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Medication for Opioid Use Disorder in Long-Term Care Program

Final Year 1 Report

December 31, 2020

About This Report

This project was funded by a State Opioid Response grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Massachusetts Department of Public Health, Bureau of Substance Addiction Services.

Contents

Glossary

(Terms are presented in order of appearance.)

DPH	Department of Public Health
BHCSQ	Bureau of Health Care Safety and Quality
MOUD	Medication for Opioid Use Disorder
LTC	Long-Term Care
HCA	Healthcentric Advisors
OUD	Opioid Use Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response
LTCF	Long-Term Care Facility (includes nursing homes and rest homes)
OTP	Opioid Treatment Program
OBOT	Office-Based Opioid Treatment
COVID-19/COVID DEA	2019 Novel Coronavirus Disease
CoP	Drug Enforcement Agency
DON	Community of Practice
BSAS	Director of Nursing
CEU	Bureau of Substance Addiction Services
PIP	Continuing Education Unit
CNA	Performance Improvement Project
	Certified Nursing Assistants

Executive Summary

The Massachusetts Department of Public Health's (DPH) Bureau of Health Care Safety and Quality (BHCSQ) is responsible for ensuring residents receive safe care in their nursing homes. Through the Medication for Opioid Use Disorder in Long-Term Care Technical Support (MOUD in LTC) Program, Abt Associates (Abt) and our partner, Healthcentric Advisors (HCA), worked with BHCSQ to develop and execute a program for LTC staff on understanding opioid use disorder (OUD) and MOUD. The purpose of this program is to provide high quality continuity of care for residents receiving MOUD, and to develop community connections. DPH provided funding for this program through a Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response (SOR) grant.

Relevance of the Program

OUD affects people of all ages, races, ethnicities, income levels, and geographic regions. Data from the Centers for Disease Control and Prevention estimates that two million Americans had OUD in 2018,[1] about 1.7 million of whom were using prescription opioid painkillers. The most common reason for their starting to use opioids was for pain relief.[2] Older adults in particular may be at risk for opioid dependence and OUD. In 2016, one third of the older adult population enrolled in Medicare's prescription drug program received at least one prescription opioid. About one-in-ten of those Medicare beneficiaries receiving prescription opioids obtained these medications for three or more months—indicating regular/long-term use.[3]

MOUD is an evidence-based treatment for OUD that supports long-term recovery. MOUD is highly regulated, and for those receiving MOUD, a stay in a long-term care facility (LTCF) can pose challenges to continuous care. In 2016, DPH issued sub-regulatory guidance in the form of a circular letter[4] (see Appendix A) outlining the expectation that LTCFs provide MOUD to residents who require such treatment and who are otherwise eligible for admission.[5] Failure to provide care for these residents has been found to be in violation of the Americans with Disability Act. The purpose of this program is to provide support to LTCF staff in caring for residents diagnosed with OUD and to improve the coordination of care among opioid treatment providers, hospitals, and LTCFs.

Overview of Program Approach

Working collaboratively with the BHCSQ, the Abt Team recruited 42 LTCFs to participate in this program. We also engaged a statewide MOUD in LTC Workgroup to oversee the

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1 Centers for Disease Control and Prevention. 2019 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published November 1, 2019. Accessed May 22, 2020 from https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillancereport.pdf.

2 Centers for Disease Control and Prevention. 2019 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published November 1, 2019. Accessed May 22, 2020 from https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillancereport.pdf.

3 U.S. Department of Health & Human Services Office of Inspector General. (2018). Opioid Use in Medicare Part D Remains Concerning. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-18-00220.pdf

4 DPH Circular Letter: https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

5 Bureau of Health Care Safety and Quality. (2016, November 15). Mass.gov. Retrieved from Circular Letter: DHCQ 16-11-662 - Admission of Residents on Medication Assisted Treatment for Opioid Use Disorder: https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

development of program content. The group had been working with HCA for 18 months prior to the launch of the current program. During this period, they assisted with the development of clear processes and the identification of best practices around safe transitions of care for MOUD patients admitted to LTCFs. The MOUD in LTC Workgroup provided input periodically throughout the current program as the Team developed example policies, the MOUD in LTC Toolkit, core competencies, training materials, and the implementation approach. Their contribution to the current program builds upon the work they had done previously with HCA.

In addition to the LTCFs and the MOUD in LTC Workgroup, the Abt Team engaged five opioid treatment programs (OTPs) and five office-based opioid treatment providers (OBOTs) for this project. The Abt Team provided all 42 participating LTCFs with a MOUD in LTC Toolkit developed specifically for this program as well as in-person and remote training and technical support. The Team provided training and technical support through telephone and email contact, virtual site visits, an in-person learning session, and a virtual Project ECHO® series. The Team also conducted pre-implementation site visits to a sample of the participating facilities to learn more about their on-site practices and to interview staff. We collected qualitative and quantitative data to assess the program's impact. Additionally, in partnership with BHCSQ, the Team shared information about the MOUD in LTC Program with stakeholders, including non-participating LTCFs, by posting the MOUD in LTC Toolkit and other training materials on the BHCSQ website.

Impact of COVID-19

The Abt Team had proposed to conduct all components of the MOUD program as in-person events throughout the spring and summer of 2020. However, due to the novel coronavirus disease 2019 (COVID-19) outbreak, except for the first in-person learning session conducted in January 2020, we redesigned the mode of presentation to virtual events. During the interim we sent bi-weekly infographics to maintain facility engagement. The Team resumed telephone outreach in July; however, facilities were still overwhelmed as a result of COVID-19. Not only were they continuing vigilance to control the disease, but facilities were inundated with new reporting requirements, additional infection control oversight, and several required or incentivized Project ECHO® sessions. As a result, the later program activities experienced low participation rates.

Summary of Key Findings

This report summarizes key findings from the program, including:

- Key baseline in-person and telephone interview results.
- Key follow-up web-based survey results.
- Pre- and post-analyses of key items of interest from baseline and follow-up data collection.
- Evaluation results from the in-person learning session and Project ECHO® series.
- Pre- and post-assessment results from the in-person learning session.

Although LTCFs were chosen with intent so that half of the facilities would have experienced caring for residents with OUD, only six of 42 reported having admitted residents receiving MOUD in the past year. Licensed long-term care providers (i.e., physicians, nurse-practitioners, and physician assistants) can obtain a SAMHSA DATA waiver to prescribe certain MOUD, but only four of the 28 facility physicians interviewed had done so. Common challenges to admitting

residents with OUD reported by LTCFs included a lack of training and the stigma associated with OUD and MOUD. Results from the in-person learning session pre- and post-assessments and evaluations indicated a statistically significant improvement in knowledge gained during the session, and all attendees (100%) agreed or strongly agreed that attending the learning session was a valuable use of time. These findings suggest that the content developed under this program is a first step in addressing some of the challenges LTCF face when caring for residents in need of MOUD treatment.

1. Introduction

The BHCSQ is responsible for developing and leading the performance, accountability and quality improvement initiatives within DPH. It also provides technical assistance, consultation, planning support, and performance measurement across the agency. These activities cover over 2,000 Massachusetts health care facilities, including LTCFs. In order to better support LTCFs in the provision of care for residents diagnosed with OUD who are receiving MOUD, and to improve the coordination of care among opioid treatment providers, hospitals, and LTCFs, the BHCSQ funded the MOUD in LTC program through a SAMHSA SOR grant. This report details Abt Associates' methodological approach to developing and implementing the program and key evaluation findings.

1.1 Background

The aging of the population combined with the opioid epidemic has placed a greater demand on the need for LTC placement and the continuity of treatment for individuals with OUD. As with the population overall, as individuals with OUD reach middle-age, the likelihood of hospitalizations due to chronic illness (e.g., heart disease, chronic obstructive pulmonary disease, diabetes), injury or joint replacement, and the subsequent need for rehabilitation in a LTCF increases. In 2016, nearly 15% of long-stay nursing home residents were under age 65, as were nearly 19% of short-stay residents.[6]

Pursuant to DPH, LTCF administrators are expected to admit residents with a diagnosis of OUD, provided it is not a primary diagnosis, and to provide high quality, safe care including facilitating the continuity of MOUD treatment. Failure to provide care to residents with OUD has been found to be in violation of the Americans with Disability Act. Regardless of this expectation, many LTCF avoid admitting residents with a diagnosis of OUD and find it difficult to coordinate care with treatment programs. Facility staff offer a number of reasons for their reluctance including underlying biases, lack of understanding of OUD as a chronic disease, a misunderstanding of MOUD treatments, and concern for combining a younger population with OUD with a complex older adult population, among others.[7]

The purpose of this program was to provide training and technical support to help staff better understand OUD and MOUD, overcome barriers to LTCF admission, support LTCF staff in caring for residents diagnosed with OUD, and improve the coordination of community care among opioid treatment providers, hospitals, and LTCFs.

1.1.1 Overview of the Opioid Epidemic and Medication for Opioid Use Disorder

The current opioid epidemic began with the vast increase of potent prescription opioids in the 1990s, leading to the misuse of these medications.[8] Then followed a rapid increase in heroin use by 2010 and, by 2013, use of illegally manufactured synthetic opioids, primarily fentanyl.[9] In 2018, over 10 million people reported using prescription pain relievers without medical

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6 Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-term care providers and services users in the United States, 2015–2016. National Center for Health Statistics. Vital Health Stat 3(43). 2019.

7 Anecdotal feedback from facility staff during baseline telephone and in-person visits.

8 National Institute on Drug Abuse (NIDA). (2019). Opioid Overdose Crisis. Retrieved from: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis.

9 Centers for Disease Control and Prevention (CDC). (2019). Opioid Basics: Understanding the Epidemic. Retrieved from: https://www.cdc.gov/drugoverdose/epidemic/index.html.

authorization or other illegal opioids during the past year, and an estimated two million people met the criteria for OUD.[10]

Although OUD is a chronic condition, it is treatable.[11] Like other chronic diseases, medications are central to the treatment of OUD. People with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment.[12] The three medications approved by the Food and Drug Administration to treat OUD include naltrexone, buprenorphine – which is typically prescribed in a combination formulation with naloxone – and methadone.[13] MOUD is best administered in conjunction with behavioral therapies or other recovery support services, as medication alone is usually not a sufficient approach to treating OUD.[14]

MOUD in the Long-Term Care Setting

An unexpected hospitalization or transfer to a LTCF often poses challenges to continuity of care for residents who receive methadone or buprenorphine. The current opioid epidemic has resulted in an increased number of individuals receiving MOUD who may need admission to a LTCF for treatment of another diagnosis (e.g., joint replacement, injury, heart disease). As a result, the appropriate supports to care of this population are now in greater demand.

As with any other resident undergoing treatment for chronic diseases, residents with OUD should have access to medications, as well as individually tailored counseling, support services, and disease management care plans. If an individual treated with methadone or buprenorphine misses a dose, he or she may begin to experience withdrawal symptoms. Residents on MOUD should have consistent connection with their prescribing physician, OTP, or OBOT to ensure that they do not miss doses and that they continue to take their medications as prescribed.

1.2 Year 1 MOUD in LTC Program Activities

Although some LTCFs throughout Massachusetts provide care for individuals who require or receive MOUD, DPH identified gaps in the continuity of care for residents. To help address these gaps, the Abt Team worked with DPH and the MOUD in LTC Workgroup to develop and implement a multifaceted training and technical support program over the course of a year (additional detail regarding the MOUD in LTC Workgroup can be found in Section 2.1). Key program activities included:

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[10] Substance Abuse and Mental Health Services Administration. (2019). Results from the 2018 National Survey on Drug Use and Health: Graphics from the Key Findings Report. Retrieved from: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHffrBriefingSlides2018_w-final-cover.pdf

[11] National Institute on Drug Abuse (NIDA). (2019). Teaching Addiction Science. In: National Institutes of Health (NIH), U.S. Department of Health and Human Services. Retrieved from: https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/5-matching-patients-to-individual-needs.

[12] U.S. Department of Health & Human Services. (2019, June). TIP 63: Medications for Opioid Use Disorder. SAMHSA. Retrieved October 2019, from TIP 63: Medications for Opioid Use Disorder: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA19-5063FULLDOC

[13] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health Executive Summary. Washington, DC: HHS, November 2016. https://addiction.surgeongeneral.gov/executive-summary/report/early-intervention-treatment-and-management-substance-use-disorders

[14] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. https://addiction.surgeongeneral.gov/executive-summary/report/early-intervention-treatment-and-management-substance-use-disorders

- Identifying core competencies related to MOUD in LTC;
- Collecting baseline data via in-person and telephone interviews to gather information on current practices and to identify existing best practices related to MOUD in LTC; and,
- Providing training and technical support to all levels of LTCF staff to improve their ability to care for residents receiving MOUD, to make community connections, and to provide relevant resources.

The overall goal of the program was to ensure that LTCFs have the necessary skills and resources to provide high quality care to residents receiving MOUD. This included improving the practices of LTCFs already serving residents with OUD and discussing with administrators in facilities that have not yet admitted residents with OUD, which policies and procedures they should develop.

Forty-two LTCFs agreed to participate in the program. Facilities were located throughout the Commonwealth and selected so that there were relatively equal numbers of facilities in each of five Communities of Practices (CoPs). Each CoP was comprised of between seven and ten LTCFs, one OTP, and one OBOT. The types of technical support that the Abt Team provided included:

- One in-person, day-long learning session held in each of the five CoPs (five learning sessions in total);
- One virtual follow-up learning session for facilities that were unable to attend the in-person sessions;
- One six-session Project ECHO® series;
- Virtual technical support site visits;
- The development and dissemination of an evidence-based MOUD in LTC Toolkit for LTCF staff;
- The distribution of bi-weekly infographics, and relevant educational opportunities forwarded by DPH; and,
- On-going telephone and email support as requested.

Exhibit 1-1 provides an overview of program tasks and activities. The top row describes the contributions of the MOUD in LTC Workgroup (additional detail regarding the MOUD in LTC Workgroup can be found in Section 2.1). The center column describes the program's key activities categorized by development of the program framework, program operations, dissemination of materials and resources, and providing training and technical support. The bottom row lists reports and deliverables.

Exhibit 1-1. Overview of Key Program Tasks and Activities

MOUD Work Group	Review and Identify Core Competencies	Provide Input on the Development of Program Activities and Protocols	Finalize Program Materials, Including MOUD Policies and Procedures
Key Activity: Develop Program Framework		Key Activity: Program Operations	Key Activity: Disseminate Materials and Resources
Summarize existing resources Develop core competencies Identify existing strategies and tools Develop data collection tools		Conduct baseline and follow-up data collection Develop training materials Conduct in-person learning session Conduct virtual learning series	Site visit materials including example MOUD LTCF policies MOUD in LTC Toolkit Evidence-based infographics
		Key Activity: Provide Training and Technical Support Conduct learning sessions Conduct virtual technical support site visits Provide on-going telephone and email support	
Key Activity: Reports and Deliverables Start-up meeting Work plan Bi-weekly meetings with DPH Recruitment		MOUD in LTC Toolkit Data collection tools List of core competencies MOUD in LTC Workgroup meetings	Training curriculum Technical support Final report

1.2.1 Impact of COVID-19 on Program Activities

In March 2020, approximately eight months after the program began, and approximately two months after the first in-person learning sessions, the COVID-19 pandemic began to escalate in Massachusetts. Because those individuals over the age of 65 years and/or those with pre-existing conditions are more likely to experience severe complications from COVID-19, and because the disease is easily transmitted through close contact with others, LTCFs in the Commonwealth were disproportionately impacted by the pandemic. As a result, the technical support and training events were paused for a few months to allow the facilities to focus their attention on the epidemic. In addition, program activities were modified from in-person to virtual in response to the Governor's orders to reduce physical contact with LTCF employees and residents. As a result, the Team requested, and received, a three-month extension to complete all planned program activities.

1.3 Format of this Report

Section 2 of this report presents our methodological approaches to developing and carrying out the training and technical support, developing and administering data collection tools, and conducting analyses. In Section 3 we discuss notable program findings, including a summary of key baseline in-person and telephone interview and follow-up survey results, evaluation results from the in-person learning session, and pre- and post-assessment results from the in-person learning session. Section 4 provides a discussion of the findings presented in Section 3, including lessons learned, promising practices, and challenges experienced. Finally, we include recruitment materials, a list of our sampling pool, data collection protocols, and learning session presentations in the Appendices. The MOUD in LTC Toolkit can be accessed through this link: https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit

2. Methods

The key activities for the MOUD in LTC program involved selecting a sample of approximately 40 LTCFs and ten OUD treatment providers (five OTPs and five OBOTs), developing data collection and training materials, conducting in-person and virtual training events, disseminating bi-weekly infographics and other OUD-relevant materials, and conducting data collection and analyses. We describe the methods used to implement key MOUD in LTC program activities below.

2.1 MOUD in LTC Workgroup

In order to address the complexity of this program, the Team gathered a diverse group of professionals to serve on the MOUD in LTC Workgroup. The group utilized the principles of learning and organizing in action and included providers and stakeholders knowledgeable about MOUD and LTC. Exhibit 2-1 lists the MOUD in LTC Workgroup members and their affiliation.

Exhibit 2-1. MOUD in LTC Workgroup Members

Workgroup Member Name	Affiliation/Experience
Providers	
Ari Kriegsman, MD	Addiction Medicine Physician, Mercy Medical Center/Providence Behavioral Health
Simeon Kimmel, MD	Physician, Boston Medical Center
Kristin Wason, NP	Boston Medical Center Office Based Opioid Treatment Center
Matt Davis	Acadia Healthcare - National Organization and Opioid Treatment Program
Robyn Sloniecki	Royal Health Group - Corporate Nursing Home Group
Tracy Desruisseaux	Spectrum Health Systems - Opioid Treatment Program
Stakeholders	
Constance Peters	Association for Behavioral Healthcare
Helen Magliozzi	Massachusetts Senior Care Association (Nursing Home Association)
Leigh Simons Youmans	Massachusetts Health and Hospital Association
Ronald Pawelski	Massachusetts Association of Residential Care Homes

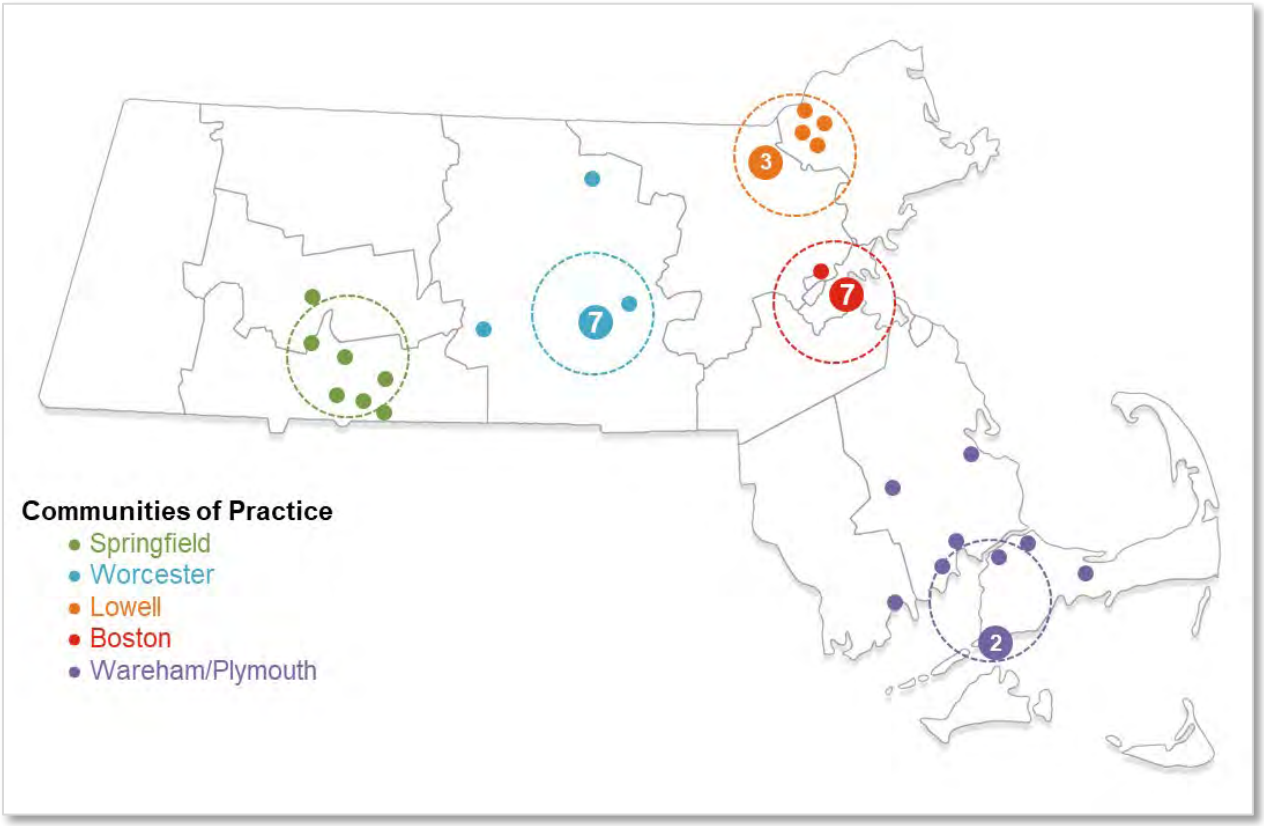
The MOUD in LTC Workgroup collaborated with the Abt Team to refine process maps and identify best practices for LTCFs for transitions of care for residents on MOUD. They reviewed and provided input on the MOUD in LTC Toolkit and contributed to the development of the in-person learning sessions and Project ECHO® series. In addition, some members of the MOUD in LTC Workgroup served as subject matter experts and presented during the in-person learning session and the Project ECHO® series. Initially, the MOUD in LTC Workgroup met every two weeks to provide input on the development of training materials and the MOUD in LTC Toolkit. The Abt Team also convened one in-person meeting focused only on the MOUD in LTC Toolkit. After the first three months, the group met monthly to receive updates on the program, collaborate on additional program activities, and provide feedback on any new program content under development.

2.2 Establishing Communities of Practice (CoPs)

In order to facilitate ongoing interactions, information sharing, and collaborative community connections, we established five CoPs geographically distributed throughout the Commonwealth and anchored around a local OTP and OBOT. To establish the CoPs, DPH provided the Abt Team with a list of Massachusetts LTCFs and a list of OTPs and OBOTs in the Commonwealth. We selected 60 potential facilities for recruitment based on geographical location, ownership, and whether or not the facility had admitted residents with a diagnosis of OUD in the past year (see Section 2.3 for details on recruitment).

All of the LTCFs included on the list provided by DPH, as well as the OTPs and OBOTs, were mapped using Maptive[15] software to identify clusters of facilities with the highest prevalence of residents with a diagnosis of OUD. A radius of five, 10, or 15 miles (depending on how dense the cluster of facilities appeared on the map) was then drawn around the center of each community and those facilities that fell within the boundaries were candidates to be included in the sampling pool of 60 facilities. Clusters identified were in and around the following Massachusetts' communities: Lowell, Springfield, Worcester, Boston, and Plymouth/Wareham. Figure 2-1 displays a map of the CoPs and the distribution of identified LTCFs within each.

Figure 2-1. Location of CoPs and Distribution of Facilities within CoPs



Note. Because of the response rate, facilities outside of the initial CoP area were selected and recruited.

Four technical support leads supported each of the five CoPs. Lowell, Worcester and Boston were each assigned one lead, while two leads shared Springfield and Wareham/Plymouth. Technical support leads were in charge of recruitment, served as the primary point of contact, and maintained communication to encourage engagement throughout the program for their assigned facilities.

2.3 Recruitment

The recruitment target was 40 LTCFs. To account for attrition, we initially sought to oversample by 10%, targeting 44 LTCFs. Recruitment targets were established for each CoP to ensure equal representation. To capture a true representation of LTCFs, we anticipated that 10% of the sample

[15] www.maptive.com

(four facilities) would consist of rest homes. Five OTPs and five OBOTs also participated in the program, one from each of the five CoPs.

2.3.1 Long-Term Care Facilities

The DPH list of LTCFs included the facility name, contact information, and a dichotomously coded variable indicating each facility as having one or more OUD admissions or having no OUD admissions within the past year with a diagnosis of OUD as reported on the Minimum Data Set (MDS). To ensure the diversity of operating procedures among participating facilities, we limited our selection to no more than two facilities from the same corporate ownership per CoP and no more than four overall.

Based on the criteria outlined above, and using the map of facilities located within the previously established CoP, the Abt Team identified five facilities in each CoP that reported on the MDS that they had admitted a resident with OUD within the past year, and five facilities that had not. In addition, we identified two rest homes in each of the five CoPs.

The Abt Team developed recruitment materials, located in Appendix B, to guide recruitment efforts. These include:

- A recruitment announcement invitation distributed to LTCFs by DPH;
- An email letter sent to LTCFs from DPH;
- Four versions of a recruitment script used to conduct telephone outreach: one each for LTCF administrators, LTCF directors of nursing (DON), LTCF medical directors, and OTPs and OBOTs; and,
- A follow-up email sent to facility contacts after the initial telephone call.

The final 60 facilities identified served as the sampling pool from which facilities were recruited. The Team aimed to recruit a relatively equal number of facilities in each CoP (i.e., eight or nine facilities). After DPH distributed the initial program announcement and granted permission to recruit facilities, technical support leads contacted the LTCFs in their assigned CoP(s) using the appropriate recruitment scripts, depending on who was available to speak about the program at the time. If no contact was made by telephone, technical support leads left messages and sent follow-up emails. Each technical support lead made multiple telephone and email attempts to recruit facilities over the course of a four-month recruitment period. In some instances, MOUD in LTC Workgroup members and DPH assisted with recruitment efforts by reaching out to facilities and encouraging their participation.

The Abt Team was not able to recruit the target number of facilities from the initial list of facilities provided by DPH. So, in collaboration with DPH, the team added facilities to each CoP and continued recruitment. By the end of the recruitment period, the technical support leads had reached out to a total of 105 facilities from which the 44 final participating facilities were recruited. However, administrators from two facilities who had agreed to participate were non-responsive after the initial data collection, and were ultimately considered lost to follow-up. The final number of participating facilities was 42. Exhibit 2-2 displays the number of each type of facility recruited in each CoP. The final list of participating facilities is located in Appendix C.

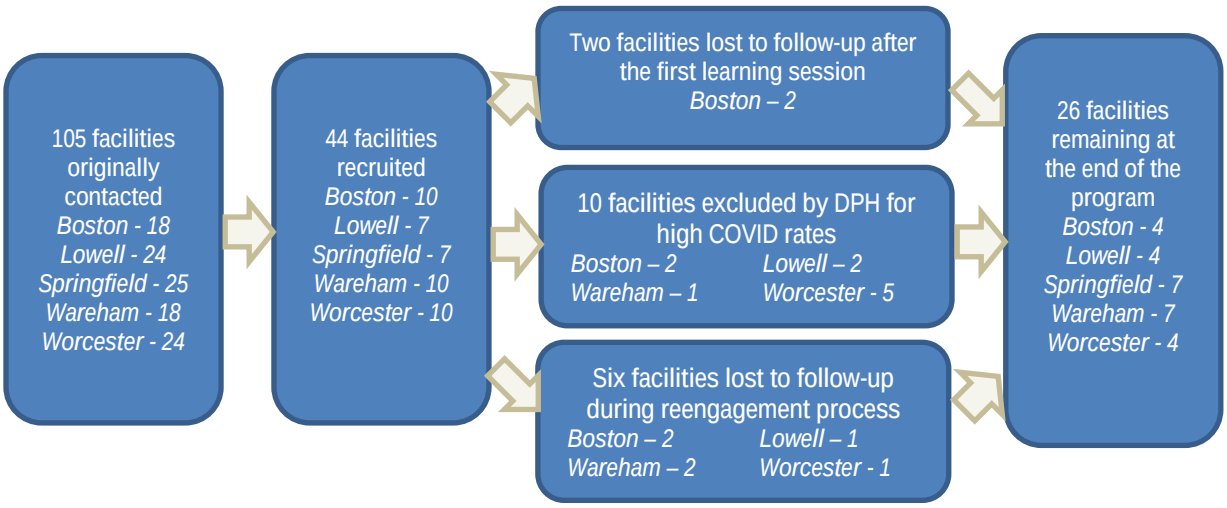
Exhibit 2-2. Total Number of Recruited Facilities by CoP and Type

CoP	# of Participating Facilities With Residents Who Have OUD	# of Participating Facilities Without Residents Who Have OUD	# of Participating Rest Homes	Total # of Participants in Each CoP
Boston	2	5	1	8
Springfield	2	3	2	7
Worcester	7	2	1	10
Wareham	7	3	0	10
Lowell	4	3	0	7
Overall	22	16	3	42

Reengagement Outreach

In June 2020, the Abt Team began direct outreach to reengage facilities in the program after delays due to the pandemic, and to inform them about upcoming events. DPH gave Abt a list of 10 facilities to exclude from the program due to their high rates at the time of COVID-19. The technical support leads made several outreach attempts to the remaining 32 facilities via email and telephone using revised recruitment materials (see Appendix D). Between July and August, an additional six facilities either withdrew from the program, or were nonresponsive to reengagement attempts, resulting in 26 participating facilities. Figure 2-2 displays the flow of recruitment from sample selection through final attrition.

Figure 2-2. Sample Selection and Attrition



2.3.2 Opioid Treatment Programs and Office-Based Opioid Treatment Providers

A convenience sample of ten opioid treatment providers, one OTP and one OBOT in each CoP, participated in the program. The selection of opioid treatment providers was based on suggestions from members of the MOUD in LTC Workgroup and DPH. All OTPs and OBOTs invited to participate in the program agreed to do so. Exhibit 2-3 presents a list of participating opioid treatment providers.

Exhibit 2-3. Participating OTPs and OBOTs by CoP

CoP	Participating OTP	Participating OBOT
Boston	Habit OPCO	Boston Medical Center
Springfield	Providence Hospital	Clean Slate - Springfield
Worcester	Spectrum Health Systems	Community HealthLink
Wareham	Habit OPCO	Clean Slate - Wareham
Lowell	Habit OPCO	Greater Lawrence Family Health Center

2.4 MOUD in LTC Core Competencies

The Team developed training materials based on a set of core competencies related to MOUD in LTC. The core competencies defined levels of expected capabilities for providers caring for residents with OUD and served as the guiding standards for the program. We conducted an initial literature review/environmental scan to identify potential competencies such as: understanding OUD as a disease, trauma-informed care, stigma, recognizing withdrawal and overdose, how to assess individuals for OUD, treatment modalities, among others. To identify potential competencies, the Abt Team conducted a simple search of websites, grey literature and the peer reviewed literature using Google and Google Scholar with the following search terms:

> *"opioids" + "opioid use disorder/medication opioid use disorder - MOUD" + "older adults" + "medication-assisted treatment - MAT" + "long term care facilities" + "nursing homes"*

This search yielded approximately 40 relevant resources that served as the basis for the draft list of competencies. The first iteration of the list was reviewed by the Abt Team and DPH. After incorporating their input, the Team submitted the next iteration of the list to the MOUD in LTC Workgroup. The MOUD in LTC Workgroup helped to further narrow and prioritize the list. The Abt Team submitted the third iteration of the list to an interdisciplinary group at DPH including the Bureau of Substance Addiction Services (BSAS), the Massachusetts Division of Health Care Facility Licensure and Certification, the Office of Health Equity, the Bureau of Community Health and Prevention, and others for their review. Following another round of review by the MOUD in LTC Workgroup and DPH, the final list of competencies was compiled and submitted to DPH. Thirty-five of the 40 results from the initial search were included as citations in the final list. Exhibit 2-4 contains the final list of OUD- and MOUD-related care core competencies.

Exhibit 2-4. Final MOUD in LTC Core Competencies

Understanding OUD: LTCF clinicians must develop and maintain knowledge, skills, and attitudes about OUD to effectively care for individuals with this chronic, re-occurring medical condition.	
Culturally responsive clinical skills when caring for residents with OUD from diverse backgrounds Distinction between use, dependence and use disorder Recognize and manage intoxication, withdrawal or overdose	Trauma informed care, including universal suicide/self-harm risk screening Stigma and dispelling misconceptions Ethical and legal guidelines when caring for residents with OUD, including current 42CFR overview
Safety Considerations for LTCF Residents with OUD: Although the LTCF population primarily includes an older and more medically complex population than individuals who reside in the community, it may also include younger adults who are admitted for short-term rehabilitation or are medically compromised and need the level of care provided in a LTCF. The following safety considerations apply when managing residents receiving MOUD.	
Medical co-morbidities Mental health/psychiatric co-morbidities Managing acute and chronic pain and OUD	Appropriate dosing Polypharmacy and drug interactions Selecting appropriate and supportive activities
LTCF Residential Milieu/Social Environment: The best practices and guidance of LTCF with residents who have OUD. LTCFs have best practices and guidance which apply to all residents, including those with OUD	
Resident-centered care Setting boundaries for residents, staff, and visitors	Assessing and treating high-risk residents with OUD Culturally and linguistically appropriate resources Strategies to optimize resident and staff safety
Caring for Residents Treated With MOUD in LTCF: Residents can receive MOUD treatment while residing in LTCFs even though these facilities are not designated as OTP or OBOT programs	
Pain management: residents with OUD require consistent and regular assessment of pain and functional levels Goals of MOUD Treatment modalities including methadone, buprenorphine, naltrexone, counseling/recovery support/peer support-coaching Meaningful communication with treatment programs Record-keeping Reporting requirements for overdose events Effective assessments and care plans based on the unique needs of each resident	Discharge planning including continuity of care and resources Protocols for medication changes and needs Competency administering naloxone (Narcan) to reverse opioid overdose to include overdose/harm reduction strategies Arranging transportation Storing, dispensing, and transporting MOUD Activities in LTCF Engaging residents' family members and friends (with residents' consent) by sharing their treatment goals and agreements
Caring for the Caregivers	
Setting personal and professional boundaries Recovering from traumatic events (e.g., overdose event or unexpected resident death) Debriefing after a crisis	Recognizing and preventing burn out Community resources (e.g., Nar-Anon, Al-Anon, Al-Ateen, family counseling)

2.5 Training

The Abt Team developed two training opportunities for this program: the in-person learning session and the virtual Project ECHO® learning series. Each of these structured trainings provided participating facilities with opportunities to develop a fundamental understanding of OUD as a disease and processes to care for residents with OUD and to coordinate MOUD. The trainings also served to establish relationships with other facilities and MOUD providers in order to promote information sharing and collaborative learning.

Because the initial in-person learning session was so well-received, DPH extended the contract so that we could add a second in-person learning session. However, due to social distancing regulations related to COVID-19, we had to pivot and develop a virtual learning series using Project ECHO®. The slides for both training events went through a multi-faceted review process including internal iterations, review by content editors, MOUD in LTC Workgroup clinicians and subject matter experts, and a final internal review (white-glove approach). The DPH

interdisciplinary group mentioned above also reviewed the slides at multiple points throughout development. The PowerPoint presentations developed for the in-person learning session and the Project ECHO® series are included in Appendix E.

Continuing Education Units

The Abt Team offered continuing education units (CEUs) to staff who participated in the in-person learning sessions and Project ECHO® series. The in-person learning session received approval for 4.5 prescribed credits for physicians by the American Academy of Family Physicians, and 4.5 contact hours for nursing by the Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Each Project ECHO® session received approval for one contact hour for nursing by the Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation, one Social Work continuing education hour for re-licensure, in accordance with 258 CMS, NASW-MA Chapter, and one contact hour for Nursing Home Administrators.

Securing Speakers

The Abt Team secured subject matter experts and speakers for the in-person sessions and the Project ECHO® series through recommendations from the MOUD in LTC Workgroup members as well as known experts in the field of OUD, recruited OTPs and OBOTs, and local community resources within the CoPs. Each of the speakers met with the Team to discuss the goal of the program and to review the trainings and resources developed as part of the program (e.g., the MOUD in LTC Toolkit). Multiple touchpoints via phone and/or email occurred with each speaker prior to the in-person sessions and Project ECHO® series to inform speakers about edits to the slides and provide updates on the agenda.

2.5.2 In-Person Learning Session

The in-person learning session content was offered five times in January 2020, once in each CoP for the convenience of the facilities, to promote community connections, and to foster networking among neighboring facilities. The Abt Team developed the overall presentation, which was then tailored by the subject matter experts from each respective CoP who agreed to present during the session. The sessions aligned with the themes presented in the MOUD in LTC Toolkit. The objectives for the in-person learning session were as follows:

- Recognize and address the stigma of OUD in LTC;
- Discuss how OUD presents, and the biological effects and underlying causes of OUD;
- Gain knowledge of the different types of OUD treatment including MOUD; and,
- Identify strategies to enhance best practices across the continuum of care.

The session in each of the CoPs followed the same agenda and covered the same topic areas. The one exception was the presentation of local CoP speakers who shared content and resources specific to their CoP. Local speakers presented on topics that included understanding OUD, an overview of their OTPs and OBOTs, and collaborating with community-based organizations. To remain consistent, the Abt Team provided each local speaker with a template that they could tailor and into which they could insert additional information that was relevant to their specific CoP and organization. In addition, a local person in recovery spoke at the beginning of each session to share their experiences with OUD. Members of the Abt Team, a pharmacy consultant, the DPH interdisciplinary group, and MOUD in LTC Workgroup members presented other

topics, including the call to action, an overview of medications used to treat OUD, approaches to delivering person-centered care, and a general overview of the MOUD in LTC Toolkit.

All in-person learning session attendees received a packet of information upon arrival which included the agenda for the day, a copy of the presentation, the MOUD in LTC Toolkit (one per facility), and an evaluation form. In addition to the packet, attendees received a knowledge assessment form at the beginning and end of each session. Clinical staff (physicians and nurses) who attended the in-person learning session could receive CEUs for participating. Virtual "make-up" learning sessions covering the material presented during the in-person learning session were held in July 2020 for staff from facilities who were unable to attend the in-person learning session.

2.5.3 Project ECHO® Series

The purpose of the six session Project ECHO® series was to build upon the information shared at the in-person learning session by taking a deeper dive into specific topics. The series, presented from mid-August through September 2020, focused on how to operationalize transitions of care for residents on MOUD and addressed topics of interest identified in the first learning session including regulations, telehealth, and transportation. In order to meet this objective, Project ECHO® was selected as the modality for the learning series, as it allows for opportunities to provide interactive sessions and peer to peer mentoring.

Extension for Community Healthcare Outcomes (ECHO) is an innovative tele-mentoring program that was developed in 2003 as a model of healthcare delivery to improve the care for rural, underserviced, and socially disadvantaged Hepatitis C patients in New Mexico. The purpose of the program is to create virtual communities of learners by bringing together healthcare providers and subject matter experts using videoconference technology, brief lecture presentations, and case-based learning, fostering an "all learn, all teach" approach. Participants are engaged in the bi-directional virtual knowledge network by sharing clinical challenges and learning from experts and peers.

The Project ECHO® series developed for the MOUD in LTC program focused on facilitating the continuity of care for residents with MOUD through the use of adult learning techniques. The series consisted of six, one-hour sessions. Speakers included subject matter experts from the MOUD in LTC Workgroup, facility representatives, one private transportation company, and DPH. The objectives of the Project ECHO® series were as follows:

- Interpret how DPH regulations fit into caring for LTC residents with OUD and how facilities can ensure fidelity;
- Identify key steps in the transition process for residents receiving MOUD;
- Define best practices for communicating with OTPs and OBOTs in caring for residents receiving MOUD; and,
- Summarize examples of how to address various social determinants of health such as transportation and housing.

Each of the six sessions focused on a different topic area and all sessions followed the same agenda and format, including a case example offered at each session. Exhibit 2-5 provides an overview of the information covered in the series.

Exhibit 2-5. Description of Project ECHO® Series Content

Session	Description
One - Telehealth	Didactic: • Reviewed current telehealth guidelines and identify one-way telehealth impacts MOUD management. Case Example: • A participating LTCF presented on how they have been able to utilize telehealth to provide counseling for a resident on MOUD.
Two – Transitions of Care to LTCF	Didactic: • Discussed key steps in the transition process from hospital LTCFs for residents on MOUD that will help establish necessary communication between LTCFs and OTPs/OBOTs. Case Example: • BSAS provided an example of key discussions that should occur between the hospital, OTP, and LTCF regarding resident's current medications, timing of discharge, and if resident reported pain and withdrawal symptoms upon arrival.
Three - Partnerships	Didactic: • Discussed best practice to aid in communicating with a facility's OTP/OBOT in caring for residents on MOUD. Case Example: • Participating LTCF presented on some key best practices and some challenges they have had in partnering with their local OTP around a resident that was on methadone.
Four - Transportation	Didactic: • Discussed some creative ways to provide transportation for residents on MOUD. Case Example: • Participating LTCF presented on some methods they have found to work in transporting patients to their appointments and some challenges they have encountered.
Five - Transitions of Care to home	Didactic: • Discussed housing options that exist for residents who are ready for discharge from the LTCF. Case Example: • Open discussion around the various housing options within each community, including some barriers to finding housing.
Six- Regulations	Didactic: • Interpret how state and federal regulations fit into caring for your residents with an OUD. Case Example: • BSAS provided case and open discussion on various regulations a LTCF may encounter including storage of methadone, resident in withdrawal, and administering naloxone (Narcan).

Clinical staff (social workers and nurses) and nursing home administrators who attended each session in the Project ECHO® series were eligible to receive CEUs, with one unit awarded for each session attended, up to six units.

2.6 Technical Support

Over the course of the program, the Abt Team provided nursing homes staff with various modes of technical support including virtual site visits, the dissemination of the MOUD in LTC Toolkit and bi-weekly infographics, and on-going telephone and email communication. Technical support was available to assist staff in developing policies and procedures relevant to MOUD,

provide modules for training all levels of staff on OUD and MOUD, and maintain engagement between the more intensive aspects of the program.

2.6.1 Virtual Site Visits

Originally, in-person site visits were to be conducted at each of the 42 participating facilities, during February and March 2020. However, because of the COVID-19 outbreak, this program activity was redesigned as group virtual events. The Team offered several virtual site visit opportunities on a variety of days and times in July and August. Attendees were divided into four cohorts as follows:

1. Administrators/DONs from facilities that had experience caring for residents with OUD;
2. Staff developers from facilities that had experience caring for residents with OUD;
3. Administrators/DONs from facilities that had not cared for residents with OUD; and,
4. Staff developers from facilities that had not cared for residents with OUD.

Because we wanted to offer participants multiple opportunities to attend, we did not group the visits by CoP. Each technical support lead facilitated two site visits and took notes for two.

Each technical support lead scheduled the virtual site visits through the facility's administrator via email. If the administrator was not responsive to attempts to schedule site visits through email, the technical support lead conducted follow-up telephone calls. If an administrator continued to be unresponsive after four attempts, the technical support lead informed them of the upcoming Project ECHO® series and sent them a sample performance improvement plan (PIP), an example of a MOUD-related policy, and the site visit presentation by email.

After the site visits were scheduled, technical support leads sent email invitations to the administrator, DON, and staff developer. Each email invitation included an agenda, a link to the virtual site visit WebEx meeting, the site visit presentation and supporting documents, the MOUD in LTC Toolkit (if they did not attend the in-person meeting), the sample PIP, an example policy, and a copy of the circular letter issued by DPH[16] (located in Appendix A). Reminder emails were sent and telephone calls were made frequently in the weeks leading up to the site visit. During the scheduling process, the technical support leads confirmed that site visit participants at each facility would have access to a computer with a camera. If a facility did not have a computer with a camera available, the program mailed a camera to them. Thirteen of the remaining facilities responded and scheduled site visits; nine ultimately participated.

The Abt Team developed two sets of site visit presentations (one for administrators/DONs, one for staff developers) with one item specific to facilities that had experience caring for residents with OUD. The same process used to review the training event materials was used to review the site visit presentations. This included multiple internal iterations, review by MOUD in LTC Workgroup clinicians and subject matter experts, and a final internal review. The DPH interdisciplinary group also reviewed the site visit presentations at multiple points throughout development. Each presentation was designed to last between 30 and 60 minutes (for staff developers and administrators, respectively). The site visit presentations are located in Appendix F and cover the following topics:

[16] DPH Circular Letter: https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

- Perspectives on the status of implementation of MOUD policies;
- Current MOUD policies at each facility and, for example, whether or not those policies have been updated, are specific and in line with current regulations, identify responsible parties and a timeline for development/update as needed;
- Example of PIPs and the advantage of conducting a PIP on the processes for residents receiving MOUD;
- Monitoring outcomes for residents receiving MOUD and the importance of doing so;
- Training modules for all levels of staff on caring for residents with OUD;
- Naloxone (Narcan) and related policies;
- A review of the MOUD in LTC Toolkit; and,
- Challenges to policy implementation and recommendations for troubleshooting.

To prepare for the site visit and to be able to establish rapport with participants, prior to the site visits, facilitators reviewed the following information for each facility:

- The impact of COVID-19 on the facility by determining the number of cases and deaths at the facility.
- Baseline in-person and telephone interview results.
- Confirm whether or not they have a history of admitting residents with OUD who are receiving MOUD.
- Review barriers to admitting or caring for residents with OUD.
- Review concerns regarding care transitions, collaborations, and other relevant issues.
- Availability of naloxone (Narcan).
- Relevant state survey results, particularly those related to care planning and any deficiencies in areas related to care for residents with OUD.
- Relevant MOUD in LTC Toolkit sections.

In addition, site visit facilitators reviewed the circular letter issued by DPH[17] (see Appendix A) and completed a sample PIP on the processes for residents receiving MOUD, including examples of measurement to monitor outcomes.

2.6.2 On-going Communications

Throughout the life of the program, the Abt Team maintained a designated email box for program communications that was monitored Monday through Friday during working hours. In addition, the Abt Team was available via telephone to respond to questions or concerns posed by staff from participating LTCFs. To maintain program involvement and engagement, the Abt Team provided participating facilities with relevant program communications throughout the duration of the program, such as bi-weekly infographics, updated COVID-19 regulations as they pertained to LTCFs and MOUD, and opportunities for learning events on relevant topics, such as

[17] DPH Circular Letter: https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

webinars offered by the Commonwealth or other organizations. Figures 2-3 and 2-4 provide an example of the type of infographics distributed to participating facilities over the course of the program.

Figure 2-3. Example Infographic Distributed to Participating Facilities

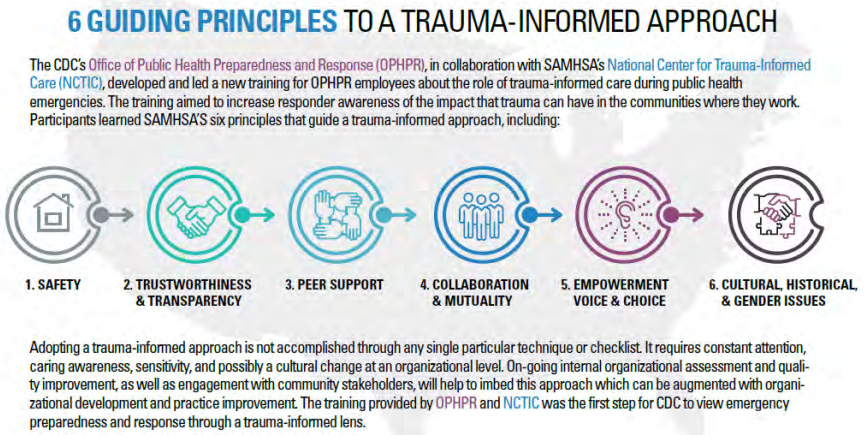
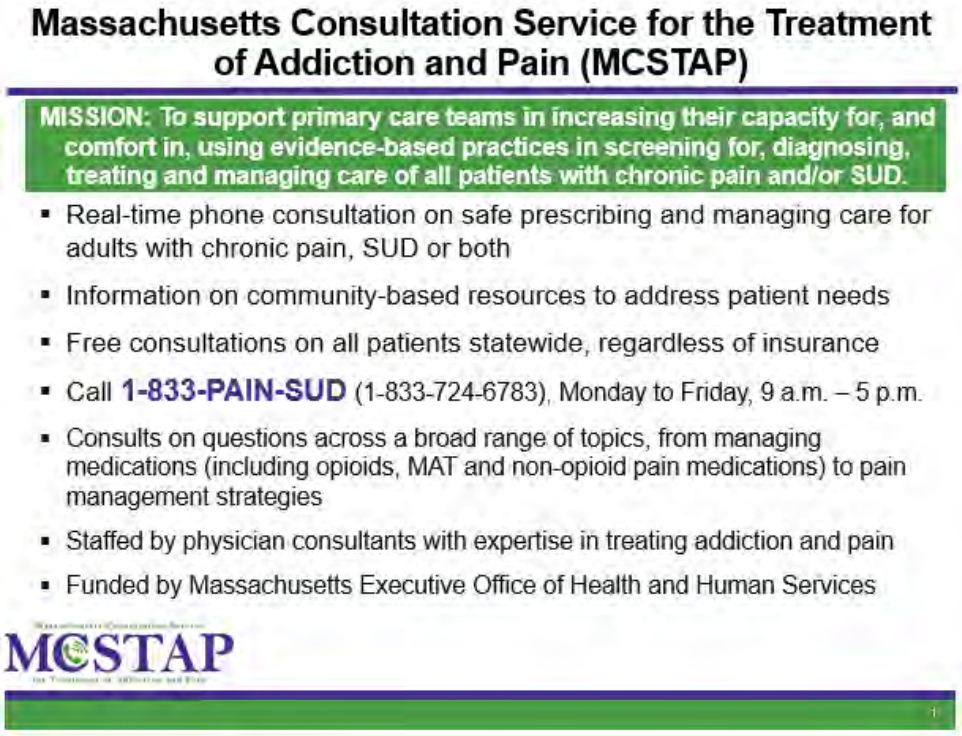


Figure 2-4. Example Infographic Distributed to Participating Facilities



2.6.3 MOUD in LTC Toolkit

The purpose of the MOUD in LTC Toolkit is to help LTCFs comply with state and federal policies and provide evidence-based care to residents on MOUD. Resources incorporated throughout the kit were designed to be utilized by administrators, DONs, medical directors, social workers, nurses, and certified nursing assistants (CNAs). The Abt Team developed the toolkit by employing a user-centered design framework, engaging stakeholders, providers, and end users to capture the needs of all intended audiences, and to build an end-user perspective into

every tip throughout the MOUD in LTC Toolkit. Multiple experts, writers, and editors contributed to the development of the MOUD in LTC Toolkit. Multiple check-in sessions were held with toolkit contributors to monitor progress. Clear processes for editing the MOUD in LTC Toolkit and defined editor roles were also developed in order to check on content, conduct clinical reviews, and consolidate feedback from reviewers, among other activities. The MOUD in LTC Toolkit went through a multi-faceted review process including multiple internal iterations, review by content editors, MOUD in LTC Workgroup clinicians and subject matter experts, and a final internal review (white-glove approach). The DPH interdisciplinary group also reviewed the toolkit at multiple points throughout development.

The MOUD in LTC Toolkit contains six sections, or "tips", to help LTCFs care for residents on MOUD. Each tip follows a uniform organizational structure and includes suggested policies, processes, and educational resources to better prepare LTCFs to work with and provide continuity of care to residents. The MOUD in LTC Toolkit tips are as follows:

- Tip 1: Understanding Opioid Use Disorder
- Tip 2: Creating a Therapeutic Environment
- Tip 3: Organizational and Workforce Approaches to Person-Centered Care
- Tip 4: Demonstrated Competencies
- Tip 5: Community-wide Resources and Partnerships
- Tip 6: Transitions of Care

The appendices consist of a table of pharmacotherapy options, process maps for transitions of care, and template forms LTCFs can adjust to fit their needs. A copy of the MOUD in LTC Toolkit is located at following link: https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit.

2.7 Evaluation

To conduct the evaluation, we collected pre- and post-program data, event evaluations, and pre- and post-in-person event knowledge assessments. In this section we describe our approach to developing data collection materials and our methods for collecting and analyzing the data collection. All data collection instruments went through the typical internal review process before DPH reviewed and approved draft and final versions

2.7.1 Baseline, Pre-Program Data Collection

The Abt Team administered in-person and telephone baseline interviews to staff from all 42 LTCFs and the selected OTPs and OBOTs. The interviews were conducted soon after the contract award (September through December 2020). The baseline interviews were programmed into the SurveyGizmo® platform so that responses could be recorded after the interview. SurveyGizmo® is user friendly and the results are easy to analyze and visualize in tables and graphics.

Baseline, Pre-Program LTCF Staff Interview Guides

The Abt Team drafted baseline semi-structured interview guides based on the core competencies, with significant input from the MOUD in LTC Workgroup. The interviews included items on whether or not facilities had received or were offered MOUD training, the number of past and current residents receiving MOUD and their average length of stay, relationships with MOUD

treatment providers in the community, and whether or not MOUD policies and procedures were in place at the facility. Three versions of the baseline interview guide were drafted: administrators/DONs, medical directors, and CNAs. Exhibit 2-6 illustrates the number of items and response options by respondent type. All versions of the baseline LTCF interviews are located in Appendix G.

Exhibit 2-6. Number and Type of Interview Items by Respondent Type

Type of Interview	Number of Items	Response Options
Administrator/DON	14 with sub-questions	Open-ended, yes/no
Medical Director	8 with sub-questions	Open-ended, yes/no
CNA	10	Open-ended, yes/no

The interview items varied slightly depending on the respondent type; for example, the administrator/DON interview guide contained questions about policies and procedures that were not included in the medical director or CNA interview guides. Additionally, CNAs were not asked about provider waivers. Despite the slight variations in the guides, a core set of questions was included in interview guides so that responses could be aggregated and analyses computed at the facility level. For example, all interview guides included an item about challenges and barriers to caring for residents with OUD. In addition to yielding data for descriptive analyses, the baseline data helped to inform the focus of the training events and site visits.

Baseline, Pre-Program LTCF Staff Interview Data Collection

Technical support leads conducted the LTCF staff interviews with individual staff, although some were conducted in group format. For example, on occasion an administrator would invite a corporate OUD counselor or quality assurance officer to join an interview. In addition, all CNA interviews were conducted as in-person group interviews. Technical support leads took notes during the interviews and recorded comments from each respondent. The interviews lasted, on average, between 15 to 60 minutes, depending on the respondent type and the interview format. CNA interviews took about 10 minutes to administer, administrator/DON interviews took about 60 minutes and medical director interviews took about 30 minutes to administer.

To facilitate the review of relevant policies, and provide an opportunity to interview CNAs, the Abt Team conducted in-person site visits to approximately 20% (n=8) of the participating LTCFs. Each technical support lead visited one or two of the LTCFs in their CoP. During the site visits they completed the in-person baseline interview and reviewed OUD- and MOUD-related policies. To standardize and guide the policy review, the Team developed a policy review checklist. Each site visit lasted approximately four hours. Technical support leads conducted telephone interviews with key staff (i.e., administrators, DONs, medical directors) from the remaining facilities in their CoP (staff from 36 facilities in total).

Baseline, Pre-Program OTP/OBOT Staff Interview Guide

The Abt Team drafted an interview guide to obtain information from OTP/OBOT representatives on current processes and procedures followed when caring for residents receiving MOUD who reside in LTCFs. The interview guide contains 11 questions with several sub-questions. Response options were yes/no and open-ended. The items included on the interview guide address core competencies, how regulations impact working with LTCFs, whether or not clients receive routine counseling, the types of policies and procedures they have in place, and the challenges they experience when caring for residents from LTCFs. The OTP/OBOT interview guide is located in Appendix G.

Baseline, Pre-Program OTP/OBOT Staff Interview Data Collection

Technical support leads conducted interviews with key OTP and OBOT staff by telephone. Similar to the baseline interviews conducted with LTCF staff, these interviews were conducted in either an individual or group format, based on the discretion of the OTP/OBOT staff. The interviews lasted, on average, between 30-to-60 minutes, depending on the staff interviewed and the level of detail provided.

2.7.2 Post-Program LTCF Staff Data

The Abt Team administered an online follow-up survey to LTCF staff at the end of the program using the SurveyGizmo® platform (note that the post-program survey was not administered to OTP or OBOT staff). The survey was sent in October 2020 to staff from those facilities that attended at least one event throughout the course of the program.

Post-Program LTCF Staff Survey Development

The Abt Team developed two versions of the follow-up online survey for LTCF staff, one for administrators and DONs, and one for medical directors. The administrator/DON survey contained seven items, some of which consisted of sub-items. There were five yes/no response options, and one open-ended response. A new item with four sub-items (see below) was scored on a three-point Likert scale. The medical director survey contained five items with two yes/no response options, two open-ended responses and four sub-items scored on a three-point Likert scale. The follow-up surveys were a modified version of the interview guides in which the Team retained key baseline questions in order to conduct pre- post-analyses. The Team added the last four sub-items that addressed respondents' experiences as a result of participating in the MOUD in LTC program:

1. I feel confident that facility staff have improved their knowledge of OUD.
2. I feel confident that facility staff have improved their knowledge of MOUD.
3. I feel confident that facility staff can manage a resident with OUD because of the knowledge we gained.
4. I am open to admitting a resident needing MOUD.

The follow-up survey is located in Appendix H.

Post-Program LTCF Staff Data Collection

Within three weeks following the final Project ECHO® session, the Abt Team sent a group email invitation to all administrators and DONs (n=72), and individual emails to the medical directors (n=27). The emails contained a reminder about the program and a link to the survey. The emails were sent to participants at all facilities that had attended at least one training event (n=36 facilities) and for whom we had a current email address (some medical directors were interviewed in-person and we were not able to obtain their email addresses). Respondents had up to five weeks to complete the survey. We sent weekly email reminders to all respondents who had not completed the survey. The administrator/DON survey took approximately 10 minutes to complete while the medical director survey took approximately five minutes.

2.7.3 Learning Session Data

LTCF staff who attended the in-person learning session completed an assessment at both the beginning and the end of the learning session to determine participants' baseline knowledge about the session content as well as to measure knowledge acquired by attending the session.

Participants also completed an evaluation at the end of the session in order to provide feedback on the content, structure, and delivery of the sessions - a requirement to receive CEUs.

In-Person Learning Session Pre- and Post-Assessments

The team administered the same assessment at the beginning and end of each of the five in-person learning sessions (i.e., the same questions). Learning session facilitators asked participants to complete an assessment form upon arrival and at the end of the learning session. This 9-item assessment, developed by DPH, evaluated changes in participants' knowledge about OUD and MOUD after participating in the learning session. Following is an example of some of the items on the assessment, presented with true/false, open-ended, and multiple choice response options:

- What is addiction?
- Which of the following are stigmatizing words?
- Which of the following are not signs of an opioid overdose?
- Which of the following are MOUD?
- Where can a resident obtain methadone?
- List the three steps that providers must take in order to obtain a waiver to prescribe buprenorphine.

Some of the items on the assessment contained multiple parts. For evaluation purposes, each part was scored individually for a total of 17 possible points across the nine items. The assessment was voluntary and took about five-to-10 minutes to complete. We present the in-person learning session pre- post-assessment form in Appendix I.

In-Person Learning Session Evaluations

In-person learning session participants received evaluation forms in their learning session packets to provide feedback on the content and other components of the learning session. At the end of the session, the facilitator asked participants to complete the form and to hand it in to the facilitator before leaving the meeting. Although the evaluation was voluntary, in order to receive CEUs, participants had to return the completed form. In addition to being a CEU requirement, the Team used the evaluation responses to assess presenter performance and overall satisfaction with the learning session. Further, through responses to the following items, the Abt Team was able to assess whether or not the program met the specified objectives:

- Recognize the stigma of OUD;
- Understand OUD - how residents present, disease severity, biological effects and underlying causes;
- Know the different types of treatment for OUD including MOUD and non-medical pathways; and,
- Identify bi-directional strategies to enhance best practices across the continuum of care for residents with OUD.

The 11 item evaluation took about five minutes to complete. Responses to a core set of questions were required to receive CEUs. Additional questions were added by the Abt Team. Questions included a combination of multiple choice, fill in the blank, and scaled response options and

some contained multiple parts (e.g., question 4a, question 4b). We present the in-person learning session evaluation form in Appendix J.

Project ECHO® Series Evaluation Data

Participants who attended the Project ECHO® series completed an evaluation at the end of each of the six sessions. Although completing the evaluation form was voluntary, participants were able to receive one CEU for each session attended, provided they submitted a complete evaluation form. The evaluation contained a total of nine questions, some with multiple parts, and branching depending on the type of CEU credit requested (e.g., nursing, administrator, social worker). Response options were primarily yes/no, agree/disagree, or scaled on five-point Likert scale. In addition to being a requirement for CEUs, the Abt Team used evaluation results to assess presenter performance, overall satisfaction with the Project ECHO® series, and whether or not the Project ECHO® series met the following objectives:

- Review current telehealth guidelines and identify how telehealth impacts MOUD management; interpret how telehealth fits into caring for your residents with OUD; and discuss a case example with subject matter experts and peers on how telehealth has impacted care for your resident, and solutions on how to break down barriers.
- Identify key steps in the transition process from hospital to LTCFs for residents on MOUD; review necessary communication between LTCFs and OTP/OBOT; and discuss a case example with subject matter experts and peers on how transitions of care have impacted the care of your resident and solutions on how to break down barriers.
- Review the LTCF and OTP/OBOT partnership; define best practices for communicating with your OTP/OBOT in caring for your residents on MOUD; and discuss a case example with subject matter experts and peers on how partnerships with OTPs/OBOTs have impacted care for your resident and solutions on how to break down barriers.
- Identify key steps in the transition process from LTCF to the community for residents on MOUD; summarize examples of how to address social determinants of health at your facility around housing; review housing programs, residential treatment programs, and mutual support services; and discuss a case example with subject matter experts and peers on how discharges to the community may have impacted care for your resident and creative solutions on how to break down barriers.
- Summarize examples of how to address social determinants of health at your facility around transportation; review creative solutions to ride scheduling for your residents with OUD; and discuss a case example with subject matter experts and peers on how transportation may have impacted care for your resident and creative solutions on how to break down barriers.
- Interpret how DPH regulations fit into caring for your residents with an OUD; interpret how BSAS regulations fit into caring for your residents with an OUD; and review how to make sure you are ensuring fidelity with DPH and BSAS regulations.

The 16-item evaluation took about 10 minutes to complete. We present the Project ECHO® series evaluation form in Appendix K.

2.7.4 Analytic Approach

The Abt Team used descriptive statistics (e.g., frequencies, means and standard deviations) to analyze baseline interview, assessment and evaluation data as well as follow-up survey data. Specifically, the Team used descriptive statistics to summarize demographic characteristics of the participating facilities (e.g., nursing home size/beds, type of facility and number of residents with OUD) as well as responses to key items of interest such as whether or not staff receive training on OUD and, the number of medical directors interviewed who have waivers to prescribe MOUD. Open-ended questions were coded and categorized by themes and quantified for analysis.

All data were entered into an excel spreadsheet and cleaned prior to analysis. To the extent possible, findings are reported as graphic visualizations and tables. Most baseline variables are aggregated to the facility level, while follow-up data and comparisons between baseline and follow-up are aggregated to the respondent level, as the follow-up online survey did not solicit any information to identify the individual respondents or their facilities.

Implications of COVID-19 on Measuring Program Impact

After an overwhelmingly positive reaction to the first learning session, it was difficult to maintain facility engagement in the program because facilities had to prioritize emergency response and management of COVID-19. The pandemic impacted subsequent program activities. This resulted in delays in program implementation, changing the design of training events from in-person events to virtual, a decrease in engagement in the program, and a high attrition rate. The loss of engagement and attrition had an impact on evaluation findings. The resulting small sample size and participants not attending all events made it difficult to estimate program impact with confidence. Further, it is likely that the facilities that remained in the program until the end were different than those that were lost to follow-up. It is possible that the facilities that remained had lower COVID-19 rates and were more motivated toward implementing quality improvement programs in their facilities than those who dropped out. Therefore, we are unable to generalize our findings from the LTCF participants to the larger population of LTCFs.

3. Results

The following section presents the results of analyses of the pre- and post-program data, the learning session evaluation, and the pre- and post-assessment data. Data are presented at the facility level (as determined from individual responses and aggregated) and respondent level, as noted. In some instances, only data from certain respondent groups are presented, as indicated.

3.1 Baseline, Pre-Program Results

3.1.1 Baseline In-Person and Telephone Interviews

Baseline interviews were conducted to document experiences and practices prior to the implementation of program activities. One-hundred, thirty-seven unique baseline in-person and telephone interviews were completed with staff from all 42 LTCFs and all 10 MOUD treatment providers (five OTPs and five OBOTs). Of the 137 interviews, 38 were conducted in-person during site visits to facilities and 99 were conducted by telephone. Interview respondents included facility administrators (39), DONs (38), medical directors (28), CNAs (10), OBOT management (5), OTP management (5), staff developers/educators/trainers (4), assistant DONs (3), and one each of the following: social workers, social service directors, transportation specialists, corporate addiction counselors, and admissions coordinators. In some instances, particularly with those conducted with the OTPs and OBOTs, multiple staff members contributed to a single interview.

Baseline LTCF Respondent Results

Experience Caring for Residents with OUD and Receiving MOUD. Of the 42 participating facilities, staff from 17 unique facilities responded that they currently admit, or have they admitted in the recent past, residents who receive MOUD. Further, six of the 10 CNAs interviewed reported that they were caring for, or had in the recent past cared for, residents with OUD. This question was not asked on the administrator/DON or medical director surveys.

DATA Waivers. Only four of the 28 facility medical directors interviewed reported they had obtained a waiver to prescribe certain MOUD at the time of the baseline survey.

Policies. Most participating facilities had policies in place for stocking and administering Narcan/naloxone, but few had policies for key methadone activities, such as self-administration and transportation of methadone. Although most facilities reported that they did not have policies addressing the storage and dispensing of methadone, many did have one for destroying methadone. We summarize key policies in Exhibit 3-1.

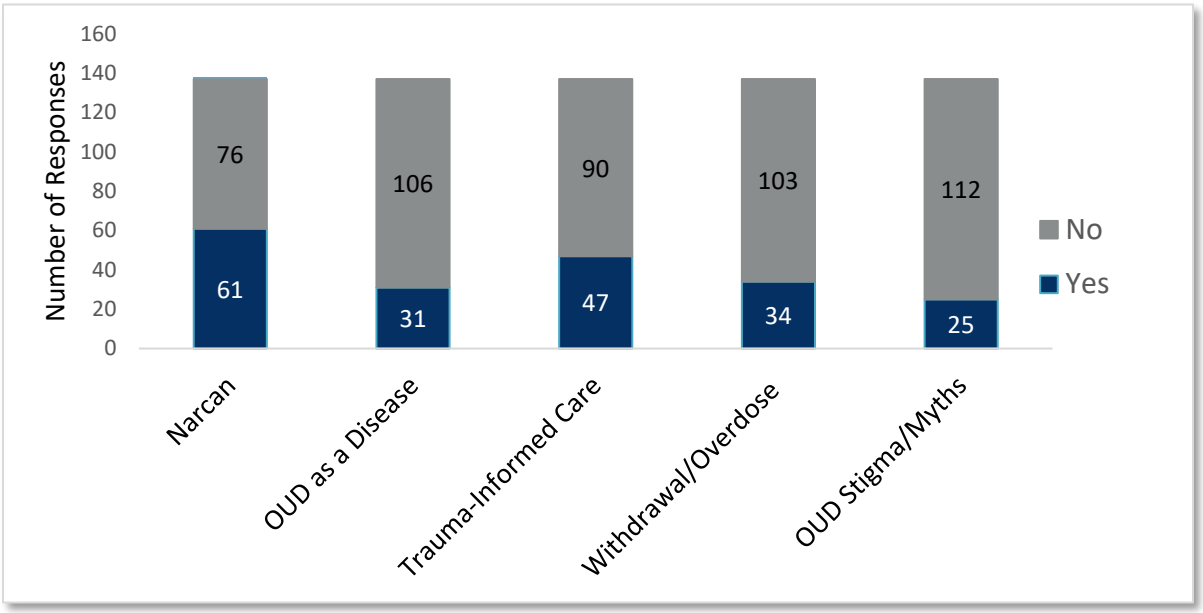
Exhibit 3-1. MOUD-Related Policies in Place at LTCFs at Baseline

Policy	% (n) of Facilities Reporting Yes (N=42)
Narcan/naloxone readily available for administration in case of an overdose.	91% (38)
Narcan/naloxone stocking/restocking.	83% (35)
Destroying methadone if it is left behind when resident is discharged and/or leaves against medical advice.	60% (35)
Administration of buprenorphine or naltrexone.	33% (14)
Waiver for responsibility of take-home medication approved by all relevant parties.	14% (6)
Transportation of medications to the LTCF if take home waiver is in place or transportation of the resident to the OTP/OBOT, as scheduled.	14% (6)
Storage of methadone including documentation required by MA DPH regulations.	12% (5)
Self-administration for methadone.	10% (4)

Note. Responses were aggregated to the facility level. Staff from a total of 42 facilities responded to the interview.

Training. With the exception of Narcan training, the majority of respondents reported at baseline that they had not received training on any of the OUD-related topics as shown in Figure 3-1.

Figure 3-1. Number of LTCF Staff Reporting at Baseline that the Facility offers OUD-Related Training (N=137)



Common Challenges. LTCF staff reported several challenges to caring for residents with OUD. The most common challenges reported at baseline include:

- Difficult behaviors, such as combativeness (n=20)
- Treating OUD (e.g., finding a waivered prescriber or community treatment center) (n=17)
- Lack of staff training/knowledge of OUD and MOUD (n=12)
- Transportation (n=9)
- Regulatory challenges (n=6)

Exhibit 3-2 below summarizes all challenges reported by LTCF staff at baseline.

Exhibit 3-2. Common Challenges Reported in Caring for Residents with OUD at Baseline by LTCF Staff

Perceived General Challenges	Greatest Challenge	Logistical Challenges
• Difficult behaviors - 20 • Treating OUD - 17 • Lack of training/knowledge/stigma - 12 • Transportation - 9 • Unknown resident/OUD history – 6 • Regulatory challenges – 6 • Transitions/continuity of care - 5 • Payment Issues/Funding - 4 • Lack of resources (not specified) - 4 • Balancing treatment and pain control - 2 • *(57 persons did not respond)*	• Behavior/Combativeness/Difficult personalities - 3 • Remembering that these residents require a lot of patience - 1 • *(132 persons did not respond)*	• Transportation - 19 • Visitors/keeping the unit secure - 6 • Limited funding/insurance/MassHealth - 4 • Supporting non-local residents - 4 • No place to discharge/setting up discharge services (e.g., housing) - 3 • Communication/scheduling - 1 • *(47 persons did not respond)*

Core Competencies. When asked, "What core competencies do you think are necessary for staff to have to care for residents diagnosed with OUD?" responses included:

- Recognizing signs & symptoms of OUD, misuse and relapse (n=42)
- Understanding MOUD and OUD treatment (n=33)
- Recognizing signs and symptoms of an overdose/use of Narcan/naloxone (n=32)
- How to support and care for residents with OUD (n=32)
- Understanding/managing behaviors exhibited by residents (n=29)
- Understanding OUD as a disease (n=20)
- Dispelling myths and stigma (n=14)

OTP/OBOT Results

Policies. At baseline, all ten OTPs and OBOTS had policies and procedures in place about administering MOUD to residents of LTCFs. However, few OTPs and OBOTs had experience collaborating with LTCFs and, therefore, could not recall policies and procedures specific to that population. Exhibit 3-3 summarizes key policies and procedures for MOUD in place at OTPs and OBOTs at baseline.

Exhibit 3-3. MOUD-Related Policies in Place at OTPs/OBOTs at Baseline

Policy	% (n) of Facilities Reporting Yes N=10
Transportation of medications to the LTCF if take home waiver is in place or transportation of the resident to the OTP/OBOT, as scheduled.	60% (6)
Administration of buprenorphine or naltrexone.	50% (5)
Waiver for responsibility of take-home medication approved by all relevant parties.	40 % (4)
Storage of methadone including documentation required by MA DPH regulations.	40 % (4)
Self-administration for methadone.	30% (3)

Counseling. All but one of ten OTP/OBOTs reported that they provide routine counseling to clients.

Impact of Regulations on Service Provision. OTPs and OBOTs stated that while the paperwork and documentation required for dispensing MOUD are burdensome, they saw it as a necessary encumbrance and they understood the purpose of doing so. Facilities also expressed that the DEA regulations around methadone are outdated and no longer relevant, particularly for residents of LTCFs. Lastly, drug diversion protocols such as random visits are difficult for residents of LTCFs, particularly if the LTCF already has trouble arranging transportation for scheduled visits. In those cases, random visits are almost impossible, and then the OTP/OBOT needs to report the missed visit to DPH.

Common Challenges. OTP and OBOT staff reported fewer challenges to caring for clients with OUD than LTCF staff. The most common challenges reported include those within the healthcare system or landscape, particularly around a lack of transitional services within the community. Exhibit 3-4 below summarizes all challenges reported by OTP and OBOT staff at baseline.

Exhibit 3-4. Common Challenges Reported in Caring for Residents with OUD at Baseline by Staff at Ten OTP/OBOTs

Perceived General Challenges	Reimbursement Challenges	Logistical Challenges
• Risky/difficult population to work with (those with OUD) - 2 • Logistics of treating OUD (e.g., providing take home dosages in severe weather, getting patients to appointments, random drug testing) - 2 • Lack of training/knowledge/stigma - 1 • Payment Issues/Funding – 1	• Payment for OUD services - 1	• Communication/scheduling – 2 • No place to discharge/setting up discharge services (e.g., housing) - 1
Challenges Within the Healthcare System or Landscape		
• Lack of transitional services (e.g., housing, outpatient OUD) - 6 • Stigma/lack of education – 2 • Lack of community resources (e.g., other facilities, OUD treatment facilities, public transit, culturally appropriate services, police) - 2 • Community safety/community substance use - 1 • Community demographics (unemployment, language barriers, cost of living, high-risk populations, etc.) - 1		

Core Competencies. The core competencies necessary to care for residents with OUD reported by OTP/OBOT staff include:

- Understanding MOUD and OUD treatment (n=9)
- Understanding OUD as a disease (n=6)
- Recognizing signs & symptoms of OUD, misuse and relapse (n=4)
- Recognizing signs and symptoms of an overdose/use of Narcan/naloxone (n=3)

3.2 Follow-Up, Post-Program Results

A follow-up online survey was administered to LTCF staff (administrators, DONs, and medical directors) to assess change in OUD and MOUD understanding between baseline and program end. A link to an online survey was sent to 72 administrators and DONs and 27 medical directors whose facilities were still participating in the program as of October 2020. Of those invited to participate in the follow-up online survey, responses were received from 19 administrators and DONs (26 percent) and 11 medical directors (41 percent), for a total of 30 responses for an

overall 30 percent response rate. Follow-up surveys did not identify individuals; as a result, we could not determine how many and which facilities had specific policies in place at follow-up.

Experience Caring for Residents with OUD and Receiving MOUD. Of the 30 respondents, 13 (43%) responded that they currently admit, or have they admitted in the recent past, residents who receive MOUD. Of the 13 affirmative responses, seven were received from administrators and DONs and six were received from medical directors. However, because facilities were not identified in the follow-up survey, it is unclear whether or not these 13 responses were mutually exclusive (e.g., a DON and medical director from the same facility could have responded affirmatively).

DATA Waivers. Although licensed long-term care physicians can obtain a waiver to prescribe certain MOUD, only four of the 11 facility medical directors who responded to the follow-up online survey had done so. Similarly, only three of the 19 administrators and DONs reported someone on staff at their facility had a waiver.

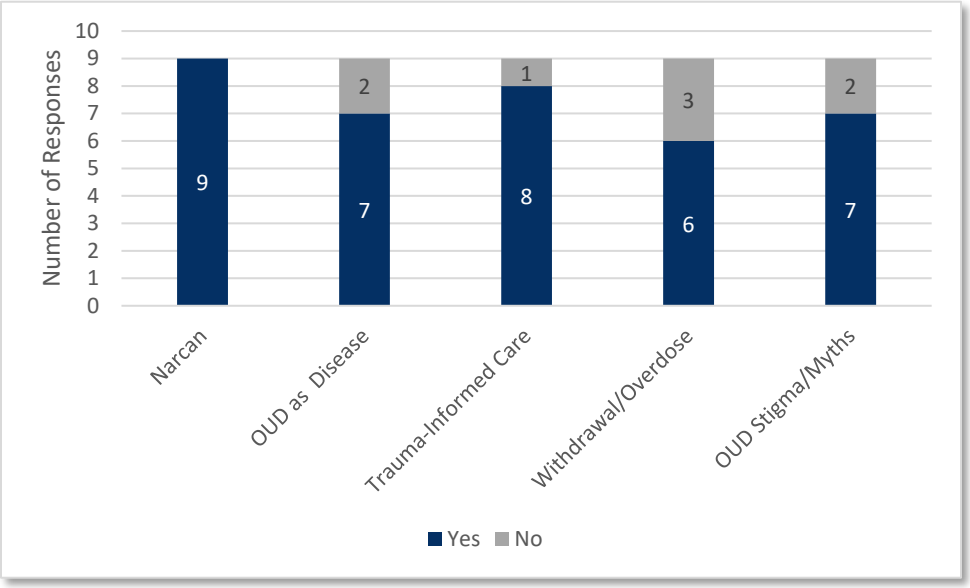
Policies. Similar to the baseline findings, at follow-up most participating facilities had policies in place for stocking and administering Narcan/naloxone, but few had policies for key methadone activities, such as self-administration and transportation of methadone. We summarize key policies in place at follow-up in Exhibit 3-5.

Exhibit 3-5 MOUD-Related Policies in Place as Reported by Administrators and DONs at Follow-Up

Policy	% (n) of Respondents Reporting Yes N=19
Narcan/naloxone readily available for administration in case of an overdose.	74% (14)
Narcan/naloxone stocking/restocking.	58% (11)
Storage of methadone including documentation required by MA DPH regulations.	26% (5)
Destroying methadone if it is left behind when resident is discharged and/or leaves against medical advice.	16% (3)
Waiver for responsibility of take-home medication approved by all relevant parties.	11% (2)
Administration of buprenorphine or naltrexone.	11% (2)
Transportation of medications to the LTCF if take home waiver is in place or transportation of the resident to the OTP/OBOT, as scheduled.	5% (1)
Self-administration for methadone.	0% (0)

Training. At follow-up, only nine of 19 respondents to the administrator/DON survey reported that staff in their facilities received training specific to OUD/MOUD. With the exception of Narcan/naloxone training, the majority of staff reported at baseline that they had not received training on any of the OUD-related topics as shown in Figure 3-2.

Figure 3-2. Staff OUD Training as Reported by Administrators and DONs at Follow-up



Common Challenges. Administrators, DONs, and medical directors reported several challenges to caring for residents with OUD. The most common challenges reported at follow-up include:

- A lack of prescriber to order MOUD for residents (n=5)
- Lack of staff training/knowledge of OUD and MOUD (n=3)
- Transportation (n=3)
- Lack of community resources (n=3)
- Troubles with coordinating care (n=2)
- Difficult population (behavior, combativeness) (n=1)
- Lack of/missing OUD background/history on patient (n=1)

Confidence Caring for Residents with OUD. At follow-up, administrators, DONs, and medical directors were asked to indicate their level of confidence with key program objectives. Responses are shown in Exhibit 3-6.

Exhibit 3-6. Program Response as Reported by Administrators/DONs and Medical Directors at Follow-Up

Response/Question	% (n) Report Feeling Completely Confident	% (n) Report Feeling Somewhat Confident	% (n) Report Feeling Not at all Confident	% (n) Not Reported
Admin/DON (N=19)				
I feel confident that facility staff have improved their knowledge of OUD.	26% (5)	58% (11)	11% (2)	5% (1)
I feel confident that facility staff have improved their knowledge of MOUD.	26% (5)	58% (11)	11% (2)	5% (1)
I feel confident that facility staff can manage a resident with OUD because of the knowledge we gained.	37% (7)	37% (7)	11% (2)	16% (3)
As a result of participating in the MOUD in LTC program I am open to admitting a resident needing MOUD.	37% (7)	37% (7)	16% (3)	11% (2)
MD (N=11)				
I feel confident that facility staff have improved their knowledge of OUD.	18% (2)	36% (4)	18% (2)	27% (3)
I feel confident that facility staff have improved their knowledge of MOUD.	9% (1)	46% (5)	18% (2)	27% (3)
I feel confident that facility staff can manage a resident with OUD because of the knowledge we gained.	9% (1)	36% (4)	27% (3)	27% (3)
As a result of participating in the MOUD in LTC program I am open to admitting a resident needing MOUD.	27% (3)	27% (3)	27% (3)	18% (2)

In addition, respondents to the follow-up survey were also asked why they did not feel comfortable admitting residents receiving MOUD after participating in the program. These responses included the following:

- Lack of staff training/knowledge of OUD and MOUD (n=2)
- A lack of prescriber to order MOUD for residents (n=1)
- Facility structure/community inappropriate for population (n=1)
- No access to recovery resources (n=1)
- Too consumed with the response to COVID-19 to focus on this population (n=1)
- Trouble with staff turnover (n=1)

3.3 Learning Session Results

Staff from participating facilities were invited to attend an in-person learning session offered in the five CoPs, as well as a Project ECHO® series. Overall, the learning sessions were well-attended, and most facilities were represented, as we show in Exhibit 3-7. We present the percentage and overall number of participants by their facility roles in Exhibit 3-8.

Exhibit 3-7 Number of Facilities Represented at the In-Person Learning Sessions, by CoP

CoP	Total Number of Facilities per COP[1]	Number of Facilities Represented at Learning Session	% of Facilities Represented
Lowell	7	7	100%
Springfield	7	7	100%
Worcester	10	7	70%
Wareham	10	7	70%
Boston	8	4	50%
Total	42	31	74%

[1]Note. Multiple staff from most facilities attended, as did representatives from corporate offices.

Exhibit 3-8. Number and Percent of In-Person Learning Session Attendees, by Role

Attendee Type	% (n)
Nurse	37.5% (45)
Nursing Home Administrator	20.0% (24)
Social Worker	15.8% (19)
Other	15.0% (18)
Physician	7.5% (9)
Nurse Practitioner	2.5% (3)
Case Manager	1.7% (2)

3.3.1 In-Person Learning Session Pre- and Post-Assessment Results

A total of 170 in-person learning session pre- and post-assessments were completed. Of these, 91 were completed before the in-person learning session began (pre-session) and 79 were completed after the in-person learning session ended. Exhibit 3-9 shows the number of assessments completed before and after in-person learning sessions held in each of the five CoPs. Twelve participants attending did not submit a completed assessment following the session.

Exhibit 3-9. Number of Pre- and Post- Learning Session Assessments Completed, by CoP

CoP	Pre-Session	Post-Session	Total Completed
Boston	10	8	18
Springfield	18	18	36
Worcester	15	15	30
Wareham	26	19	45
Lowell	22	19	41
Total	91	79	170

We conducted a two sample t-test assuming unequal variances (alpha = 0.05) to determine differences between the overall pre- and post-assessment scores. Results indicate a statistically significant improvement in knowledge gained during the session. There was a statistically significant improvement in participants' overall understanding of OUD and MOUD after the learning session compared to before ($t = 9.28$, $p < .0001$). Figure 3-3, shows the overall mean scores (47.6%), the mean scores from the pre-assessment (37.0%), and the mean scores from the post-assessment (59.8%). Exhibit 3-10 shows the t-test statistics and Exhibit 3-11 displays the standard deviation and range of assessment scores.

Figure 3-3. Mean Assessment Scores – Overall, Pre-Session, and Post-Session

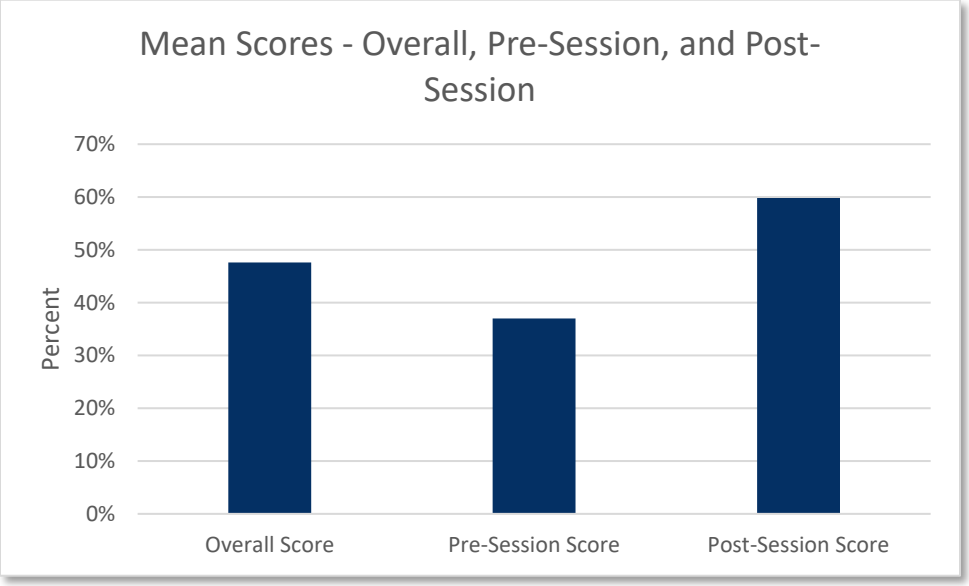


Exhibit 3-10. Two Sample T-Test Assuming Unequal Variances for Pre- and Post-Assessment Scores

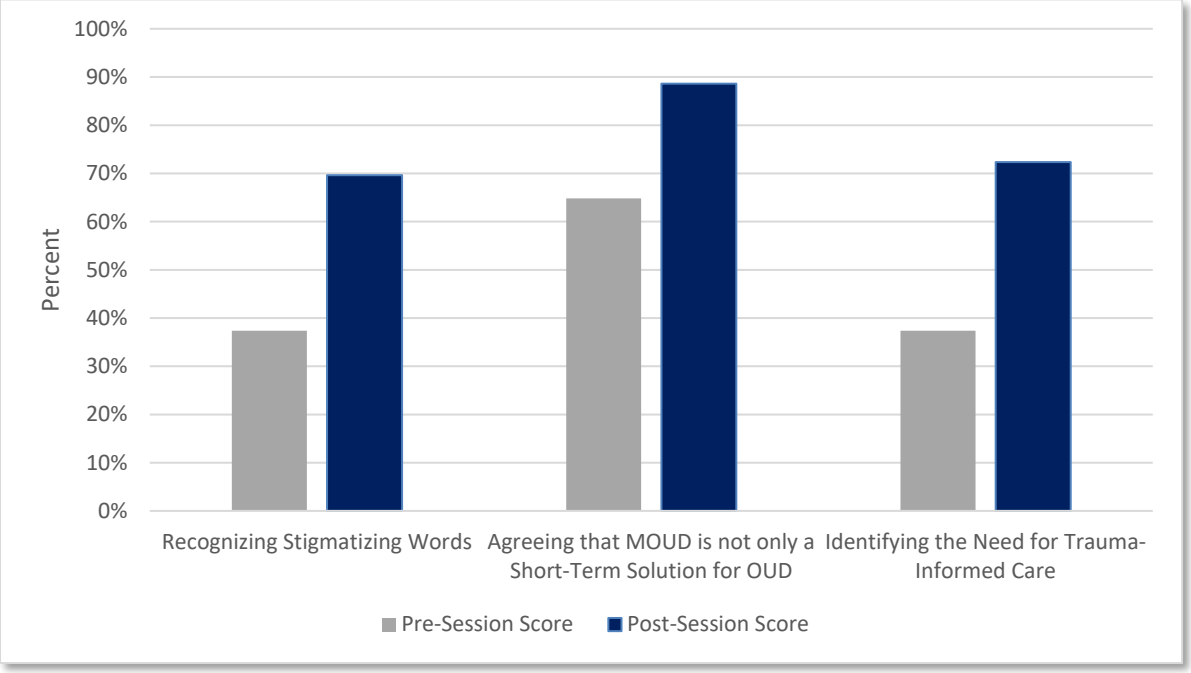
CoP	Pre-Assessment Values	Post-Assessment Values
Mean	36.97%	59.79%
Variance	01,97%	03.06%
Observations	91	79
df	149	
t Stat	9.28013	
P(T<=t) one-tail	<0.0001	
P(T<=t) two-tail	<0.0001	

Exhibit 3-11. Standard Deviations and Ranges of Assessment Scores – Overall, Pre-Session, and Post-Session

Assessment	Standard Deviation	Range
Overall	19.4%	6% - 94%
Pre-Session	14.0%	6% - 82%
Post-Session	17.5%	24% - 94%

Figure 3-4 demonstrates a statistically significant improvement in recognizing stigmatizing words after the learning session compared to before (t=4.43, p<001), and in identifying Medication for OUD as a long-term solution (t = 3.74, p<001). Figure 3-4 also shows the statistically significant improvement between the pre- and post-assessment values for correctly identifying what is required for trauma-informed care (t=5.14, p<.0001).

Figure 3-4. Percent of Learning Session Attendees Correctly Responding to Key Assessment Questions Before and After the Learning Session.



3.3.2 In-Person Learning Session Evaluation Results

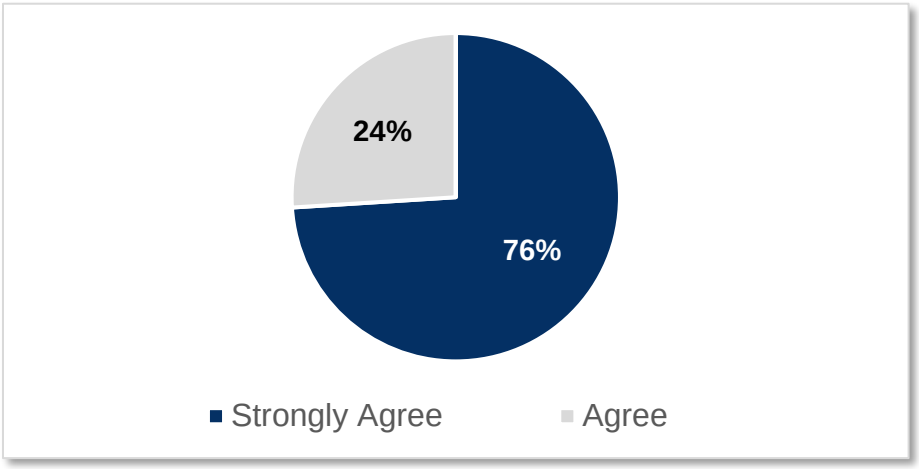
Program facilitators encouraged participants to complete an evaluation at the end of the in-person learning session. In addition to being a requirement to receive CEUs, the form provided feedback on the content, effectiveness, and satisfaction with the learning sessions. The evaluation was administered at the end of each of the five learning sessions. A total of 110 evaluation forms were completed. Exhibit 3-12 presents the number of evaluation forms completed per CoP.

Exhibit 3-12. Number of Evaluations Completed by CoP

CoP	Evaluations Completed
Worcester	34
Wareham	26
Lowell	21
Springfield	19
Boston	10
Total	110

Ninety-seven percent of attendees agreed that the learning session met all four of the stated objectives. In addition, 100% of respondents agreed that they better understood OUD as a chronic disease, 100% agreed they were better able to recognize the stigma of OUD, 98% felt they increased their knowledge of OUD treatment including MOUD, and 97% felt they could identify bi-directional strategies to enhance best practices. Ninety-six attendees (87%) felt that presenters gave effective/complete talks, while 100 attendees (91%) felt the presenters' demonstrated thorough knowledge of the subject matter on which they were presenting. All attendees agreed or strongly agreed that attending the learning session was a valuable use of time and were, overall, satisfied or very satisfied with the learning session. Figure 3-5 displays the reported positive value of the learning session.

Figure 3-5. Attendees Reporting on the Positive Value of the Learning Session



Note. Although "disagree" and "strongly disagree" were included as response options, neither were selected.

3.3.3 Project ECHO® Series Evaluation Results

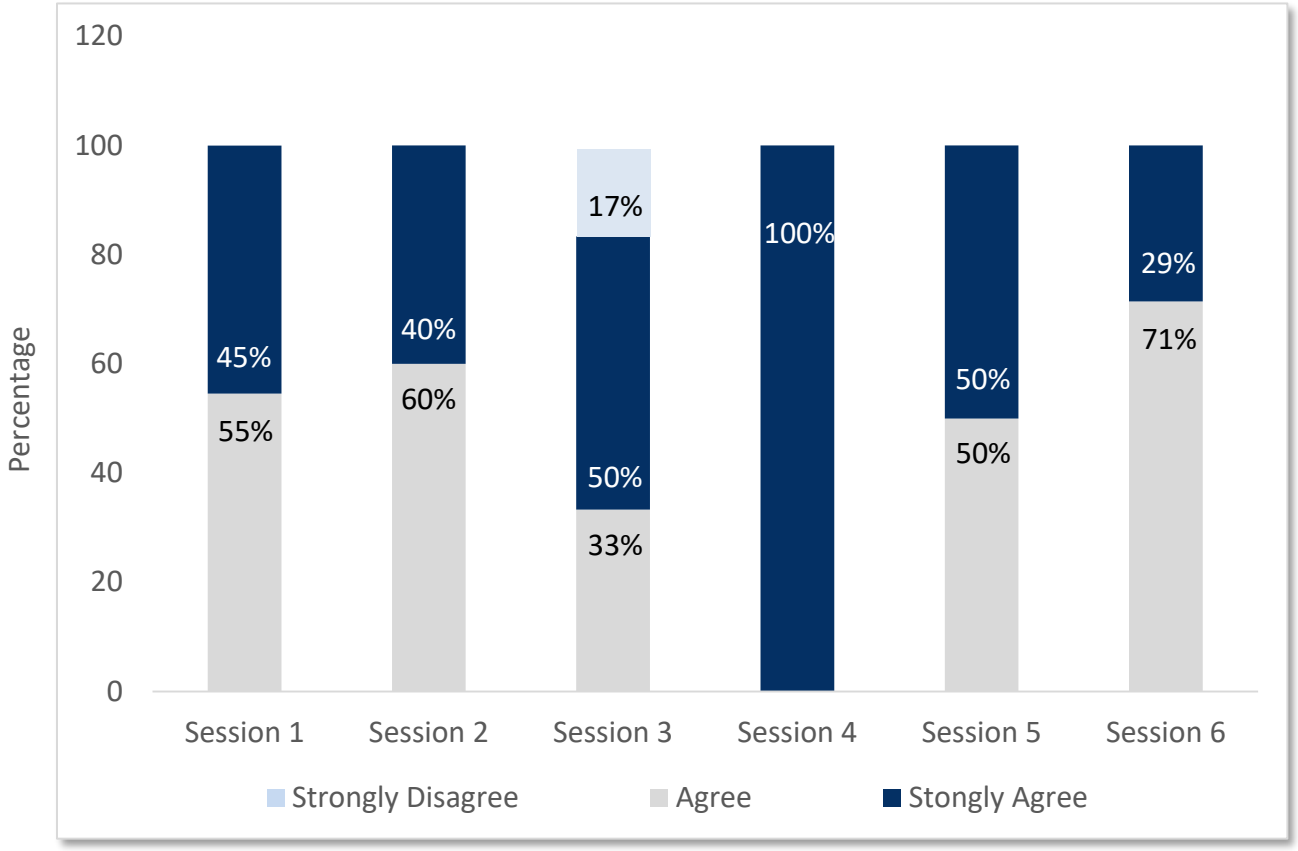
An average of six facilities were represented at the Project ECHO® sessions (range 1-11). The ECHO® facilitator encouraged participants to complete an evaluation at the end of each of the six ECHO® sessions. In addition to being a requirement to receive CEUs, the form provided feedback on the content, effectiveness, and satisfaction with the learning sessions. Exhibit 3-13 presents the number of evaluation forms completed per learning session.

Exhibit 3-13. Number of Evaluations Completed by CoP

Learning Session	Evaluations Completed
Session 1: Telehealth	9
Session 2: Transitions of Care to LTCF	8
Session 3: Partnerships	5
Session 4: Transportation	3
Session 5: Transitions of Care to home	4
Session 6: Regulations	6
Total	35

One-hundred percent of respondents across all six sessions agreed that with the knowledge gained during the sessions they were able to address issues related to the topics discussed. Similarly, 100% of respondents agreed that the training met learning objectives, allowing them to review, interpret and discuss the learning session topics. All respondents reported affirmatively that the sessions provided appropriate instruction, were relevant and current, and were suitable and/or useful for their work. Finally, as shown in Figure 3-6, all respondents either agreed (n=44%) or strongly agreed (n=52%) that participating in the ECHO sessions was a valuable use of their time (overall average of 3 of 5).

Figure 3-6. Reported Results of the Sessions being a Valuable Use of Respondents Time



Note. Although "disagree" and "neutral" were included as response options, neither were selected.

4. Conclusions

The MOUD in LTC Program began as a tremendous success. The first in-person learning session received an overwhelmingly positive response from participants and many asked for additional similar opportunities. Participants rated items on the first in-person learning session evaluations high, and their assessment responses demonstrated knowledge of important OUD and MOUD areas acquired during the training. The first in-person learning session was so well received that DPH extended Abt's contract so that we could plan a second, similar in-person event. In addition to the training event, participants, stakeholders, and subject matter experts considered the MOUD in LTC Toolkit to be a necessary, thorough and comprehensive guidebook to help facility staff care for residents with OUD and facilitate the continuity of MOUD treatment.

In early March, the COVID-19 pandemic severely impacted Massachusetts LTCFs. The Abt Team put direct contact with facilities on hold for several months. Ultimately, 16 facilities were lost to follow-up either directly or indirectly as a result of the pandemic.

Although attendance at the last training event, the Project ECHO® series, was low (range = 1 - 11), those who participated found that the program was very useful, met all the objectives, and was appropriate, relevant, and suitable for their work. In addition, they all agreed that they gained useable knowledge across all six session topics. Although the pandemic caused many of the facilities to drop from the program, we view the program as a success for those that were able to continue participation.

4.1 Lessons Learned and Promising Practices

During baseline in-person and telephone interviews, it was clear that very few facilities were prepared to admit and provide evidence-based care to residents receiving MOUD. They lacked a general understanding of OUD and medication treatments, most of their physicians and physician extenders did not have a DATA waiver to prescribe certain MOUD, and they did not have policies that articulated appropriate procedures for caring for residents receiving MOUD. This lack of fundamentals regarding the care of residents with OUD demonstrates the need for programs such as the MOUD in LTC Training Program. Our training events (the in-person learning session and virtual Project ECHO® series) were interesting and engaging because subject matter experts led topic-specific discussions on OUD and MOUD. The purpose of these discussions was to dispel myths, help make community connections, and offer available resources within each CoP.

Further, we began each in-person session with an individual in recovery who shared his or her experiences with the disease. This grounded the session and immediately grabbed the participants' attention. Training events that not only increased knowledge and awareness but also included a variety of speakers, an interesting slide presentation, and meaningful handouts (e.g., the MOUD in LTC Toolkit) helped to foster an eagerness to learn and an environment and platform in which participants could absorb the material. The response to the learning sessions indicates this type of training event is useful for educational purposes as well as an opportunity for collaborative learning and networking.

However, it is clear that additional similar training and education about OUD and MOUD is needed. Specifically, future trainings should address the lack of understanding of the culture of OUD and the stigma that persists surrounding OUD and MOUD, and provide education on appropriateness of trauma informed care when treating residents with OUD. Policies, education,

and resources are essential to providing clinically appropriate care for LTCF residents with OUD and continuity of care for residents receiving MOUD.

4.2 Challenges

There were several challenges identified over the course of the program, including those involving the perceived irrelevance of the program and the pandemic. First, it was difficult to recruit the target number of LTCF (44) because many facilities felt that the program was not relevant to their resident population. Most of the participating LTCFs have not admitted or cared for residents with OUD. They lacked an understanding of the disease and many of them reported that they could not afford to accommodate transportation to treatment centers, or that they did not want to mix their medically complex elderly population with a younger population with OUD. Although LTCFs may not currently care for residents with OUD, the opioid epidemic combined with the aging population will increase the demand for beds as individuals with OUD recover from conditions that necessitate a stay in a LTCF.

As noted, it was difficult to maintain facility engagement in the program after the start of the pandemic. Not only did facilities have to maintain vigilance to control the virus, but we heard repeatedly from facility administrators that their time was being absorbed by multiple new federal and state reporting and training requirements. Facilities were encouraged and incentivized to attend virtual training sessions offered by the Centers for Disease Control and Prevention, CMS, and other federal agencies. Despite being willing to continue their participation, most facilities did not have the time or the bandwidth to participate fully. Loss to follow-up undoubtedly created selection bias since facilities that remained in the program were likely different in measurable ways than those that were lost to follow-up. For example, it is likely that the facilities that remained in the program may have had lower COVID rates and were more motivated toward implementing quality improvement programs than those who dropped out.

Another effect of COVID-19 was that the Team had to rethink the mode of presentation and adapt to virtual events. Although we suspected that the personal interaction and networking might be less effective in a virtual session, the Team was able to easily pivot and adapt the second learning session to a series of events using the Project ECHO® platform. This proved to be an effective alternative. Most participants used their cameras so that all participants could see each other. Having the ability to see the speakers and each other likely facilitated active engagement in the session.

It is important to mention that COVID-19 decreased participation in our Project ECHO® series evaluations and post-program, follow-up data collection. When we resumed outreach in June, DPH removed 10 facilities that had experienced a high number of positive COVID-19 cases. Further, throughout the remaining program, six additional facilities were lost to follow-up or participated minimally (e.g., participated in only one of the six Project ECHO® series sessions). Further, we had a low response rate from our follow-up survey due to a higher than usual facility turn-over rate, and because staff from most facilities had not been actively involved in the program since the pandemic hit in March. As a result, we did not have the power to confidently report on program impact.

4.3 Next Steps

To ensure sustainability of the knowledge attained through this program, and for additional facilities to have an opportunity to participate, DPH should consider offering similar training

events on an on-going basis. Given the state recommendation that all LTCF administrators should admit residents with OUD provided it is not a primary diagnosis, surprisingly few actually do. Continuing to provide training that dispels myths and provides community connections and resources will help to reduce the reluctance to admit residents with OUD. It is clear that most facilities that participated in the MOUD in LTC Program need help in developing policies and procedures for caring for residents with OUD and MOUD treatment.

Appendices

Appendix A: 2016 Circular Letter Issued by DPH

Circular Letter: DHCQ 16-11-662 - Admission of Residents on Medication Assisted Treatment for Opioid Use Disorder

11/15/2016
ORGANIZATION:
Bureau of Health Care Safety and Quality
REFERENCED SOURCES:
105 CMR 700.00: Implementation of MGL c.94C
105 CMR 150.00: Standards for long-term care facilities Purpose

The purpose of this circular letter is to provide guidance for long-term care facilities (LTCF) that admit residents who require skilled nursing care and who are also being treated for opioid use disorder with medication assisted treatment (MAT).

Background

Some residents requiring skilled nursing care have completed detoxification and are receiving MAT, which includes treatment with methadone, buprenorphine, or naltrexone[1]. In those cases, if the resident would otherwise be eligible for admission to the LTCF, the facility is expected to admit the resident and provide for the administration of MAT as directed by the prescribing or ordering physician at the resident's opioid treatment program (OTP) or Office Based Opioid Treatment with Buprenorphine program (OBOT). Substance use disorder would not be the primary condition for which treatment is sought at the LTCF. This circular letter does not address the prescription of methadone for pain management, which should be handled in the same manner as any other drug prescribed for pain management.

Methadone for Medication Assisted Treatment

As part of the LTCF admission process, and prior to administering any take-home methadone, the LTCF shall review all prescription orders, including the take-home methadone documentation obtained from the OTP, to ensure that medications prescribed at the LTCF are not contraindicated due to interactions with the currently prescribed medications for medical conditions.

The LTCF shall establish a procedure for obtaining take-home methadone doses from the resident's OTP. The procedure shall include instructions for secure transport of the drugs, transfer documentation, and completion of a chain of custody form. The LTCF shall ensure that all take-home methadone doses received from the OTP are properly packaged and labeled. Once the methadone is in the custody of the LTCF, the facility shall store the drugs in a double-locked secure area in the LTCF nursing unit, administer the drugs consistent with Department of Public Health (Department) regulations at 105 CMR 700.000 and 105 CMR 150.008(D) and applicable federal regulations, and document each administration in the resident's record.

When residents using methadone for medication assisted treatment are discharged from the LTCF, the residents may take all remaining methadone doses with them, if they have a written order from the OTP physician to do so. If the resident dies or if the take-home medication is only available to the patient until the patient is ambulatory or the medication is discontinued, the LTCF shall destroy the medication in compliance with Drug Enforcement Administration (DEA) and the Department's Office of Prescription Monitoring and Drug Control rules, as with all medications.

Buprenorphine for Medication Assisted Treatment

A resident who is receiving buprenorphine treatment at an OBOT from a Drug Addiction Treatment Act (DATA) waived[2] physician may need to continue this treatment in a LTCF. The resident shall continue to see a DATA waived physician for this treatment. The prescription should be reviewed by the LTCF's medical director, who should be in communication with the DATA waived physician, and can be filled by the pharmacy and administered in the same manner as all other prescription medications.

For patients receiving buprenorphine treatment through OTPs, the LTCF staff should follow the same protocol as described for methadone take home medication.

Extended Release Injectable Naltrexone for Medication Assisted Treatment

A resident who is receiving injectable naltrexone treatment through a prescribing physician may wish to continue this treatment in a LTCF. The resident shall continue to see a physician for this treatment. The prescription should be reviewed by the LTCF's medical director and can be filled by the pharmacy and administered in the same manner as all other prescription injectable medications. The injection is generally given once a month and can be given by a health professional who is allowed within his or her licensing scope of practice to give injections.

Use and Storage of Naloxone

Given the widespread use of opioids in LTCFs, naloxone, a schedule VI medication, shall be stored for emergencies pursuant to 105 CMR 150.008(E) and used only upon the orders of a physician or physician assistant or nurse practitioner. Administrators shall meet with the facility's Medical Director and Pharmacy service to ensure the availability of naloxone in case of an emergency and develop standing orders, pursuant to the attached Department Policy on the Use of Standing Orders for the Use of Naloxone (See Appendix A).

Contact Information

For more information, or if you have any questions on this guidance, please contact the Division of Health Care Facility Licensure and Certification via email at **paul.dinatale@state.ma.us**. Thank you.

Resources

The Department of Public Health is available to provide training resources including:

- **SAMHSA's website on MAT**
- **Providers' Clinical Support System for Opioid Therapies**
- **SAMHSA' s website on resources for integrating primary care and behavioral health services**
- **BSAS website on Practice Guidance documents on MAT and other relevant topics**
- **Relevant training programs sponsored by BSAS**

Appendix A

Policy on the Use of Standing Orders for the Use of Naloxone

The Department of Public Health highly recommends that Long Term Care Facilities develop standing orders for the use of naloxone as part of their institutional practices, subject to the following conditions:

1. The order shall be part of the institution's policies and procedures. The policy statement shall reference current standards and/or guidelines for the use of naloxone. The accountability for development and implementation of the policy within the institution shall be clearly stated.
2. The order for administration of medication or treatment shall be signed by the facility Medical Director. Alternatively, attending physicians often include a "standing order" to administer a medication, immunization or treatment as part of admission orders, or annual renewal of orders. This order, when written well in advance of the time the medication or treatment is administered, indicates the resident is medically cleared, and authorizes the administration.
3. Policies shall include parameters for use, i.e., eligible individuals for whom the order is appropriate, and any restrictions or exclusions. Additionally, a screening procedure shall be developed for use at the time of administration.
4. Policies and procedures shall include requirements for documentation in the medical record, including transcription of the order, established patient assessment and consent, and documentation of administration.
5. Professional staff administering the medication or treatment shall conduct an immediate assessment of the patient for medical contraindications, and document the results of the assessment in the medical record, in accordance with established policies.

1. Commonly used trade names for buprenorphine/naloxone are Suboxone®, Zubsolv®, and Bunavail®. The commonly used trade name for buprenorphine is

Subutex®. The commonly used trade name for injectable naltrexone is Vivitrol®. See the SAMHSA link on MAT for further information.

2. "On October 17, 2000, Congress passed the Drug Addiction Treatment Act (DATA) which permits qualified physicians to treat narcotic dependence with schedules III-V narcotic controlled substances that have been approved by the Food and Drug Administration (FDA) for that indication.

The legislation waives the requirement for obtaining a separate Drug Enforcement Administration (DEA) registration as a Narcotic Treatment Program (NTP) for qualified physicians administering, dispensing, and prescribing these specific FDA approved controlled substances. Physicians registered with the DEA as practitioners who apply and are qualified pursuant to DATA are issued a waiver (DWP) and will be authorized to conduct maintenance and detoxification treatment using specifically approved schedule III, IV, or V narcotic medications. DATA waivers are only granted to qualified physicians. Hospitals and mid-level practitioners do not qualify under the DATA." Please reference this web page for additional information: **http://www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm**

REFERENCED SOURCES:

105 CMR 700.00: Implementation of MGL c.94C105 CMR 150.00: Standards for long-term care facilities

Appendix B: Recruitment Materials

Medication for Opioid Use Disorder (MOUD) in Long Term Care Community Collaborative

The Massachusetts Department of Public Health (MDPH), Bureau of Health Care Safety and Quality (BHCSQ) invites you to participate in a community based MOUD in Long Term Care Collaborative, led by Abt Associates in partnership with Healthcentric Advisors.

Medication for Opioid Use Disorder (MOUD), the use of medicine such as naltrexone (Vivitrol), buprenorphine (Suboxone) or methadone — along with therapy and support — is an evidence-based approach to address opioid use disorder and support long-term recovery. In 2017, 22,200 Massachusetts residents received MOUD in opioid treatment programs (OTPs) and another 11,600 via office-based opioid treatment (OBOTs)[1]. An unexpected hospitalization or transfer to a long term care facility (LTCF) can pose challenges to the continuity of care for these patients. Massachusetts state law now requires all emergency departments to screen, assess, and provide treatment to patients presenting with an opioid-related event.

The MDPH issued a circular letter[2] in 2016 asserting that care facilities are expected to provide MOUD to residents who require such treatment, and who otherwise are eligible for admission. Over the next year, selected nursing homes and rest homes, will have an opportunity to participate in a training and technical support program. Participants will learn more about Opioid Use Disorder (OUD), evidence- based treatment, and best practices for supporting and caring for residents who require MOUD.

Benefits of Participation

Enhancing the quality of care you offer your residents and their caregivers	
• Community-based training • Evidence-based resources • Individualized technical support • Collaboration with local OBOTs/OTPs	• Implementing new MOUD-related polices • Enhanced continuity of care for patients with OUD • Staff training • Continuing Education Units (CEUs) • Continuing Medical Education (CMEs)

Expectations

Leadership Commitment	Program Team Commitment
• Participate in interviews/provide program feedback • Participate in a one-day in-person training • Facilitate a half-day technical support visit • Participate in a one-hour virtual peer-learning • Adopt customized MOUD policies and procedures • Ensure staff participation and engagement	• Participate in interviews/provide program feedback • Participate in a one-day in-person training • Participate in a one-hour virtual peer-learning session Implement customized protocol • Participate in a technical support site visit

A member of the program team from Abt or their partners at Healthcentric Advisors may be contacting you within the next week to discuss the program in more detail and address any questions.

[1] Substance Abuse and Mental Health Services Administration. National Survey of Substance Abuse Treatment Services (N-SSATS): 2017, Data on Substance Abuse Facilities, 2017 State Profiles. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

[2] http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/healthcare-quality/health-care-facilities/long-term-care-facilities/circular-letter-1611662.html

Dear Colleagues,

The purpose of this communication is to share information about the Massachusetts Department of Public Health's (the Department) collaborative efforts to address care for residents with substance use disorder in long term-care facilities. In July 2019, the Department launched the Medication for Opioid Use Disorders in Long-Term Care Program (MOUD in LTC Program), which aims to reduce challenges to the continuity of care for individuals who receive medication for opioid use disorders at opioid treatment programs and are residents in long-term care facilities.

For those receiving medication for opioid use disorders, a stay in a long-term care facility can present several challenges to resident care. The work completed in the MOUD in LTC Initiative will augment efforts to address timely coordination among opioid treatment programs (OTP), office-based opioid treatment facilities (OBOT), hospitals, and long-term care facilities.

With funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the State Opioid Response grant and through a competitive procurement process, the Department has contracted to work with Abt Associates and their partner Healthcentric Advisors. The Department, Abt Associates, and Healthcentric Advisors will collaboratively work with long-term care facilities, OTPs/OBOTs, and industry stakeholders to develop policies and training materials for long-term care facilities about MOUD and appropriate care for residents with substance use disorder (SUD)/opioid use disorder (OUD).

The Department is engaging 40 long-term care facilities and 10 OTPs and OBOTs from regions across the Commonwealth to participate in the first year of this initiative. Participating facilities include both those that have a history of caring for residents with SUD/OUD and those that have less experience, as well as rest homes to ensure accurate representation of the Commonwealth's long-term care facilities.

We look forward to sharing more information about the MOUD in LTC Program, including the Toolkit, with our long-term care stakeholders in the future. Thank you for your continued commitment to quality nursing home and rest home resident care in the Commonwealth.

If you have any questions about the MOUD in LTC Program, please contact the Department of Public Health at NursingHomeQI@state.ma.us.

Sincerely,

The Bureau of Health Care Safety and Quality

MOUD in LTC Telephone Recruitment Script

Respondent is the Administrator of a Long-Term Care Facility.

Hello, my name is [NAME], and I am from Abt Associates. I am following up on an announcement sent out by the Massachusetts Department of Public Health, or DPH, introducing a training and technical assistance program to help long-term care facilities implement policies for residents who are being treated for opioid use disorder. Do you have a few minutes to speak with me?

> **[If no]:** Is there a better time when I can call you again?) Thank you, I will call back then.

[If yes]: To give you some background, the Massachusetts DPH issued a circular letter in 2016 which said, "Some residents requiring skilled nursing care… are receiving medication assisted treatment (MAT), which includes treatment with methadone, buprenorphine, or naltrexone. In those cases, if the resident would otherwise be eligible for admission to the LTCF, the facility is expected to admit the resident and provide for the administration of MAT as directed by the prescribing or ordering physician at the resident's opioid treatment program (OTP) or Office Based Opioid Treatment with Buprenorphine program (OBOT). Substance use disorder would not be the primary condition for which treatment is sought at the LTCF." We know that LTCFs face many challenges in providing high quality care for patients who require medication for opioid use disorder (MOUD), and this program seeks to guide facilities like yours through some of those challenges.

The Massachusetts DPH, has contracted with Abt, and their partner Healthcentric Advisors, to implement this program. The program will help providers admit residents and provide for the administration of medication assisted treatment, or MOUD, as prescribed.

Over the course of the next year, facilities participating in this program will receive evidence-based resources, an in-person group learning session, individualized technical support and virtual peer-to-peer collaborative learning. We will be applying for continuing education units, or CEUs, for staff participating in the group learning session. The program is free to you and would only require commitment of your time and the time of some of your staff.

> Are you interested in participating in the program?
>
> **[If no]**: Can I ask why not? [Try to address identified barriers.]
>
> **[If they still refuse to participate]**: Thank you for your time. The training materials developed from this program will be posted next year on the Massachusetts DPH website for your reference. [End call]
>
> **[If they agree to participate:]** Thank you for your willingness to participate.

Site Visit

As a next step, I'd like to set up a day when we can visit your facility. The site visit will last about four hours. During the visit we would like to conduct interviews with you [the Administrator], the director of nursing, the medical director, and a few CNAs [if it is a very small facility, might

interview only one CNA – interviewer should know this prior to the call]. I will reach out directly to the medical director by telephone to confirm that he/she will have time while on site. We expect that the interviews with you and the DON will last approximately one-hour each. The interview with CNAs will be about 15 minutes.

While on site we will review any policies that you have related to caring for residents with a diagnosis of OUD or a diagnosis of SUD receiving MOUD for opioid addiction. As contractors for the Massachusetts DPH, we also will review the care plans of residents diagnosed with OUD. It's important to note that we will not collect individual resident-level data; we are interested in learning about your procedures for caring for these residents. The data that we collect will be shared with DPH. However, only the name of the facility will be identified. No other identifying information about you, your staff or your residents will be recorded or shared.

What day(s) of the week will work best for us to visit your facility?

> [If you are **able** to schedule the visit, confirm that the administrator will arrange times to conduct the interview with him/her, the DON and the group of CNAs.] Thank you. I will follow-up this phone call with an email that contains information about the MOUD training/TS program and confirms the date and details of the site visit.
>
> [If you are **unable** to schedule the visit.] I will follow-up this phone call with an email that contains information about the MOUD training/TS program and a request for your availability and that of your staff to conduct a site visit.

While I have you, will you please provide me with contact information for [interviewer should insert the name of the **medical director** prior to the call]?

Thank you so much for agreeing to participate in this program, we look forward to seeing you on **[DATE]**. Before I go, do you have any questions about the interviews or the program overall?

Telephone Interviews

As a next step, I would like to set up a time when we can conduct an informal telephone interview with you [the Administrator], the director of nursing, and the medical director. I will reach out directly to the DON and medical director to schedule their interviews. We expect that the interviews will last approximately one-hour. Can we schedule your interview now? What works best?

While I have you, will you please provide me with contact information (email addresses and telephone numbers) of your medical director and DON?

> [If you are **able** to schedule the telephone interview.] Thank you. I will follow-up this phone call with an email that contains information about the MOUD training/TS program and confirms the date and details of the interview.
>
> [If you are **unable** to schedule the visit.] I will follow-up this phone call with an email that contains information about the MOUD training/TS program and a request for your availability to conduct the interview.

Thank you so much for agreeing to participate in this program. Before I go, do you have any questions about the interviews or the program overall?

MOUD in LTC Telephone Recruitment Script

Respondent is the DON of a Long-Term Care Facility.

Hello, my name is [NAME], and I am from Abt Associates. Abt along with our partner Healthcentric Advisors has been contracted by Massachusetts Department of Public Health to assist in the development and training of medication for Opioid Use Disorder or MOUD policies for residents in long-term care facilities who have been diagnosed with opioid use disorder. [Name of administrator], has agreed to have staff from [name of facility] participate in the MOUD training and technical support program, and shared your contact information as a nominated participant. Do you have a few minutes to speak with me?

[If not]: is there a better time when I can call you?)

[If yes]: The program will provide your facility with the tools needed to care for your residents that are on MOUD, for opioid use disorder. In January, [name of facility] will receive evidence-based resources and an in-person group learning session. Sometime in the spring we will provide your facility with individualized technical support followed by virtual peer to peer collaborative learning.

Do you have any questions about the program?

To help inform the development of training materials, we will be conducting interviews with the administrator, medical director, CNAs, and yourself. It's important to note that we will not collect individual resident-level data; we are interested in learning about your procedures for caring for residents with opioid use disorder. The data that we collect will be shared with DPH. However, only the name of the facility will be identified. No other identifying information about you, other staff or residents will be recorded or shared. Are you willing to participate in a [telephone or in-person] interview?

[If no]: Can I ask why? [Try to address their concerns.]

[If they still refuse to participate]: Thank you for your time. Do you have an Assistant Director of Nursing or nurse practitioner we could interview in your place?

[If DON **names an alternative**] Thank you. Will you please give me his or her name and contact information and I will reach out directly. Thank you very much for your time. [End Call]

[If the DON **does not name an alternative**] I understand, thank you for your time. [End call]

[Site Visit Interview – N/A; assume that administrator or designee will arrange the site visit interview for the DON**]**

Telephone Interviews [DON]

Thank you for agreeing to a telephone interview with us. We'd like to set-up the time that would work for you. Do you have your calendar available? Can we schedule a time to hold a 60 minute interview with you? It may not take that long, but we'd like to be prepared if it does.

> [If you are **able** to schedule the visit.] Thank you. I will follow-up this phone call with an email that contains information about the MOUD training/TS program and confirms the date and details of the interview.
>
> [If you are **unable** to schedule the visit.] I will follow-up this phone call with an email that contains information about the MOUD training/TS program and a request for your availability to conduct the interview.

Thank you very much for your willingness to participate in this important program. Do you have any questions about the interviews or the program overall?

MOUD in LTC Telephone Recruitment Script

Respondent is the Medical Director of a Long-Term Care Facility.

Hello, my name is [NAME] and I am from Abt Associates. Abt along with our partner Healthcentric Advisors has been contracted by Massachusetts Department of Public Health or the DPH, to assist in the development and training of Medication for Opioid Use Disorder, or MOUD, policies for residents in long-term care facilities who have been diagnosed with opioid use disorder. [Name of administrator], has agreed to have staff from [name of facility] participate in the MOUD in Long-Term Care training and technical support program, and provided me with your contact information. Do you have a few minutes to speak with me?

> **[If not]:** is there a better time when I can call you again? Thank you for your time, I will call back then.

[If yes]: The program will provide your facility with the tools needed to care for residents who are on MOUD. Over the course of the next year, [name of facility] will receive evidence-based resources, an in-person group learning session, individualized technical support, and virtual peer to peer collaborative learning.

Your commitment in the program will include participating in a 30-minute in-person or telephone interview, and a one-day learning session to be offered in several locations throughout the Commonwealth. Should the timing of the leaning session not be convenient to your schedule, we will provide you with materials from the session, and make arrangements to brief you at another time.

Do you have any questions about the program?

To help inform the development of training materials, we will be conducting interviews with staff from **[name of facility]**. We believe that your participation and input is crucial to the success of the program. We will be providing the de-identified interview data to the DPH, but your name and the names of your colleagues will not be recorded or shared with DPH. Are you willing to participate in an interview with us?

> **[If no]**: Can I ask why? [Try to address their concerns.]
>
> **[If the MD still refuses to participate]:** Thank you, I understand. As I said we will be interviewing the administrator, DON, and CNAs, is there anyone else, maybe a Nurse Practitioner or Physician Assistant with whom you work, that you think we should interview in your place?
>
> > **[If MD provides provides an alternative**: Request names and contact information.] Thank you very much for your time. [End call]
> >
> > **[If MD declines to provide an alternative]**: That's okay. Thank you very much for your time. [End call]
>
> **[If MD agrees to participate in an interview]**

[In-person Interview]

We have arranged a site visit to [name of facility] on [date and time]. It is my understanding that this is a day when you are at [name of facility] to see residents. Is it possible to set up a time on this day when we can meet with you for a 30-minute interview?

> [If you are **able** to schedule an in-person interview.] Thank you. I will follow-up this phone call with an email that contains information about the MOUD training/ technical assistance program and confirms the date and details of the interview.
>
> [If the medical director is **not available during the site visit**.] That's okay. Can we schedule a time when we can conduct the interview over the phone? Alternatively, we can send you a list of questions via email and ask that you respond with feedback.

[**Telephone Interview]**

> [If you are **able** to schedule a telephone interview.] Thank you. I will follow-up this phone call with an email that contains information about the MOUD training/ technical assistance program and confirms the date and details of the interview.
>
> [If the MD prefers a telephone interview, but you are **unable** to schecdule it at this time]. I will follow-up this phone call with an email that contains information about the MOUD training/technical support program and ask that you send me a couple of options for your availability for a 30-minute interview. In turn, I will select a date and send you a calendar invitation for the interview with the call line information.

[Virtual Interview]

> [If MD expresses a preference to have the questions emailed to him/her]. I will follow-up this call with an email that contains information about the MOUD training/technical support program and includes a list of questions for which we would like your feedback. We ask that you send your responses via email within two weeks of receiving them. However, please don't hesitate to let me know if you need more time or if you have any questions.

Thank you very much for your willingness to participate in this important program. Do you have any questions about the interviews or the program overall?

MOUD in LTC Telephone Recruitment Script

Respondent is a representative of OTPs/OBOTs.

Hello, my name is [NAME] and I am from at Abt Associates. I believe that [name of BSAS regional manager and MOUD stakeholder] has reached out to you recently about the MOUD in Long-Term Care program funded through the Massachusetts Department of Public Health, or DPH. Abt along with our partner Healthcentric Advisors has been contracted by the DPH to assist in the development and training of MOUD policies for residents in long-term care facilities – which includes both nursing homes and rest homes - who have been diagnosed with opioid use disorder. Do you have a few minutes to speak with me?

[If no] Is there a better time when I can call you again?

Thank you for your time, I'll call back then. **[End call]**

[If yes] Thank you. To give you some background, the DPH issued a letter in 2016 addressed for circulation to DPH-regulated long-term care facility administrators. The circulation letter stated that long-term care facilities are expected to provide MOUD to residents who require treatment. However, long-term care facilities face many challenges in providing high quality care to patients who require MOUD.

We have an opportunity to improve care delivery to ensure the safety of all long-term care residents. The MOUD in LTC program will provide long-term care facilities with technical support and training on opioid use disorder and MOUD. We are interested in your participation as a vital part of the care continuum. Your participation will involve contributing to a 60-minute group interview with your leadership team and attending a full-day, in-person learning session with long-term care facilities in your area. I will describe both of these activities in more detail, but first, do you have any questions about the program?

[Recruiter, be prepared to respond to questions. For questions that you cannot answer, refer respondent to Rosanna Bertrand, project director, at 617-349-2556 or Kate Fillo, DPH, at 617-624-0504]

In order to help inform the development of training materials, including MOUD policies and procedures, we will be collecting information from key people such as: long-term care facility staff and hospital discharge planners/ case workers. We would also like to interview your leadership team, including your organization leader, clinical director, and nurse supervisor.

Would your leadership team be able to participate in a group telephone interview about the processes and procedures that you follow when treating patients who are going to a long-term care facility or who are currently residents at a long-term care facility?

[If no]: Can I ask why you don't want to participate? [Try to address their concerns.]

[If they still refuse to participate]: I understand; thank you for your time. [End call]

[If they agree to participate:] Thank you for you willingness to participate. We expect that the interview will take approximately 60 minutes. I will follow-up this phone call with an email that contains additional information about the MOUD training/technical support program and ask that you get back to me with a couple of times when the leadership team such as your organization leader, clinical director, and nurse supervisor are available for a group interview. Can I please have your email address so that I can send you this information?

In January, we will be offering a full-day learning session in several locations throughout the Commonwealth. We encourage and welcome your participation and input into one of these sessions to share your experiences of coordinating patient care with the hospital and long-term care facilities. The session will present a unique face-to-face opportunity to meet representatives from local long-term facilities and to strengthen or build relationships with them.

In the meantime, the technical support team, in collaboration with the DPH and our MOUD workgroup will be focused on developing core competencies and policies for long-term care facilities to ensure smooth transitions for patients diagnosed with an opioid use disorder through the continuum of care. We anticipate that as a result of participating in this program, long-term care facilities will serve as better partners with organizations like yours, and ultimately the quality of care provided to your shared patients will be improved.

Do you have any final questions about the interview or the program overall? Thank you very much for your time.

Scheduling Email

To be used after there is an agreement to participate but were unable to schedule the site visit/telephone interview during the recruitment telephone call.

Respondents are Long-Term Care Facility administrator, DON, or medical director; representative of an OTP, OBOT, or hospital.

Dear [respondent name]

I am writing to follow-up on [yesterdays or insert correct reference] telephone conversation [or voice message] regarding the medication for opioid use disorder (MOUD) technical support (TS)/training program that Abt Associates is conducting in collaboration with our partner, Healthcentric Advisors. Thank you again for your willingness to participate.

The purpose of the program is to assist the Massachusetts Department of Public Health (MDPH) to develop and train staff on appropriate MOUD policies and procedures for caring for long-term care residents diagnosed with opioid use disorder (OUD). As mentioned during our conversation [or as mentioned in my voice mail], we are conducting a series of interviews to understand your current practices and to help inform the development of training materials.

[Site visit – LTCF Administrator]

One or two team members will be visiting your facility to conduct the interviews with you and your staff. We anticipate that the site visit will last approximately four hours. These interviews may not take this long, but we'd like to be prepared if it does. While on site we would like to conduct individual interviews with you, your director of nursing (DON), the facility's medical director, and three or four **[modify based on the number of CNAs per shift]** of your certified nursing assistants (CNAs). In addition to the interviews, while on site we will review any relevant MOUD policies as well as the care plans of residents who have been diagnosed with OUD or SUD and are receiving MOUD.

I would like to work with you to arrange the site visit to take place during the month of **[MONTH YEAR].**

Our goal is to best accommodate your schedule, so please send me three options for a four-hour site visit. We will select one option and forward an email invitation to you and your staff. Please be sure to include times for the following interviews:

(1) Administrator (60-minute interview)
(2) DON (60-minute interview)
(3) A small group of CNAs (15-minute interview) **[modify based on the number of CNAs per shift, determined in advance of the interview]**

I will reach out separately to arrange a time to speak with the medical director, either during the site visit or by telephone, once we have scheduled the date.

I look forward to hearing from you soon. Please let me know if you have any questions or concerns.

Thank you again for your assistance with this important work.

[Telephone interview - LTCF DON and medical director; OTP, OBOT representatives]

Dear [respondent name]

I am writing to follow-up on [yesterdays or insert correct reference] telephone conversation [or voice message] regarding the medication for Opioid Use Disorder (MOUD) technical support training program that Abt Associates is conducting in collaboration with our partner, Healthcentric Advisors. Thank you again for your willingness to participate.

The purpose of the program is to assist the (MDPH) to develop and train staff on appropriate MOUD policies and procedures for caring for long-term care residents diagnosed with opioid use disorder (OUD). As mentioned during our conversation, we are conducting a series of interviews to understand your current practices and to help inform the development of training materials.

I would like to arrange a time when we can hold a telephone interview during the next two weeks**.** To best accommodate your schedule, please send me three options for a [Interviewer, fill in as follows for the correct recipient of this follow-up email]

DON: 60-minute interview

Medical director: 30-minute interview

OTP/OBOT: 60-minute group interview with your leadership team including your organization leader, clinical director, and nurse supervisor.

We will select one option, set up a WebEx call and forward an email invitation to you with dial-in information.

I look forward to hearing from you soon. Please let me know if you have any questions or concerns.

Thank you again for your assistance with this important work.

Appendix C: List of MOUD Program Participating Facilities

Facility Name	Site
Burgoyne Rest Home	Boston
Cambridge Rehab	Boston
Marian Manor	Boston
North End Rehab and Healthcare Center	Boston
Sherrill House	Boston
Soldier's Home in Chelsea	Boston
Spaulding Nursing and Therapy Center	Boston
ST.JOSEPH R&N CENTER	Boston
Bear Mountain at Andover	Lowell
Cedar View Rehabilitation and Healthcare Center	Lowell
Fairhaven	Lowell
Northwood Rehab and Healthcare	Lowell
Royal Wood Mill Nursing and Rehabilitation Center	Lowell
The Meadows Health Center at Andover	Lowell
Care One at Holyoke	Springfield
Care One at Lowell	Springfield
Chicopee Gardens Nursing and Rehab	Springfield
East Longmeadow Skilled Nursing Center	Springfield
River Valley Rest Home	Springfield
St. Luke's Home	Springfield
Vero of Hampden	Springfield
Vero of Wilbraham	Springfield
Alden Court Nursing Care and Rehab Center	Wareham
Cape Heritage Rehab and Health Care Center	Wareham
Cape Regency Rehab and Health Care Center	Wareham
Hannah B.G. Shaw Home for the Aged	Wareham
JML Care Center	Wareham
Life Care Center of Plymouth	Wareham
Royal Cape Cod Nursing and Rehab Center	Wareham
Royal Nursing Center	Wareham
Sippican	Wareham
Wareham Healthcare	Wareham
Blaire House of Worcester	Worcester
Brook Have Assisted Care	Worcester
Christopher House	Worcester
Fitchburg Rehabilitation and Nursing Center	Worcester
Holy Trinity Eastern Orthodox Nursing and Rehab Center	Worcester
Parsons Hill Rehab and Health Care Center	Worcester
Shrewsbury Nursing and Rehab Center	Worcester
St. Francis Rehab and Nursing Center	Worcester
West Side House	Worcester
Worcester Rehab and Healthcare	Worcester

Appendix D: June 2020 Outreach Email and Telephone Scripts

Greetings [administrator or other contact];

I am reaching out to you today to reignite your enthusiasm for the Medication for Opioid Use Disorder (MOUD) in Long-Term Care Program. In no way do I mean to minimize the effect that the COVID-19 pandemic has had on the vast majority of nursing home residents, families and staff. In fact, our team is looking to re-engage your facility and offer our assistance as we all move through and past this pandemic.

As you recall, the purpose of this program is to provide training to your staff on providing safe and continued care to residents being treated with MOUD. We have gained knowledge about creative alternatives to providing continued care and services to this population during the pandemic. Imparting this knowledge will help to ensure continued safe care now, and will help to build your capacity should other such disruptions occur in the future. In light of the pandemic, all future training events will take place in a virtual space rather than in-person. I believe you told me that you have a camera for your computer, but if not, please let me know so that you can fully engage in the virtual events.

To "pick up where we left off," but with even more to offer, the following activities are planned:

- Next week (week of June 22): We will reach out to you by phone to talk with you about the effects of the pandemic on your facility, offer our help in straddling additional COVID hurdles, and to go over the following future MOUD events.
- The weeks of July 27 and August 3: Virtual site visits for all facilities. One, 1-hour visit with the Administrators and Directors of Nursing; and one, 30-minute visit with your Staff Developer or equivalent staff. For each of these visits, we will offer five different scheduling options.
- The weeks of August 17 – September 21: Given the tremendous enthusiasm that we received for the first learning session, we are offering a second similar virtual event. A series of six ECHO learning sessions will be offered on Tuesdays and Thursdays (you can sign up for either) for six consecutive weeks. If you've never heard of ECHO, you may want to check it out here: https://echo.unm.edu/join-the-movement/need-to-know and in the attached flyer.

We look forward to reengaging with you and your colleagues. We are excited to offer you, what we feel will be efficient, time-saving and informative knowledge delivered in a virtual environment, allowing you the time to continue to do what you all do so well.

If you have any questions or concerns, please feel free to email nursinghomeqi@state.ma.us. As always, our thoughts continue to be with your residents, and each of you and your staff as you continue to recover from the pandemic and provide high-quality care to residents.

Best,

If you reach the administrator

Hello **[administrator's name]**;

This is **[callers name]** from **[Abt Associates or Healthcentrics working with Abt Associates]**. I am calling to follow-up on an email that I sent to you last week. Did you receive the email **[if yes, good; if no, check that you had the correct email address and say that's okay, we'll go over it today].**

First, how are you and your staff and residents doing? I see that you had x cases (check the DPH weekly COVID dashboard before you call: https://www.mass.gov/doc/weekly-covid-19-public-health-report-june-17-2020/download. Go to long term care facilities). Give the administrator a chance to talk about his/her experiences. Have the COVID talking point (attached) available, if needed.

As I said in the email message, we are reaching out to reignite your enthusiasm for the Medication for Opioid Use Disorder (MOUD) in Long-Term Care Program.

As you recall, the purpose of the MOUD program is to provide training to your staff on providing safe and continued care to residents being treated with MOUD. In light of the pandemic, all future training events will take place in a virtual space rather than in-person.
You will need a camera on your computer so that you can fully engage in the virtual events. **Do you have a camera for your computer? [If yes, good; if no, we will mail one to you in advance of the first event]**.

The upcoming MOUD activities are:

- **[Read only for the seven who were represented at the January learning session]** The week of July 13: A one-hour virtual review of the January Learning Session for facilities that were unable to make the in-person event. Abt will be sending a doodle poll in the next day or two to determine the day/time when most facility attendees are available. **Please be sure to respond to the Doodle poll right away! It was send to you by my colleague Cayla Roby.**

- The weeks of July 27 and August 3: Virtual site visits for all facilities. One, 1-hour visit with the Administrators and Directors of Nursing; and one, 30-minute visit with your Staff Developer or equivalent staff. For each of these visits, we will offer five different scheduling options.

- The weeks of August 24 – September 29: Given the tremendous enthusiasm that we received for the first learning session, we are offering a second similar virtual event. A series of six ECHO learning sessions will be offered on Tuesdays and Thursdays (you can sign up for either) for six consecutive weeks. Are you familiar with ECHO? **[If no, you can go to their website https://echo.unm.edu/join-the-movement/need-to-know to familiarize yourself with it]**.

[Ask only of facilities that admit residents with OUD, being treated with MOUD. We will need two volunteers for each of the following topics, so let's alert each other as to the name of the facility and the topic, as soon as you engage a volunteer.]

For the ECHO learning session we are asking facilities to present a very brief (5-10 minute) MOUD- relevant case studies. This could be about barriers you experienced due to regulations; experiences with telehealth; experience in transitions of care from hospital to LTCF; experience in developing a partnership with OTPs/OBOTs including barriers; barriers experienced in setting-up successful transportation to treatment; experience in connecting to community supports,

including housing options. Do you have any of these experiences to share? **[If yes, great which topic? We will provide you with a template to make it easier for you. If no, that's okay, I just wanted to give you an opportunity to share].**

Do you have any questions about the upcoming events?

Before we go, would you please confirm that **[DON name]** is still your DON and this is his/her email address [**DON email address**]. [**If no, get the name and email address of the new DON]**. What is the name and contact number of your staff educator?

Thank you for your time. I'm looking forward to reengaging with you and your colleagues.

If you have any questions or concerns, don't hesitate to reach out to me.

<u>If you leave a voice message</u>

Hi, this is **[your name]** from **[Abt Associates or Healthcentrics working with Abt Associates]**. I sent you an email last week and mentioned that I would be following up with a telephone call. I want to hear about how you, your staff and your residents are doing in the wake of the COVID crisis. I hope that things have stabilized and you can see a bit of your normal routine returning. I'd like to have a chance to talk with you about the upcoming events related to the Medication in Opioid Use Disorder program. Please give me a call back at **[your number]** at your earliest convenience. Thank you.

Appendix E: PowerPoint Presentations from MOUD Training Events

i. In-Person Learning Sessions

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 · 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.

2

Disclosure of Financial Relationships & Commercial Support

Disclosure:

- It is the policy of the contract team (Abt Associates and Healthcentric Advisors) to ensure independence, balance, objectivity, scientific rigor, and integrity in all of its continuing education activities. Our presenters will disclose any significant relationships with commercial interests whose products or devices may be mentioned in the activity or with the commercial supporter of this continuing education activity. Identified conflicts of interest were resolved prior to accreditation of the activity and may include any of or combination of the following: attestation to non-commercial content; notification of independent and certified CME/CE expectations; restriction of topic area or content; restriction to discussion of science only; amendment of content to eliminate discussion of device or technique; use of other author for discussion of recommendations; independent review against criteria ensuring evidence support recommendation; moderator review; and peer review.

Disclaimer:

- This program is designed solely to provide the healthcare professional with information to assist in his/her practice and professional development and is not to be considered a diagnostic tool to replace professional advice or treatment. The program serves as a general guide to the healthcare professional, and therefore, cannot be considered as giving legal, nursing, medical, or other professional advice in specific cases. Abt Associates and Healthcentric Advisors specifically disclaim responsibility for any adverse consequences resulting directly or indirectly from information in the course, for undetected error, or through participant's misunderstanding of the content.

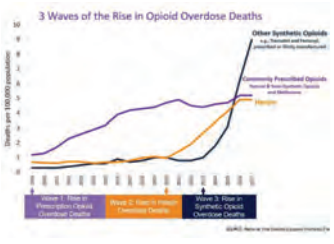
3

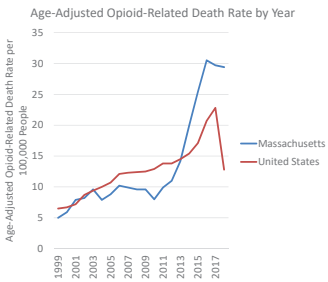
Call to Action

Marybeth McCabe, BA
Department of Public Health, Bureau of Health Care Safety and Quality

4

The Opioid Epidemic: Nationally and Locally

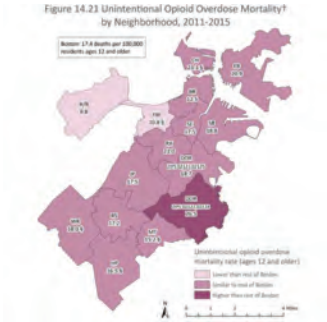




MA statistics from https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-november-2019/download; U.S statistics from CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics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

5

Boston Community of Practice

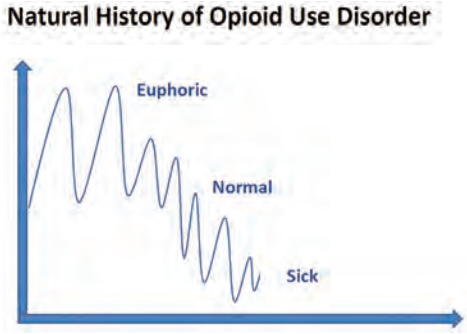


Mortality Rates from 2011-2015

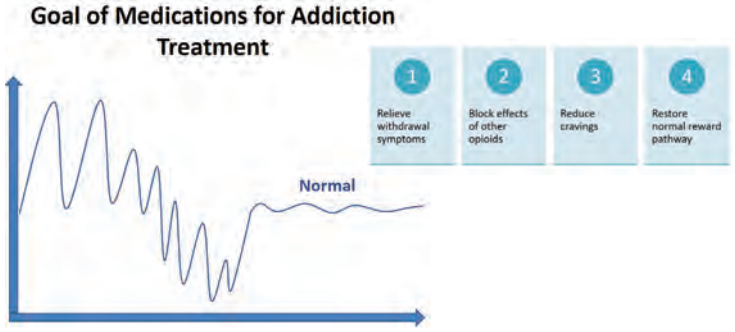
For 2011 to 2015, the unintentional opioid overdose mortality rate was higher for Dorchester (zip codes 02122, 02124) compared with the rest of Boston. The rate was lower in Allston/Brighton and Fenway compared with the rest of Boston.

6

Dr. Wakeman's Natural History of OUD



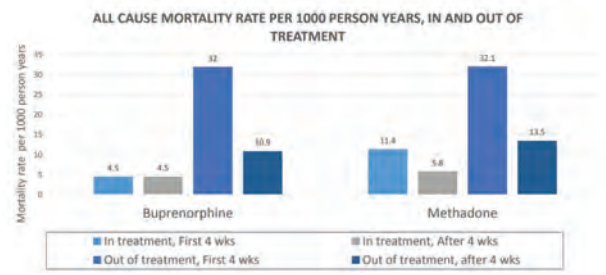
Dr. Wakeman's Natural History of OUD: Goals of Treatment Medications



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

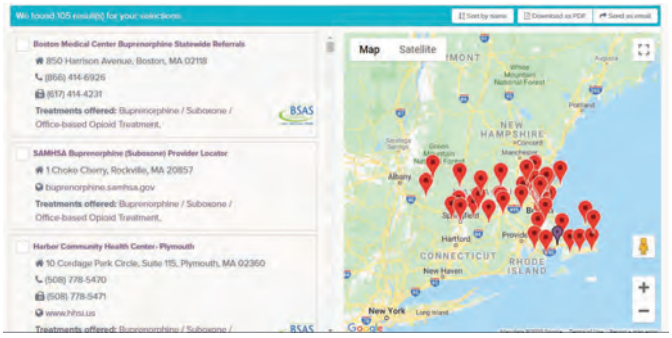
MOUD Saves Lives



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

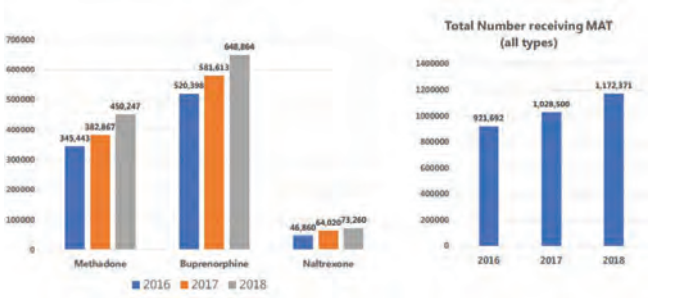
MA Resources for Addiction

Access to MOUD



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

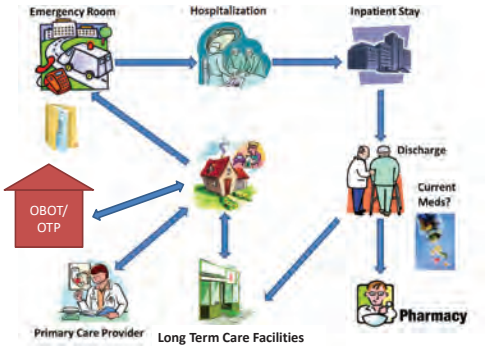
Number of Individuals Receiving MOUD Nationally



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

13

A Journey Through the Care Continuum



14

Pathways to Recovery Personal Journey

Julie Bunch
Massachusetts Organization for Addiction Recovery

15

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

16

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

17

Objectives

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

18

Understanding Opioid Use Disorder

Simeon Kimmel, MD, MA
Boston Medical Center

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

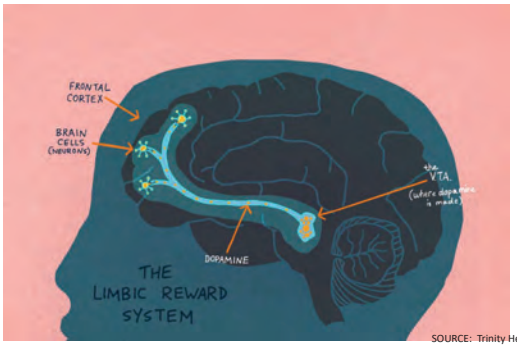
Biological Background

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

25

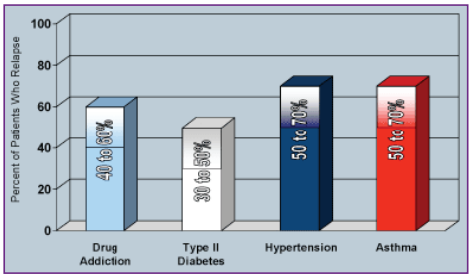
Addiction is Chronic Brain Disease



SOURCE: Trinity Health Presentation

26

Addiction is Chronic Disease



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

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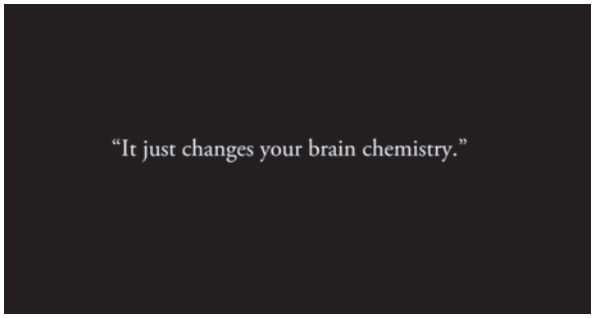

https://youtu.be/H7HfmYDkBzg

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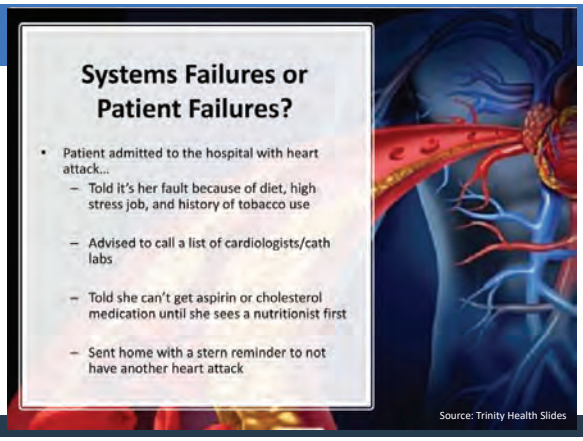

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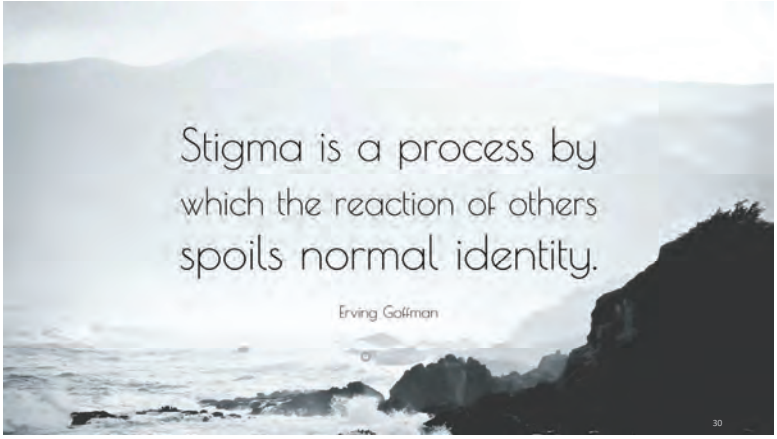


30

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

31

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

32

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

33

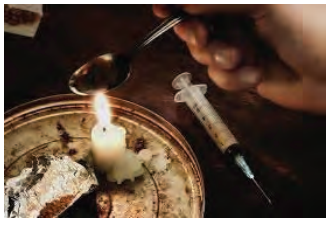
Avoid Stigmatizing Language - Words Matter

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

34

Dependence and Addiction



35

How OUD is Diagnosed (DSM-5)

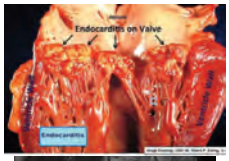
Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill 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

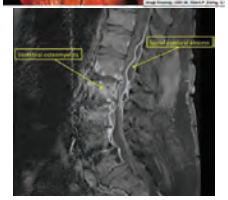
Source: https://www.psychiatrictimes.com/special-reports/opioid-use-disorder-update-diagnosis-and-treatment

36

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





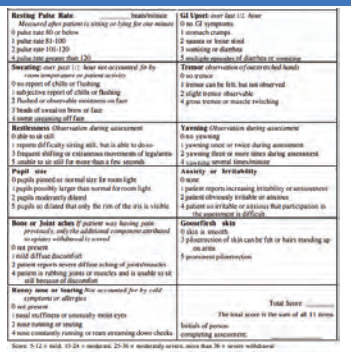
Case Example 2

- 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



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

43

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

44

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

45

Harm Reduction

46

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.

47

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.

48

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

49

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

50

An Overview of Medication to Treat Opioid Use Disorder

Marghie Giuliano, R. Ph.
Healthcentric Advisors

51

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

52

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**

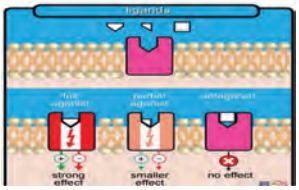
53

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)

55

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

56

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)

57

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

58

Methadone Recap

Question:

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

60

Answer:

✓Structured treatment/dispensing with daily interaction

✓Eliminates withdrawal symptoms

✓Helps people function better

61

Question:

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

62

Answer:

✓Overdose risk

✓Diversion possibility

✓Requires OTP visit

63

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)

64

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

65

Buprenorphine Potential Challenges

- Overdose (risk is low)
- Diversion

66

Buprenorphine Recap

67

Question:

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

68

Answer:

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

69

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

70

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

71

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)

72

Naltrexone Recap

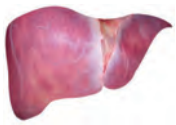
Question:

- What rare but serious condition can naltrexone cause?

74

Answer:

- Hepatotoxicity (Liver Toxicity)



75

MOUD in LTCF

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

76

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

77

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**

78

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

79

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

80

How can you support your residents on MOUD?

81

Questions?

82

Approaches to Delivering Person-Centered Care

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

83

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

84

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."

85

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

86

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

87

What is Trauma?

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

88

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

89

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?

90

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.**

91

Who Experiences Trauma?

Residents

Staff & Volunteers

Family & Caregivers

92

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

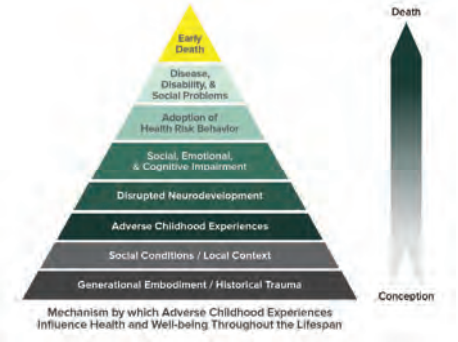
22%
were sexually abused as children

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

93

How do ACEs and Adverse Events Affect People?



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

94

Early Adversity has Lasting Impacts

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

95

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?**

96

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

97

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

98

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

99

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

100

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

101

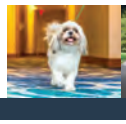
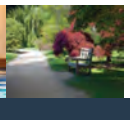
Engagement Strategies

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

102

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.

103

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

104

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

105

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.

106

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

107

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

108

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

115

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

116

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

117

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

118

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

119

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

120

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.

121

Office Based Opioid Treatment Program

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

122

Office Based Opioid Treatment (OBOTs)

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

123

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

124

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

125

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**

126

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

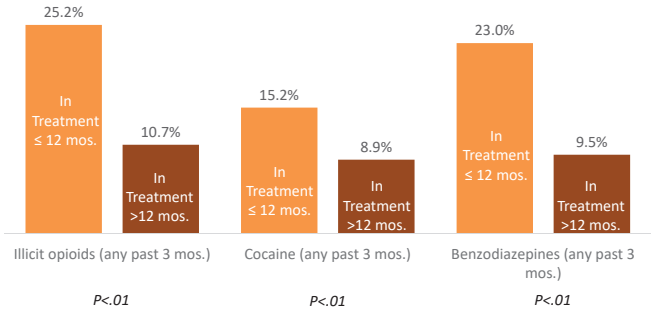
127

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

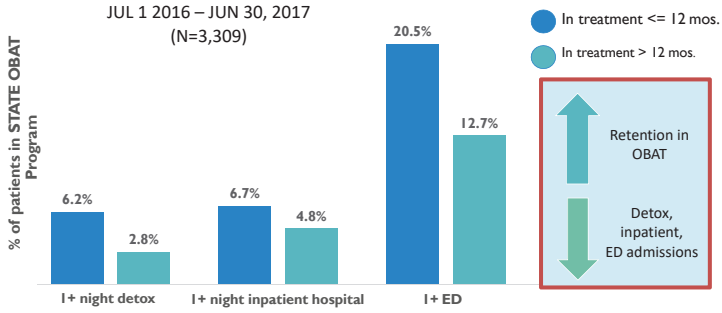
128

Urine Toxicology Outcomes for MA OBOT Sites



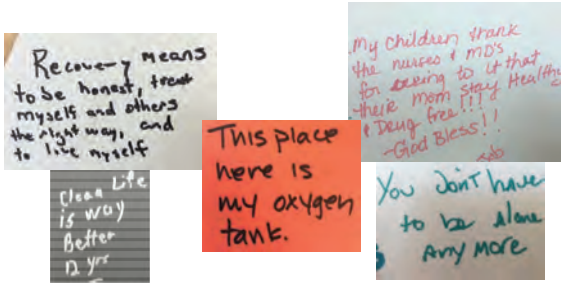
129

Health Care Utilization Outcomes MA OBAT Sites



130

Patient Testimonials



131

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

132

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

133

Additional Community Supports

134

Community Supports

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

135

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

136

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

137

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/

138

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

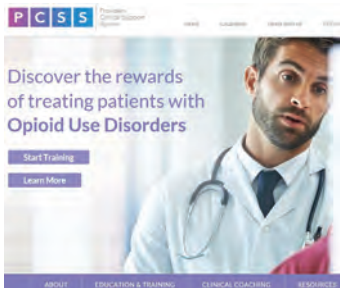
Harm Reduction Education and Materials:

- 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



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

145

Objectives

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

146

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

147

Using the Toolkit

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

148

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

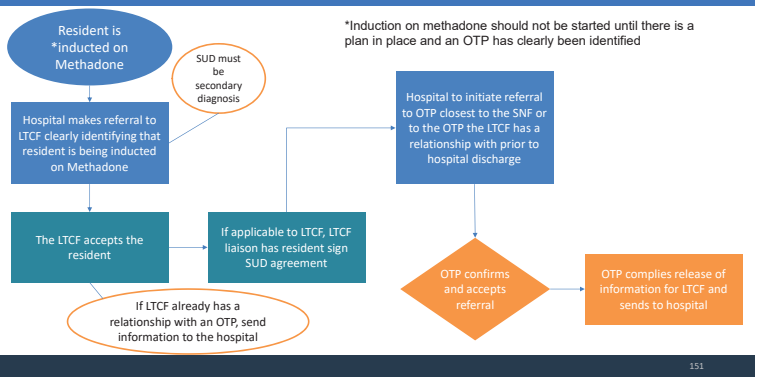
149

Care Transitions

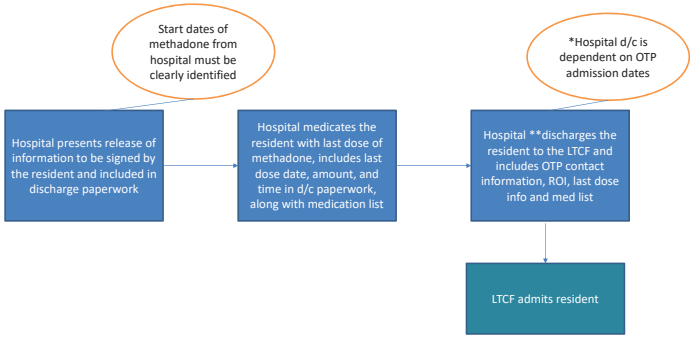
- Process Maps
  - Resident is on Methadone Maintenance (*only for residents on methadone maintenance*)
  - Resident is newly inducted on Methadone (*only for residents newly inducted on methadone*)
    - Note: Residents newly inducted on methadone will require more coordinated efforts between LTCFs 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*)

150

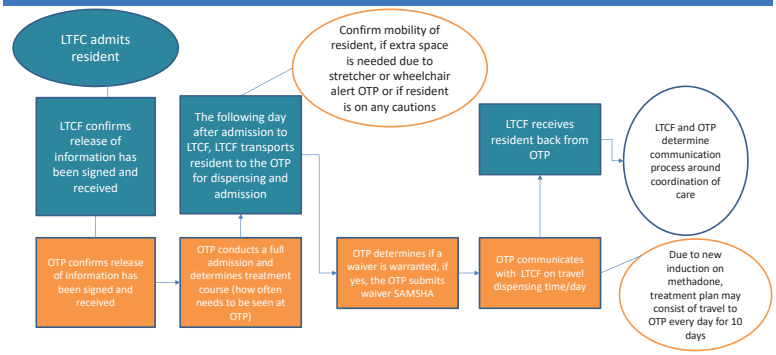
Resident is Inducted on Methadone



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

157

Leaving in Action

Rosanna Bertrand, PhD

158

Opportunity to utilize resources

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

159

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

160

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

161

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Questions/Discussion

SAMHSA

MOUD IN LONG TERM CARE

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Thank you!

A Few Logistics:

Please remember to turn in your evaluation

Continuing education certificates will be distributed electronically following the program

SAMHSA Healthcentric Advisors MOUD IN LONG TERM CARE

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Massachusetts Department of Public Health

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

www.mass.gov/dph

164

ii. Project ECHO® Series

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Project ECHO Healthcentric Advisors New England

Learning Session: Overview of Telehealth

SAMHSA | Abt | Healthcentric Advisors | MOUD IN LONG TERM CARE

For educational and quality improvement purposes, we will be recording this video-session

By participating in this clinic you are consenting to be recorded. We appreciate and value your participation

If you have questions or concerns, please email echo@healthcentricadvisors.org or use chat to Stephanie Baker

Some helpful tips

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- Mute microphone when not speaking
  - Left bottom corner of your screen
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To indicate your name and facility

- Click on the three dots on your small screen or click "Participants"
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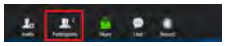

3

Some helpful tips (cont.):

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4

Continuing Education

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5

Disclosure of Financial Relationships & Commercial Support

Disclosure:

- It is the policy of the contract team (Abt Associates and Healthcentric Advisors) to ensure independence, balance, objectivity, scientific rigor, and integrity in all of its continuing education activities. Our presenters will disclose any significant relationships with commercial interests whose products or devices may be mentioned in the activity or with the commercial supporter of this continuing education activity. Identified conflicts of interest were resolved prior to accreditation of the activity and may include any of or combination of the following: attestation to non-commercial content; notification of independent and certified CME/CE expectations; restriction of topic area or content; restriction to discussion of science only; amendment of content to eliminate discussion of device or technique; use of other author for discussion of recommendations; independent review against criteria ensuring evidence support recommendation; moderator review; and peer review.

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6

Learning Objectives

- Review current telehealth guidelines in regards to MOUD management.
- Discuss a case example with subject matter experts and your peers on how telehealth has impacted care for your resident.
- Consider solutions for breaking down barriers to using telehealth.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Zoom overview and SME introductions	Stephanie Baker
1:05- 1:20 pm	How Spectrum Health Systems has utilized telehealth	Lisa Blanchard, Spectrum
1:20 – 1:35 pm	Case presentation	Durai Rajasekar, River Valley Rest Home
1:35- 1:55 pm	Discussion	All participants
1:55- 2:00 pm	Questions/ ending announcements	

***Chat will be monitored by Stephanie Baker and Kate Crump**

8

Rules of Engagement

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* Adapted from Rules of the Road by RIZE Massachusetts

Overview of Telehealth in the Long-Term Care Facility (LTCF)

Lisa Blanchard
Spectrum Health Systems

10

Telehealth Across Systems

- *Spectrum Health Systems responded immediately to the COVID 19 pandemic with telehealth solutions.*
- *Significantly reduced barriers to pandemic-related care and beyond.*
- *Implications for a positive impact on long-term care residents on MOUD.*

Telehealth Outpatient Response

- Immediately moved all counseling services to a telehealth model.
- Approval from all payers to provide telehealth with additional coding.
- Codes allowed video and telephonic sessions.
- Opioid Treatment Programs (OTPs) had a significant increase in take-home medication.
- Suboxone providers have more flexibility for telehealth and prescribing practices.

Telehealth Outpatient Response (cont.)

- Spectrum chose the doxy.me program
  - All clinicians and prescribers secured accounts within one week
- Notices were sent to clients in several ways:
  - All clinicians/prescribers secured accounts within one week
  - Letters
  - Text message
  - Reminder calls

Telehealth Outpatient Response (cont.)

- Pilot tested telephonic and video group sessions one-month after completing telehealth session.
- Initial groups held for court mandated clients (e.g., driver alcohol, batterer intervention).
- Added groups for the OTP clients.
  - Began with later phase, cohesive groups, then added early phase, early recovery groups.
  - Began with telephonic and added video options.

Telehealth Inpatient Response

- Challenges with providing adequate clinical services in congregate care settings.
- Reduced group sizes to allow for social distancing.
  - Offered multiple smaller groups.
- Conducted group and individual sessions in outside recreation areas.

Telehealth Inpatient Response

- Created an isolated withdrawal management unit and clinical stabilization unit for patients COVID-19 positive.
  - The goal is to treat in isolation, patients who tested positive, thus preventing exposure to other patients and staff.
  - Clinical services are provided entirely by telehealth via tablets.
  - Tablets have preloaded clinical materials as well as links to online self-help meetings and recovery content.

Practical Considerations for Conducting Telehealth

- Ensure a private location.
- Consider a noise reduction/white noise machine.
- Pay attention to what can be seen in camera view.
- Turn off television, mute phones, relocate pets.
- Dress appropriately, such as business causal.
- Use headphones with a microphone to allow clear audio, and protect privacy.
- Test technology in advance.
- Obtain verbal consent for the session – **document!**

Lessons Learned

- Not all existing equipment allowed for video sessions (e.g., no computer cameras and/or audio).
- Sessions via the phone require a great deal more work for the clinician.
  - Clinicians cannot accurately assess engagement, and must visualize the client while simultaneously guiding the session.
  - Clinicians report feeling exhausted at the end of a day filled with telephonic sessions.

Lessons Learned (cont.)

- Beneficial to utilize video to reduce cognitive load and improve engagement.
  "Clients who struggled to engage in face-to-face meetings reported that it is easier to engage from home vs coming into the office. There are fewer barriers because it is in the client's control to answer the phone versus arranging transportation to attend a physical session. Clients feel more comfortable to open up during sessions in their own space. Video chat has provided insight into clients' living space, allowed clients to share personal items they would not have shared normally in the office; coping skills they have or use."
- Challenging to teach clients to use a system that is brand new to the clinician.
  - Helpful to have "cheat sheets" available that clients complete prior to the session.
- Better response from later phase, more cohesive groups.
  - Challenges and resistance in early phase groups.

Opioid Use Treatment Considerations

- Typical monitoring may not be possible due to COVID (i.e. routine toxicology screening).
  - Frequent clinical contact utilizing video can provide clinical value and monitoring.
- Social isolation is challenging and dangerous for those in recovery.
  - Ensuring connectedness is important to support recovery.
  - An increased likelihood of substance use which increases the risk of overdose.
- Access to Narcan in the house.
  - Outreach can be prevention measures.
- App that sends an alert if an individual uses and doesn't respond.

Telehealth to Continue Care in LTCFs

- The same technology adapted for community-based care can be adapted for long-term care.
- Virtual platforms allow providers to provide care, communicate with the LTCF staff and provide a seamless level of care.
- Inpatient/outpatient lessons learned are valuable when connecting LTCF residents to OTPs/office-based opioid treatment (OBOT) programs.
- Telehealth is likely here to stay – adapt to provide seamless care across the continuum of care.

Telehealth to Continue Care in LTCFs (cont.)

- Think outside the current healthcare box to support across the healthcare systems.
  - Tablets or other electronic systems used can be used with LTCF residents.
  - Telehealth counseling can be offered via video and telephonically
- Continuation of an existing clinical relationship allows for trust, aftercare planning, and continued treatment plan goal achievement.
  - Simultaneously supporting residents with OUD in recovery, supports integrated care and improve outcomes.
- Stigma associated with OUD is reduced when the patient is given a virtual connection to providers.

Case Study

Durai Rajasekar, Administrator
River Valley Rest Home

23

Case Summary – Resident's History

- Sexually abused as a teen
- No psychosocial support
- Attempted suicide
- Turned on to heroin
- Became pregnant
- PCP offered to start with a Methadone program or enter an inpatient program to detox
- Started on Methadone
- Transitioned to Suboxone
- Resident of Rest Home for 6 months
- Exhibits anxiety
- Therapy sessions provided
- Transitioned to a group home

Discussion Questions

- How could telehealth been used to provide therapy sessions?
- How could telehealth address concerns of confidentiality?
- What are some key ways to communicate with this resident who exhibits anxiety?

Best Practices- Communication Techniques

- Identify, demonstrate understanding, practice effective communication techniques
  - Especially important with telehealth.
- Factors that affect resident self-report:
  - Embarrassment
  - Being judged
  - Topics one rarely discusses
  - Confidentiality
  - Relevance to care
- The "how" of asking questions
  - Wording
  - Order
  - Form

Best Practices- Communication Techniques

- Telehealth can ease some of the anxiety when specific techniques are used:
  - Being well prepared for the meeting
  - Careful, mindful wording of questions
  - Presenting the option of not answering a question
  - Using closed-ended questions
  - Offering response choices
- Techniques that improve the quality and the specificity of the resident-reported information:
  - Asking for facts vs. judgments
  - Asking specific terms vs. general terms

Key Takeaways from the Session

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Questions?

Massachusetts Department of Public Health

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Thank you!

Please remember to turn in your evaluation.

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DPH blog
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www.mass.gov/dph

31

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Project ECHO Healthcentric Advisors New England

Learning Session: Safe Transitions of Care for Residents on Medication for Opioid Use Disorder (MOUD)

SAMHSA Abt Healthcentric Advisors

MOUD IN LONG TERM CARE

For educational and quality improvement purposes, we will be recording this video-session

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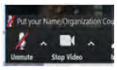

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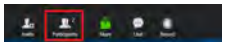

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6

Learning Objectives

- Identify key steps in the transition process for residents on MOUD upstream and downstream.
- Discuss a case example with subject matter experts and your peers on how transitions of care have impacted the care of your resident.
- Explore solutions to break down communication barriers between your facility and the hospital.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Zoom overview and SME Introductions	Stephanie Baker
1:05- 1:30 pm	Care transitions from the hospital to LTCF	Robyn Sloniecki
1:30 – 1:35 pm	Case Presentation	Jennifer Miller, BSAS
1:35- 1:55 pm	Discussion	All participants
1:55- 2:00 pm	Questions/ Ending Announcements	

***Chat will be monitored by Stephanie Baker and Kate Crump**

8

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* Adapted from Rules of the Road by RIZE Massachusetts

Overview of Transitions from Hospital Discharge to the Long-Term Care Facility (LTCF)

10

Hospital Perspective

- How can the hospital and LTCF best work together to provide appropriate care for residents receiving MOUD?
- What are some key items to be communicated?
  - MOUD plan / addiction consultation
  - Interactions between MOUD and medication
  - Pain plan / other conditions

LTCF Perspective

- What information is needed by LTCF prior to transfer from hospital?
  - MOUD / addiction plan
  - Outpatient follow-up
  - COVID test results
  - What additional information has been communicated to the patient on MOUD?

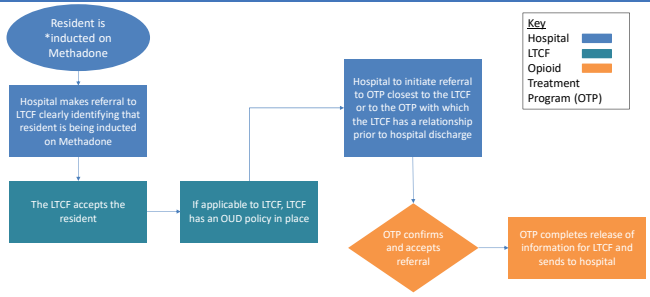
Review of the Process Map

Hospital Discharge to LTCF

Robyn Sloniecki

13

Transitions of Care



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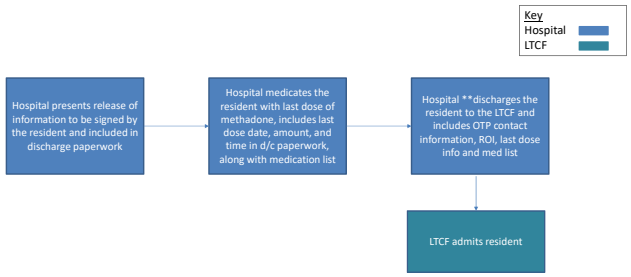
Transitions of Care (cont.)



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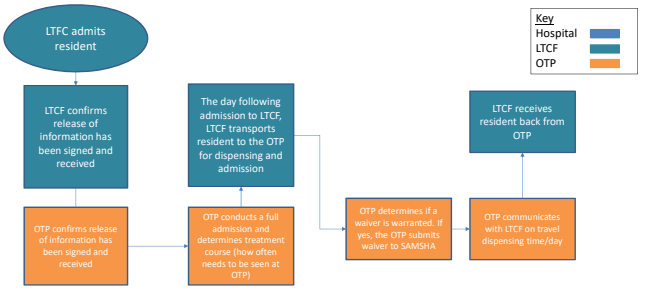
Transitions of Care (cont.)



16

Case Presentation

17

Case Summary

- Fifty-eight year old, Caucasian, male with a history of opioid disorder.
- Recently spent over a year in the hospital due to stage 4 lymphoma treatment.
- Current Methadone dose: 15mg daily.
- Established care with a local OTP.
- Other Relevant medical and psychiatric history:
  - Chronic shoulder pain
  - History of cerebral vascular accident
  - Peripheral vascular disease
  - History of deep vein thrombosis
  - Hepatitis C Virus (HCV).
- Other current medications include: Bupropion, morphine, Lamotrigine, Mirtazapine, Cyclobenzaprine, Gabapentin, Rivaroxiban, prednisone, Clonidine, and hydroxyzine.
- Resident reported pain and withdrawal symptoms upon arrival.

General Information

- Organization type: Nursing Home
- Residents in the past year:
  - How many were on Methadone? 3
  - How many were on Buprenorphine? 1
  - How many were on Vivitrol? 0

Resident Information

- Resident prescribed Methadone
  - Newly inducted
  - Has an established home OTP

Transitions - Successes and Challenges

- Successes
  - Good communication with discharge planner about resident's current medications and needs.
  - Able to maintain connection with the resident's OTP/OBOT.
- Challenges
  - Timing of discharge.
  - Resident reported pain and withdrawal symptoms upon arrival.

Questions for Peers and Subject Matter Experts

- How can you work with this resident and the OTP/OBOT to address pain and withdrawal symptoms?
- When coordinating with the OTPs, what day/times typically work best?
- How have you communicated to the hospital about the need for a more coordinated discharge plan?

Key Takeaways from the Session

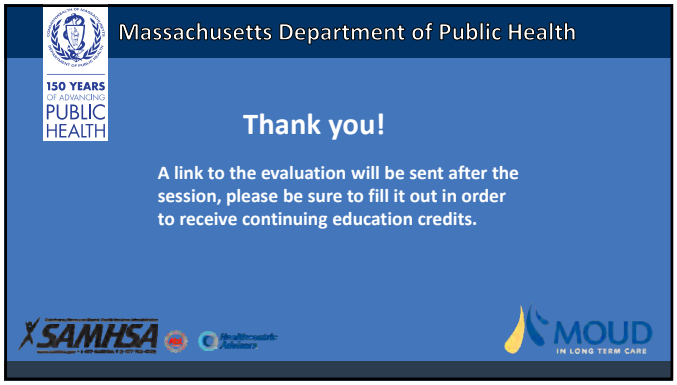
Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Questions?

SAMHSA

MOUD IN LONG TERM CARE


Massachusetts Department of Public Health
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HEALTH
Thank you!
A link to the evaluation will be sent after the session, please be sure to fill it out in order to receive continuing education credits.
SAMHSA
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Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Project ECHO Healthcentric Advisors New England

Learning Session: Establishing Partnerships

SAMHSA Abt Healthcentric Advisors MOUD IN LONG TERM CARE

For educational and quality improvement purposes, we will be recording this video-session

By participating in this clinic you are consenting to be recorded- we appreciate and value your participation

If you have questions or concerns, please email echo@healthcentricadvisors.org or use chat to Stephanie Baker

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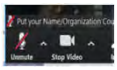

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Continuing Education

- This program has been approved for **1** Social Work Continuing Education hours for relicensure, in accordance with 258 CMR. NASW-MA Chapter CE Approving Program, Authorization Number **D 81667-3**.

5

Disclosure of Financial Relationships & Commercial Support

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6

Learning Objectives

- Define best practices for communicating with an Opioid Treatment Program (OTP)/Office-Based Opioid Treatment Clinic (OBOT) in caring for your residents on MOUD.
- Discuss a case example with subject matter experts and your peers on how partnerships with OTPs/OBOTs have impacted care for your resident
- Consider solutions on how to breakdown the barriers to establishing relationships.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Zoom overview and SME introductions	Stephanie Baker
1:05- 1:15 pm	Establishing a partnership with your OBOT	Kristin Wason
1:15 – 1:25 pm	Establishing a partnership with your OTP	Matt Davis or Tracy Desruisseaux
1:25 – 1:35 pm	Case presentation	Brenda E. Millar- St. Luke's
1:35- 1:55 pm	Discussion	All participants
1:55- 2:00 pm	Questions/ ending announcements	

***Chat will be monitored by Stephanie Baker and Kate Crump**

8

Rules of Engagement

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* Adapted from Rules of the Road by RIZE Massachusetts

How Can You Work with Your Local OBOT

- Admission of resident on MOUD
  - Develop a Qualified Services Organization Agreement (QSOA)
    - Include types of services QSO provides (e.g., medical services, counseling services, on-site call coverage, treatment plan.
    - Best practice to have in place prior to admission, however it can also be initiated or in process
  - Discussions between long-term care facility (LTCF) and OBOT administrators.
  - Develop a Release of Information (ROI)
    - Designates what information can be released.
  - Determine how the medication will be prescribed/dispensed to the resident.

10

How Can You Work with Your Local OTP

- Develop a QSOA
  - Should include types of services QSOA provides, medical services (e.g., counseling services, on-site call coverage, treatment plan).
  - Best practice to have in place prior to admission, however it can also be initiated or in process
  - Discussions between LTCF and OTP administrators.
- Release of Information (ROI)
  - Designates what information can be shared.

11

How Can You Work with Your Local OTP (Cont.)

- Determine how 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).
    - Varies for each client, one example is they could come in weekly to pick up one week's worth of take-home doses.
  - Methadone and/or Buprenorphine delivery.
    - OTP nurse delivers and administers the methadone daily.

12

Case Scenario Activity

Brenda Millar, RN, Director of Nursing
St. Luke's Rest Home

13

General Information

- Organization type: Rest Home
- Residents in the past year:
  - How many were on Methadone? 1
  - How many were on Buprenorphine? 3
  - How many were on Vivitrol? 1

Resident Information

- Resident prescribed Methadone
  - Not newly inducted; has been on Methadone treatment for several years.
  - Has an established home OTP
    - OTP allows staff to pick up medication every two weeks.

Partnership - Successes and Challenges

- Have partnered successfully with an OTP, and communicate with the OBOT.
- Initial meeting with Methadone clinic supervisor was very helpful, training of staff was very supportive.
  - A best practice is to hold this meeting and training prior to admission.
- Transportation and delivery of medication can be difficult.
  - Staff have to pick up the medication the next town over.

Partnership – Best Practices

- Prior to admission.
  - Set up resident support systems.
  - Establish a team with whom to communicate resident needs.
  - Partner with clinic prior to admission.
- Know the expectations of the OBOT at admission and overall.
  - Consider setting up OUD training by OTP for facility staff .

Questions for Peers and Subject Matter Experts

- Monthly medication distribution vs biweekly or weekly.
- Marijuana use—we are federally funded and follow those guidelines for illegal use.
  - How have others handled this?
- A more complete understanding of the policies and protocols from the clinics perspective:
  - What happens if a resident engages in illicit drug use while on Methadone?
  - What are the differences from Methadone in Suboxone treatment, distribution, monitoring and documentation?

Key Take a Ways from the Session

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Questions?

SAMHSA

MOUD IN LONG TERM CARE

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Thank you!

Please remember to turn in your evaluation.

SAMHSA

MOUD IN LONG TERM CARE

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Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Project ECHO Healthcentric Advisors New England

Learning Session: Creative Solutions to Address Transportation

SAMHSA | Abt | Healthcentric Advisors | MOUD IN LONG TERM CARE

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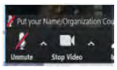

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5

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6

Learning Objectives

- Summarize examples of how to address various social determinants of health at your facility such as transportation.
- Discuss a case example with subject matter experts and your peers on how transportation may have impacted care for your resident.
- Consider creative solutions to finding transportation options.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Zoom overview and SME Introductions	Stephanie Baker
1:05- 1:20 pm	UberHealth Overview	Thomas Donnell
1:20 – 1:35 pm	Case Example	Christopher Gilliseen- Fitchburg
1:35- 1:55 pm	Discussion	All Participants
1:55- 2:00 pm	Questions/ Ending Announcements	

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8

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* Adapted from Rules of the Road by RIZE Massachusetts

UberHealth

Thomas Donnell

Care begins with getting there

Provide rides to & from your organization using Uber Health.

Lack of transportation limits access to care

3.6M+

Annual appointments missed because of transportation issues[1]

30%

No-show rates nationwide, each open 60-minutes typically costing $200[2]

$150B

Lost annually by providers due to missed appointments[2]

Every dollar spent on NEMT (non-emergency medical transportation) could save up to **$11 in healthcare costs for the entire system**[1]

Uber Health

A HIPAA-compliant solution for healthcare organizations to **arrange rides on behalf of others** using the same on-demand driver-partners as Uber.

Provide rides for patients with Uber Health

Cost efficient with transparent pricing

Reliable service with an established network

Fewer no-shows, more on-time appointments

Step 1

A healthcare associate books a ride on demand or for a future appointment, using the Uber Health dashboard to seamlessly coordinate rides for those in need.

Step 2

The passenger is contacted by text or call with their trip details at the time the ride is booked and once again when a driver is on the way to pick them up.

Step 3

The passenger is picked up and dropped off on schedule. No additional action on behalf of the healthcare associate is required to get them to and from care.

Arranging the right ride

Make scheduling rides work with your office's existing workflow by selecting the best option for you & your patients.

Schedule rides now or later

Easily schedule rides for now or later to make scheduling a breeze – pre schedule rides for upcoming appointments up to 30 days in advance.

Allow riders to confirm when ready

Send a redeemable ride to make sure riders are ready for their pickup by requiring them to reply when ready

Request multiple rides

Use Uber Health to request multiple rides for patients or staff concurrently from one account.

Our commitment to safety

Uber Health is committed to the safety of riders & the safety of their data.

HIPAA compliant

Comprehensive assessment conducted by a third party to ensure PHI is handled by Uber Health with utmost care.

Driver screenings

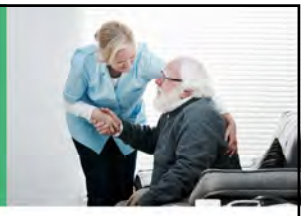
All driver screenings include criminal history checks & driving history review before getting behind the wheel.

HIPAA compliant support team

Specially-trained response team to help with any urgent issues around the clock.

Transparent reporting

The Uber Health dashboard allows you to manage & monitor your trips from one centralized location.



Live Dashboard
Manage all your requested rides in one easy-to-use dashboard, in real-time.

Detailed ride history
Exportable data delivers actionable insights on costs per trip, ride timestamps & billing codes for easier monitoring & management

Monthly Billing
Aggregated billing to simplify paperwork with a monthly invoice showing an all-in-total for your Uber Health rides in one place.

What our partners are saying...

Resolve last-minute transportation issues

We can request an Uber trip in time to help a patient make an appointment they would otherwise miss.

Courtesy transportation home from facility.

Within days of using Uber Health to arrange trips for our patients, we stopped using traditional transportation services. Coordination is seamless for us and rides are easy for patients.

Increase serviceable area & population.

Uber Health helps us stay on schedule for our enrollment. The rides get participants here who would have otherwise not shown up.

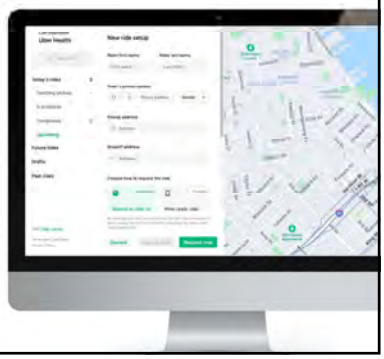
Uber Health dashboard

A **web-based solution** that can be accessed from your desktop or mobile internet browser.

Monitor everything from the Uber Health dashboard- past, active and upcoming - in one centralized place.

Enter the rider's info

To arrange a ride on behalf of someone - just input their name, phone number, and where they need to go.



Scheduling rides

Choose when they'll ride.

Today and Now: Immediate Pick-up
Request a ride for now to pick up the rider within minutes.

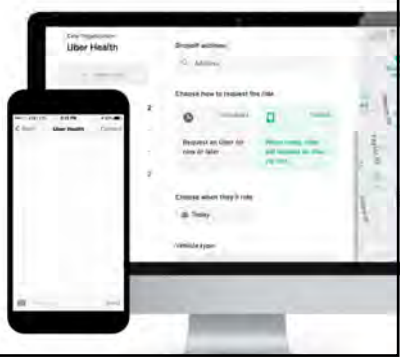
Scheduled In-Advance
Set up a ride for a specific date and time for up to 30 days in advance

Flexible rides

Allow the rider to confirm once they're ready to ride using flexbie rides.

Set the destination & date
Control where the ride goes along with the day that it is valid up to 60 days in advance

Confirm when ready
Wait until the rider is ready to go to send the driver their way.



Manage future rides

See all your upcoming rides in one place to help coordinators with advance scheduling.

Both **Redeemable Rides** and **Scheduled Rides** will appear in the same tab.

Rider experience

If a rider has a mobile phone they will receive an SMS with their driver details and pickup ETA.

If a rider does not have a mobile phone, you can give a caregiver's details or call them directly when the Uber driver is on their way.

They do not need to be an existing Uber rider or have the Uber rider app installed.

Deep dive into data & reporting

Export CSVs

All data can be downloaded as a .CSV file to make reporting easier in spreadsheet format.

This makes it easy to import the data into your tools and learn even more about your patients, members, and those you serve.

Case Scenario Activity

Christopher Gilliseen, Administrator
Fitchburg

28

General Information

- Organization type: Nursing Home
- One residents in the past year on Methadone
  - Not newly inducted
  - Has an established home Opioid Treatment Program (OTP)

Transportation- Challenges

- All Ambulance companies stopped chair van service
- Used taxi, Uber, and personal cars
- Purchased a van and hired a driver

Transportation – Challenges

- Local treatment center initially refused to work with nursing home to coordinate Methadone dispensing/pickup
- COVID pandemic
  - Initially transported resident to OTP
  - Now nursing staff picks up medications weekly

Questions for Peers and Subject Matter Experts

- How have others been able to find ways to transport residents?
- What has worked well for you? What has not worked well?

Key Take a Ways from the Session

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Questions?

SAMHSA · MOUD IN LONG TERM CARE

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Thank you!

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SAMHSA · MOUD IN LONG TERM CARE

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Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Project ECHO Healthcentric Advisors New England

Learning Session: Safe Transitions of Care for Residents on Medication for Opioid Use Disorder (MOUD) from LTCF to Home

SAMHSA | Abt | Healthcentric Advisors | MOUD IN LONG TERM CARE

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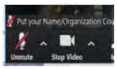

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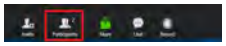

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- This nursing continuing professional development activity was approved for 1 credit by Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- Nursing Home Administrator credits pending

5

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6

Learning Objectives

- Identify key steps in the transition process for residents on MOUD downstream.
- Discuss a case example with subject matter experts and your peers on how discharges to the community may have impacted care for your resident.
- Explore creative solutions on how to breakdown the barriers to finding housing.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Zoom overview and SME Introductions	Stephanie Baker
1:05- 1:20 pm	Transitions to the Community	Charmaine Lastimoso
1:20 – 1:35 pm	Case Presentation	John Seaman- Cape Regency
1:35- 1:55 pm	Discussion	All Participants
1:55- 2:00 pm	Questions/ Ending Announcements	

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* Adapted from Rules of the Road by RIZE Massachusetts

Overview of Transitions of Care from LTCF to Home

Charmaine Lastimoso
Boston Medical Center

10

Discharge to Community

- Communicate with the Opioid Treatment Program (OTP)/ Office-Based Opioid Treatment (OBOT) clinic at discharge.
  - Schedule follow-up appoint prior to discharge.
  - OTP- last dose letter will be required.
  - OBOT- discharge summary with updated medications.
- What services are available and/or needed at home.
  - Connect and inform home health agency that resident is on MOUD.
  - If home without services connect with aging service and access point (ASAP).

Discharge to Community

- Involve identified caregiver in care plan.
- Alert primary care physicians of discharge.
- Share resources with the resident for transportation to appointments.
  - If possible, set-up prior to discharge?

Discharge to Community

- Consider whether or not telehealth is an option.
  - Access to technology and connectivity in the home
  - Ability to manage technology (cognition, tech literacy)
  - Alternatives if technology does not work

Housing Options

- Best addressed early on in the discharge process, things to consider:
  - What's available in the community?
  - To whom do you reach out to make the connection?
  - Are there any funding options?
  - What is the housing application process?
  - Are there temporary housing options (e.g., homeless shelters)?
  - Are VA services an option?

Residential Treatment Programs

- Types of Residential Treatment Programs:
  - Under 30 days.
  - Over 30 days.
  - Recovery Homes.
- Eligibility for services and how to apply.
  - What are the conditions to remaining
  - TSS- individual assessment
  - Funding options
- Veteran services

Outpatient Treatment Programs

- Outpatient treatment programs:
  - Intensive outpatient program (IOP)
  - Partial hospitalization program (PCP)
  - Day programs

Peer Recovery Supports

- Peer Recovery Supports
  - Recovery coach or recovery support navigator
  - Check eligibility for CSP or Community Health Worker
  - Invite a peer to visit and meet resident prior to discharge

Resources

- 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/

Case Presentation

John Seaman, WADCI/CBIS
Cape Regency

19

General Information

- Organization type: Skilled Nursing Facility (4 sites combined)
- Residents in the past year:
  - How many were on Methadone? 4
  - How many were on Buprenorphine? 2
  - How many were on Vivitrol? 1
  - How many were on Camprell? 1

Resident Information

- Residents prescribed Methadone
  - Not newly inducted
  - Has an established home OTP
- Residents on Buprenorphine and Vivitrol
  - Newly inducted
  - No established OBOT

Transitions - Challenges

- Transitions
  - Follow-ups with aftercare providers
  - Coordination of aftercare programs
  - Challenges- insurance- transportation- regressions.

Transitions- Additional challenges

- Take homes during COVID
- Sunday transportation to clinics- pre- COVID
- Working with IDT/ nursing to adjust medication times as indicated for methadone/suboxone to reduce over sedation/possible overdose.

Questions for Peers and Subject Matter Experts

- Harm reduction with alcohol
  - Programming challenges- DPH no DMH clients
- Specific DPH regulations
  - SUD in long-term care

Key Takeaways from the Session

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Questions?

SAMHSA

MOUD IN LONG TERM CARE

Massachusetts Department of Public Health

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Thank you!

A link to the evaluation will be sent after the session, please be sure to fill it out in order to receive continuing education credits.

SAMHSA

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@MassDPH

Massachusetts Department of Public Health

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

www.mass.gov/dph

28

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Learning Session: Regulations

SAMHSA | Abt | Healthcentric Advisors | MOUD IN LONG TERM CARE

For educational and quality improvement purposes, we will be recording this video-session.

By participating in this clinic you are consenting to be recorded. We appreciate and value your participation.

If you have questions or concerns, please email:
echo@healthcentricadvisors.org
or use chat to Stephanie Baker

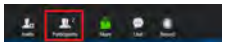
Some helpful tips

Muting and Unmuting

- Mute microphone when not speaking
  - Left bottom corner of your screen
- Remember to unmute before speaking
- If on the phone, press *6 to unmute

To indicate your name and facility

- Click on the three dots on your small screen or click "Participants"
- Choose "rename"
- Type your name(s) and your facility's name



3

Some helpful tips (cont.)

- **Use chat function** for comments and questions.
  - Use chat function to submit names of all attendees for your site for **attendance.**
  - You can chat to "everyone" or another participating group or individual.

4

Continuing Education

- This program has been approved for **1** Social Work Continuing Education hours for relicensure, in accordance with 258 CMR. NASW-MA Chapter CE Approving Program, Authorization Number **D 81667-6**.
- This nursing continuing professional development activity was approved for 1 credit by Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- Nursing Home Administrator credits pending

5

Disclosure of Financial Relationships & Commercial Support

Disclosure:

- It is the policy of the contract team (Abt Associates and Healthcentric Advisors) to ensure independence, balance, objectivity, scientific rigor, and integrity in all of its continuing education activities. Our presenters will disclose any significant relationships with commercial interests whose products or devices may be mentioned in the activity or with the commercial supporter of this continuing education activity. Identified conflicts of interest were resolved prior to accreditation of the activity and may include any of or combination of the following: attestation to non-commercial content; notification of independent and certified CME/CE expectations; restriction of topic area or content; restriction to discussion of science only; amendment of content to eliminate discussion of device or technique; use of other author for discussion of recommendations; independent review against criteria ensuring evidence support recommendation; moderator review; and peer review.

Disclaimer:

- This program is designed solely to provide the healthcare professional with information to assist in his/her practice and professional development and is not to be considered a diagnostic tool to replace professional advice or treatment. The program serves as a general guide to the healthcare professional, and therefore, cannot be considered as giving legal, nursing, medical, or other professional advice in specific cases. Abt Associates and Healthcentric Advisors specifically disclaim responsibility for any adverse consequences resulting directly or indirectly from information in the course, for undetected error, or through participant's misunderstanding of the content.

6

Learning Objectives

- Identify MOUD-relevant regulations.
- Discuss a case example with subject matter experts and your peers on what a facility should do if a resident has been given 14 COVID take home bottles from an OTP.
- Explore solutions to understanding State and Federal regulatory oversight.

7

Agenda

Time	Presentation	Presenter(s)
1:00 – 1:05 pm	Hub and spoke site introductions	Stephanie Baker
1:05- 1:35 pm	Regulations related to MOUD in LTCFs	Jen Babich - BSAS
1:35 – 1:55 pm	Round-robin discussion	All participants
1:55- 2:00 pm	Questions/ ending announcements	

***Chat will be monitored by Stephanie Baker and Kate Crump**

8

Rules of Engagement

Can we agree to support each other in following these guidelines?

- **Sharing**. We are here to learn from one another. Take turns sharing and be concise to maximize our time together.
- **Ask genuine questions and make comments that stay on topic**. Enables focused conversation, fosters understanding of various viewpoints and elicits curiosity about differing viewpoints.
- **Actively listen.** Listen to whoever is speaking instead of mentally preparing a response.
- **Honor all experience and expertise equally**. They come in many forms.
- **Confidentiality.** To build trust don't share outside the group, what members discussed. If using a real-life example, don't use any personal identifiers, like names.

* Adapted from Rules of the Road by RIZE Massachusetts

Regulatory Oversight of Opioid Treatment Programs

State

- Bureau of Substance Addiction Services (BSAS)
  - https://www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-abuse-treatment-programs)
- Drug Control Program (DCP)
  - https://www.mass.gov/orgs/drug-control-program

Federal

- Drug Enforcement Agency (DEA)
  - https://www.deadiversion.usdoj.gov/fed_regs/rules/2019/index.html
- Substance Abuse and Mental Health Services Administration (SAMHSA) / Center for Substance Abuse Treatment (CSAT)
  - https://www.samhsa.gov

OTP Regulatory Requirements - Medication

- Three FDA approved medications for opioid use disorder (MOUD):
  - Methadone, Buprenorphine, Naltrexone
- Methadone and Buprenorphine
  - Dispensed daily, unless an approved exception request.
- MassHealth can reimburse Buprenorphine and Naltrexone (Vivitrol) in the Opioid Treatment program (OTP).
- Majority of the MA OTPs are licensed to provide Buprenorphine.
  - A few are licensed to provide Naltrexone (Vivitrol).
- BSAS emphasizes the importance of providing individualized treatment.
  - Ensure each resident is given options and education regarding all forms of MOUD.
  - Medication decision based on a resident assessment.
  - Medication should be a mutual decision between the resident and the provider.

OTP Regulatory Requirements – Medication (cont.)

- Communication between the OTP and the LTCF is crucial.
- The LTCF should immediately report to the OTP:
  - Signs of impairment
  - Sedation
  - Illness
  - Hospitalizations
  - Instability
- Integrating Opioid Overdose Prevention:
  - Naloxone can reverse opioid overdose
  - BSAS Practice Guidance *Integrating Opioid Overdose Prevention Strategies into Treatment* https://www.mass.gov/files/documents/2016/07/nz/care-principles-guidance-opioid-overdose.pdf.
- The LTCF reports the resident's medications including new medications.
- Dose assessment is conducted by the OTP medical team; depends on many factors.
- Resident signs a consent to release information, complying with 42 CFR Part 2 and HIPAA.

OTP Regulatory Requirements – Take Homes

- Per Federal and State OTP regulations, an OTP patient must attend the OTP to receive daily in-person medication dispensed by the OTP nursing staff.
- Take home medications are allowed if certain criteria are met.
  - Must meet federal and state regulatory requirement of an 8-point criteria including:
    - Reduction/lack of positive drug screens
    - Attendance
    - General compliance with the policies of the OTP
    - Stability
  - If patient meets the criteria they may receive a certain number of take homes based on the federal and state schedule.
  - Take home medications belong to the patient, and can be taken with him/her traveling or to a residential facility as long as they are secured in a lockable container in compliance with the facility's regulations.

RB23

OTP Regulatory Requirements – Take Home Exception Requests

- Exceptions to the take home criteria.
  - 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.).
  - If the patient does not meet the 8-point criteria the OTP / medical director must submit a take home exception request through the SAMSHSA's Extranet for federal and state (BSAS SOTA) approval.

OTP Regulatory Requirements - Take Home Exception Requests (cont.)

- All take home exception requests for OTP residents in LTCF must contain a statement which includes:
  - Name and location of LTCF/ residential program.
  - Schedule of OTP supervised doses.
  - Schedule of doses at LTCF.
  - Dosing procedure at LTCF.
  - Details of plan for transportation between LTCF/residential program and OTP.
  - Provision for safe storage from pick-up to transport, to on-site, etc.
  - Plan for ensuring and maintaining chain of custody.
  - Plan for termination (for any reason).
  - Plan for managing remaining doses after patient's termination/discharge.
  - Any other pertinent information about the patient.

RB24

OTP Regulatory Requirements - Take Home Exception Requests (cont.)

  - Schedule of OTP supervised doses.
  - Schedule of doses at LTCF.
  - Dosing procedure at LTCF.
  - Details of plan for transportation between LTCF and OTP
    - Methods for delivery/transport of take home medication include:
      - Nurse to Nurse pick-up.
      - Drop-off from the OTP.
      - Resident receives the take home medication at the OTP and is accompanied through the OTP and to the "van" with the LTCF staff.

OTP Regulatory Requirements – Take Home Exception Requests (continued)

- Provision for safe storage of the medication
  - LTCF is responsible to utilize their policies on safe-keeping of controlled substances.
- Plan for ensuring and maintaining chain of custody
  - If medication is handled by other than the OTP licensed dispensing medical staff, both the dispensing/observing person (e.g., VNA nurse, long-term care facility/residential staff) and the resident must sign or initial each day when medication is administered. RB25
  - When completed, the form should be returned to the OTP and placed in the resident's medical record with a copy in the program's quality assurance file.

Note: The resident should contact the OTP immediately if the medication seems altered in any manner.

OTP Regulatory Requirements – Take Home Exception Requests (continued)

- **Plan for termination (for any reason).**
  - Discharge planning should be communicated between the resident, OTP, and LTCF.
  - Ensure the ability to continue maintenance of OUD treatment.
- **Plan for managing remaining doses after patient's termination/discharge.**
  - When an OTP patient is in a LTCF and has a take home exception *(they don't meet the 8 point criteria)*, if the resident leaves AMA, should the facility destroy the methadone or give it to the resident?
    - This plan should be communicated/documented between the OTP and the facility upon admission.
    - The resident should not be given the methadone and it should be destroyed by the facility (per the LTCF policies), documented and communicated to the OTP.
    - If the resident "earned" regular/ non-exception request bottles, he/she would take the methadone when they leave. Please see SAMHSA's federal OTP regulations 42 CFR Part 8.12 and the BSAS regulations 105 CMR 164.304 C for reference.
    - Regardless- if a resident is presenting as unstable at the time of discharge/leaving AMA, consult the medical team and the OTP regarding giving the patient the take homes upon leaving.

COVID-19 Blanket Exception for OTPs

- In March of 2020 to help limit the spread of Coronavirus and consistent with SAMHSA guidance, BSAS received a blanket exception from SAMHSA on behalf of OTPs for take-home doses of medication for opioid use disorder.
- The Blanket COVID exception enable medical directors to provide:
  - Up to 28 days of take-home medication for all stable patients.
  - Up to 14 days of take-home medication for those patients who are less stable but who the OTP believes can safely handle this level of take-home medication.
  - For COVID take homes, the 8-point criteria is waived.
  - All take home decisions are the medical directors and the OTPs.
  - The LTCF should always consult with the OTP when a resident is being discharged and/or experiencing any medical / clinical emergencies, especially regarding take home medications.

Case Example

Resident has been given 14 COVID take home bottles from an OTP and they are residing in a long-term care facility.

What should the facility do if the patient:

- Is leaving AMA?
- Has received new medication?
- Is showing signs of sedation/impairment?

20

Key takeaways from the Session

Massachusetts Department of Public Health

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Questions?

SAMHSA

MOUD IN LONG TERM CARE

Massachusetts Department of Public Health

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Thank you!

Please remember to complete your evaluation.

SAMHSA

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

www.mass.gov/dph

24

Appendix F: Site Visit Presentations

MOUD Virtual Site Visit Protocol

Preparing for the virtual group site visits:

- During initial outreach to reengage facilities; confirm that they have a camera on their computer. If not, Healthcentric Advisors will send one to them in advance of the virtual site visit. They will need the camera for the site visit and the EHCO learning sessions.
- Understand the impact of COVID-19 on the facility.
    - Prior to the meeting determine the number of cases and number of deaths at each facility. Since this will be a group virtual meeting, do not discuss these numbers, but educate yourself about them.
    - Obtain a list from DPH of facilities that should not be contacted due to the impact of the virus.
- Review pre-implementation interview results.
    - Familiarize yourself with whether or not the nursing home/rest home currently admits individuals with opioid use disorder (OUD) and more specifically those receiving MOUD.
    - Know whether or not Naloxone (Narcan) was available at their nursing home/rest home.
    - Review any concerns that they mentioned in care transitions and collaboration processes.
- Review the MOUD toolkit, tagging sections that are particularly relevant to the nursing home/rest home based on interview responses and survey results.
- Review the elements of a performance improvement project (PIP) and measurement in the SPOT toolkit. Prepare an example of a PIP on the processes for residents receiving MOUD. Prepare examples of the process of measurement to monitor/measure outcomes.
- Review the circular letter (including Appendix A)
- Send an email to initiate scheduling the virtual site visit. Note that there will be two separate virtual site visits. One with administrator and director of nursing (DON) or equivalent rest home staff and one with the staff developer or equivalent staff.
    - If no response, follow-up with telephone calls to the nursing home administrator /rest home manager until the virtual site visit is scheduled.

        - Send an email invitation to the administrator and the DON or equivalent rest home staff. The invitation will include an agenda, a link to the virtual session, links to the MOUD and SPOT toolkits on the MA DPH website, the example policy, and a copy of the circular letter (including Appendix A).
        - Send an email invitation to the administrator and staff developer or equivalent staff. Confirm that he/she will have access to a computer with a camera (mention that a camera was sent to the administrator if they did not previously have one). The invitation will include an agenda, a link to the virtual session, links to the MOUD and SPOT toolkits on the MA DPH website, the three training presentations, a copy of "I Pledge to stop the stigma associated with addiction," and a copy of the circular letter (including Appendix A).
        - Send reminder emails for the virtual site visit one week in advance and again, two days in advance.
    - If an administrator refuses to participate, inform him/her of the scheduled ECHO learning series. Send them the sample policy and the training presentations. Thank them for their earlier participation in the program.
    - Have a partner available off camera to take notes during the virtual site visits.

Virtual On site:

Group virtual meeting with the nursing home administrator/rest home manager and DON or equivalent rest home staff (60 minutes).

- **Develop rapport**
    - Express your empathy for their experiences with COVID-19.
    - Thank those who attended the original in-person learning session or Stephanie's follow-up virtual session.
    - Confirm that they have received links to the MOUD and SPOT toolkits, the example MOUD policy, and a copy of the circular letter (these items would have been included in the invitation email).
- **Policies**
    - Discuss whether or not the facilities (or corporate) have updated policies related to MOUD based on what they learned during the learning session.
        - Ask whether or not the policies are specific and in line with current regulations, and if they identify responsible parties and indicate a timeframe for review (refer to the Policy Review Guide).
        - If policies are written at the corporate level, ask them to discuss how the policies have been interpreted.

        - Ask if the procedures are working well as written, or if they need updates of modifications.
        - Make recommendations where appropriate.

- **Example Policy**
    - Share (on the screen) the example policy developed for this project and walk through the example.
- **Challenges/Barriers**
    - From their baseline interviews:
        - Discuss challenges/barriers to policy implementation and ask if there are any new challenges or barriers that they would like to address or discuss.
        - Challenge examples: Who is responsible/involved, when/where do the appropriate staff start, how do you measure outcomes?
        - Suggestion examples: MOUD information from the toolkit.
- **SPOT activities**
    - Inquire whether or not they are monitoring/measuring outcomes. Share on the screen the measurement document from the SPOT toolkit with examples, and discuss the importance of measurement.
    - Share (on the screen), the PIP worksheet and discuss the advantage of conducting a PIP on the processes for residents receiving MOUD. Walk through the prepared example of a PIP for MOUD.
- **Naloxone (Narcan)**
    - Ask if they have a policy in place for training staff to use Narcan.
        - Point to Appendix A of the 2016 MA DPH Circular Letter. Ask whether or not their staff have received Naloxone training.
        - If yes, ask who provided the training and how it was received. Inquire if they have any remaining questions about the use of Naloxone.
            - If no, discuss further with the staff development coordinator/rest home manager and/or nursing/medical staff.
- **Review MOUD Toolkit**
    - Walk through the toolkit table of contents and go to a section that was identified in advance of the site visit (from the baseline interview) as particularly relevant to at least one of the nursing homes/rest homes on the call.
    - Show them the section on resources and walk through this section with them (show on the screen).

- **End the meeting**
    - Thank the nursing home administrator/rest home manager, DON or equivalent rest home staff, and corporate representative (if this person attended) for meeting with you.
        - Inform the administrator/ DON or equivalent rest home staff of additional phases of the project ECHO series that will begin in two weeks.
        - Inform them that you will send them an email with the meeting slides.

Group virtual meeting with the Staff Developer or equivalent staff (30 minutes).

- Develop rapport
    - Express your empathy for their experiences with COVID-19.
    - Confirm that the staff developer (SD) received a copy of the MA DPH circular letter with Appendix A and the three power point training presentations.
    - Ask whether or not the SD attended the learning session and whether or not she/he has had a chance to look over the MUD toolkit (if the facility was not represented at learning session 1, the toolkit would have been mailed to the administrator prior to the virtual learning session hosted by Stephanie).
    - Inquire about their understanding and perspective on caring for individuals with OUD.
- Review MOUD Toolkit
    - Inquire about the staff developer's (or equivalent rest home staff) understanding of MOUD and where they think they could improve their understanding.
    - Walk through the toolkit table of contents (shown on the screen) and spend time on a section that the staff developer suggested they could improve their understanding.
    - Walk through the section on resources (show on the screen).
- Training
    - Discuss what training is currently provided to staff regarding caring for those with OUD.
    - One at a time, walk through each of the training programs that were sent with the invitation (*Recognizing and Responding to an Overdose* and *Dispelling Myths and Overcoming Biases*, as time allows. Mention to the SD (or equivalent rest home staff) the talking points that are provided.
    - Confirm that they received a copy of "I Pledge to stop the stigma associated with addiction" that was sent as an attachment with the invitation email. Suggest that they print enough for all staff and ask that their staff read and sign the pledge.

- Ask whether or not staff have received training on the use of Narcan. Point to Appendix A of the 2016 DPH Circular Letter.
    - If yes, ask who provided and received the training and how it was received. Inquire if he/she has any remaining questions about the use of Naloxone.
    - If no, ask if training is scheduled, and if not inquire why.

- End the staff developer (or equivalent rest home staff) meeting.
    - Thank the staff developer (or equivalent rest home staff) and remind her/him that you are available by phone or email if additional help is needed.
    - If the facility is particularly hesitant to admit individuals receiving MOUD, suggest that understanding OUD as a disease and stigma might be a good first training.
    - Remind the SD that you are available by phone or email if they have any questions or concerns related to caring for residents treated with MOUD. Inform the SD of the upcoming ECHO series learning session.

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Medication for Opioid Use Disorder Virtual Site Visit Office Hour

SAMHSA Abt Healthcentric Advisors MOUD IN LONG TERM CARE

Welcome and Introductions

- Introductions
  - Abt staff
  - Participating LTC staff
- Confirm receipt of materials
  - MOUD toolkit
  - Link to SPOT toolkit
  - Example MOUD policy
  - DPH Circular letter

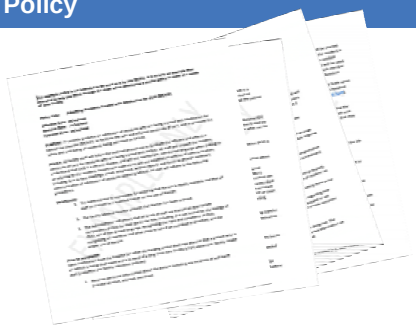
Objectives

- Policy review
- Discuss Challenges/Barriers
- Provide Resources for Quality Improvement
- Discuss Narcan Training

Policies for MOUD

- Questions to consider:
  - Are policies specific and in-line with current regulations?
  - Do your policies identify responsible parties?
  - Is there a timeframe indicated for review?
  - Are current policies working as implemented?

Example Policy



Challenges/Barriers

Strategies for Managing Difficult Reactions

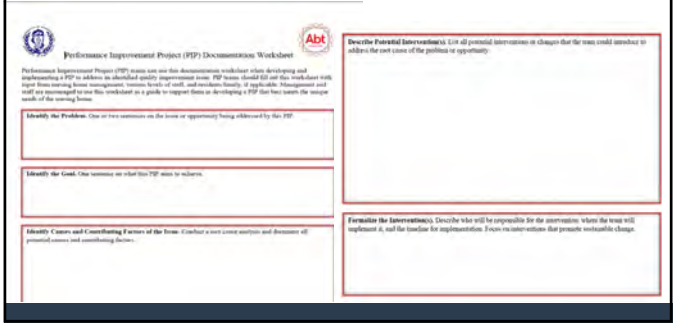
Reactions	Management Strategy
The resident is anxious, agitated, or panicking	Approach the resident in a calm and confident manner Reduce the number of people attending to the resident Carefully explain any interventions and what is going on Minimize the risk of self-harm
The resident is confused or disoriented	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 residents 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

SPOT Performance Improvement Project (PIP) Workbook

Supportive Planning and Operations Team (SPOT)

- In 2016, the Commissioner of Public Health announced a new initiative, the Supportive Planning and Operations Team (SPOT), to foster quality care delivery in skilled nursing facilities across Massachusetts.
- This program provided resources and technical assistance to nursing homes in developing their quality assurance and performance improvement (QAPI) infrastructure.
- Provided individualized recommendations and support, including offering best practice frameworks and targeted training to skilled nursing facility staff, that enabled nursing homes to develop and maintain a QAPI framework.
- https://www.mass.gov/service-details/nursing-home-quality-improvement-initiatives

Performance Improvement Project (PIP) Worksheet



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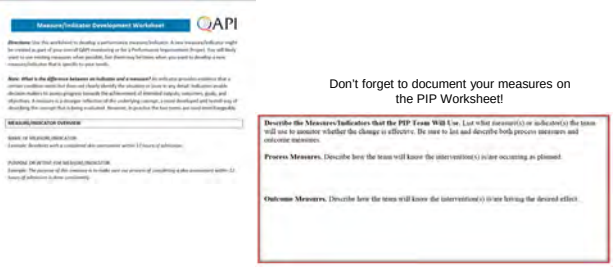
QAPI Measure/Indicator Worksheet



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Performance Improvement Project (PIP) Worksheet

Naloxone (Narcan) Training

- 2016 MA DPH Circular Letter - Appendix A: Policy on the use of Naloxone
  - Part of the facilities' policies and procedures
  - Signed by the Medical Director or standing order from attending physician
  - Policies include parameters (e.g., exclusions)
  - Policy includes requirements for documentation in the medical record
  - Staff administering medication shall conduct an assessment for contraindications
- Staff must be trained in the use of Naloxone.

TM44

MOUD Toolkit

- 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

Avoid Stigmatizing Language

The language we choose shapes the way we treat our patients…	
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, in recovery
"dirty (referring to a person)"	In a period disease exacerbation, or relapse
"shooting up"	Injecting
"shooter"	Person who injects drugs

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

15

TM44

MOUD Toolkit

- 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

Coming up next…

- Six consecutive weekly virtual ECHO® sessions: Tuesdays and Thursdays from 1:00-2:00 PM (Starting 8/25 with the final session on 9/29).
  - −You choose the day (Tues or Thurs), but you need to sign up for all six sessions.
- The goal of these ECHO® sessions is to enhance community connections and partnerships related to integrating care for residents on MOUD, and to increase awareness of available resources.
- To learn more about ECHO® you can go to their website:
  - https://echo.unm.edu/join-the-movement/need-to-know

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Thank you!

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Medication for Opioid Use Disorder
Staff Educator
Virtual Site Visit
Office Hour

SAMHSA | Abt | Healthcentric Advisors | MOUD IN LONG TERM CARE

Welcome and Introductions

- Introductions
  - Abt staff
  - Participating LTC staff
- Confirm receipt of materials
  - DPH Circular letter with Appendix A
  - Two PowerPoint training slides
  - Document, "I Pledge to Stop the Stigma Associated with Addiction"

Objectives

- Review Understanding of MOUD
- Review of MOUD Toolkit Content and Resources
- Discuss Available Training

TM44

MOUD Toolkit

- 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

Avoid Stigmatizing Language

The language we choose shapes the way we treat our patients…	
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, in recovery
"dirty (referring to a person)"	In a period disease exacerbation, or relapse
"shooting up"	Injecting
"shooter"	Person who injects drugs

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

23

Training

- Recognizing and Responding to an Overdose
- Dispelling Myths and Overcoming Biases

Naloxone Training

- 2016 MA DPH Circular Letter - Appendix A: Policy on the use of Naloxone
  - Part of the facilities' policies and procedures
  - Signed by the Medical Director or standing order from attending physician
  - Policies include parameters (e.g., exclusions)
  - Policy includes requirements for documentation in the medical record
  - Staff administering medication shall conduct an assessment for contraindications
- Staff must be trained in the use of Naloxone.

Coming up next…

- Six consecutive weekly virtual ECHO® sessions: Tuesdays and Thursdays from 1:00-2:00 PM (Starting 8/25 with the final session on 9/29).
  - You choose the day (Tues or Thurs), but you need to sign up for all six sessions.
- The goal of these ECHO® sessions is to enhance community connections and partnerships related to integrating care for residents on MOUD, and to increase awareness of available resources.
- To learn more about ECHO® you can go to their website:
  - https://echo.unm.edu/join-the-movement/need-to-know

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Thank you!

This example policy is not intended to be used as is by any facility. It is strictly an example intended to help LTCF staff think through the steps when developing a similar policy to meet the needs of LTCFs.

Policy Title: Admitting Residents Treated with Medication for Opioid Use Disorder (MOUD)

Effective Date: xx/xx/xxxx
Revision Date: xx/xx/xxxx
Approval Date: xx/xx/xxxx

PURPOSE: To provide guidance on admission of residents who are being treated with Medication for Opioid Use Disorder (MOUD), to facilitate the safe and efficient continuity of care, and to promote the safety and well-being of residents being admitted on MOUD.

POLICY: All facility staff will follow the outlined procedures to facilitate the efficient and effective continuity of care for residents who are being treated with MOUD. All staff will respect the resident, understand that OUD is a chronic disease, and will use appropriate, non-stigmatizing language when talking to or referring to the resident. Department supervisors will use established vehicles of communication, including face to face meetings, email, telephone, written reports and forms to provide necessary communication of admission of residents receiving MOUD. All staff will adhere to the following procedures.

PROCEDURE:

1. The Administrator is responsible for ensuring that Naloxone/Narcan is readily available and that all staff on trained by a qualified trainer on the use of Naloxone/Narcan.

2. The facility Medical Director ensures that a Naloxone/Narcan standing order policy has been implemented at the facility.

3. The Administrator will ensure that all levels of staff are trained on appropriate components of OUD for their particular role, including, but not limited to: the biology of OUD, use of non-stigmatizing language, recognizing the signs and symptoms of OUD, recognizing and responding to an overdose, and the proper use of Naloxone/Narcan.

Prior to acceptance:
Upon notification from the hospital (or other discharging entity) discharge planner that a patient who is on MOUD is being discharged and is in need of a long-term care facility (LTCF) placement, facility intake staff [customize per facility admission policies]:

1. Receives pertinent information about the patient including any incidents of self-harm (suicidal ideation, attempt, overdose)

2. Transportation requirements and schedule to OBOT/OTP for medication and inquire regarding the potential for guest dosing.

3. Counseling requirements and schedule.

If upon discussion with interdisciplinary staff [Customize per facility] of the individual's needs it is determined that an appropriate bed to meet the needs of the resident/patient (e.g., not a locked dementia unit) is available, the discharging entity is notified that the facility is able to accept the patient into the facility.

Prior to admission:

1. The nurse responsible for a resident's admission completes the appropriate document(s) (e.g., notice of admission form) with any pertinent information. The form is distributed via interoffice mail to all departments as appropriate [Providers are to determine what can be disclosed and to whom per HIPAA and/or 42 CFR Part 2 requirements].

2. The admission director [Customize per facility] ensures that release of information (ROI) is obtained from discharging entity prior to resident discharge.

3. The admission director [customize per facility] upon receiving transfer information about the resident, will contact the OTP/OBOT to:
    a. Adapt and/or develop a Qualified Service Organization Agreement (QSOA) with the Opioid Treatment Program (OTP) or with the Office-Based Opioid Treatment (OBOT) services to ensure that communication between parties regarding the resident can be disclosed and/or re-disclosed (as applicable). If the resident has been prescribed buprenorphine, and a facility physician, nurse practitioner, or physician's assistant has a waiver to prescribe buprenorphine, then the QSOA with the OBOT or OTP should address who will provide the prescription for buprenorphine during the resident's stay at the facility and what other roles the OBOT or OTP may fill during that time (ex: counseling, supportive services, medication monitoring). However, they would need to comply with HIPAA regarding disclosure of information.
    b. The admission director ensures that release of information (ROI, customized per facility) is obtained from OBOT or OTP entity prior to resident admission.

4. Appropriate staff (e.g., Case/Unit Manager, Social Services, DON) upon receiving transfer information about the resident, will contact the OTP/OBOT and discuss care, medication and counseling needs to ensure continuity of care including:
        i. Current physical, mental health care and recovery providers
        ii. Family, social supports
        iii. Physical and mental health status and history including pain history (acute and/or chronic w/OUD)
        iv. Changes in physical/mental health status and accommodations needed

v. Review of medications (incl. over-the counter) and medication reconciliation
vi. If resident is on methadone: determine how this medication will be received (in-facility guest dosing or at OTP), establish pick-up schedule for methadone w/OTP.
vii. If resident is on buprenorphine and the LTCF physician is waivered: inform the OTP/OBOT that the medication will be admistered at the facility. If the physician does not have a waiver, then either work with the physician to obtain a waiver, or work with the OTP/OBOT to determine how this medication will be received (guest dosing or at the OTP/OBOT).
viii. Transportation services and schedule so that the resident is ready to be transported according to the established schedule (if applicable)
ix. Functional status (incl. any recent falls)
x. Self-harm reduction strategies (if applicable)
xi. Other impulse-control disorders, co-addiction issues (e.g., gambling, poly-substance use, etc.)
xii. Recovery support/peer-coaching/counseling with OTP/OBOT and coordinate with internal resources (Social Service, Activities supports)

Upon Admission

1. Upon notification of admission of a resident on MOUD, the director of nursing (DON) will notify department heads of this new admission during Daily Morning Report. [Providers are to determine what can be disclosed and to whom per HIPAA and/or 42 CFR Part 2 requirements].

2. The DON will communicate and work with the resident and the OTP or OBOT on the established goals of MOUD and medication receipt/delivery.
    i. If desire is to self-administer methadone initiate appropriate protocols for testing of ability to self-administer, availability of lock-box, etc.
3. The facility social worker, substance use counselor or other designated staff will arrange the first visit if resident is going to OTP or OBOT (if applicable), as well as schedule ongoing visits.

4. The facility social worker or other designated staff (e.g., activities director, transportation aid) will arrange ongoing transportation to facilitate appropriate access to treatment (e.g., initiate application for PT1, Uber health, facility transport).

5. Per established Nursing communication policies (e.g., Nursing Huddles, Nursing Report):
    a. DON will notify nurse managers/nurse supervisors of new admission of resident on MOUD.
    b. Charge Nurses will provide a report of the new resident to the oncoming nurse prior to leaving or will provide a recorded report.

i. Oncoming CNAs will obtain report from the Charge Nurse regarding new resident and discuss care needs ensuring that they are equipped to set expectations with the resident, as well as proide resources and strategies for resident and staff safety.

6. Resident Care Cards (if applicable)
    a. Resident Care Cards will be created by nursing manager and/or designee. The charge nurse will review with the CNAs to ensure that the detailed information on how to provide appropriate care for the resident is understood.

7. Resident Care Plan (per established care planning policies):
    a. A preliminary Person-Centered Interdisciplinary Resident Care Plan will be started with information received from the hospital or referring entity.
    b. Once the resident is admitted, the social worker will conduct a thorough interview with the resident and/or family/responsible party. The information from the interview(s) will be used to inform the care plan.
    c. The care plan will be updated, as needed, by each member of the interdisciplinary team who has a care plan, and overseen by the Resident Assessment Instrument (RAI) coordinator or other appropriate staff.
    d. Designated staff (e.g., DON) will complete the Clinical Opiate Withdrawal Scale (COWS) upon admission to determine a baseline of the stage or severity for opiate withdrawal if the resident was newly inducted on MOUD (within 7 days). Facility staff will consult with OTP/OBOT regarding any further monitoring using the COWS or other assessment.

8. Nursing Report Book (if applicable)
    a. Nurses document any information that needs to be communicated regarding the new admission to additional shifts in a Nursing Report Book, present on each unit. The oncoming nurses review the Nursing Report Book for any information that may assist them in caring for the resident being admitted.

9. 24 Hour Report
    a. Nurses will document pertinent resident information on the 24-hour report document, which is present on each unit. Nurse Managers provide copies of the 24-hour report document to the Daily Morning Report participants for review.

10. Supervisor Report Book (if applicable)
    a. Supervisor documents any information that needs to be communicated related to the entire house.
    b. Oncoming supervisors review the documentation at start of shift.

11. Discharge planning will begin upon admission (if applicable) to ensure continuity of care and connection with appropriate post-discharge resources
    a. Appropriate discharge documentation will be coordinated by Social Services, Therapy and Nursing, taking into account resident needs and services required upon discharge.
    b. Communication with key partners in caring for residents on MOUD throughout stay (e.g., daily, every other day, weekly, etc.)and upon discharge will ensure continuity of care (e.g., with OTP/OBOT, hospitals and community-wide service organizations).
    c. Ensure that OTP/OBOT is informed of resident anticipated discharge date, discharge location (e.g., home, family/friend's home, residential program, etc.), and actual discharge so that subsequent appointments with OTP/OBOT are planned and prescriptions (e.g., buprenorphine) are provided as necessary until at least first appointment post-discharge.
    d. Connect resident with community services as needed (e.g., peer-coach, counseling, etc.)

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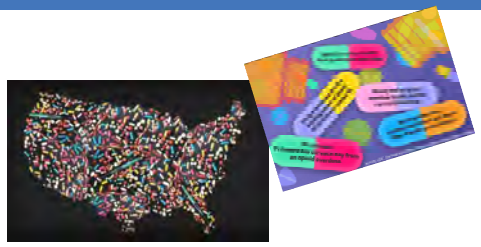
Accepting and Caring for the Needs of Residents on Medication for Opioid Use Disorder (MOUD) in Long-Term Care

SAMHSA · AGH · Healthcentric Advisors · MOUD IN LONG TERM CARE

Purposes of this Training

- Understand opioid use disorder (OUD) as a chronic disease.
- Understand the medications for opioid use disorder (MOUD).
- Address the myths about MOUD
- Address the stigma of OUD:
  - The importance of using appropriate language.
  - Identifying and using effective language when discussing OUD.
  - Eliminating the use of stigmatizing language in the medical field.

Opioid Use Disorder



Opioid Use Disorder

- What is OUD?
- Biology of OUD.
- Treatment for OUD.

What is Opioid Use Disorder?

- OUD is:
  - A prevalent, treatable chronic disease.
  - Characterized by compulsive opioid seeking behaviors and use despite harmful consequences.
  - Cyclical – involving cycles of relapse and remission.

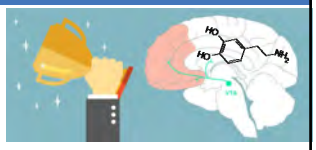
Although there is no cure OUD **can** be successfully managed.

Biology of Opioid Use Disorder

- Like other chronic diseases, OUD changes the biology of an individual. For example:
  - Coronary heart disease results in decreased heart metabolism and impacts heart functioning.
  - OUD results in decreased brain metabolism and impacts brain functioning.

Biology of Opioid Use Disorder (cont.)

- The common reward pathway in the brain for all pleasurable activities involves the neurotransmitter dopamine.
- OUD effects the reward pathway of the brain.
  - This pathway is activated by activities the brain finds pleasurable (eating, drinking, sex, etc.).



The drugs that can cause addictive behaviors are those that hijack the natural pleasure circuitry of the brain.
(Grayken Center for Addiction and RIZE MA)

Treatment for Opioid Use Disorder

- OUD is a treatable disease.
- Treatment outcomes for OUD are as good as those for other chronic diseases.
- Treatment adherence and engagement is crucial to achieving successful outcomes.
- Goal is to prevent complications.

Treatment for Opioid Use Disorder (cont.)

- Treatment includes a combination of :
  - Behavioral supports (therapy, counseling, etc.).
  - Lifestyle changes.
  - Self-help and peer support groups.
  - Other recovery support services (housing, vocational, educational, etc.).
  - Medications (methadone, buprenorphine, naltrexone).

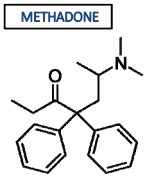
Medication for Opioid Use Disorder

Medication for Opioid Use Disorder

- Three medications for OUD (MOUD):
  - Methadone.
  - Buprenorphine.
  - Naltrexone.
- Benefits/potential challenges or side effects of MOUD.
- Myths about MOUD.

Medication for Opioid Use Disorder (cont. 1)

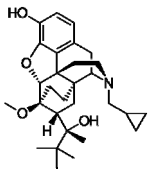
- Methadone:
  - Synthetic opioid.
    - Used for treatment of pain.
    - Used for treatment of OUD.
  - Dispensed only through an Opioid Treatment Program (OTP).



Medication for Opioid Use Disorder (cont. 2)

- Buprenorphine:
  - o Semi-synthetic opioid.
    - Can be used as a treatment for pain.
    - Used for treatment of OUD.
  - o Can be dispensed at a community pharmacy or administered at an office-based opioid treatment (OBOT) clinic.
    - Comes in many forms: sublingual tablet, sublingual film, buccal film, transdermal patch (pain only), injectable (subcutaneous), implant.

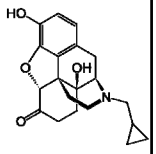
BUPRENORPHINE



Medication for Opioid Use Disorder (cont. 3)

- Naltrexone:
  - o Pure opioid antagonist used to block the activity of opioids in the brain.
  - o Approved for opioid use disorder and alcohol use disorder.
  - o Can be dispensed at a community pharmacy or administered at an OBOT.
    - Currently available as tablet or injectable.
  - o Before starting Naltrexone, a resident needs to be opioid free for a minimum of 7 to 10 days due to risk of withdrawal symptom exacerbation.

NALTREXONE



Benefits versus Risks of MOUD

Methadone	Buprenorphine	Naltrexone
Benefits of MOUD		
• Reduces desire for other opioids. • Eliminates withdrawal symptoms from discontinuation. • Reduced risk of overdose; administered in a controlled setting.	• Available at community pharmacy. • Lower misuse potential than methadone. • Lower opioid overdose symptom risk. • Various dosage/options from which to choose.	• Blocks the effects of opioids. • Can reduce cravings for residents with OUD. • Can be dispensed at community pharmacy. • Low diversion risk. • Low/no overdose risk.
Potential Challenges/ Side Effects of MOUD		
• Overdose risk. • Diversion possibility. • Must go to an OTP for treatment, making access more difficult.	• Overdose. • Diversion possibility.	• Can trigger withdrawal. • Blocks effects of opioid pain management. • May not eliminate cravings. • Reduces tolerance to opioids. • High risk of overdose if relapse. • Could cause hepatotoxicity.

Stigma About Medication for Opioid Use Disorder

- Many false assumptions exist around medications for opioid use disorder (MOUD).
- Stigma is a barrier to OUD treatment and results in the underutilization of MOUD.
- Recognizing stigma is an important first step in creating an environment in which MOUD can be successfully implemented.

Myths versus Truth About MOUD

MOUD MYTHS	TRUTH
It just trades one addiction for another.	A combination of behavioral therapies and MOUD can successfully treat OUD and support long-term recovery.
It's only for short-term use.	Persons on MOUD for at least 1-2 years have the greatest rates of long-term success.
Increases the risk of overdose.	Persons on MOUD experience less cravings, so significantly less likely to overdose as a result.
Isn't any better than abstinence.	MOUD improves functioning and quality of life.
Can disrupt the recovery process.	Evidence suggests MOUD as a best practice when treating OUD and support long-term recovery and may help repair the reward pathway.

Addressing the Stigma of Opioid Use Disorder

Addressing the Stigma around Opioid Use Disorder

Addressing the Stigma of Addiction

- What is stigma?
- Impact of stigma.
- Avoiding stigmatizing language.

What is Stigma?

- Attribute, behavior, or condition that is socially discrediting.
- Influenced by cause and controllability:
  - Stigma is decreased when someone is not at fault for something.
- Language can perpetuate stigma.

What is Stigma (cont.)?

- Stigma associated with OUD from:
  - Within – blame, shame, embarrassment.
  - Recovery community – focus on abstinence.
  - Clinicians – belief that treatment is ineffective.
  - Outside – that OUD is a choice and not a disease.

Impact of Stigma

- Erodes confidence that OUD is a valid and treatable health condition.
- Barrier to jobs, housing, relationships.
- Stops people from seeking help.
- Impacts clinical care and treatment decisions.

Avoiding Stigmatizing Language

- Language matters!!!
- Use of person-centered language is key:
  - Substance abuser versus **person with substance use disorder/opioid use disorder**.

Avoiding Stigmatizing Language

Instead of…	You can say…
Drug Abuse	Substance Use Disorder
Addict or Junkie	Person with Substance Use Disorder
Dirty Urine	Abnormal or positive urine test result
Clean Urine	Normal or negative urine test result
Clean	In a period of relapse
Shooting Up	Injecting
Shooter	Person who injects drugs

Quiz

True/False

Methadone, buprenorphine, and naltrexone are the three medications used to treat OUD.

- A. True.
- B. False

True/False (cont.)

The stigma of OUD is a barrier to jobs, housing, and relationships.

- A. True.
- B. False.

True/False (cont.)

Language does not have an impact on the stigma of OUD.

- A. True.
- B. False.

Language matters. Language perpetuates stigma. The use of person-centered language is important in reducing the stigma around OUD.

Key Lessons

Key Lessons

- OUD is a chronic disease, not a choice.
- OUD is treatable.
- Medications for OUD work.
- Individuals with OUD often face stigma from many sources.
- Language and approach to caring for people with OUD matter.

Key Lessons

- What can you do?
  - Be mindful of language:
    - Sign a language pledge.
  - Treat individuals with OUD with dignity.
  - Speak up when you encounter stigma and discrimination.
  - Understand how OUD is treated with science-based strategies.

Resources

Resources

- Local OTPs.
- Local OBOTs.
- Peer recovery coaches.
- Patient navigators.
- Recovery support centers.

Resources (cont.)

Access to Treatment for OUD:

- **SAMHSA National Helpline**: 1-800-662-HELP (4357), www.samhsa.gov/find-help/national-helpline.
- **Massachusetts Treatment Resource & Helpline:** English: https://helplinema.org/; Spanish: https://helplinema.org/?lang=es.
- **The Massachusetts Consultation Service for Treatment of Addiction and Pain (MCSTAP):** 1-833-PAIN-SUD (1-833-724-6783).
- **Project Assert:** 1-617-414-4388 https://www.bmc.org/about-us/stories/bmcs-project-assert.
- **Providing Access to Addictions Treatment, Hope and Support (PAATHs):** http://www.bphc.org/whatwedo/Recovery-Services/paaths-connect-to-services/Pages/paaths.aspx.

Resources (cont.)

Overdose Education and Naloxone:

- **Prescribe to Prevent:** http://prescribetoprevent.org/.
- **Office Based Addiction Treatment Training and Technical Assistance:** https://www.bmcobat.org/.

Resources (cont.)

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 individuals with substance use disorders and emotional or psychiatric illness.
- **Learn to Cope:** A non-profit support network for parents, family members and friends coping with a loved one addicted to opiates or other drugs: 1-508-738-5148 or https://www.learn2cope.org.

Resources (cont.)

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/	Clean Slate Centers Locations throughout MA, Refer to website for location contact info: https://www.cleanslatecenters.com	Brien Centers Locations throughout Western MA, Refer to website for location contact info: briencenter.com

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Recognizing and Responding to Opioid Overdose

SAMHSA · ALN · Healthcentric Advisors · MOUD IN LONG TERM CARE

Objectives for this Training

- Understand the types of opioids.
- How to recognize and respond to an overdose.
- Learn how naloxone works to reverse an overdose.
- Dispel naloxone myths

Types of Opioids

Types of Opioids (cont.)

1. **Prescription Opioids**
   - Oxycodone
   - Percocet
   - Vicodin
2. **Illicit Opioids**
   - Heroin
   - Fentanyl
3. **Medications for Opioid Use Disorder**
   - Methadone
   - Buprenorphine
   - Naltrexone

Methadone and Buprenorphine can also be prescribed for pain management.

Recognizing and Responding to an Overdose

Opioid Overdose

- **Definition**:
  - Injury to the body (poisoning) that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.
- **Opioid overdose happens as a process – breathing slows down *before* it stops.**
  - It takes minutes to hours after most opioids are used.
  - Fentanyl overdoses take seconds to minutes.
- **Slang:** fell out, went out, shot out, OD'd, going, check his pockets.

Distinguishing Intoxication from Overdose

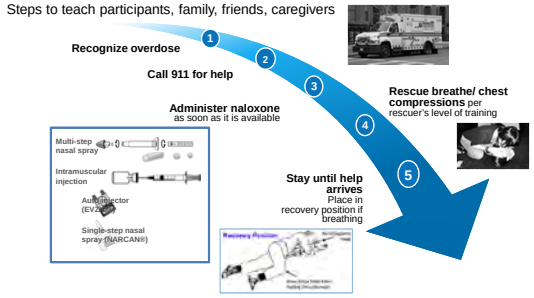
REALLY HIGH	OVERDOSE
Muscles become relaxed	Deep snoring or gurgling ("death rattle")
Speech is slowed/slurred	Very infrequent or no breathing
Sleepy looking	Pale, clammy skin
Nodding	***Heavy*** nod, not responsive to stimulation
Will respond to stimulation like yelling, sternal rub, etc.	Slow heartbeat/pulse

Stimulate and observe

CALL 911
Give naloxone
Rescue breathe/CPR
Chest compressions

How to Respond in an Overdose

Steps to teach participants, family, friends, caregivers



How to Respond in an Overdose (cont. 1)

- The first thing you should do is call for help/911 if you suspect an overdose.
- As in any 911 situation try to stimulate the person using sternal rub so that they wake up.
- Call 911 whether or not you are able to wake the person, as they may have other medical issues.
- If you administer naloxone, the person can overdose again once naloxone wears off, so it is important that they receive medical care.

Note: It may take multiple doses of naloxone to reverse the overdose.

How to Respond in an Overdose (cont. 2)

DO NOT leave the person alone, and do not…

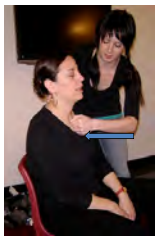
- Put them in a bath.
- Pour ice water or ice over them or directly on their body.

These methods of stimulation take more time and can add more risk.

There is a better alternative form of stimulation: **Sternal Rub.**

How to Respond in an Overdose (cont. 3)

- If calling out the person's name and shaking the person does not work, **rub your knuckles into the sternum** (the breastbone in middle of chest).
  - You can also rub your knuckles on their upper lip.
- Tell them you are going to administer naloxone.
- If the person is aroused but refuses naloxone, stay with them and observe until EMTs arrive.



Good Samaritan Law

- The Massachusetts (MA) Good Samaritan Law protects victims and those who call 9-1-1 for help from charge, prosecution, and conviction for possession or use of controlled substances, but does not protect individuals from being prosecuted for other offenses such as:
  - Drug trafficking
  - Weapons charges
  - Outstanding warrants
- For more information about the MA Good Samaritan Law go to: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c/Section34a
- For more information about how to stop an overdose with Naloxone go to: https://www.mass.gov/stop-an-overdose-with-narcanr

How Naloxone Reverses Opioid Overdose

Naloxone and Potential Effects

- Antidote to an opioid overdose.
- Naloxone blocks opioid receptors.
- Temporarily reverses the opioid effects, giving the person the chance to breathe.
- Usually works in about 3 minutes and lasts 30 to 90 minutes.
- Hypersensitivity (rash, worsening/difficulty breathing) is very rare
- Naloxone cannot cause overdose.
- Naloxone can cause withdrawal symptoms such as:
  - Anxiety, runny nose and eyes, chills.
  - Muscle discomfort, disorientation, combativeness.
  - Nausea/vomiting.
  - Diarrhea.

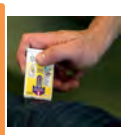
Different Forms of Naloxone

Narcan Nasal Spray "Single-Step"

Adapt Pharma

Nasal with separate atomizer "Multi-step"

Amphastar Pharmaceuticals



Auto-injector

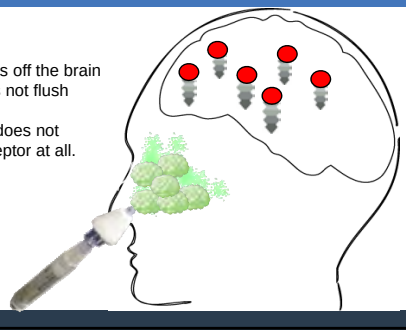
Kaleo Inc.

Intramuscular Injection

Various Companies

How Naloxone Reverses Opioid Overdose

1. Restores breathing.
2. Knocks opioids receptors off the brain (blocks opioids but does not flush them out).
3. No activity→ Naloxone does not stimulate the opioid receptor at all.



What to Expect after Administering Naloxone

- Most people start breathing again in 3-5 minutes.
  - Some require more doses especially with fentanyl.
- Most often people feel very confused, embarrassed, anxious, etc.
- The goal of using naloxone is to get people breathing again, not necessarily to wake them up right away.
  - If we are in a hurry to wake them up, we are more likely to give more naloxone which can induce withdrawal.
  - Withdrawal symptoms can vary.
- Reassure them that withdrawal symptoms will diminish as the naloxone wears off.

Stay with the Person

Recovery Position

WHY MONITOR AND SUPPORT?

- Naloxone lasts 30–90 minutes…
  - But an **opioid overdose** may last as long as **4 hours,**
  - And a **methadone overdose can last up to 8 hours.**
- Stay with the person during the risk period:
  - So they don't continue using the substance they overdosed on.
  - For when naloxone wears off.

Naloxone Myth Busters

- Naloxone will not make a person feel high; it takes the high away.
- People do not become tolerant to naloxone.
- Naloxone only reverses effects from opioids.
  - Does not reverse overdoses from other substances.
- Drug test will still be positive after naloxone.
- Naloxone DOES NOT make people violent.

Quiz

Quiz #1

Which of the following may be types of opioids?

1. Prescription pain medication.
2. Illicit drugs.
3. Medication for Opioid Use Disorder (MOUD).
4. All of the above.

21

Quiz #2

Which of the following is a symptom of overdose?

1. Slowed/slurred speech.
2. Sleepy look.
3. Heavy nod, not responsive to stimulation.
4. Relaxed muscles.

22

Quiz #3

Which of the following should you do if you suspect an overdose?

1. Call 911.
2. Pour ice water on the person.
3. Conduct a sternal rub.
4. Slap the person to wake them up.
5. 1 and 3.

23

Quiz #3

Is this statement true or false? It is safe to leave someone alone after you've called 911 and administered naloxone.

1. True.
2. False.

24

Key Lessons

Key Lessons

- An opioid overdose is caused by an injury to the body (poisoning) that happens when a drug is taken in excessive amounts and progresses to where breathing has slowed/stops and the person is unresponsive.
- Symptoms of an overdose are:
  - Deep snoring or gurgling.
  - Very infrequent/no breathing.
  - Pale, clammy skin.
  - Heavy nod, not responsive to stimulation.
  - Slow heartbeat/pulse.

Key Lessons (cont.)

- If an opioid overdose is suspected:
  - Call 911.
  - Attempt to wake the person (conduct a sternal rub).
  - Administer naloxone if available.
  - Administer rescue breaths/chest compression (if capable).
  - Place in a rescue position.
  - Stay until help arrives.

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Thank you!

- **Check out these resources:**

prescribetoprevent.org
Harmreduction.org
Mass.gov/stop-an-overdose-with-narcanr

SAMHSA | MOUD IN LONG TERM CARE

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

MOUD in LTC Contact:
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nursinghomeqi@state.ma.us

SAMHSA | MOUD IN LONG TERM CARE

Appendix G: Baseline In-Person and Telephone Interview Protocols

Informed Consent

Respondent is a staff member of a Long Term-Care Facility, OTP, or OBOT.

Thank you very much for taking the time to [speak with us/complete the survey]. Abt Associates, a private research and consulting firm, and our partner / Healthcentric Advisors, has been contracted by the Massachusetts Department of Public Health to assist in the development and training of medication-assisted treatment (MAT) policies and procedures for opioid use disorder among residents in long-term care facilities. [for interviews, insert name of LTCF/ OTP/ OBOT] has been selected to participate in program.

The feedback that you provide will help us in the development of MAT training materials. [Interview only: I will be taking notes during the interview, but will not record the discussion.] [Our discussion today/the survey] should take about [15 for CNAs; 30 for medical directors; 60 for all other interviewees; 15 for survey respondents] minutes to complete. Your participation is voluntary. If you choose not to participate, or to stop the interview at any time, you will not be penalized in any way. There may be some questions you may not be able to answer or that are more appropriate for other staff. If you are unable to answer or would prefer not to answer a question, just let me know.

The information gathered during this and other [interviews/surveys] will be included in a final report to the Department of Public Health. This report will not include individuals' names, facility names, or locations. We will provide summaries of what we learn through the [interviews/surveys], but will not use your name or the name of the facility in those summaries or in our report. The information that we collect will be used for research and quality improvement purposes only. This is not an evaluation of you or this facility, this is about helping the Department of Public Health understand how to serve long-term care facilities as they care for residents with opioid use disorders.

If you have any questions that I cannot answer at this time, or at any time after this interview, you may contact Katherine Fillo at the Massachusetts Department of Public Health, Bureau of Health Care Safety and Quality 617-624-0504.

Do you have any questions about today's discussion before we begin?

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

[Interviewer introduces herself/himself and describes the purpose of the interview.]

Thank you for meeting with us this morning/afternoon. My name is [NAME] and I will be interviewing you. ***[INTRODUCE OTHER STUDY STAFF PRESENT]***

To give you a little background, we are working with the Massachusetts Department of Public Health's Bureau of Health Care Safety & Quality on a project called the Medication for Opioid Use Disorders (MOUD) in Long Term Care Technical Support Program. This interview will help us understand the current procedures being followed, identify best practices, and learn what training that has been provided to prepare staff to care for residents receiving MOUD.

We are reaching out to long-term care facilities, opioid treatment programs (OTPs), office-based opioid treatment (OBOT) programs, and hospitals to better understand and support the continuity of care in MOUD and incorporate your knowledge and expertise to inform our program development.

This work will help facilities overcome the challenges that they face in providing high quality, continuity of care for these residents.

While we have some specific questions that we plan to ask, we welcome additional input, so please feel free to share any information that you feel is important for us to know, even if we do not ask about it directly. Your opinions and experiences matter to us.

Discussion Questions

1. Does your facility currently have, or have you cared for in the recent past, residents who have been diagnosed with Opioid Use Disorder or OUD who are on medication assisted treatment (naltrexone, buprenorphine or methadone)?

   [If yes, continue with question 2]

   [If no, skip to question 6]

2. How many, if any, of your residents are currently receiving Methadone treatment?
3. How many, if any, are currently receiving Buprenorphine treatment?
4. How many, if any, are currently receiving Naltrexone treatment?
5. How do you currently support your residents with a diagnosis of OUD who are on medication assisted treatment (buprenorphine, naltrexone or methadone)?

   - What can you tell me about any initiatives in place that are related to this population of residents? (prevention, treatment, recovery, MOUD, and research)
   - Is your Medical Director able to prescribe Buprenorphine or other MOUD?
   - What additional settings do you work/partner with to support residents with OUD/SUD?
   - How would you describe your current resident population?
   - How do you support front-line staff who work with residents with a diagnosis of OUD?
     - Do you provide training/informational support so that care providers are well equipped to manage residents with OUD?
     - Do you provide emotional support since these residents have often experienced trauma

and may share their stories with the staff who may in turn be traumatized or need some additional psycho-social supports?

- What kind of data are you collecting or monitoring on your residents with OUD/SUD?

6. Do you have policies and procedures in place that address the following?

Transition of Care

a. Notification by the hospital/bridge clinic that a new resident has an OUD or SUD (associated with opioid use) as a secondary diagnosis and is on MOUD.
b. Process in place to confirm that a Release of Information (ROI) for OTP /OBOT and the LTCF is presented to resident prior to discharge.
c. Development of a Qualified Services Organization Agreement (QSOA) to define the responsibilities of each organization.
d. LTCF provides clinician's contact information to OTP/OBOT upon admission.
e. Resident medical information including face sheet, diagnoses, progress note sent to OTP/ OBOT upon admission.
f. Plan in place for transportation to OTP/OBOT for treatment/counseling if applicable.

Upon Admission

a. Medication reconciliation upon admission.
b. Plan for storage and distribution of medication.
c. Assessment of any other treatment concerns.
d. Care plan including treatment plan developed in partnership with OTP/OBOT.
e. Biopsychosocial and list of community supports provided to resident and/or family.
f. Protocols for residents currently on MOUD including working with OTP/OBOT for MOUD management.
g. Waiver for responsibility of take-home medication approved by OTP/OBOT medical director and/or physician and agreed to by admitting physician in the LTCF ((SNF Medical Director or assigned primary care provider (PCP)).

Once Admitted

a. Transportation of medications to the LTCF if take home waiver is in place. If take-home waiver is not in place, transportation of the resident to OTP/OBOT as scheduled.
b. Chain of custody process in place for Methadone.
c. Self-administration policies/procedures in place for Methadone.
d. Policies/procedures in place for administration of Buprenorphine or Naltrexone.
e. Drug Testing upon suspicion of recurrence of opioid use, or per protocol.
f. Follow-up counseling appointment scheduled with OTP clinic.
g. Transportation scheduled for follow up appointment with OTP clinic.
h. Narcan readily available for administration in case of an overdose.
i. Communication to LTC pharmacy regarding inclusion of Methadone on med list or dispensing of Buprenorphine or Naltrexone.
j. Billing and reimbursement policies/procedures in place for medication and counseling.

Storage and Dispensing of Methadone

a. Policies/procedures in place for storage of Methadone including documentation required by MA DPH regulations.

b. Policies/procedures in place to identify and respond to potential diversion activity.
c. Policies/procedures in place to destroy Methadone if it is left behind when resident is discharged and/or leaves against medical advice (AMA).
d. Policies/procedures in place for Narcan stocking/restocking.

7. What core competencies do you think are necessary for staff to care for residents diagnosed with OUD?
8. Are staff required to participate in training related to caring for residents diagnosed with OUD?

[If yes, continue with question 10.]

[If no, skip to question 11.]

9. Are staff trained in any of the following areas?

a. Narcan or overdose training.
b. Understanding OUD/SUD as a disease.
c. Trauma Informed Care.
d. Recognizing withdrawal or overdose symptoms.
e. Stigma – dispelling misconceptions.

[Ask questions 11-13 only if the facility currently admits residents with a diagnosis of OUD (i.e., answers yes to question 1).]

[Ask question 14 only if they have not admitted residents with a diagnosis of OUD (i.e., answers no to question 1)]

10. Is there a social worker on staff who is qualified to provide counseling to residents receiving MOUD?

a. ***[If no]*** Have you partnered with an OTP or OBOT for the provision of counseling?

11. Can you describe any best practices or innovative practices your facility has developed or used for caring for residents with OUD?

- How did you identify this practice?
- What successes have you seen?
- How have you spread or shared this practice within your facility/with others?

12. Can you describe any challenges/barriers you have experienced when caring for this population?

- What is the greatest challenge in providing care to this population?
- Do you encounter any logistical challenges (e.g., scheduling appointments, arranging for transportation, etc.)?
- Are there challenges related to reimbursement for treatment of residents with OUD?
- How would you describe challenges within the health care system or landscape in your community/state?

[Interviewer, do not share these example with the interviewee, but we are looking for something like the following: coordinating with partners such as OTPs/OBOTs, stigma of accepting residents with addiction disorders, age differences between typical LTC residents and younger residents being treated for these conditions in LTCFs, information transfer, insurance, provider shortage, and rurality.]

- How have regulations (state, or federal – e.g., HIPAA/42 Code of Federal Regulations/privacy concerns) impacted your work with this population?

13. ***[Only ask if they do not admit]*** What do they think the challenges/barrier are that limit your ability to admit residents with a diagnosis of OUD?

14. Is there anything else that you would like us to know?

Closing Remarks

Thank you for taking the time to meet today, we value your perspectives as we develop program. The information that you provided will help us develop policies and materials that will be used during the January learning session and technical support visits.

On behalf of the Abt team, and the MA Department of Public Health, thank you once again for your time and participation.

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

[Interviewer introduces herself/himself and describes the purpose of the interview]

Thank you for meeting with us this morning/afternoon. My name is [NAME] and I will be interviewing you. ***[INTRODUCE OTHER STUDY STAFF PRESENT]***

To give you a little background, we are working with the Massachusetts Department of Public Health on a project called the Medication for Opioid Use Disorders in Long Term Care Technical Support Program. The MOUD in LTC program will help facilities overcome the challenges that they face in providing high quality, continuity of care for residents with opioid use disorder or OUD, including adverse drug events.

We are reaching out to long-term care facilities, opioid treatment programs (OTPs), office-based opioid treatment (OBOT) programs, and hospitals to better understand and support the continuity of care in MOUD, and incorporate their knowledge and expertise to inform our program development. The interview with you will help us understand the current procedures being followed, best practices identified, and training that has been provided to prepare staff to care for residents receiving MOUD.

While we have some specific questions that we plan to ask, we welcome additional input/ideas, so please feel free to share any information that you feel is important, even if we do not ask about it directly. Your opinions and experiences matter to us.

Discussion Questions

1. Does this facility currently admit, or have they admitted in the recent past, residents who have been diagnosed with OUD who are on medication assisted treatment (buprenorphine, naltrexone or methadone)?

   [If yes, continue to question 2]

   [If no, skip to question 3]

2. How would you describe the current resident population at this facility?

3. How do you currently support your residents with a diagnosis of OUD who are on medication assisted treatment (buprenorphine, naltrexone or methadone)?

- Do you have a waiver so that you can prescribe Buprenorphine?
- What can you tell me about any initiatives in place at this facility that are related to this population of residents? (staff training, prevention, treatment, recovery, MOUD, and research)

- Do you work with an OTP or OBOT to support residents with OUD?

  [***If yes]*** Are residents provided with take-home doses from their OTP**?**

4. What core competencies do you think are necessary for staff to have to care for residents diagnosed with OUD?

[Ask questions 5-7 only if the facility currently admits residents with a diagnosis of OUD/SUD (i.e., answers yes to question 1]

5. Can you describe any best practices or innovative practices this facility has developed or used for caring for residents with OUD?

- What successes have you seen?
- How have you spread or shared this practice within this facility/with others?

6. Can you describe any challenges/barriers you have experienced when caring for this population?

- What is the greatest challenge in providing care to this population?

Do you encounter any logistical challenges (e.g., scheduling appointments, arranging for transportation, etc.).
How would you describe challenges within the health care system or landscape in your community/state?

[Interviewer: do not share these examples, but we are looking for any of the following: coordinating with partners such as OTPs/OBOTs, transportation, staffing challenges, stigma of accepting residents with addiction disorders, age differences between typical LTC residents and younger residents being treated for these conditions in LTCFs, information transfer, insurance, provider shortage, and rurality.]

7. Do you feel that you are provided with enough support and/or resources to care for this population?

[*If no]* Can you provide me with an example of the type of support that would help you to care for this population?

8. Is there anything else that you would like us to know?

Closing Remarks

Thank you for taking the time to meet today, we value your perspectives as we develop program. The information that you provided will help us develop policies and materials that we will share with this facility and others.

On behalf of the Abt team, and the MA Department of Public Health, thank you once again for your time and participation.

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

[Interviewer introduces herself/himself and describes the purpose of the interview.]

Thank you for meeting with us this morning/afternoon. My name is [NAME] and I will be talking with you today about the care you provide to your residents. ***[INTRODUCE OTHER STUDY STAFF PRESENT]***

We are working with the Massachusetts Department of Public Health on a training program for long-term care facilities such as this one. We are not State Surveyors, and your comments will not be used for any survey-related activity. Our program is associated with the quality improvement division at DPH, so please feel free to share your thoughts with us. Our goal is improving the quality of care in long term care facilities.

By interviewing CNAs in this and other facilities, we hope to learn about how facilities provide care to residents who have an opioid use disorder diagnosis. Learning about this will help us to identify approaches that work and also challenges that you face when caring for these residents.

Even though we have specific questions, you are welcome to share any other feedback you have. Your opinions and experiences matter to us.

Discussion Questions

1. Do you currently, or have you in the past, cared for any residents with a diagnosis of opioid use disorder or substance use disorder?

   [If yes] At this facility or at a previous facility? **[Continue with question 2]**
   [If no **Skip to question 3]**

2. Can you tell us if you help with any of the following tasks?

   a. Transportation to medication treatment appointments

   b. Setting up appointments with treatment program)?

3. As far as you know, does your facility have any policies or procedures related to caring for residents with a diagnosis of opioid use disorder (prevention, treatment, recovery, MOUD, and research)?

   [If yes] Can you tell me about them?

4. Have you received any training on how to care for residents with a diagnosis of opioid use disorder?

   [If yes Continue with question 5]
   [If no Skip to question 6]

5. **Were you trained in any of the following areas? (Circle as many as apply.)**

   a. Narcan or overdose training. Narcan is a medication used to block the effects of opioids.
   b. Understanding opioid use disorder as a disease.
   c. Trauma Informed Care or practices that promote a culture of safety, empowerment, and healing.
   d. Recognizing withdrawal or overdose symptoms.
   e. Stigma or a mark of disgrace associated with a particular behavior, quality, or circumstance – dispelling misconceptions.

[Ask questions 6-9 only if the answer to question 1 is yes]

6. What do you think has worked well when caring for residents diagnosed with opioid use disorder in the past? ***[Interviewer, make note if the best practice was from a previous facility]***

7. Can you tell us about any challenges you have faced when caring for these residents?

9. Of the challenges you just mentioned, what would you say is the greatest?

10. Is there anything else that you would like us to know?

Closing Remarks

Thank you for taking the time to meet with us today. We value your thoughts as we develop this training program.

On behalf of the Abt team and the MA Department of Public Health, thank you once again for your time and participation.

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

[Interviewer introduces herself/himself and describes the purpose of the interview]

Thank you for meeting with us this morning/afternoon. My name is [NAME] and I will be interviewing you. ***[INTRODUCE OTHER STUDY STAFF PRESENT]***

We are working with the Massachusetts Department of Public Health's Bureau of Health Care Safety & Quality on a project called the Medication for Opioid Use Disorders (MOUD) in Long Term Care Technical Support Program. Your answers well help us understand the current processes and procedures followed, and help us to develop a training and technical support program to assist in long-term care facilities to provide high quality and smooth transitions of care. This work will help remediate the challenges that long-term care facilities and OTP/OBOT programs face in providing continuity of care for this population, including adverse drug events.

While we have some specific questions that we plan to ask, we welcome additional input/ideas, so please feel free to share any information that you feel is important, even if we do not ask about it directly. Your opinions and experience matter to us.

Discussion Questions

1. How would you define the community you serve?
    a. What is your overall mission?
2. How do you currently support clients with a diagnosis of OUD or SUD who are receiving MOUD who reside in long term care facilities?
    a. Please describe the policies and procedures that you follow when residents from long-term care facilities access your program(s) (e.g., prevention, treatment, counseling)
    b. What medications is your clinical team able to prescribe (e.g., Buprenorphine, Naltrexone or Methadone)?
    c. Do you provide telehealth services to your patients? If yes, please describe.
    d. Beyond long-term care facilities, with what other provider/client settings do you work and/or partner?
    e. Do you collect data for tracking purposes or to monitor your long-term care residents who access your program(s)?
    f. Do you track and analyze patient data including outcome data?
3. Do you have policies and procedures in place that address the following?

    Transitions of Care

    a. Notification by a hospital/bridge clinic that a patient is on MOUD (Buprenorphine, Naltrexone or Methadone) and is being transferred to a long-term care facility:
        i. New Patient.
        ii. Current Patient.
        iii. Guest Patient (only in rare cases)
            1. Is there a process in place to address guest OTP/OBOT clients or if one of your clients goes to another treatment program out of your system?
    b. Process in place to confirm that a Release of Information (ROI) for OTP/OBOT and long-term

care facility is presented to patient prior to discharge.

c. Development of a Qualified Services Organization Agreement (QSOA) in place to define responsibilities of each organization.
d. OTP/OBOT provides clinician's contact information to long-term care facility upon admission.
e. OTP/OBOT receives long-term care facility resident's medical information including face sheet, diagnoses, and progress notes.
f. Plan in place for transportation to OTP/OBOT for treatment/counseling if applicable.

Upon Admission

a. Letter of medical necessity from the medical director or the admitting physician at the long-term care facility.
b. Medication reconciliation upon admission.
c. Assessment of any other treatment concerns.
d. Care plan including treatment plan developed in partnership with long-term care facility.
e. Scheduling of projected dates that the patient is expected to be receiving treatment in the long-term care facility.
f. Biopsychosocial assessments and list of community supports provided to client resident and/or family.
g. Are there any other protocols for clients currently on MOUD that were not previously covered?
h. Waiver for responsibility of take-home medication approved by OTP/OBOT medical director and/or physician
i. Waiver for responsibility of take-home medication agreed to by admitting physician in the long-term care facility [long-term care facility medical director or assigned primary care provider (PCP)].

Once Admitted

a. Transportation of medications to the long-term care facility if take home waiver is in place.
    i. If waiver is not in place, schedule for transportation of the client to OTP/OBOT agreed to by long-term care facility and the OTP/OBOT.
b. Chain of custody process in place for Methadone.
c. Self-administration policies/procedures in place for Methadone.
d. Policies/procedures in place for administration of Buprenorphine and Naltrexone.
e. Follow-up counseling appointment scheduled with OTP/OBOT clinic
    i. At the long-term care facility
    ii. At the OTP/OBOT
    iii. Via telehealth
f. Communication to long-term care facility pharmacy regarding inclusion of Methadone on med list or dispensing of Buprenorphine or Naltrexone.
g. Billing and reimbursement for medication and counseling.

Storage and Dispensing of Methadone

a. Storage of Methadone including documentation required by MA DPH regulations – confirmed with long-term care facility.
b. Long-term care facility to communicate with OTP/OBOT about client discharge and/or leaves against medical advice (AMA).

4. What core competencies do you think are necessary for long-term care staff to care for residents diagnosed with OUD or diagnosed with SUD who are being treated for opioid addiction?

   [Interviewer: Do not share the examples, but we are looking for something like: trauma informed care, understanding dementia and/or other co-morbidities of the older adult population]

5. Do patients routinely receive counseling?

   [If yes] What is the counseling schedule (e.g., only at admission, monthly, weekly)?

   [If no] Are you aware if your patients receive counseling at the long-term care facility?

6. What has worked well in your organization/experience for caring for client in long-term care facilities receiving MOUD?

   a. What successes have you seen?
   b. Have you been able to spread or share best practices with others?

7. Can you describe any challenges/barriers you have experienced when caring for residents from long-term care facilities receiving MOUD?

   a. What is the greatest challenge that you encounter?
   b. Do you encounter any logistical challenges with long-term care facility clients?
   c. Are there challenges related to reimbursement for this population (i.e., OUD/SUD)?
   d. How would you describe challenges within the health care system or landscape in your community/state?

   [Interviewer: Do not share the examples, but we are looking for something link: coordinating with partners such as hospitals and long-term care facilities, information transfer, insurance, provider shortage (e.g., limited receptive long-term care facilities), and rurality]

8. How have regulations impacted your work with clients from long-term care facilities receiving MOUD?
   Are you aware of any data, either from your organization or others, that we could access to better understand this population? *(Note: We are a covered entity and have the capacity to manage large data sets.)*

   [If yes] What can you tell us about this data?

9. Of all of the topics covered today, which do you think is most important to address in policies/procedures?

10. Of all of the topics covered today, which do you think is most important to address in trainings for long term care staff?

11. Is there anything else that we didn't cover that you would like us to know?

Closing Remarks

Thank you for taking the time to meet today, we value your perspectives as we develop our program. The information that you provided will help us develop policies and materials that we will share with Massachusetts long-term care facilities. On behalf of the Abt team, *and the MA Department of Public Health,* thank you once again for your time and participation.

Appendix H: Follow-Up Online LTCF Staff Survey

MOUD in LTCF Administrators and DON Survey

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

Thank you for completing this survey.

As a reminder, Abt Associates and our partner Healthcentric Advisors are working with the Massachusetts Department of Public Health's Bureau of Health Care Safety & Quality on a project called the Medication for Opioid Use Disorders (MOUD) in Long Term Care Technical Support Program. At the beginning of the program, we conducted an interview with you and others of your staff. This survey is a follow-up to that interview and designed so we can identify any changes in policies regarding admission of residents with a secondary diagnosis of OUD, as well as your procedures and understanding of OUD and MOUD.

This is a brief survey and should take no more than 10 minutes to complete.

1. Does your facility currently have, or have you cared for in the past year, residents who are on medication for opioid use disorder (MOUD) such as naltrexone, buprenorphine or methadone?
    - o Yes
    - o No
2. Does anyone on your staff (i.e., Medical Director, physicians, nurse practitioners, physician assistants) have a waiver from Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe Buprenorphine or other MOUD? **Note, this does not include prescribing methadone for pain.**
    - o Yes
    - o No
3. Do you have policies and procedures in place that address the following?
    a. Waiver for responsibility of take-home medication approved by Opioid Treatment Program (OTP)/Office-Based Opioid Treatment (OBOT) medical director and/or physician and agreed to by the long-term care facility (LTCF) admitting physician.
        - o Yes
        - o No
    b. Transportation of medications to the LTCF if take home waiver is in place. If take-home waiver is not in place, transportation of the resident to OTP/OBOT, as scheduled.
        - o Yes
        - o No
    c. Self-administration for Methadone.
        - o Yes
        - o No
    d. Administration of Buprenorphine or Naltrexone.
        - o Yes

- o No

e. Narcan readily available for administration in case of an overdose.
   - o Yes
   - o No

f. Storage of Methadone including documentation required by MA DPH regulations.
   - o Yes
   - o No

g. Destroying Methadone if it is left behind when resident is discharged and/or leaves against medical advice (AMA).
   - o Yes
   - o No

h. Narcan stocking/restocking.
   - o Yes
   - o No

4. Are staff required to participate in training related to caring for residents diagnosed with OUD?
   - o Yes
   - o No

[If yes, continue with question 5; if no, skip to question 6]

5. Are staff trained in any of the following areas?

a. Narcan or overdose training.
   - o Yes
   - o No

b. Understanding OUD/SUD as a disease.
   - o Yes
   - o No

c. Trauma Informed Care.
   - o Yes
   - o No

d. Recognizing withdrawal or overdose symptoms.
   - o Yes
   - o No

e. Stigma – dispelling misconceptions.
   - o Yes

- o No

6. What challenges/barriers have you experienced when caring for this population, or that limit your ability to admit residents with a diagnosis of OUD? **[open-ended response]**

_____
_____

7. As a result of participating in the MOUD in LTC program:
   a. I feel confident that facility staff have improved their knowledge of OUD.
      - o Completely confident
      - o Somewhat confident
      - o Not at all confident
   b. I feel confident that facility staff have improved their knowledge of MOUD.
      - o Completely confident
      - o Somewhat confident
      - o Not at all confident
   c. I feel confident that facility staff can manage a resident with OUD because of the knowledge we gained.
      - o Completely confident
      - o Somewhat confident
      - o Not at all confident
   d. I am open to admitting a resident needing MOUD.
      - o Yes
      - o No

On behalf of the Abt team, and the MA Department of Public Health, thank you for taking the time to complete this survey and for your participation in the MOUD in LTC program.

MOUD in LTCF Medical Director Survey

MODERATOR'S GUIDE, STRUCTURED INTERVIEWS

Introduction

Thank you for completing this survey.

As a reminder, Abt Associates and our partner Healthcentric Advisors are working with the Massachusetts Department of Public Health's Bureau of Health Care Safety & Quality on a project called the Medication for Opioid Use Disorders (MOUD) in Long Term Care Technical Support Program. At the beginning of the program, we conducted an interview with you and others of your staff. This survey is a follow-up to that interview and designed so we can identify any changes in policies regarding admission of residents with a secondary diagnosis of OUD, as well as your procedures and understanding of OUD and MOUD.

This is a brief survey and should take no more than 5 minutes to complete.

1. Does your facility currently have, or have you cared for in the past year, residents who are on medication for opioid use disorder (MOUD) such as naltrexone, buprenorphine or methadone?
    - o Yes
    - o No
2. Do you have a waiver from Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe Buprenorphine or other MOUD? **Note, this does not include prescribing methadone for pain.**
    - o Yes
    - o No
3. Do you work with an Opioid Treatment Program (OTP) or Office-Based Treatment Program (OBOT) to support residents with receiving MOUD treatment?
4. What challenges/barriers have you experienced when caring for this population, or that limit the facility's ability to admit residents with a diagnosis of OUD? **[open-ended response]**

    _____

    _____
5. As a result of participating in the MOUD in LTC program:
    a. I feel confident that facility staff have improved their knowledge of OUD.
        - o Completely confident
        - o Somewhat confident
        - o Not at all confident
    b. I feel confident that facility staff have improved their knowledge of MOUD.
        - o Completely confident
        - o Somewhat confident
        - o Not at all confident
    c. I feel confident that facility staff can manage a resident with OUD because of the

knowledge we gained.

- o Completely confident
- o Somewhat confident
- o Not at all confident

d. I am open to admitting a resident needing MOUD.

- o Yes
- o No

On behalf of the Abt team, and the MA Department of Public Health, thank you for taking the time to complete this survey and for your participation in the MOUD in LTC program.

Appendix I: Learning Session Pre-Post-Assessment Form

MOUD in LTC Knowledge Evaluation

Directions: You will be given this short test at the beginning and at the end of today's training. This will help us understand what you already know and what you learned today. This test should take no more than 20 minutes to complete. Once you have finished your test, please turn it in to the facilitators. For each of the following questions choose the best answer. You do not need to write your name on this test. It is ok if you don't know the answers to some of these questions.

1. What is addiction?

a. Something that happens to bad people
b. A chronic disease
c. A moral failing
d. A voluntary behavior

2. Which of the following are stigmatizing words (**select all that apply**)?

a. Junkie
b. Addict
c. Person with opioid use disorder
d. Clean

3. Which of the following are **not** signs of an opioid overdose?

a. Blue lips and fingertips
b. Rapid pulse
c. Nonresponsive to voice or sternal rub
d. Small pupils

4. True or False?

a. Medication for opioid use disorder can successfully treat opioid use disorder.
   T F
b. Medication for opioid use disorder is a short-term solution.
   T F
c. Providing medication for opioid use disorder is a key component of a person's recovery.
   T F
d. There is no proof that MOUD is better than abstinence.
   T F

5. Which of the following are MOUD medications (**select all that apply**)?

a. Methadone
b. Buprenorphine
c. Naloxone
d. Naltrexone

6. **Fill in the blanks.** Per CMS regulations, what should your facility have in place regarding trauma-informed care?

The facility must ensure that residents who are trauma survivors receive _____, _____-_____ care in accordance with professional standards of practice and accounting for residents' _____ and preferences in order to eliminate or mitigate _____ that may cause retraumatization of the resident.

7. Where can a resident access methadone?

a. Opioid Treatment Program
b. Office Based Opioid Treatment Provider
c. Both
d. Neither

8. What documents need to be in place between a facility and an OTP or OBOT ***prior to*** resident admission? (**select all that apply**)

a. Qualified Services Organization Agreement
b. Confidentiality Agreement
c. Release of Information
d. Exception Request
e. PT-1
f. Take-home waiver

9. List the three steps that providers must take in order to obtain a waiver to prescribe Buprenorphine?

1. _____
2. _____
3. _____

Appendix J: Learning Session Evaluation Form

Medication for Opioid Use Disorder in Long-Term Care Program
LEARNING SESSION EVALUATION

Department of Public Health
Bureau of Health Care Safety & Quality

Please complete the following evaluation and return to the registration table. Questions marked with (*) are required.

ATTENDEE INFORMATION

1) Please provide your contact information: (*)

Name: _____ Organization: _____

Title: _____ Email address: _____

2) Please select your role(s): (*)

☐ Nurse
☐ Nurse Practitioner
☐ Physician
☐ Nursing Home Administrator
☐ Case Manager
☐ Social Worker
☐ Patient/Family Advisor
☐ Pharmacist
☐ Other (please specify): _____

3) Please select which continuing education credits you are seeking: (*)

☐ CEUs ☐ CMEs ☐ None

4) Please indicate which session you attended: (*)

☐ Boston ☐ Lowell ☐ Springfield ☐ Worcester ☐ Plymouth

OBJECTIVES

5) Please indicate by selecting one of the following, the extent the learning session objectives were met

Participants will be able to:	Met	Partially Met	Not Met
1. Recognize the stigma of OUD,	☐	☐	☐
2. Understand OUD – how residents present, disease severity, biological effects and underlying causes,	☐	☐	☐
3. Know the different types of treatment for OUD including MOUD and non-medical pathways, and	☐	☐	☐
4. Identify bi-directional strategies to enhance best practices across the continuum of care for residents with OUD.	☐	☐	☐

PRESENTER PERFORMANCE

6) Please indicate to what extent each presenter gave an effective talk and demonstrated thorough knowledge of the subject matter.

	Effectiveness of Talk			Knowledge of Subject		
Presentation:	Effective/ Complete	Partially Effective and/or Complete	Ineffective and/or Incomplete	Effective/ Complete	Partially Effective and/or Complete	Ineffective and/or Incomplete
Call to Action	☐	☐	☐	☐	☐	☐
Pathways of Recovery – Personal Journey	☐	☐	☐	☐	☐	☐

Medication for Opioid Use Disorder in Long-Term Care Program
LEARNING SESSION EVALUATION

Department of Public Health
Bureau of Health Care Safety & Quality

PRESENTER PERFORMANCE (continued)

6) (continued) Please indicate to what extent each presenter gave an effective talk and demonstrated thorough knowledge of the subject matter.

Presentation:	Presentation Style			Knowledge of Subject		
	Effective/ Complete	Partially Effective and/or Complete	Ineffective and/or Incomplete	Effective/ Complete	Partially Effective and/or Complete	Ineffective and/or Incomplete
Understanding OUD	☐	☐	☐	☐	☐	☐
An Overview of Medications to treat OUD	☐	☐	☐	☐	☐	☐
Approaches to Delivering Person-Centered Care	☐	☐	☐	☐	☐	☐
Overview of Community Resources	☐	☐	☐	☐	☐	☐
Implementation of the MOUD Toolkit	☐	☐	☐	☐	☐	☐
Leaving in Action	☐	☐	☐	☐	☐	☐

OVERALL SATISFACTION

7) Please rate your overall satisfaction with the following:

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
Presentations and shared learning	☐	☐	☐	☐
The faculty selection and location	☐	☐	☐	☐

8) Please rate your reaction to the statement: "This learning session was a valuable use of my time." (*)

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

9) Please share what else would be useful to help you and your team be successful with your program:

_____

_____

_____

10) The audience was informed on the absence of any conflict of interest. (*)

☐ Yes ☐ No

11) The speakers did not show commercial bias in the presentation. (*)

☐ Agree ☐ Disagree (please explain): _____

Thank you for your feedback! Please return this evaluation to the registration table.

Appendix K: Project Echo® Series Evaluation Form

Healthcentric Advisors

Project ECHO®: Taking a Collaborative Approach to Integrating Care for Residents on Medication for Opioid Use Disorder (MOUD) in Long-Term Care Facilities (LTCFs)

Session Evaluation, All 6 Sessions

1) Attendee contact information:

Name: _____
Title:
Organization: _____
Address 2:
City/Town: _____
State/Province: _____
Zip/Postal Code: _____
Email address: _____
Phone Number: _____

2) Please select which continuing education credits you are seeking:

☐ CEUs (nursing) ☐ CEs (social work) ☐ CEs (administrators) ☐ None

3) Knowledge gained: as a result of this activity I was/will be able to:

	Agree	Disagree
1. Review current telehealth guidelines and identify one-way telehealth impacts medication for opioid use disorder management.	☐	☐
2. Identify two key steps in the transition process from hospital to long term care facilities (LTCFs) for residents on medication for opioid use disorder, that well help establish necessary communication between LTCFs and Opioid Treatment Program/Office Based Opioid Treatment.	☐	☐
3. Define one best practice to aid in communicating with your Opioid Treatment Program/Office Based Opioid Treatment in caring for your residents on medication for opioid use disorder.	☐	☐
4. Summarize one example of how to address social determinants of health at your facility around transportation.	☐	☐
5. Provide one example of how to address social determinants of health at your facility around housing.	☐	☐
6. Interpret how Bureau of Substance Abuse Service regulations fit into caring for your residents with an opioid use disorder.	☐	☐
If you disagree, please explain: _____ _____		

4) Speaker Feedback: Please indicate to what extent each presenter gave an effective talk

	Very Effective	Effective	Neutral	Partially Effective	Ineffective
Didactic	☐	☐	☒	☐	☐
Case Presentations	☐	☐	☐	☐	☐
Recommendations	☐	☐	☐	☐	☐

Comments:

_____

5) You just completed the [insert type of CEU seeking] specific portion of the evaluation. Are you seeking additional types(s) of educational credits?

6) Learning Objectives: As a result of this activity, I was/will be able to (specific to each session topic):

	Agree	Disagree
Review	☐	☐
Interpret	☐	☐
Discuss	☐	☐

7) Did this course provide:

	Yes	No
Appropriate instruction for your education, experience, and licensure level?	☐	☐
Relevant and current instruction for your professional practice?	☐	☐
Suitable and/or useful instructional materials?	☐	☐

8) Were the instructors:

	Yes	No
Knowledgeable in the subject matter and responsive to participants?	☐	☐
Clear and effective in presenting the subject matter?	☐	☐
Able to utilize technology to support participant learning?	☐	☐

9) Were you satisfied with the:

	Yes	No
Technology/Location?	☐	☐
Administration of the Program?	☐	☐
Timeline of the course (was it as advertised)?	☐	☐

10) The audience was informed on the absence of any conflict of interest.

☐ Agree ☐ Disagree

11) The speakers did not show commercial bias in the presentation.

☐ Agree ☐ Disagree (please Explain):_____

12) Participating in this ECHO session was a valuable use of my time.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

13) Please share what else would be useful to you and your team to help you be successful with your program.

_____

_____

Thank you for your feedback!