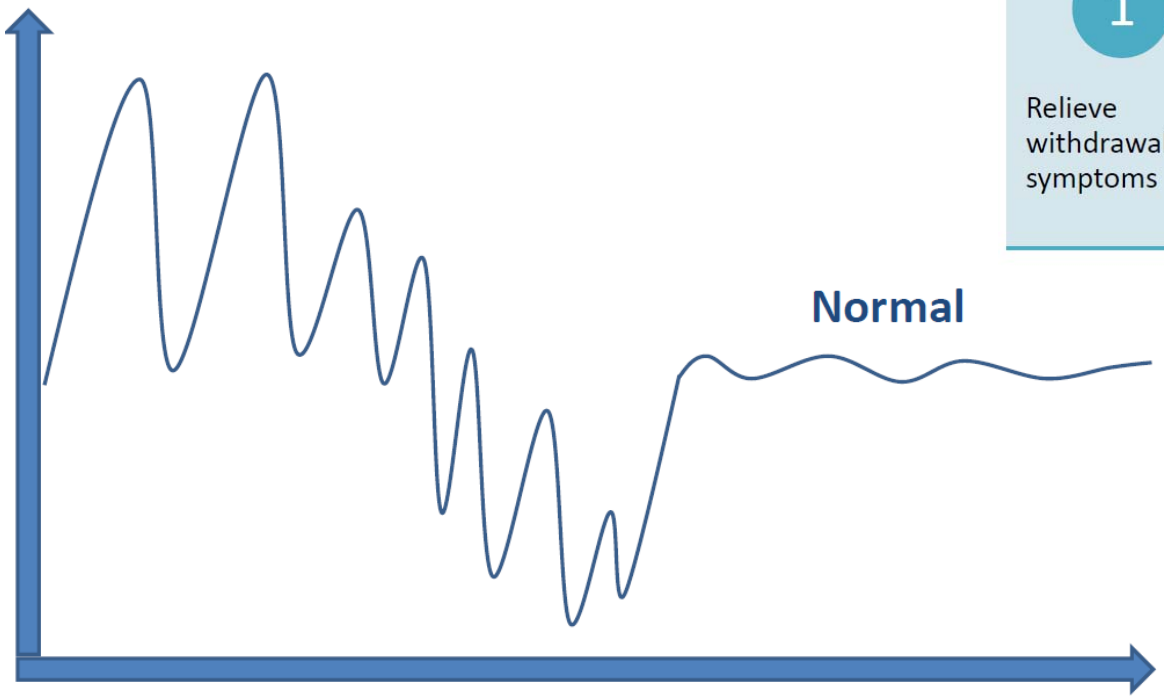
For 2011 to 2015, the unintentional opioid overdose mortality rate was higher for Dorchester (zip codes 02122, 02124) compared with the rest of Boston. The rate was lower in Allston/Brighton and Fenway compared with the rest of Boston.

Dr. Wakeman's Natural History of OUD



Dr. Wakeman's Natural History of OUD: Goals of Treatment Medications

Goal of Medications for Addiction Treatment

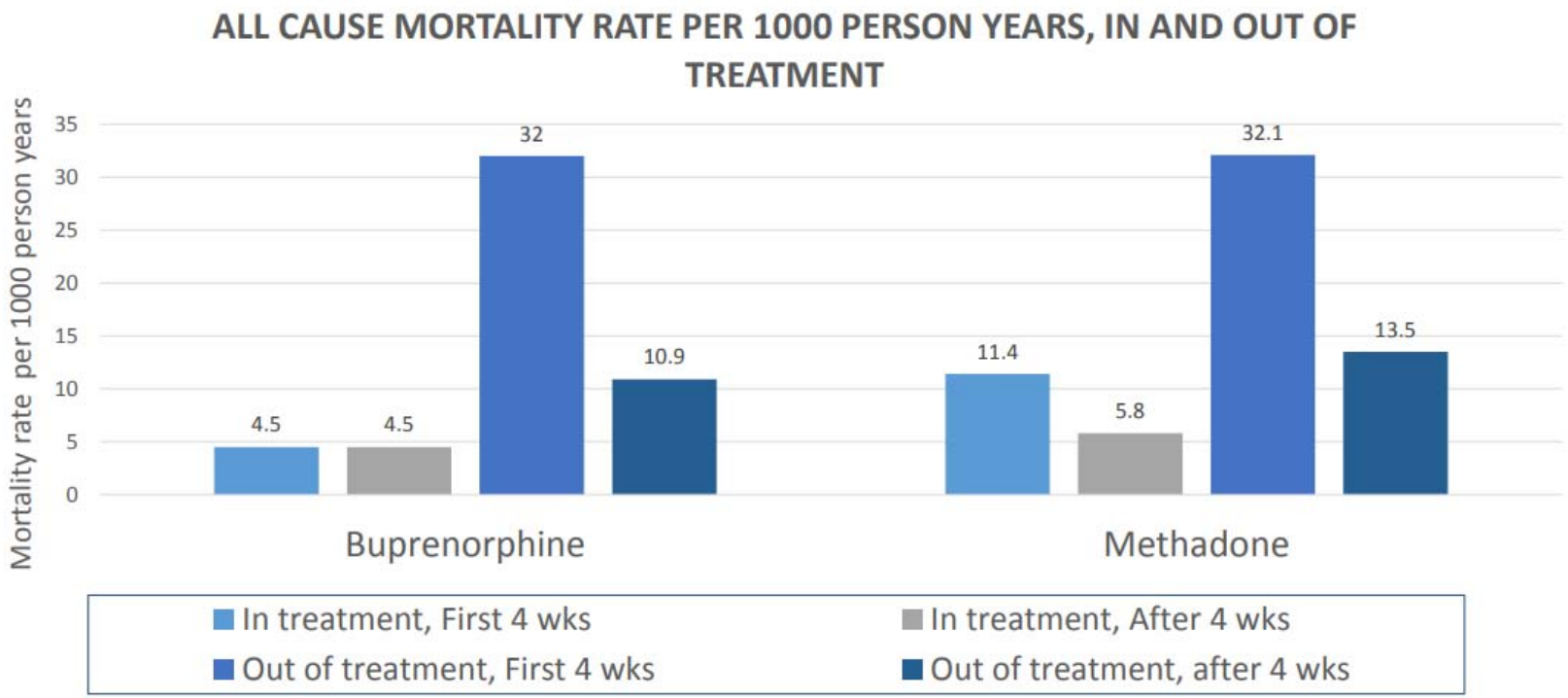


1. Relieve withdrawal symptoms
2. Block effects of other opioids
3. Reduce cravings
4. Restore normal reward pathway

MOUD is Effective and…

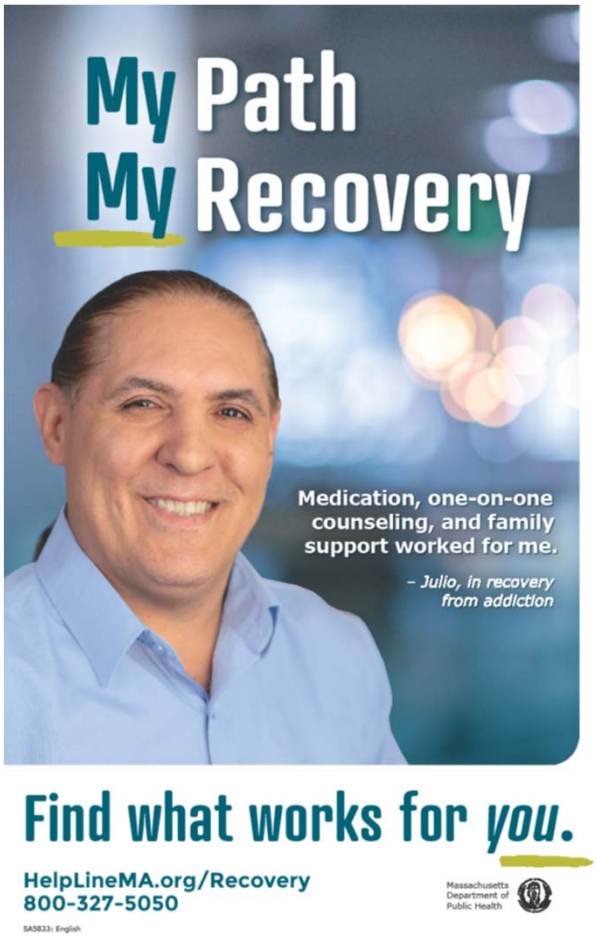
- **Similar to management of other chronic health conditions such as Diabetes or HIV**
  - No cure
  - Goal is to prevent acute and chronic complications
  - Individualized treatment plans and goals
  - Treatment includes:
    - Medication
    - Lifestyle changes
    - Regular monitoring for complications
    - Behavioral support

MOUD Saves Lives

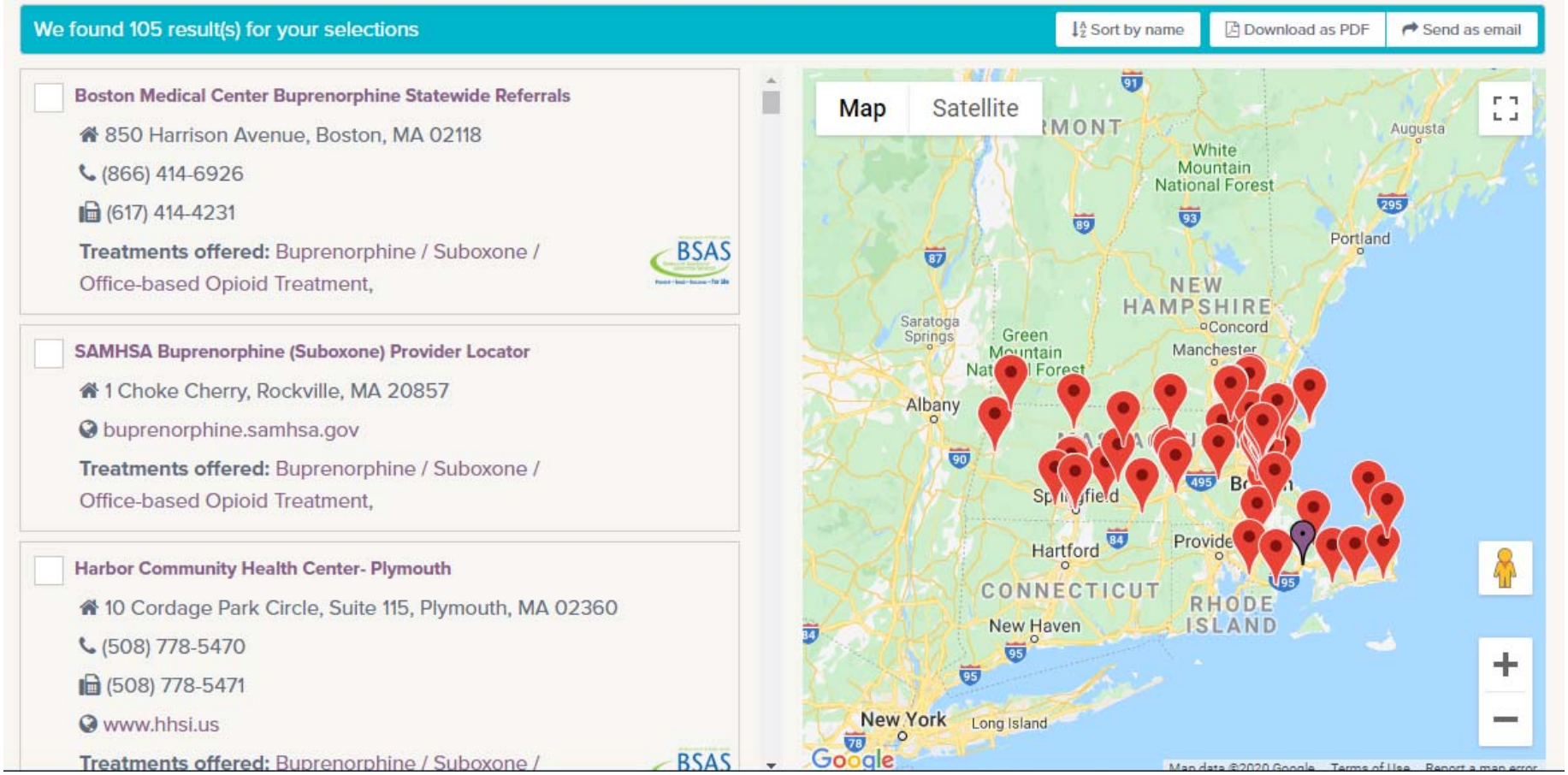


Source: Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. BMJ 2017 Apr 26;357:j1550. https://www.mass.gov/files/documents/2019/02/04/Walley-MAT-Commission-190124.pdf

MA Resources for Addiction

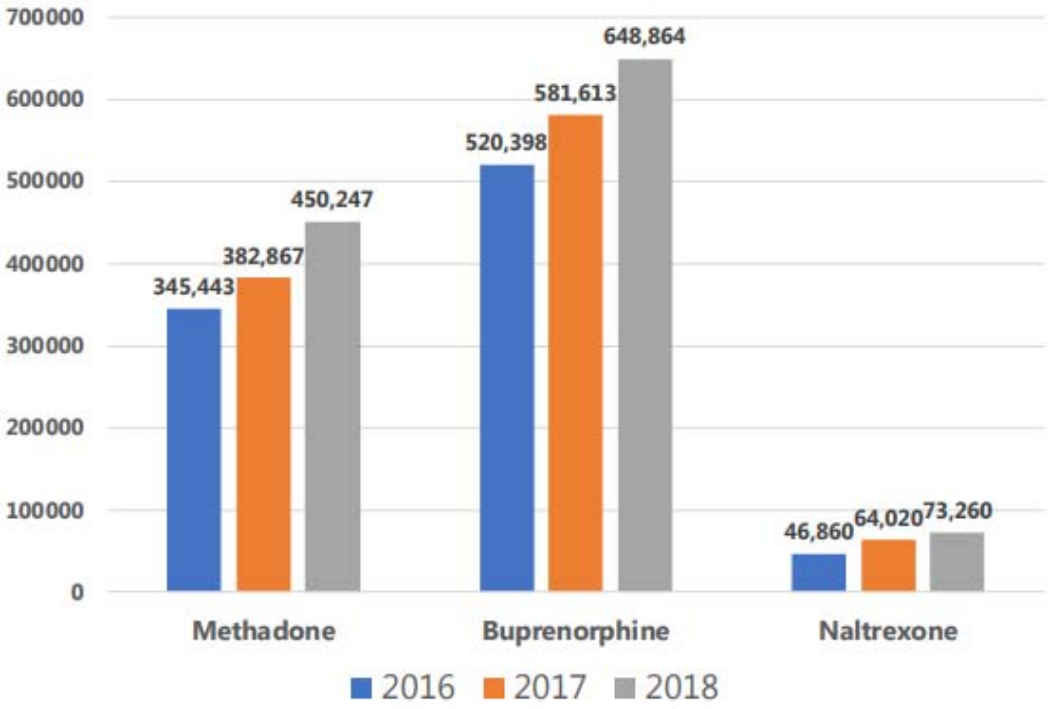


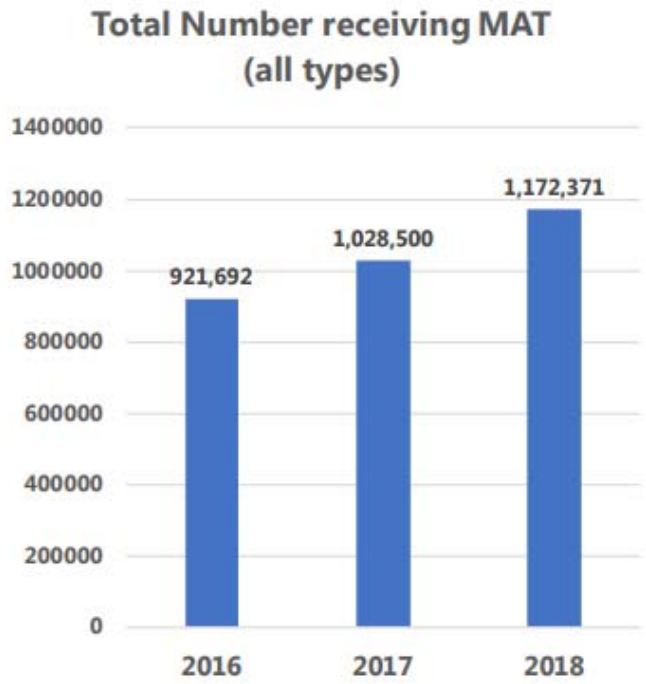
Access to MOUD



Source: https://mahelplineonline.custhelp.com/app/account/opa_result

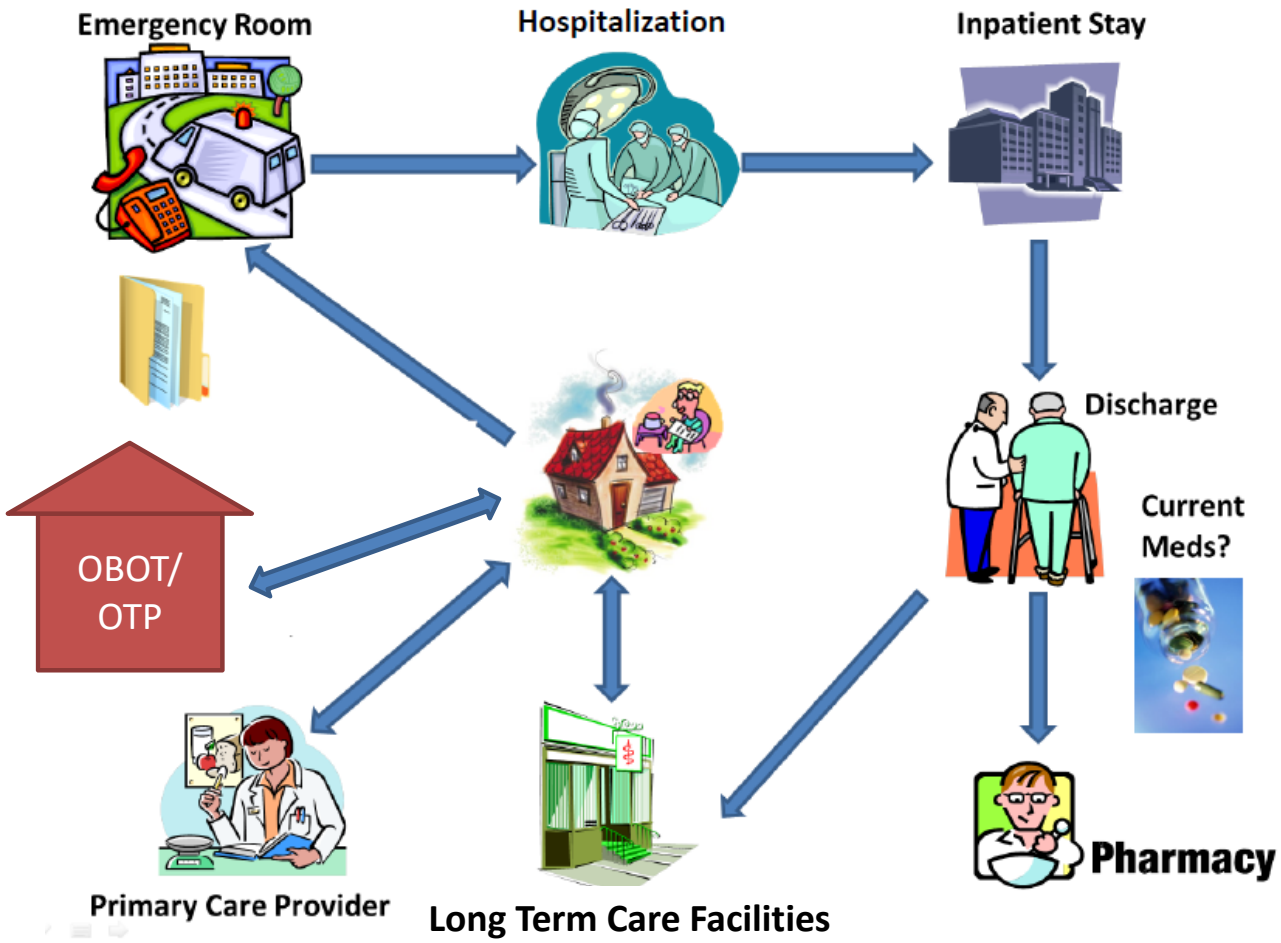
Number of Individuals Receiving MOUD Nationally





Source: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018_presentation.pdf

A Journey Through the Care Continuum



Pathways to Recovery Personal Journey

Julie Bunch
Massachusetts Organization for Addiction Recovery

Learning Objectives

- Recognize and address the stigma of opioid use disorder (OUD) in long term care facilities (LTCFs)
- Discuss how OUD presents; biological effects and underlying causes
- Gain knowledge of the different types of OUD treatment including medications for opioid use disorder (MOUD)
- Identify strategies to enhance best practices across the continuum of care

Agenda

10:00 AM – 10:15 AM	Call to Action
10:15 AM – 10:45 AM	Pathways to Recovery
10:45 AM – 11:30 AM	Understanding OUD
11:30 AM – 12:15 PM	An Overview of Medication to Treat OUD
12:15 PM – 12:45 PM	Lunch
12:45 PM – 1:30 PM	Approaches to Care
1:30 PM – 2:15 PM	Community Resources
2:15 PM – 2:45 PM	Implementation of the Toolkit
2:45 PM – 3:00 PM	Leaving in Action

Objectives

- Discuss how residents present; biological effects and underlying causes
- Recognize stigma of addiction
- Dispel misconceptions of persons with OUD

Understanding Opioid Use Disorder

Simeon Kimmel, MD, MA
Boston Medical Center

Source: Grayken Center for Addiction and RIZE Massachusetts

Source: Grayken Center for Addiction and RIZE Massachusetts

Source: Grayken Center for Addiction and RIZE Massachusetts

Biological Background

- Why does the human brain develop a substance use disorder?
- Why can we only develop addictive behaviors in response to some substances?

Source: Grayken Center for Addiction and RIZE Massachusetts

Biological Background

The Reward Pathway

- A particular pathway in the brain is activated by all of the activities that we find pleasurable
  - Food, water, sex; “appetites”
  - Interpersonal relationships, spirituality, exercise, art, music, beauty
- The common reward pathway in the brain for all pleasurable activities involves the neurotransmitter **dopamine**

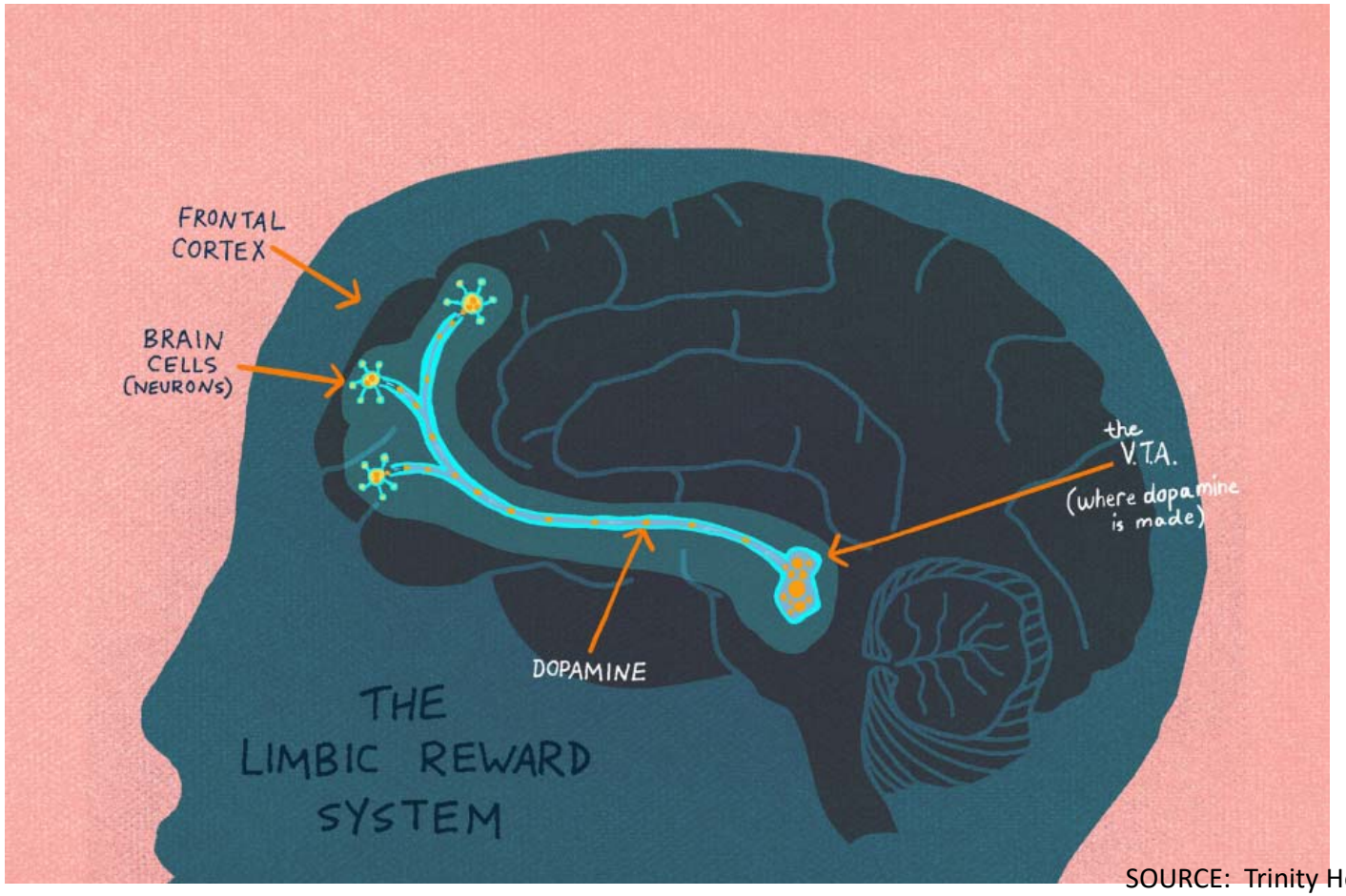
Source: Grayken Center for Addiction and RIZE Massachusetts

Biological Background

The drugs that can cause addictive behaviors are those that hijack the natural pleasure circuitry of the brain

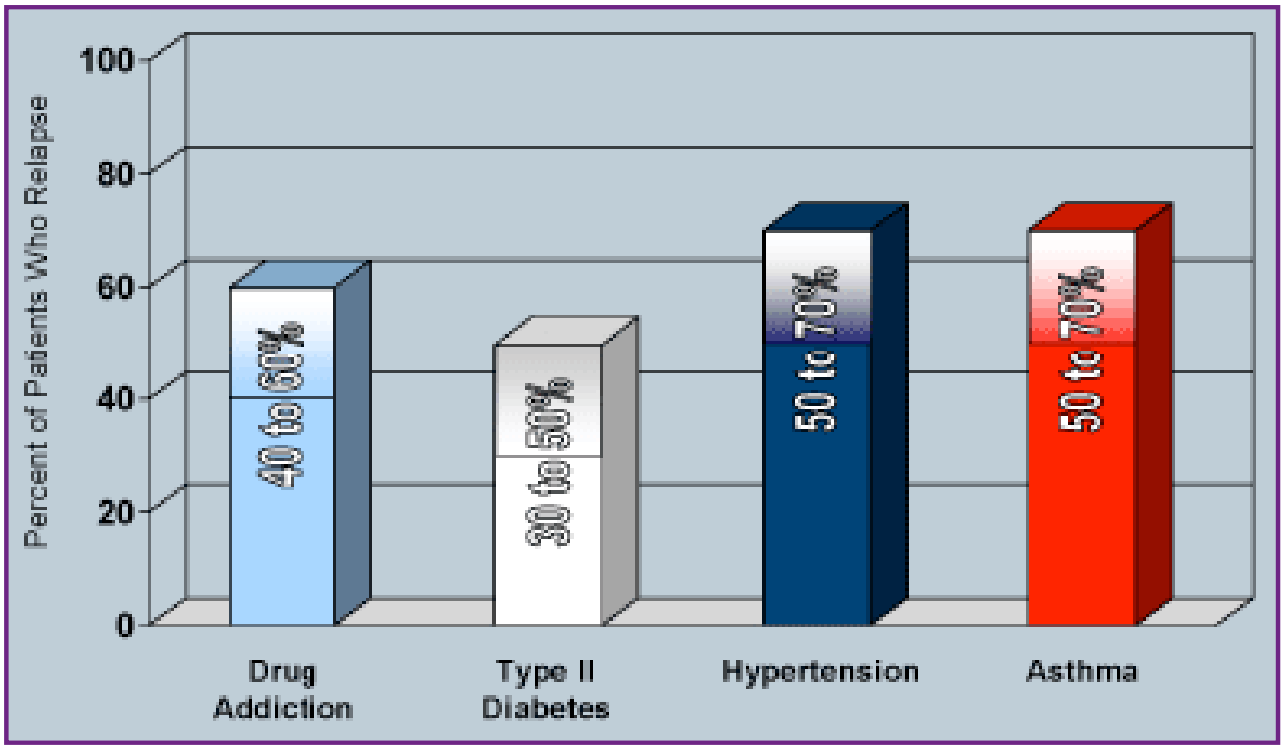
Source: Grayken Center for Addiction and RIZE Massachusetts

Addiction is Chronic Brain Disease

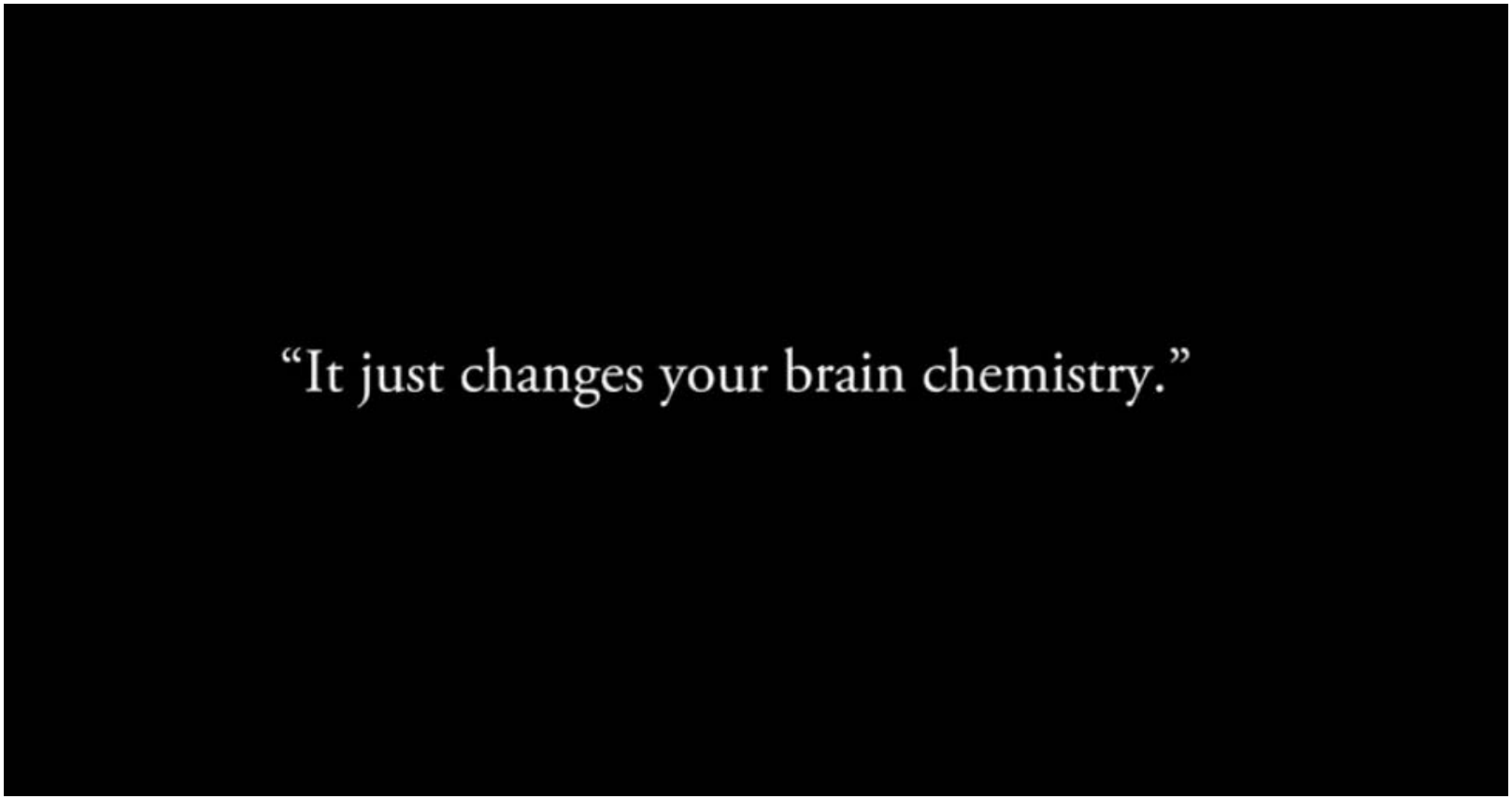


SOURCE: Trinity Health Presentation

Addiction is Chronic Disease



SOURCE: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery, pulled from Trinity Health Presentation

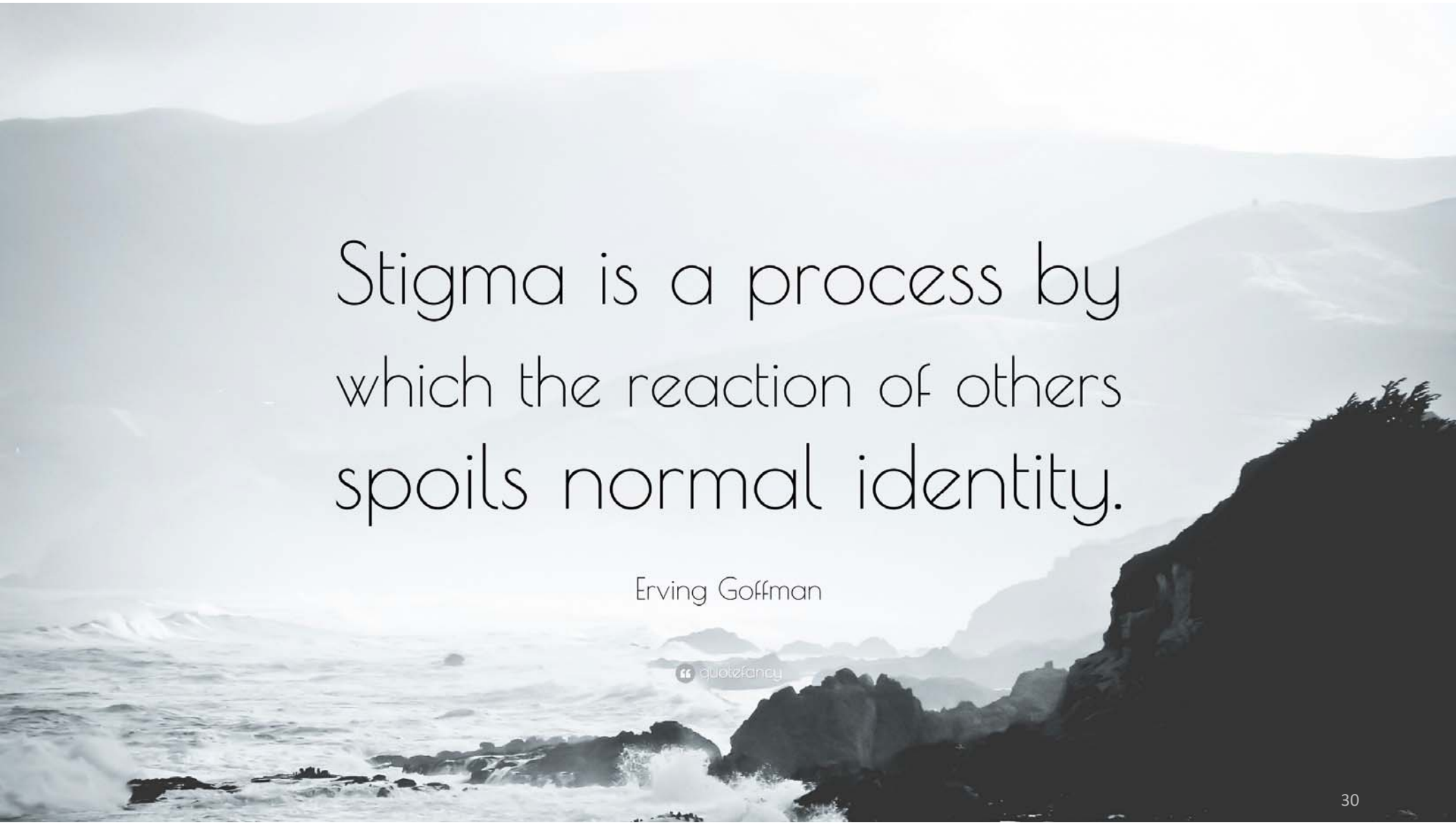


https://youtu.be/H7HfmYDkBzg

Systems Failures or Patient Failures?

- Patient admitted to the hospital with heart attack…
  - Told it's her fault because of diet, high stress job, and history of tobacco use
  - Advised to call a list of cardiologists/cath labs
  - Told she can't get aspirin or cholesterol medication until she sees a nutritionist first
  - Sent home with a stern reminder to not have another heart attack

Source: Trinity Health Slides


Stigma is a process by
which the reaction of others
spoils normal identity.
Erving Goffman
quotefancy

Stigma

Why is it socially "ok" to express stigma toward a few groups, such as people who use drugs or are obese, but not so much toward others, such as people with physical disabilities?

Source: Grayken Center for Addiction and RIZE Massachusetts

Stigma

What are some examples of stigmatizing language used by professionals about people who have substance use disorders?

Junkie

Addict

Alcoholic

Abuser

Drug of choice

Shooter

Dirty

Clean

Source: Grayken Center for Addiction and RIZE Massachusetts

Stigma

- "Substance Abuser" vs. "Substance Use Disorder"

- Example:
  - Mr. Williams is a substance abuser and is attending a treatment program through court…
  - Mr. Williams has a substance use disorder and is attending a treatment program through the court…

Source: Kelly JR, 2010, Int J Drug Policy, adapted from Grayken Center for Addiction and RIZE Massachusetts

Avoid Stigmatizing Language - Words Matter

The language we choose shapes the way we treat our residents…	
Instead of:	You can say….
“drug abuse”	Substance use disorder
“addict” or “junkie”	Person with a substance use disorder
“alcoholic”	Person with alcohol use disorder
“dirty urine”	Abnormal, positive, or unexpected urine test result
“clean urine”	Normal or negative urine test result
“clean” (referring to a person)	Abstinent, in remission, or in recovery
“dirty” (referring to a person)	In a period of disease exacerbation, or relapse
“shooting up”	Injecting
“shooter”	Person who injects drugs

SOURCE: Boston Medical Center- https://www.bmc.org/addiction/reducing-stigma

Dependence and Addiction

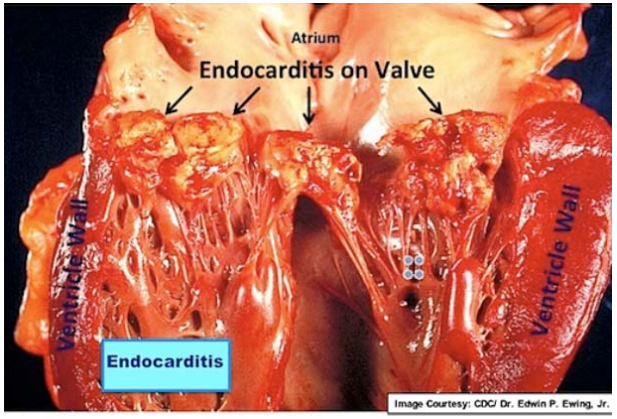
How OUD is Diagnosed (DSM-5)

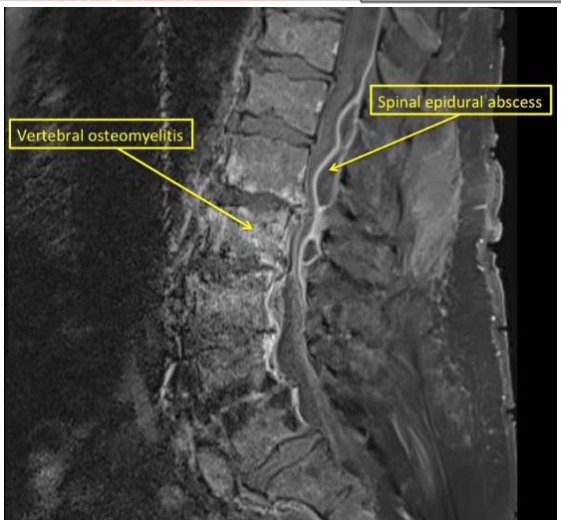
Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

Source: https://www.psychiatrictimes.com/special-reports/opioid-use-disorder-update-diagnosis-and-treatment

Case Example 1

- 40 year old female with history of intravenous drug use (IVDU) presents with back pain
- Has left against medical advice (AMA) from two local hospitals where she was diagnosed with endocarditis and spinal osteomyelitis
- She left due to untreated pain and withdrawal; “It was just too much for me to take”
- She had not been offered medication for OUD at the other hospitals





Case Example 2

- Resident was started on methadone in hospital day 1, as well as dilaudid to treat her acute pain
- Was transferred to LTCF to complete her six weeks of IV antibiotics
- She reconnected with her family and children while at the LTCF
- From LTCF transferred to residential drug treatment program
- Remained in treatment and was abstinent at six month follow-up

Symptoms of Withdrawal

- Nausea and vomiting
- Anxiety
- Insomnia
- Hot and cold flashes
- Perspiration
- Muscle cramps
- Watery discharge from eyes and nose
- Diarrhea

Source: World Health Organization. (2009). Clinical Guidelines for Withdrawal Management

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Communication Strategies

How to approach residents with compassion:

- Use medically accurate, person-first, non-stigmatizing language
- Be aware of one's own anxieties, feelings, and non-verbal communication
- Convey warmth and care for a resident's well being
- Ask permission to discuss sensitive topics
- Reflect on treatment progress thoughtfully while using language that demonstrates respect
- Use open-ended questions
- Engage with the resident as a partner in treatment planning

Source: https://www.bmcobat.org/resources/?category=8#Challenging+Patient+Conversations

Relationship-Building Skills

Include reflective listening and empathetic statements to destigmatize OUD diagnosis and treatment; use statements such as:

- "My primary motivation is to provide care that leads to the healthiest version of 'you' in the long term."
- "Getting help for this is like getting help for any other chronic medical problem."
- "I want you to have the best possible care, and this difficult but productive conversation is a first step for us."

Source: https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Explaining Treatment Methods

Use statements such as:

- "There are a number of treatment options. Let's explore them together."
- "We will work together to find a treatment plan that works best for you."

Source: https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Strategies for Managing Reactions

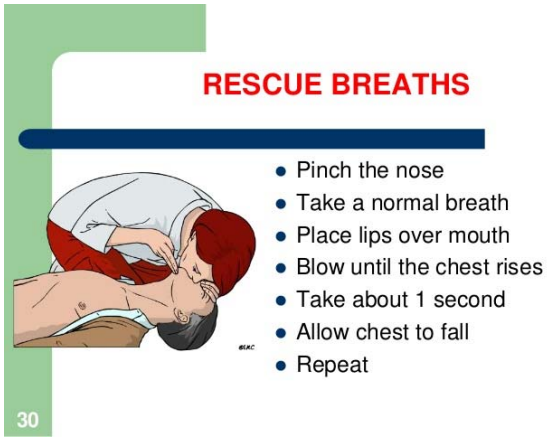
Reactions	Management Strategy
The resident is anxious, agitated, or panicking	Approach the resident in a calm and confident manner Reduce the number of people attending to the resident Carefully explain any interventions and what is going on Minimize the risk of self-harm
The resident is confused or disorientated	Ensure the resident is frequently supervised Provide reality orientation – explain to the resident where they are and what is going on
The resident is experiencing hallucinations	Talk to the resident about what they are experiencing and explain what is and isn't real Ensure the environment is simple, uncluttered and well lit Protect the resident from harming him or herself, and others
The resident is angry or aggressive	Ensure that staff and other resident are protected and safe When interacting with the resident remain calm and reassuring Listen to the resident Use the resident's name to personalize the interaction Use calm open-ended questions Use a consistent and even tone of voice, even if the resident becomes hostile and is shouting Acknowledge the resident 's feelings Do not challenge the resident Remove source of anger if possible

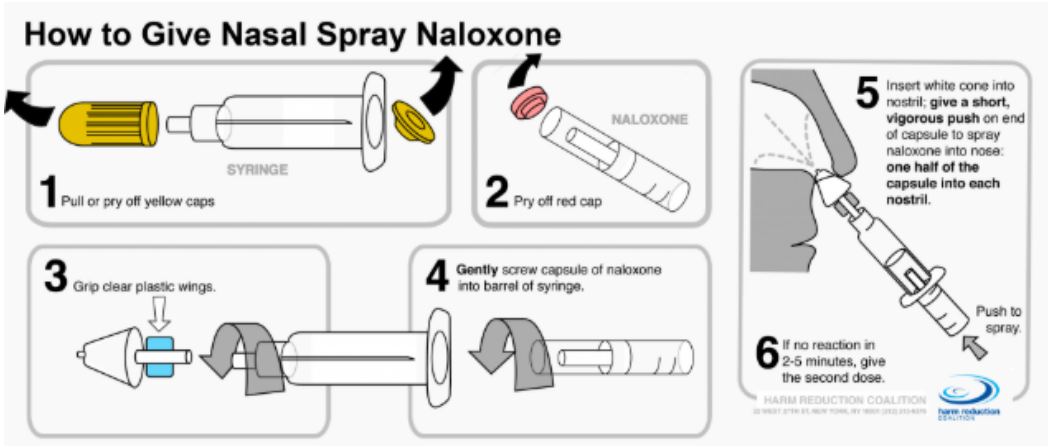
How To Recognize an Opioid Overdose

- Blue lips and fingertips
- Limp and pale
- Small pupils
- Breathing slow, irregular or has stopped
- Pulse slow, erratic, absent
- Nonresponsive to voice or sternal rub

What To Do If Suspected Overdose

- Assess the scene
- Assess the person
- Call 911
- **Rescue breathing**
- Administer Naloxone
- Stay with the person until help arrives
- Continue rescue breathing





Harm Reduction

Harm Reduction Principles

Accepts that drug misuse is part of our world and chooses to work to minimize its harmful effects rather ignore or condemn them.

Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors.

Establishes quality of individual and community life and well-being for successful interventions and policies.

Ensure residents have a real voice in the creation of programs and policies designed to serve them.

Empower users to share information and support each other in strategies which meet their actual conditions of use.

Does not attempt to minimize or ignore the real and tragic harm and danger associated with drug misuse.

Policy Considerations at Your Organization

- Incorporate harm reduction principles throughout your organization and within your existing policies.
- Incorporate a section on OUD into your internal discrimination policy to reduce stigma and to help foster a positive culture that strives to ensure that staff see addiction as a medical condition.
- Integrate the use of the Clinical Opiate Withdrawal Scale (COWS) as a method to help identify opioid withdrawal and guide the care for the resident.

Key Points and Who Should Be Involved

- Addressing stigma - involve all staff
- Harm reduction principles - identify a champion, involve all staff
- Understanding how OUD presents and screening - involve all staff
- Recognize symptoms of withdrawal - Nurse or DON
- Strategies for managing difficult reactions - Nurse, CNA, activities coordinator
- What to do if suspected overdose - involve all staff in training
- Naloxone stored/accessible on site

Many Slides Adapted From The Following Presentations

- Boston Medical Center OBAT Training and Technical Assistance
  www.bmcobat.org
- Boston and Cambridge Hospital Consortium presentation developed by Miriam Komaromy, MD, Medical Director, Grayken Center for Addiction at Boston Medical Center, with the support of Scott Weiner, MD; Lorraine Magner, NP; Claudia Rodriguez, MD; and Maia Gottlieb, MPH
- Medical Director of Addiction Medicine Consult Services, Ari Kriegsman, MD, from Trinity Health, presentation given to Skilled Nursing Services in the Springfield and Holyoke region

Grayken Center for Addiction
Boston Medical Center

rize massachusetts

Trinity Health

Boston Medical Center

An Overview of Medication to Treat Opioid Use Disorder

Marghie Giuliano, R. Ph.
Healthcentric Advisors

Objectives

- Identify the Myths about Medication for Opioid Use Disorder (MOUD)
- Review the types of medications used for MOUD
- Identify roles in supporting the delivery of MOUD in the Long Term Care Setting

Dispelling Myths

The Top 7:

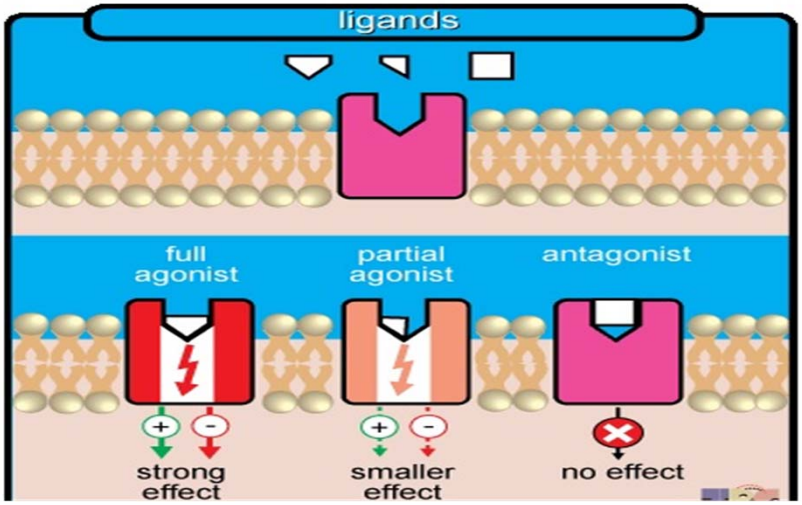
- MOUD just trades one addiction for another
  - **A combination of medication and behavioral therapies can successfully treat OUD**
- MOUD is only for the short term
  - **Persons on MOUD for at least 1-2 years have the greatest rates of long-term success**
- My patient's condition is not severe enough to require MOUD
  - **MOUD adds another tool in the toolbox to help achieve individualized goals**
- MOUD increases the risk of overdose in patients
  - **Persons prescribed MOUD experience less cravings and withdrawal and are significantly less likely to overdose**

Dispelling Myths

- Providing MOUD will only disrupt and hinder a patient's recovery process
  - **Improves quality of life, level of functioning, ability to handle stress, helps reduce mortality**
- There isn't any proof that MOUD is better than abstinence
  - **Now evidence to consider MOUD as a best practice**
- Most insurance plans don't cover MOUD
  - **Individualized by plans**
  - **Progress in this area**

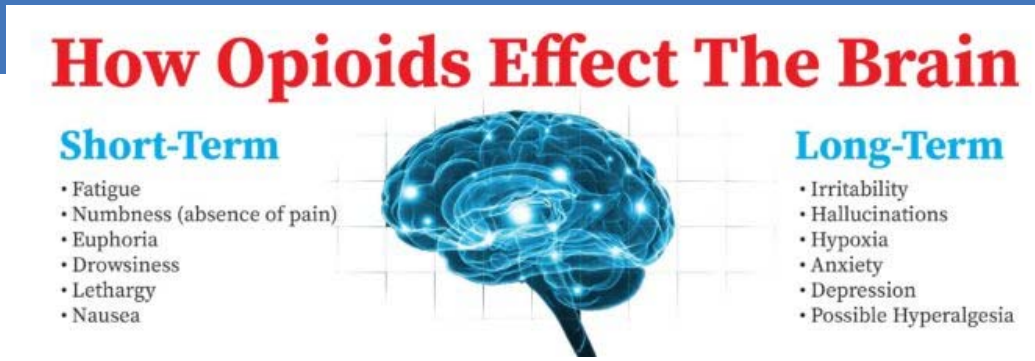
MOUD

- More than medication
  - Person-centered approach
  - Appropriate medication choice
  - Resident counseling and support



- Three medications used for MOUD
  - Methadone (full agonist)
  - Buprenorphine (partial agonist)
  - Naltrexone (antagonist)

Methadone



- Synthetic opioid
  - Used for pain
  - Used for MOUD
- Long-acting
- Full agonist - **full** activation of opioid receptors in the brain
- Administered by Opioid Treatment Program (OTP)
  - Dosing is managed and monitored by OTP
    - Typically daily
  - Must be dispensed at OTP clinic for the treatment of OUD

Methadone - Benefits

- First line of treatment for MOUD; reduces desire for other opioids (full agonist)
- Eliminates withdrawal symptoms from discontinuation of opioid (anxiety, nausea/vomiting/abdominal pain, etc.)
- Administered in controlled setting by OTP (reduces risk of overdose)

Methadone – Potential Challenges

- Overdose risk - Sedation, slowed breathing, respiratory depression
  - Always a risk with any opioid
- Diversion possibility
- Must go to OTP for treatment
  - Positive due to oversight, creates a supportive/structured setting
  - Could be a challenge due to access/stigma

Methadone Recap

Question:

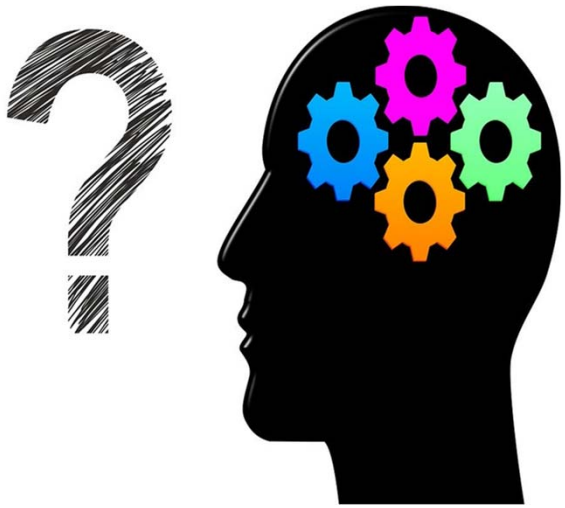
- Can you name some benefits of using Methadone as a treatment for MOUD?

Answer:

- ✓Structured treatment/dispensing with daily interaction
- ✓Eliminates withdrawal symptoms
- ✓Helps people function better

Question:

- Can you name some challenges of Methadone use for MOUD?



Answer:

- ✓Overdose risk
- ✓Diversion possibility
- ✓Requires OTP visit

Buprenorphine (or buprenorphine/naloxone combination)

- Semi-synthetic opioid
  - Used for treatment of OUD
  - Can be used for pain
- Long-acting
- Partial agonist
  - Binds to opioid receptors in brain but only causes **limited or partial opioid effect** in body relative to full agonist
- Community pharmacists CAN dispense this medication with a prescription
- Comes in many forms:
  - Sublingual tablet, sublingual film, buccal film, transdermal patch (pain only), injectable (sub-cutaneous)

Buprenorphine Benefits

- Available at community pharmacy
- Lower misuse potential than full agonist
- Lower opioid overdose symptom risk
- Various dosage forms and options to choose from in consultation with medical provider

Buprenorphine Potential Challenges

- Overdose (risk is low)
- Diversion

Buprenorphine Recap

Question:

- Does a resident need to go to an OTP to receive buprenorphine?

Answer:

- No; Buprenorphine can be dispensed at a community pharmacy with a prescription from an authorized prescriber

Naltrexone

- Approved for opioid use disorder and alcohol use disorder
- Long acting
- Opioid antagonist - **blocks** activation of opioid receptor
  - Prevents opioid like-effects
  - Reduces desire to take opioids
- Currently available as tablet or injectable
- Before starting Naltrexone, a resident needs to be opioid free for a minimum of 7-10 days due to risk of withdrawal symptom exacerbation

Naltrexone Benefits

- Blocks the effects of opioids
- Can reduce cravings for residents with OUD
- Can be dispensed at a community/specialty pharmacy
- Low diversion risk
- Low/no overdose risk

Naltrexone Side Effects

- Can trigger withdrawal
- Blocks pain management effects of opioids
- May not **eliminate** cravings
- Will reduce tolerance to opioids
  - High risk of overdose if there is a relapse
- Could cause hepatotoxicity (liver toxicity)

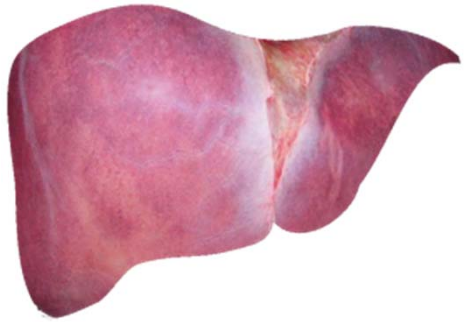
Naltrexone Recap

Question:

- What rare but serious condition can naltrexone cause?

Answer:

- Hepatotoxicity (Liver Toxicity)



MOUD in LTCF

How you and your staff can support residents on MOUD...

Support and Empathy

- **Team Approach:** All healthcare staff work together as a team with the resident to put together best treatment plan

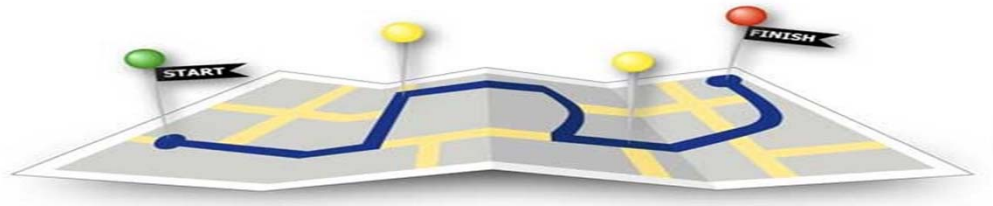
- Empathy and support builds trust; **if** resident feels they can trust staff they are more likely to be open and honest about their MOUD

Education

- All staff members are up to date with latest clinical data and protocol concerning MOUD
- Staff members familiarize themselves with common opioid overdose symptoms, medication options/side effects, risk of diversion
- Staff members should be trained on Naloxone administration to address overdose
- **Better informed staff makes a better informed resident**

Chain of Custody for Methadone

- If residents in LTCFs can and do receive methadone as part of their care, who is in charge of handling methadone from OTP to patient's hands?
- Potential role in LTCF that describes one who is responsible for overseeing the chain of custody of methadone:
  - OTP ⇨ manage pre-poured doses ⇨ administration ⇨ destruction



DATA 2000 Waiver

- Licensed independent practitioners in LTCF can receive waiver to prescribe buprenorphine
- To apply, practitioner must submit intent to SAMHSA Center for Substance Abuse Treatment (CSAT)
  - Complete online waiver request form
- This could potentially open doors and opportunities for practitioners in LTCF to directly treat residents with MOUD
  - Can potentially lead the way for future similar advances for medications such as methadone/naltrexone

How can you support your residents on MOUD?

Questions?

Approaches to Delivering Person-Centered Care

Annie Huppert, MPH, CPHQ Healthcentric Advisors
Terri Mota, BSN, RN Abt Associates

Objectives

- Creating a person-centered culture that includes residents with OUD
- Raise staff awareness of range of approaches to caring for residents on MOUD including trauma-informed care
- Identify techniques to foster a therapeutic environment

Wellness and Person-Centeredness

- Wellness
  - "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."
- Person-centeredness
  - "The need to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives."

Person-centered Care is Trauma-Informed

- Part of a multi-layered, interdisciplinary, person-centered approach to supporting residents
  - Especially residents on MOUD
- Trauma-informed care as part of an organization's culture
- Crucial to supporting both residents and staff
  - Help to reduce fatigue, burnout, and turnover

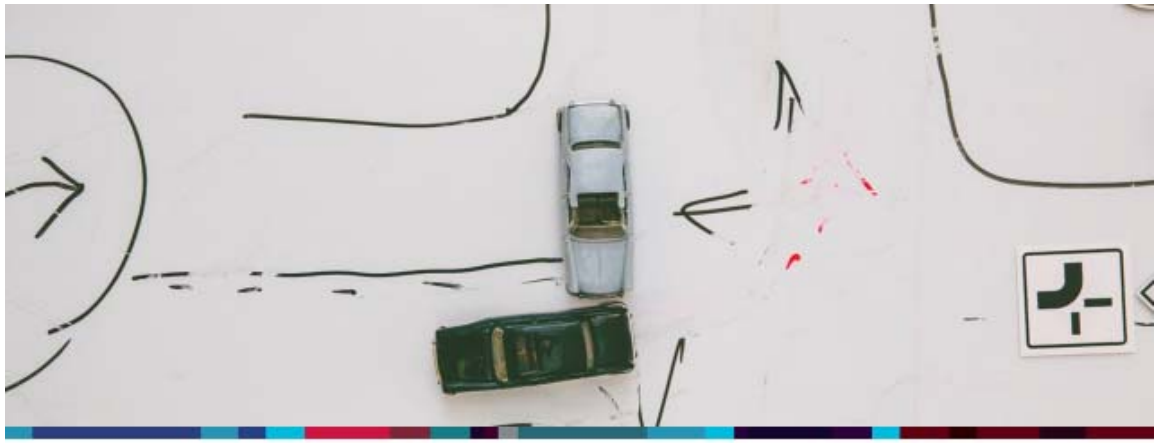
Requirements of Participation: Phase 3

F699: §483.25(m) Trauma-informed care

- The facility must ensure that residents who are trauma survivors receive **culturally competent**, **trauma-informed care** in accordance with professional standards of practice and accounting for residents' experience and preferences in order to eliminate or mitigate triggers that may cause retraumatization of the resident.
- Implemented beginning November 28, 2019

What is Trauma?

- What do you think of when you hear the word: trauma?



What is Trauma?

- Medical trauma
- Physical abuse
- Refugee trauma
- Sexual abuse
- Terrorism and violence
- Traumatic grief
- Early childhood trauma
- Military service trauma
- Bullying
- Community violence
- Complex trauma
- Disasters
- Domestic violence
- Transfer trauma
- Historical trauma

Discussion Questions

- Have you ever worked with a resident who has experienced trauma? What did you notice?
- When you work with a resident who is acting out or showing puzzling reactions, what are some things to consider?
- Give an example of a time when you had trouble understanding a resident's reactions. What did you learn?
- Why might residents be reluctant to talk about their trauma histories?
- In what ways have you seen society view PTSD or mental health conditions?
- How can we prevent residents from being triggered in the environment?

SAMHSA's Definition of Trauma: The Three E's

An **event** of actual or extreme threat of physical or psychological harm which an individual **experiences** as traumatic, and which causes long-lasting **effects.**

Who Experiences Trauma?

Residents

Staff & Volunteers

Family & Caregivers

What are Adverse Childhood Experiences (ACEs)?

- Centers for Disease Control and Prevention and Kaiser Permanente collaboration (1995-1997)
- Largest study ever done on this subject, involved 17,000 people, two waves of data collection
- Participants were given a survey that listed 10 types or categories of trauma

1 in 4
exposed to 2 categories of ACEs

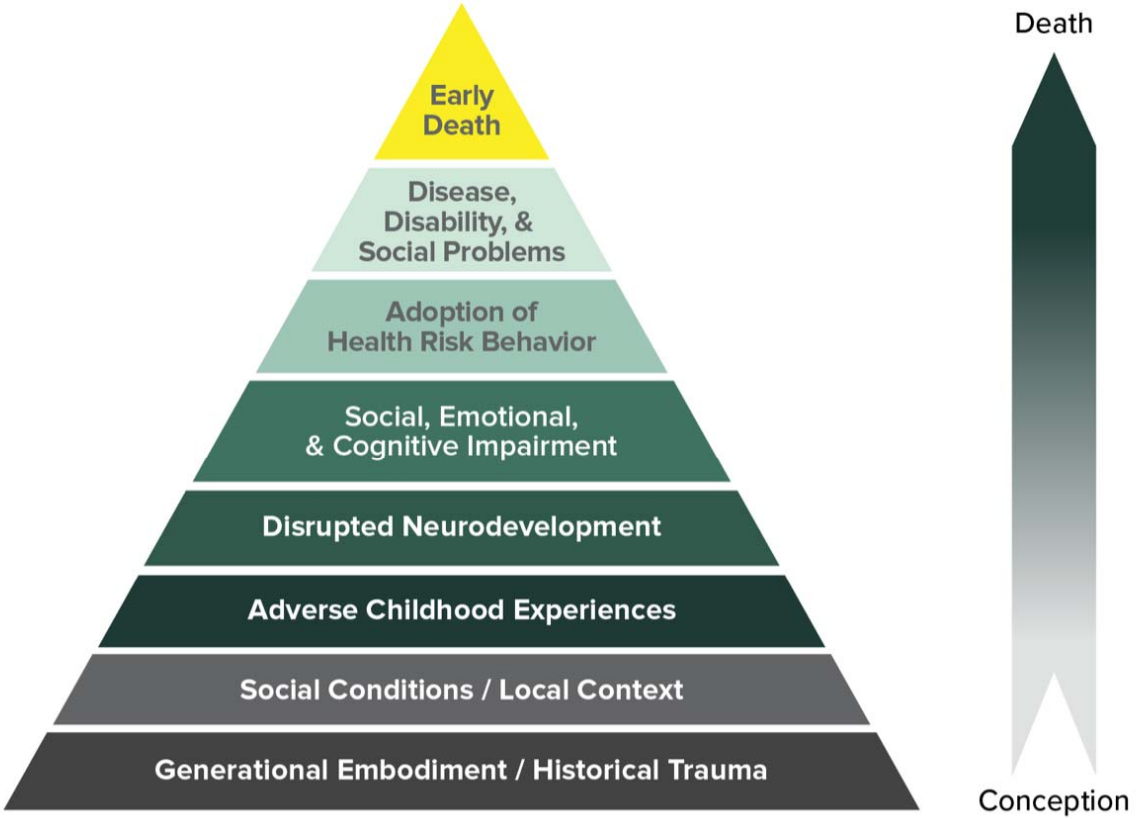
1 in 16
was exposed to 4 categories

22%
were sexually abused as children

66%
of the women experienced abuse, violence or family issues in childhood

Women were 50%
more likely than men to have experienced 5 or more ACEs

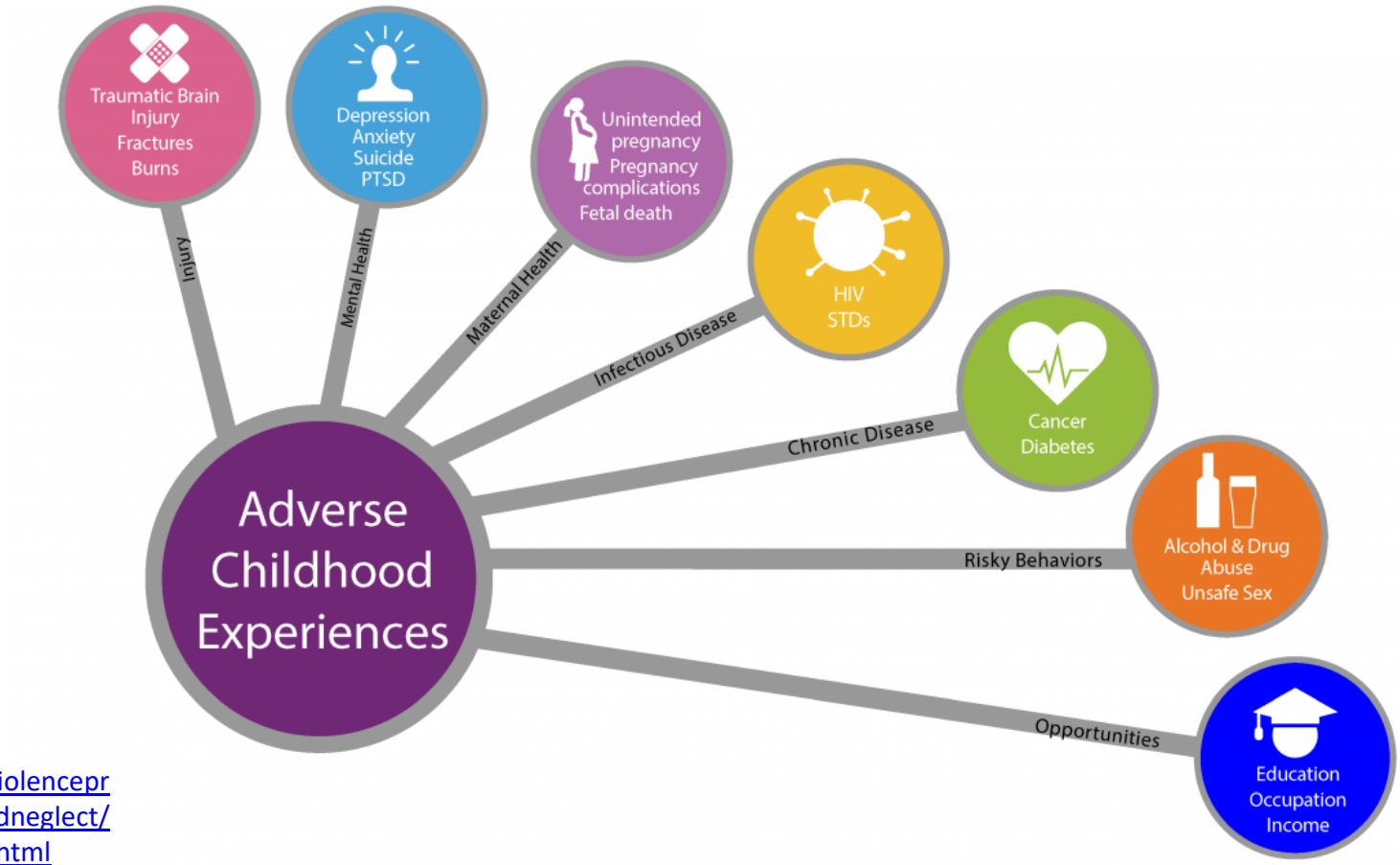
How do ACEs and Adverse Events Affect People?



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html

Early Adversity has Lasting Impacts



Source: https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html

Importance of Communication and Relationships

What damages relationships?

- Interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, judgmental
- Language barriers
- Referring to people by their condition
- "It's not that bad"
- "Worse things have happened to people"

What builds relationships?

- Interactions that express kindness, patience, reassurance, acceptance, listening
- Asking for clarification
- Person-first language
- "I'm sorry this happened to you"
- "That must have been very scary!"

What's wrong with you? vs. **What's happened to you?**

Importance of Understanding Trauma History

Common misdiagnoses when a trauma history is not considered:					
Dementia	Psychosis	Personality disorders	Mood disorders (depression, bipolar disorder)	Oppositional	Hoarding/ Collecting

Screening

Find out if the resident may have experienced trauma

If so, what triggers the resident?

Find ways to help de-escalate if he/she does feel triggered

Compassion Fatigue

- **Resident-related flashbacks**: troubling dreams, intrusive thoughts, sudden recall of frightening experiences, losing sleep
- **Burnout:** feelings of being trapped, hopeless, tired, depressed, worthless, unsuccessful at separating work from personal life
- **Budget constraints:** limited leave, supervision, increased caseloads
- **Personal trauma history**: ineffective coping skills, current stressors in personal life

What is a Therapeutic Environment?

- Recognizes and supports all residents, regardless of diagnosis, culture, and language
- **Actively reduce stigma and myths associated with certain diagnoses**
- Centers the resident's needs and interests
- Involves family and caregivers
- Minimizes external stressors i.e. noise, clutter, chaos
  - Acknowledges specific vulnerabilities of residents with dementia
- Utilizes individualized, flexible designs to support range of functional levels

Prioritize Well-being of Residents and Staff

- Work with residents to ensure that their well-being is prioritized
  - Social engagement, meaningful activities, sense of purpose
  - Quality sleep, positive sleep environment
  - Adequate nutrition, healthy diet
- Involve staff in discussions of well-being – what does this mean to them?
  - Solicit the input of all levels of staff on vision and mission statement discussions
  - Illustrate how to shift the culture and care of your residents – to help it to resonate with every staff member
  - Provide residents with OUD information to empower them to be partners in their care
  - Identify a champion who will assist in creating culture change

Engagement Strategies

- Brainstorm
  - What are examples of strategies and activities to engage residents?

Engagement Strategies

- Views or pictures of nature
- Chapel, meditation room
- Music
- Access to nature
- Physical exercise
- Pets and other elements that allow for sense of stimulation
- Privacy and control
- Schedule of daily tasks and activities to foster sense of purpose and good habits
- Light jobs
- Invite residents to utilize talents/skills on behalf of the community.


Supportive Person Involvement

- Resident and Family Advisory Councils
- Share community resource information
  - Assist with transportation, support participation
- Set appropriate expectations for visitors and guests
  - Provide list of prohibited items to bring in while visiting
- Educate regarding stigmatizing language and bias that can be harmful to the resident
- Reducing environmental stressors pertaining to the resident

Other Approaches to Consider

- Ensure access to mental health services, medical care, and counseling
  - **This should be included in the care plan in partnership with the OTP or OBOT**
- Recovery support services
- Peer support /Recovery Coaching
- Family, Caregivers, and Friends- www.Learn2Cope.org
- Connection to mutual help groups
- Motivational interviewing (MI)
  - Build relationships
  - Collaborative and goal oriented

Policy Considerations at Your Organization

- Integrate and train staff on a trauma-informed approach to caring for residents with OUD,
- Incorporate development of a therapeutic environment into your existing orientation polices, and,
- Review and incorporate a person-centered approach into existing policies.

Key points and who should be involved?

- Trauma-informed care approach; involve all staff
- Staff training; leadership team
- Positive engagement strategies; all staff
- Non-medication approaches; case management/social worker

Resources

- Partnering with Patients and Families to Strengthen Approaches to the Opioid Epidemic - Institute for Patient and Family-Centered Care.
- Tribal Healing to Wellness Court Series - this resource provides an overview of Tribal Healing to Wellness Courts and some evidence based programs or practices of Wellness.
- Resources for Families Coping with Mental and Substance Use Disorders
- Recovery and Recovery Support Resources

Questions?

Community Resources

Objectives

- Describe Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatments (OBOTs)
- Identify common community resources

Opioid Treatment Programs

Gary Frankowski,
Boston Habit Opco- OTP

Opioid Treatment Programs

- An outpatient program that provides services to treat and manage OUD in a clinical setting
- Regulated by SAMHSA
- Directory of clinics by state can be found here: https://dpt2.samhsa.gov/treatment/directory.aspx

Opioid Treatment Program Services

- Dispense or administer medications including:
  - Methadone (currently)
  - Buprenorphine, Buprenorphine and Naloxone combination, and/or Naltrexone (coming soon)
- Administration of medications occurs either:
  - On-site (majority of the time)
  - Take-home pre-poured doses
- Admission criteria for OTPs:
  - One year history of opiate dependence documented
  - Exclusions to criteria for pregnant residents and just released from incarceration

Opioid Treatment Program Services

- Admission process includes drug screens, in-depth clinical evaluation & medical screening and physical examination.
- Integrated emotional, social, and behavioral health services that are required by SAMHSA include:
  - Counseling
  - Treatment
  - Care planning
  - Diversion control

Methadone Treatment: Highly Regulated Care

Department of Public Health (DPH) Drug Enforcement Agency (DEA)* The Joint Commission (TJC)* Commission on Accreditation of Rehabilitation Facilities (CARF)*

- Clinics provide: Medical examinations, lab assessments, daily nurse assessments, weekly counseling, education
- Relationship building, vocational, educational and employment referrals related to quarterly treatment plans
- Drug testing at least 15/year: oral fluid, blood, urine
- Observed daily medication based on safety and assessment
- Take-home medication may be prescribed but is limited

How Can You Work with Your Local OTP

- Develop a Qualified Services Organization Agreement (QSOA)
  - Should include types of services QSOA provides, medical services (example counseling services, on-site call coverage, treatment plan, etc.)
  - Discussions between LTCF and OTP administrators should occur prior to admission of residents on MOUD
  - Should be completed prior to admission
- Release of Information (ROI)
  - Consent is required to share information from the OTP to the LTCF and other providers

How Can You Work with Your Local OTP, Cont'd

- Determine how the methadone will be dispensed to the resident
  - Take-home waiver (with or without the waiver)
    - LTCF nurse picks up the take home doses (daily or 1x weekly)
    - Client comes in weekly to pick up one week's worth of take-home doses
  - Methadone delivery
    - OTP nurse delivers and administers the methadone daily

42 CFR EXCEPTION Process: Chain of custody dosing

Exception requests are required when an OTP treatment team proposes a deviation from limitations or protocols established by regulation (42 CFR Part 8 and 105 CMR 164.300 et seq.). The most common reasons for these requests are to permit exceptions to the number of allowed take home doses, and exceptions to detoxification limits. There are regulations r/t :

- Authorization to submit exception requests
- Assessing and documenting justification for an exception request
- Process of submission, including how to complete the on-line form
- BSAS and SAMHSA Responses and action required

Entry into Long Term Care Facility

(see sample justification on next slide)

- Name and location of residential program
- Schedule of OTP supervised doses
- Schedule of doses at LTCF
- Dosing procedure at LTCF
- Details of plan for transportation between LTCF program and OTP
- Provision for safe management of pre-poured doses
- Plan for ensuring and maintaining chain of custody
- Plan for termination (for any reason)
- Plan for managing remaining doses after resident's termination/discharge

Sample Justification

Per agreement between this OTP and [name of program], the **resident will pick up 6 TH's on [specify day each week**] in the company of staff from [name of program]. On [specify day of pick up], he/she will be dosed at [name of OTP]. Six methadone **doses will be placed in a locked box** and will be transported back to the LTCF by staff from [name of program] with the resident. The resident and a staff member from the LTCF will **sign a chain of custody** for these take homes. The resident will receive his/her daily methadone doses at the LTCF. After **each daily ingestion, the resident will sign that s/he received the dose**. On [specify day each week] the resident will return to the OTP with the locked box with the empty methadone bottles and chain of custody form. The LTCF and the resident have been made aware that if the resident leaves the program at any point in time (whether for voluntary or administrative) all take homes will be automatically terminated. Any remaining doses will be disposed of in accordance with the LTCF's policy on disposal of medication left behind.

Office Based Opioid Treatment Program

Kristin Wason, MSN, NP-C, CARN
Boston Medical Center, OBAT

Office Based Opioid Treatment (OBOTs)

- Outpatient facility
- Primary care or general health care practitioners provide care, after obtaining a waiver to prescribe Buprenorphine

OBOT Model

- Evidence-based model of care to treat substance use disorders
- Addiction trained and specialty licensed providers treating substance use disorders within an office based setting managed by a central Nurse Case Manager
  - Massachusetts utilizes award winning Nurse Care Manager Model in which the nurse is the primary point of contact for the resident throughout treatment
- Resident-centered, utilizing medication for addiction treatment
  - Buprenorphine and/or naltrexone formulations; not methadone

Candidates for OBOT Treatment

- Resident must have a *DSM-5* diagnosis of OUD or other Substance Use Disorder (SUD)
- Resident is interested in medication for addiction treatment
- Resident is able to come to visits during office hours of operation
- Resident is able to be treated in clinic setting safely without harm to self or others
- Resident should be willing to address use of other harmful and/or substances they may be misusing

OBOTs Provide Comprehensive Services

Follow-up visit flow:

- Assess and address recent substance use
- Assess medication dose, adherence, cravings, withdrawal
- Provide ongoing education: medication administration, side effects, interactions, support
- Provide or connect a patient with counseling services
- Arrange for psychiatric evaluation with follow-up as needed
- Medical issues: HIV, HCV, routine health maintenance, acute needs
- Family planning
- Social supports: housing, employment, family, friends, recovery coach
- Labs as clinically indicated
- **Support the recovery process and build trust**

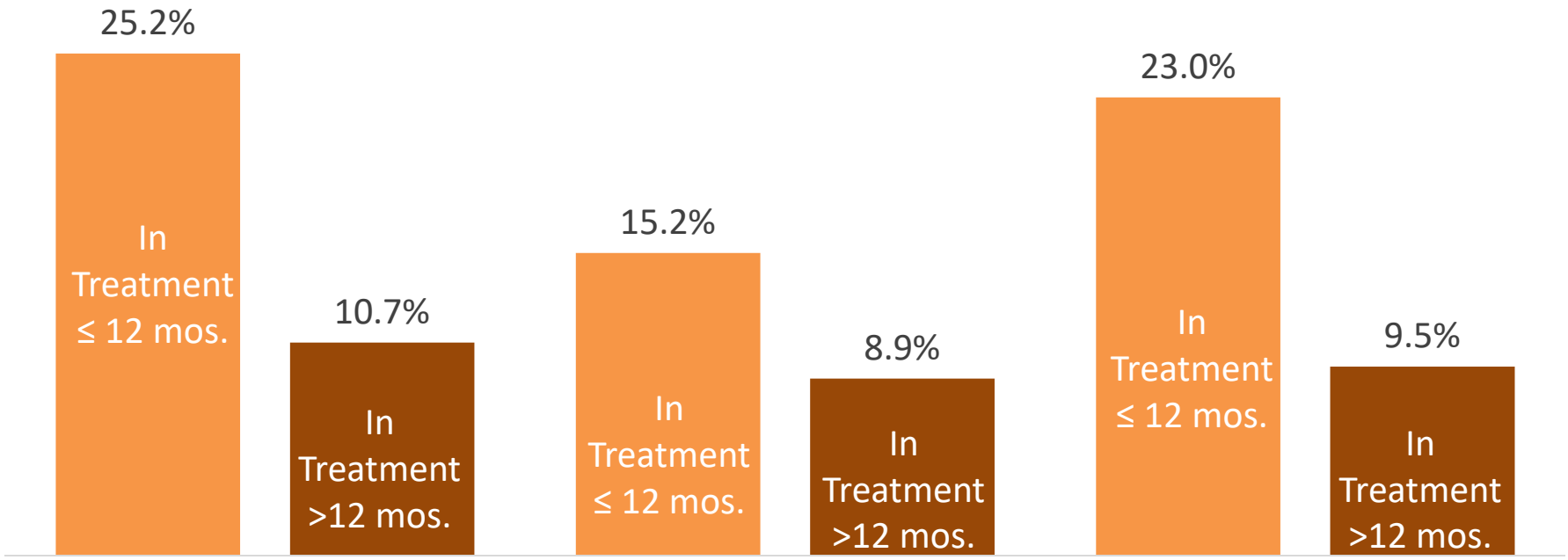
DATA 2000 – Practitioner Waiver Requirements

- Licensed provider with DEA registration
- Subspecialty training in addictions or completion of an 8-hour course for physicians or 24 hour course for nurse practitioners and physician assistants
- Registration with SAMHSA and DEA
- Must affirm the capacity to refer residents for appropriate counseling and ancillary services
- Must adhere to resident panel size limits
- Recent CARA and SUPPPORT legislations passed permitting advanced practice providers (APPs) prescriptive authority to prescribe buprenorphine
- Requires a total of 24hours of addiction training for waiver

OBOT Treatment Philosophy

- A substance use disorder is a chronic medical condition that responds best when treated with evidence-based, resident-centered, ongoing, comprehensive medical care.
- Patient/client with substance use disorders deserve to be treated with dignity and respect.
- The goals of treatment include:
  - Cessation or reduction in harmful substance use,
  - Active participation and engagement in treatment,
  - Restoration physiologic functions, and
  - Improvement in one's quality of life.
- Strives for lowest possible barrier, treatment on demand

Urine Toxicology Outcomes for MA OBOT Sites



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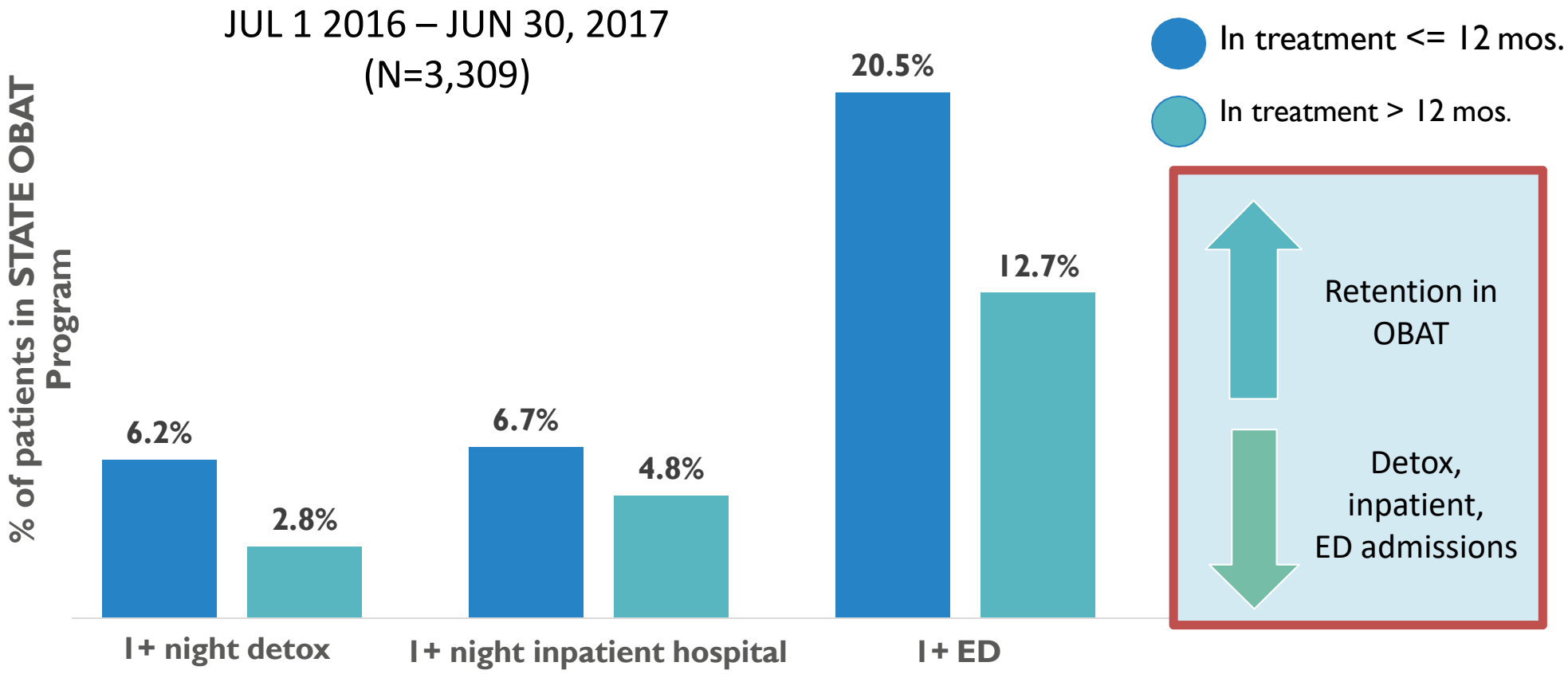
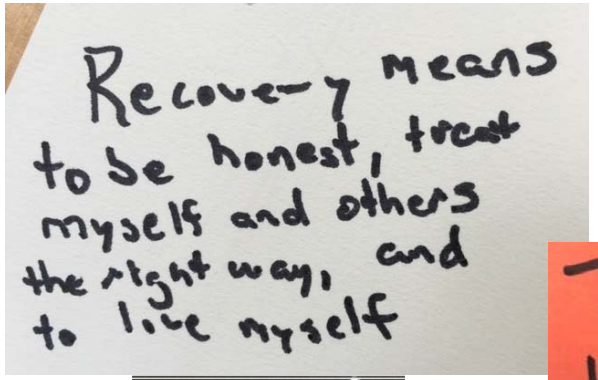
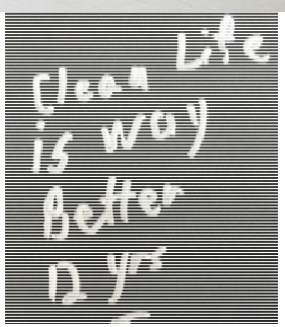
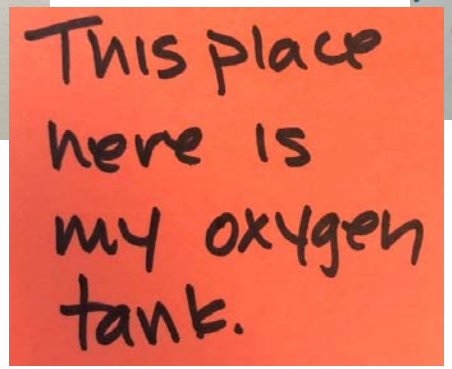
Health Care Utilization Outcomes MA OBAT Sites

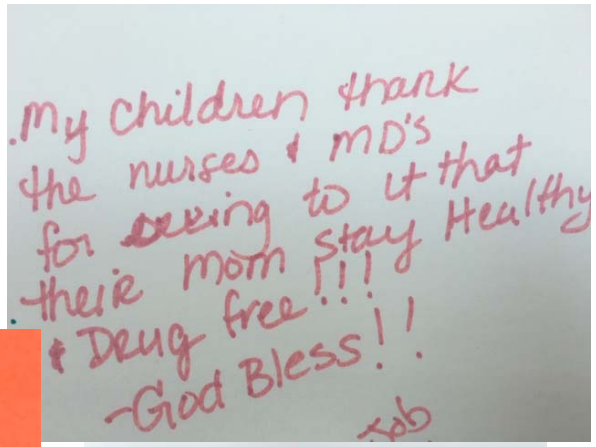


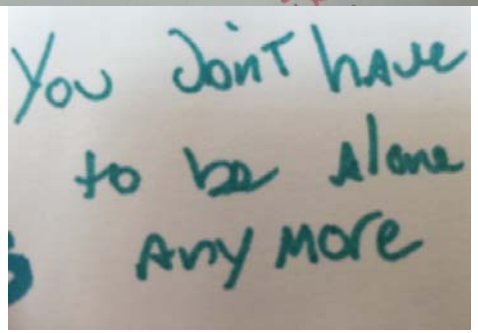
Patient Testimonials











How Can You Work with Your Local OBOT

- Develop a Qualified Services Organization Agreement (QSOA)
  - Should include types of services QSO provides, medical services (counseling services, on-site call coverage, treatment plan, etc.)
  - Discussions between LTCF and OBOT administrators should occur prior to admission of residents on MOUD
  - Should be completed prior to admission
- Release of Information (ROI)
  - This form helps to designate what information can be released
- Determine how the medication will be prescribed/dispensed to the resident

Office Based Addiction Treatment Training and Technical Assistance

OBAT TTA
Office Based Addiction Treatment Training and Technical Assistance

Boston Medical Center's OBAT TTA provides education to and technical support for health care professionals and support staff treating substance use disorders. We support and facilitate implementation of the Massachusetts Nurse Care Manager Model into practice settings with a focus on community health centers (CHC's). Trainings are also available to LTC staff.

Trainings include:

- Introduction to Addiction and Treatment
- Essentials of Office Based Addiction Treatment
- Buprenorphine Waiver Training for Prescribers
- Certified Addiction Registered Nurse (CARN) Review Course
- And many more….

Our website offers resources, including national and Massachusetts Clinical Guidelines, assessment tools, and documentation templates from NIDA.
To register for a scheduled training event, request a training event for your organization, or request technical assistance from our experienced addition treatment team, please visit:
WWW.BMCOBAT.ORG

Additional Community Supports

Community Supports

- Discussion Question
  - What have been some valuable resources within your community?

Community Resources

- Peer Recovery Coaches
  - Develop recovery plans and own recovery pathways and emotional support, information, concrete support, and connections.
- Patient Navigators
  - Identify resident needs and direct to sources of emotional, financial, administrative, legal, social, or cultural support.

"Peer support helped me see that I was not hopeless. It gave me my voice back and bolstered my self-worth." – Michelle

West Tennessee Area of Narcotics Anonymous. (n.d.) My Story. Retrieved October 2019, from https://www.na-wt.org/blog/my-story

Peer-driven Recovery Support Centers

- RECOVER Project, Greenfield
- Everyday Miracles, Worcester
- The Recovery Connection, Marlborough
- New Beginnings Recovery Support Center, Lawrence
- **Stairway to Recovery, Brockton**
- **STEPRox Recovery Support Center, Roxbury**
- **Devine Recovery Center, South Boston**
- **Quincy Recovery Support Center , Quincy**
- Holyoke Recovery Support Center, Holyoke
- Hyannis Recovery Support Center, Hyannis

www.helpline-online.com for locations

Community Supports

- Local services
  - Massachusetts Substance Use Helpline, 1-800-327-5050
    - English https://helplinema.org/
    - Spanish https://helplinema.org/?lang=es
- National Helpline
  - SAMHSA's National Helpline, 1-800-662-HELP (4357)
- Learn to Cope
  - Is a non-profit support network for parents, family members, and friends coping with a loved one addicted to opiates or other drugs.
  - (508) 738-5148 or https://www.learn2cope.org/

Community Supports, Cont'd

Mutual Help Groups

- Narcotics Anonymous (NA) – 12-step recovery program
- Nar-Anon – 12-step recovery program for family and friends
- SMART Recovery® – recovery program for all addictive behaviors focusing on self-regulating thoughts, emotions, and actions
- Dual Recovery Anonymous – 12-step recovery program for people with substance use disorders with simultaneous emotional or psychiatric illness

"Going to meetings has kept me clean when nothing else could, talking to other addicts, service work and surrounding myself with this program has been invaluable." – Terry

Source: https://www.na-wt.org/blog/my-story

Outpatient Counseling and Case Management Services

- Men's Health and Recovery – 774 Albany St Boston, MA 617-534-2185
- MOM's and MORE Program – 774 Albany St Boston, MA 617-534-7411
- AdCare – Locations throughout eastern MA, Toll free: 800-345-3552 , or http://adcare.com/
- Arbour – Locations throughout eastern MA, refer to website for location contact info: http://www.arbourhealth.com/
- Riverside – Locations throughout eastern MA, Phone: 781-329-4579

Harm Reduction Resources

- **Naloxone (Narcan)** can be picked up at any pharmacy in Massachusetts
- **SSP locations:** http://harmreduction.org/connect-locally/massachusetts/ahope/
- **AHOPE** – Harm reduction education and needle exchange site. Free HIV and STI testing, referral to treatment, Overdose Education and Narcan training.
  - 774 Albany Street, Boston, MA: Open M-F: 7:30am-4pm. 617-534-3967
- **Project Trust:** Drop-in navigation and referral services, harm reduction education and supplies.
  - 721 Mass. Ave, right next to the Mass Ave bus stop on the #CT1 or #1. M-F 8:30am-5pm.
- **SPOT:** Safe Place for Observation Treatment. 780 Albany Street, lobby, Boston, MA
- **Peer Support Meetings:** AA, NA, SMART Recovery, Refuge, ALANON

Additional Resources

Access to Treatment for SUD:

- SAMHSA National Hotline: www.samhsa.gov/find-help/national-helpline 1-800-662-HELP (4357)
- Massachusetts Treatment Resource linkage**:** https://helplinema.org/
- Project Assert**:** BMC, 850 Harrison Ave, Ground Floor, Rm. G301 617-414-4388 https://www.bmc.org/about-us/stories/bmcs-project-assert
- PAATHs: http://www.bphc.org/whatwedo/Recovery-Services/paaths-connect-to-services/Pages/paaths.aspx

Harm Reduction Education and Materials:

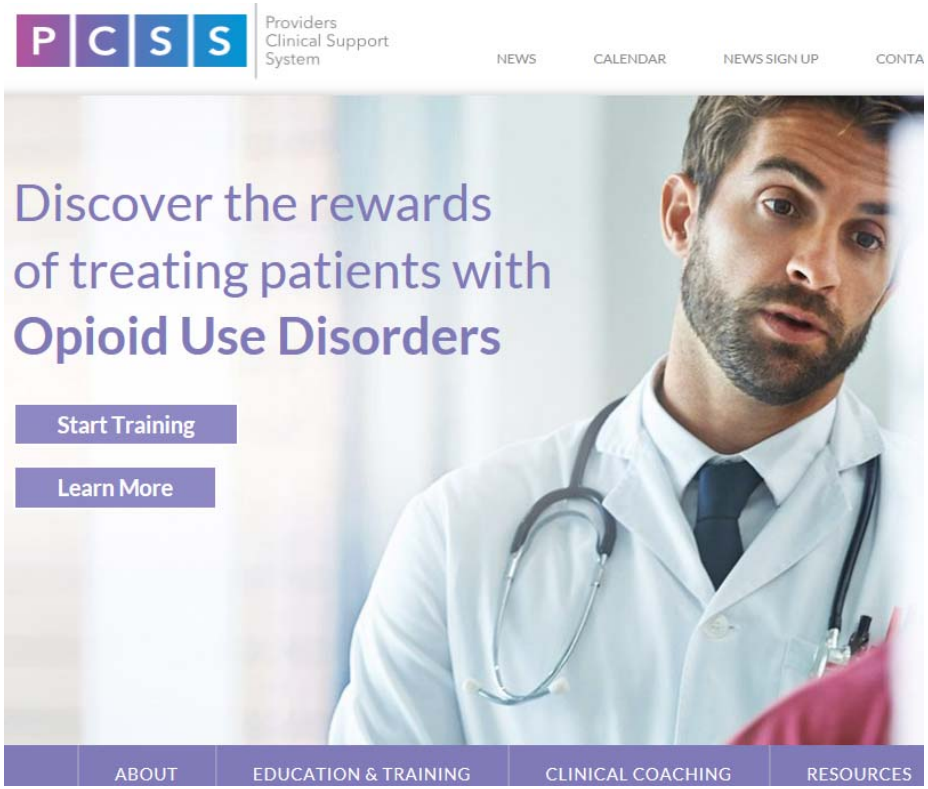
- Harm Reduction Coalition: http://harmreduction.org/
- Needle Exchange Sites: http://harmreduction.org/connect-locally/massachusetts/ahope/

Overdose Education and Naloxone:

- Prescribe to Prevent: http://prescribetoprevent.org/
- Office Based Addiction Treatment Training and Technical Assistance https://www.bmcobat.org/
- Where to access Naloxone in MA: https://www.mass.gov/service-details/how-to-get-naloxone

Additional Education Resources

globalacademy.hms.harvard.edu/OUDEP3



PROVIDER CLINICAL SUPPORT SYSTEM (PCSS)
HTTPS://PCSSNOW.ORG/

Policy Considerations at Your Organization

- Incorporate within policies a communication strategy and develop a plan of how you'll utilize community-wide resources in care of residents on MOUD.

Implementation of the Toolkit

Stephanie Baker, MHA, CPHQ

Objectives

- Identify available supporting resources
- Understand the layout and content of the toolkit
- Consider how to use the toolkit

Using the Toolkit

- MOUD comparison chart
- Tip 1- Understanding OUD
- Tip 2- Creating a therapeutic environment
- Tip 3- Organizational and workforce approaches
- Tip 4- Competencies
- Tip 5- Community-wide partnerships
- Tip 6- Transitions of care

Using the Toolkit

- Suggested policies
- Background information
- Resources/educational materials
- Implementation key point chart

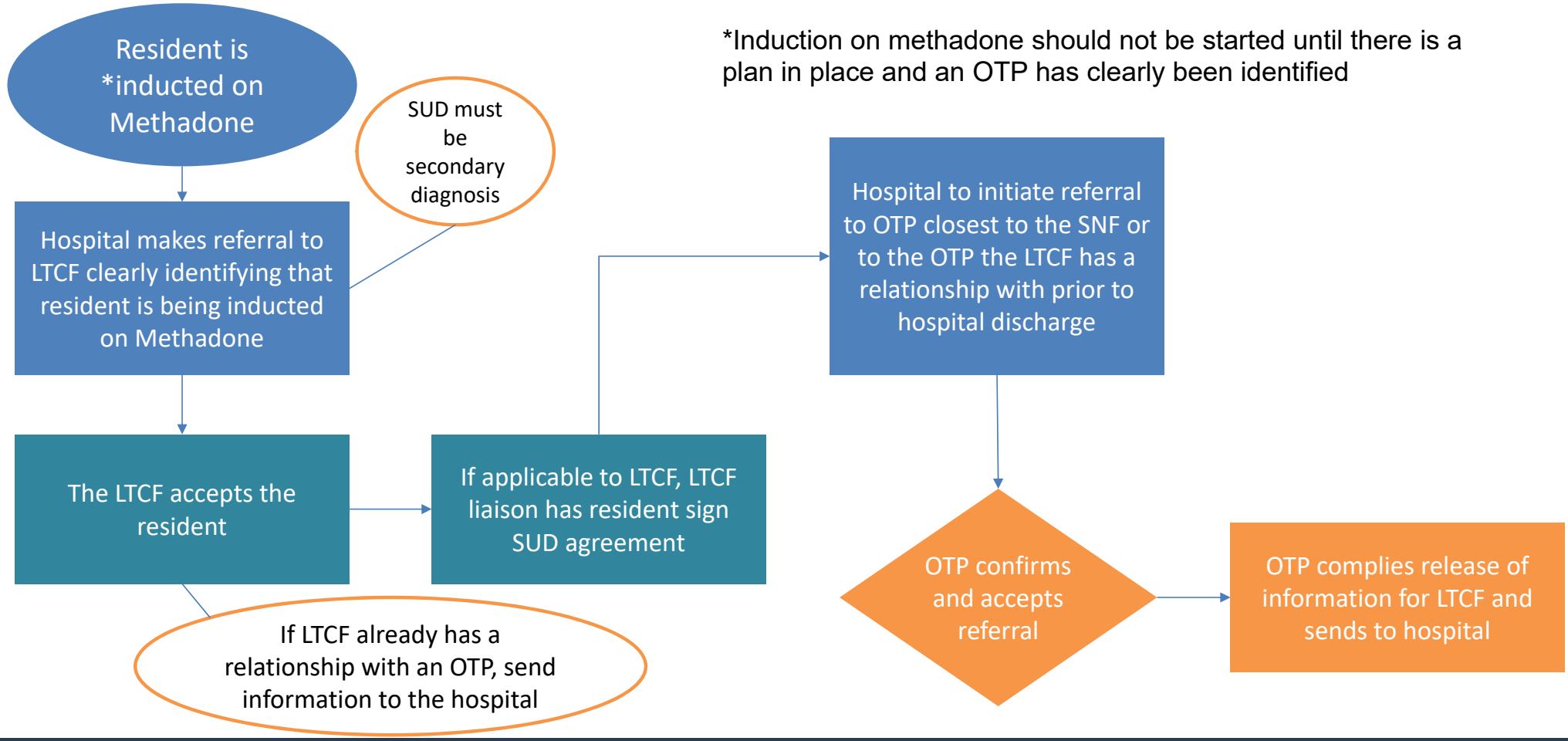
Core Competencies Checklist

- Core competencies checklist- knowledge, skill, or attitude
- Understanding OUD
- Special considerations
- Resident's social environment
- Caring for individual on MOUD
- Caring for the caregivers

Care Transitions

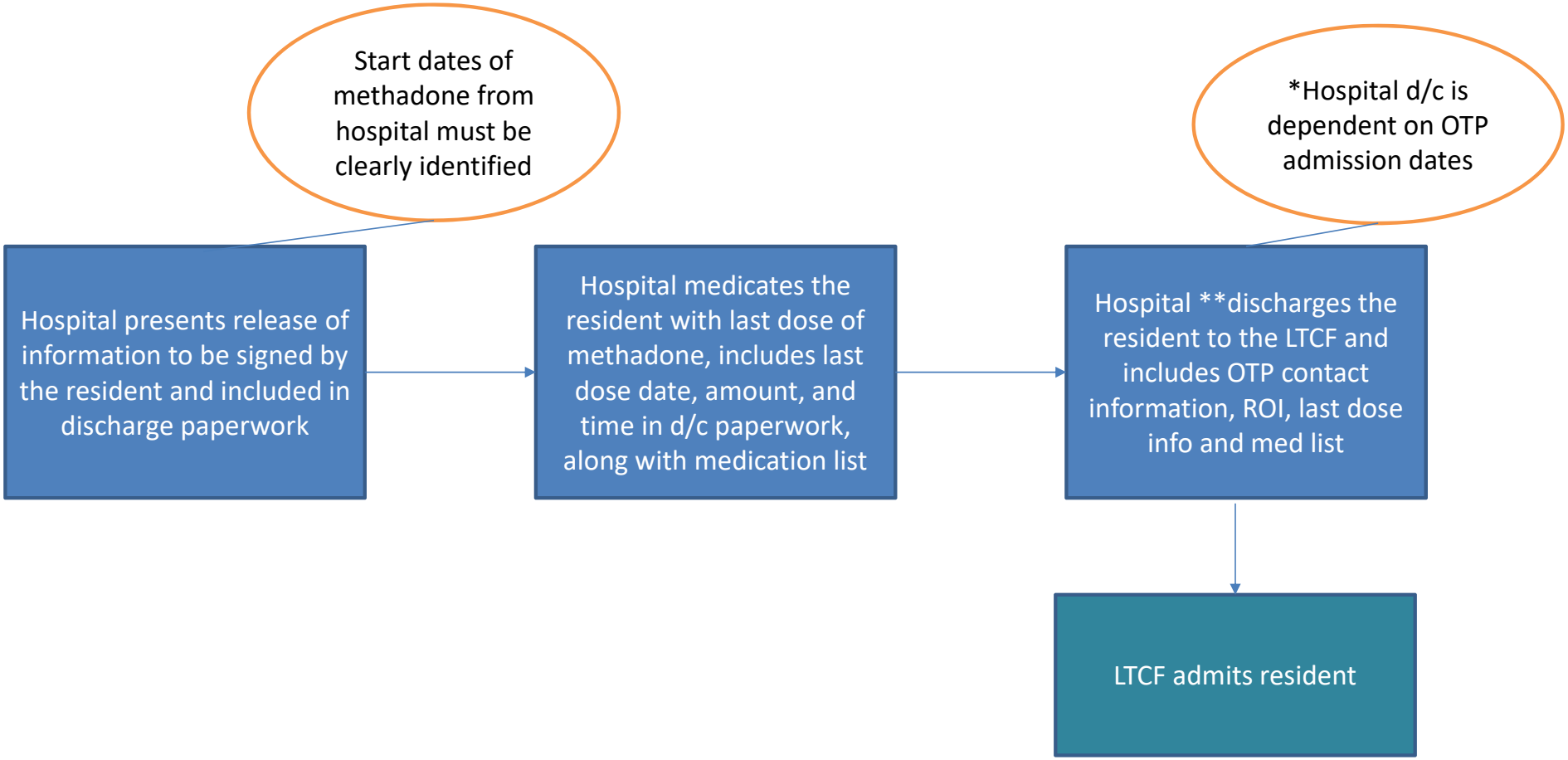
- Process Maps
  - Resident is on Methadone Maintenance (*only for residents on methadone maintenance*)
  - Resident is newly inducted on Methadone (*only for residents newly inducted on methadone*)
    - Note: Residents newly inducted on methadone will require more coordinated efforts between LTCFs and the OTP. Be sure to reach out to your community OTP regarding their admission process. Residents must be transported to the OTP the morning after they've been discharged from the hospital.
  - Resident is on Buprenorphine (*only for residents on Buprenorphine or Vivitrol, newly inducted or maintenance*)

Resident is Inducted on Methadone

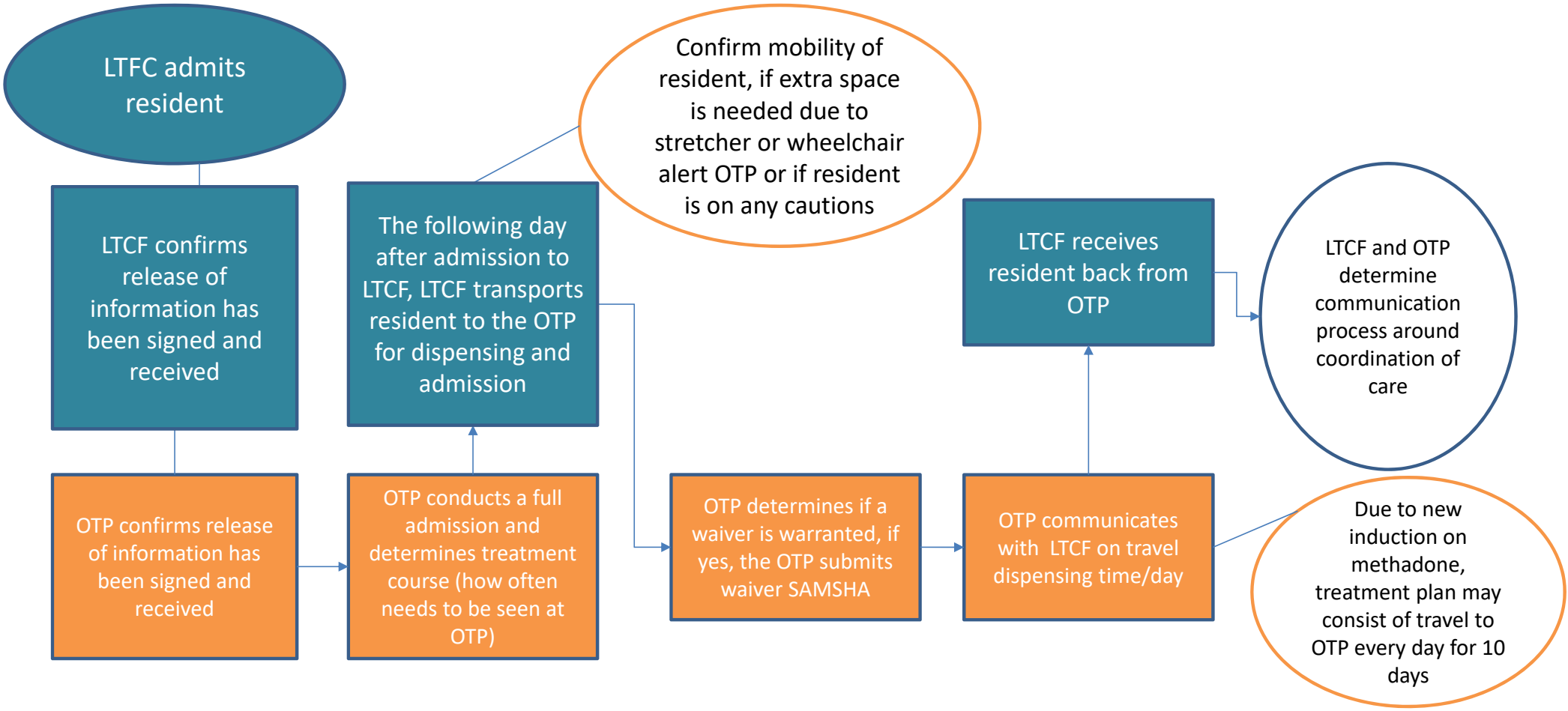


*Induction on methadone should not be started until there is a plan in place and an OTP has clearly been identified

Methadone Induction, continued



Methadone Induction, continued



Care Transitions

- QSOA
- ROI
- OUD agreement
- Management of pre-poured doses
- Self-administration
- Discharge planning

Transportation

- Transportation to and from OTP is not a covered service under Medicare or Medicaid
  - $180/day- average daily Medicaid reimbursement
  - $50-$100 plus mileage- average cost of round trip transportation

Transportation Options - No Take-home Waiver

- PT-1 Transportation – if OTP request
- Medical Necessity Form – if resident needs chair service
- Public transportation
- UberHealth
- LTCF own transportation

Transportation - Take-home Waiver in Place

- Diversion trained RN/LPN
- Coordinate with OTP for the best time
- Chain of custody form
- Lock boxes

Leaving in Action

Rosanna Bertrand, PhD

Opportunity to utilize resources

- OTP and OBOT resources
- Community resources such as recovery coaches
- LTCF resources

Our Next Steps

- Follow-up Technical Assistance via
  - Phone
  - Email
  - In-person visit
- Webinar
  - Peer-to-Peer opportunity to share case examples
  - Topic based on needs of the communities

Your Next Steps

- Review the toolkit
- Consider applying for DATA waiver
- Review facility policies and procedures
- Discuss opportunities to support residents on MOUD with other staff at your facility

150 YEARS OF ADVANCING PUBLIC HEALTH

Questions/Discussion

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Thank you!

A Few Logistics:

Please remember to turn in your evaluation

Continuing education certificates will be distributed electronically following the program

Substance Abuse and Mental Health Services Administration SAMHSA www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Abt

Healthcentric Advisors

MOUD IN LONG TERM CARE

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DPH blog
https://blog.mass.gov/publichealth

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