MOUD
IN LONG TERM CARE

# The Care of Residents with Opioid & Stimulant Use Disorders in Long-Term Care Settings

**Supporting the Care Needs of Individuals in Long-Term Care Facilities (LTCFs)**

COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
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**Massachusetts Department of Public Health**
Bureau of Health Care Safety & Quality
www.mass.gov/dph/bhcsq

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## Introduction

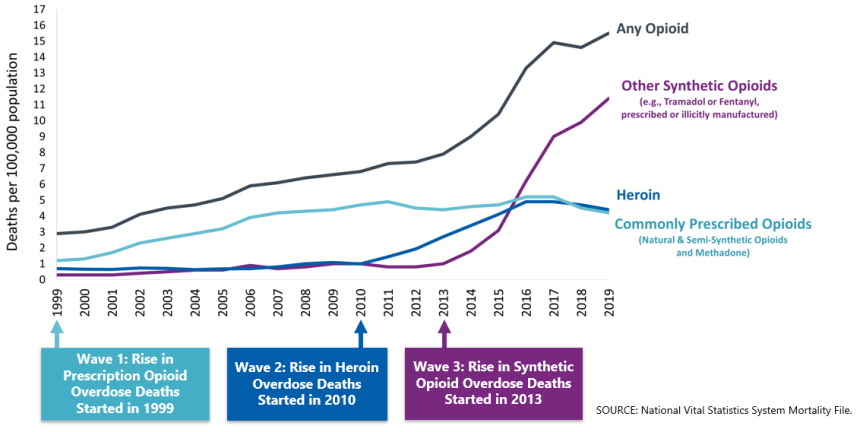
### Background

Opioid use disorder (OUD) affects people of all ages, races, ethnicities, income levels, and geographic regions. Since 2016, OUD decreased from 2.0 million in 2018 to 1.6 million in 2019.[1] Solutions that helped initiate this decrease include increased access to medication for opioid use disorder (MOUD), along with the establishment of psychosocial and community recovery support groups.[2] However, with this decrease in cases across the country, opioid-related deaths in Massachusetts have remained consistently high from 2016 to 2020—2,102 and 2,104 (estimated), respectively.[3] Nationally, older adults, in particular, may be at risk for opioid misuse, and, in 2018, 25% of adults who were 65 years of age and older had at least one opioid prescription filled.[4]

Further, nationally in 2020, there were 1,895 opioid-related overdose deaths where a toxicology screen was available. Findings show that cocaine was present in approximately 40% of opioid-related deaths, and amphetamines were present in about five percent.[5] The rate of deaths involving cocaine (a stimulant) and opioids increased substantially from 2009 to 2019 in the U.S., with the highest percentage of deaths found in the Northeast.[6] Approximately 22,200 Massachusetts clients received MOUD in opioid treatment programs (OTPs) and another 11,600 in office-based opioid/addiction treatment (OBOT/OBAT) clinics.[7] Medicaid enrollees with OUD and other substance use disorders (SUD) were significantly less likely to receive MOUD than those with OUD only.[8] Best practices for the care and treatment of co-occurring opioid and stimulant use in long-term care settings are not currently widely established. Therefore, an unexpected hospitalization followed by a transfer to a long-term care facility (LTCF) poses challenges to the continuity of care for these patients.

Stimulant use disorder (StUD) is also on the rise. Amphetamines and other stimulants are the second most widely used class of illicit drugs globally after cannabis.[9] Deaths involving psychostimulants, including cocaine and methamphetamines, and illicitly manufactured fentanyl contributed to recent increases in stimulant-involved overdose deaths. The specific drugs and drug combinations involved in overdose deaths have implications for SUD treatment regimens and outcomes, overdose prevention strategies (e.g., avoidance of using drugs alone), and overdose response. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), naloxone effectively reverses overdoses where opioids are present in combination with other sedatives or stimulants. Naloxone does not work on overdoses where the only substance present is benzodiazepines. Naloxone effectively treats only opioid overdoses; however, other substances, such as fentanyl, may contain opioids. In this case, naloxone should be administered. Naloxone has no effect on someone who does not have opioids in their system.

*Figure 1: Four Waves of the Rise in Overdose Deaths*

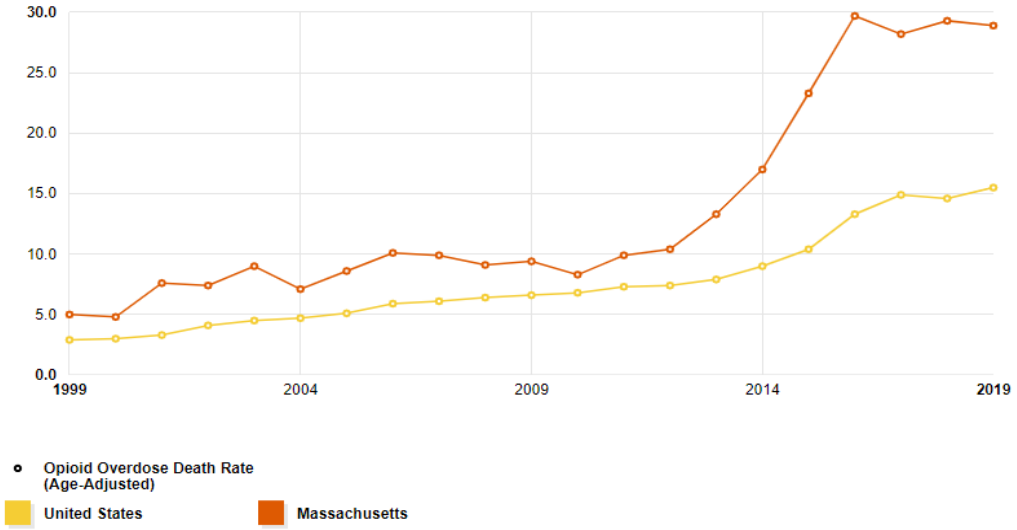



SOURCE: National Vital Statistics System Mortality File.

Historically, there have been four waves of opioid overdose deaths in the U.S.: first, a rise in prescription and non-prescription opioid deaths, then a rise in heroin-related deaths, and now, a rise in synthetic opioids (e.g., fentanyl) deaths. These national trends have been reflected in Massachusetts (Figure 1).

Data from 2019 shows a decline in overdose deaths, due in part to an expansion of life-saving emergency naloxone and expanded access to MOUD (Figure 2[10]). Preliminary data from 2020, however, is showing a 5% increase in opioid–related overdose deaths in Massachusetts.[11]

*Figure 1: Age-Adjusted Opioid Related Death Rate by Year per 100,000 People*




According to the Centers for Disease Control and Prevention (CDC), 28 people die every day from overdoses involving psychostimulants. Between February 2019 and February 2020, Massachusetts was one of four states, including Washington, New York, and Florida, with a significant increase in suspected all-stimulant overdoses.[12] In 2018, there were over 27,000 stimulant overdose deaths, which is roughly 40% of all overdose deaths in the United States.

According to SAMHSA and the National Institute on Drug Abuse (NIDA), addiction is a chronic, treatable illness requiring continuing care for effective treatment. Like other chronic diseases, addiction often involves cycles of relapse and remission. In 2018, an estimated 2 million Americans had OUD, but only 26% received any addiction treatment.[13]

MOUD, as defined in the next section, is an evidence-based life-saving treatment for OUD, which supports long-term recovery. In 2017, 22,200 Massachusetts residents received MOUD in OTPs and another 11,600 via OBOTs/OBATs. Of the Massachusetts OTPs, 27% offer programs specific to the older adult population. Access to MOUD has been and continues to be, expanded. Emergency orders during the coronavirus disease (COVID-19) pandemic lifted the training requirements for eligible providers to prescribe buprenorphine. They also expanded access for support through telehealth.

For residents with OUD or StUD, a stay in a LTCF can pose challenges for continuous care. The Massachusetts Department of Public Health (MDPH) issued a circular letter[14] in 2016 asserting that LTCFs must provide MOUD to residents who require such treatment and who are otherwise eligible for admission. Failure to provide MOUD to people with OUD is a violation of the Americans with Disability Act. This toolkit will assist your efforts to care for residents diagnosed with OUD and StUD while addressing timely coordination of care among OTPs, OBOTs/OBATs, hospitals, and LTCFs.

# Management of Opioid and Stimulant Use Disorders

## Treatment for Opioid Use Disorder

Like other chronic diseases, medications are central to the treatment of OUDs. People with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment.[15] The U.S. Food and Drug Administration (FDA) has approved three types of medication for the treatment of OUD:

- naltrexone (Vivitrol®)
- buprenorphine (Subutex®), buprenorphine/naloxone (Suboxone®), buprenorphine extended-release (Subclocade®)
- methadone

These medications block the effects of opioids; methadone and buprenorphine also normalize the brain chemistry and body function, suppress withdrawal, reduce opioid cravings, and significantly decrease opioid overdose mortality.[16,17] MOUD is an integral component of caring for patients diagnosed with OUD and is often combined with behavioral health counseling.

As with any other resident undergoing treatment for chronic disease, residents with OUD should have access to medications, individually tailored counseling, support services, and disease management care plans. If an individual is treated with methadone or buprenorphine and misses a dose, they may experience withdrawal symptoms. If not managed, withdrawal will make the resident more irritable, participate less in care, seek out opioids or other substances to treat their symptoms or leave against medical advice (AMA). If an individual is treated with extended-release naltrexone and misses a dose, there will be no withdrawal symptoms; rather, the resident may experience more cravings.

Additionally, stopping any of these medications has been shown to increase mortality as the individual's tolerance for opioids declines; if they return to use, they will have an increased risk of overdose.[18] Residents on MOUD should have consistent connections with their physicians and other licensed prescribers, OTP, or OBOT/OBAT to ensure no missed doses and that there are no stops to medications.

Here are two helpful videos that discuss MOUD in more detail.[19]

- Medication-Assisted Treatment Overview: Naltrexone, Methadone, and Suboxone[20] (5 minutes)
- Medication-Assisted Treatment[21] (10 minutes)

The table in Appendix 1 compares the different pharmacotherapy options for MOUD, including how they treat OUD, their side effects, and recommended safety precautions.

## Treatment for Stimulant Use Disorder

There are no FDA-approved medications to treat StuD, although research is ongoing. Psychostimulants, n-acetylcysteine, opioid agonist therapy, disulfiram, and antidepressant pharmacological interventions were found to have insufficient evidence to support or discount their use.[22] Current pharmacological treatment options focus on patients' ongoing withdrawal symptoms, such as medications for sleep, appetite stimulation, and psychiatric symptoms. Other treatment options for StUD include behavioral and psychosocial interventions and practices are listed below and in Exhibit 1.

**Exhibit 1: Treatment Options for Stimulant Use Disorder in Long-Term Care Settings**

| Evidence-Based Treatments | Description of Treatment | Details |
|---|---|---|
| **Contingency Management** | Provides incentives (money, gift cards, motivational encouragement, etc.) for treatment attendance and expected urine toxicology screens. Strong evidence. Contingency management is grounded in classical and operant conditioning theory and can be offered in various settings (some programs have adapted to be web-based). A variety of providers can deliver, meaning having a clinical background is not necessary. It has been used successfully for individuals with co-occurring OUD. | ▪ Yes, training is available.<br>▪ No prescribed intensity and duration.<br>▪ Typically a duration of 12-weeks. |
| **Motivational Interviewing** | Resolving clients' ambivalent feelings and insecurities and enhancing the internal motivation need to change behavior.<br>Strong evidence. Motivational interviewing can be used by clinical and non-clinical providers (e.g., peers) with little or no training in counseling or therapy. It is effective in various settings and can be provided in a single or multiple sessions. | ▪ Yes, training is available.<br>▪ No prescribed intensity and duration. |
| **Exercise Supported Recovery** | There are varying exercise programs, but those with a combination of daily aerobic and anaerobic exercise are associated with a positive correlation for long-term recovery. | ▪ No training is available.<br>▪ Intensity and duration are based on the physical limitations of the individual resident. |
| **Trauma-Informed Care Seeking Safety** | A therapeutic model for treating co-occurring post-traumatic stress disorder and SUD that emphasizes the need to be safe to explore and cope with trauma. It can be done in group or individual sessions. | ▪ Yes, training is available.<br>▪ Duration and intensity varies based on the target population. |
| **Community Reinforcement Approach** | It is identifying behaviors that reinforce stimulant use and making a substance-free lifestyle more rewarding than one that includes substances.<br>Strong evidence. Community reinforcement approach is often used in conjunction with contingency management. It is generally provided in inpatient settings or during home visits, although used successfully in outpatient settings. Best provided by clinical staff with solid counseling skills. | ▪ Yes, training is available.<br>▪ No prescribed intensity and duration.<br>▪ Recommended for 24 weeks. |
| **Cognitive Behavioral Therapy** | Helping clients improve the quality of their lives not by changing their circumstances but by altering perceptions of those circumstances. Strong evidence. It is a psychotherapy treatment provided in various settings, administered by professionals trained in CBT principles. National training is available to mental health professionals and non-professionals with a 4-year college degree. | ▪ Yes, training is available.<br>▪ No prescribed intensity and duration.<br>▪ Typically a duration of 5-10 month. |

Source: This was modified from the Substance Use and Mental Health Services Administration (SAMHSA) Evidence-Based Resource Guide Series, Treatment of Stimulant Use Disorders and from the Boston Medical Center Office-Based Addiction Treatment Training and Technical Assistance presentation, Introduction to Methamphetamines, presented to the Lynn Health Center, May 10, 2021.

## Understanding Opioid Use Disorder and the Co-Occurring Use of Stimulants

National data shows there is an increase in the counts of deaths involving co-occurring use of opioids and stimulants.[23] Rates of first-time stimulant use have increased significantly since 2015, while the number of cocaine, and other psycho-stimulant related deaths have climbed sharply.[24] Cocaine use is highest among those aged 18-25 and methamphetamine use is highest among those aged 26-49.[25]

Overdose deaths that involve both opioids and stimulants can represent individuals who knowingly consumed both opioids and stimulants or individuals who consumed a stimulant that unknowingly contained an opioid. In 2018, 86% of deaths involving stimulants also involved opioids. The number of deaths involving stimulants without opioids declined by 4% between 2000 and 2015 and has remained relatively stable since. While stimulant-related deaths have increased since 2010, this increase is closely linked to the opioid overdose epidemic, specifically fentanyl. These data suggest that interventions that address stimulant use alone will not be sufficient to reduce stimulant-related deaths.[26]

The rate of overdose deaths involving stimulants and opioids is higher among males than females. The rate rose by 28% per year for males and 27% per year for females from 2010 to 2018. Understanding the gender breakdown and the risk that males experience is vital to inform gender-specific strategies to engage individuals who use both opioids and stimulants and those who primarily use stimulants. [27]

The rate of overdose deaths involving stimulants and opioids is currently highest among Hispanic residents (12.3 per 100,000). The rate among Hispanics increased by 36% per year from 2012 to 2018. The rate among non-Hispanic whites increased 35% per year from 2010-2015, and the rate among non-Hispanic blacks increased 31% per year from 2012-2018. Over time, understanding who is at most significant risk by race and Hispanic ethnicity allows us to best focus prevention programs and treatment resources to address population-specific needs. [28]

For a variety of reasons, the lesbian, gay, bisexual, transgender, queer, intersex, asexual, gender-diverse, or those who identify on the spectrum of sexuality or gender identity (LGBTQIA+) community is disproportionately affected by SUD. In a 2015 national survey on drug use, LGBTQIA+ people were far more likely to misuse prescription pain relievers and showed a three times greater risk of OUD. When initiating MOUD in this population, it is essential to note that medications such as methadone and buprenorphine have known interactions with certain antiretroviral and hormone modulating medications, which may unnecessarily deter some individuals from seeking treatment. Co-prescribing, particularly buprenorphine, is safe with appropriate clinical monitoring and follow-up.[29]

## Using This Toolkit

This toolkit outlines six tips to help your LTCF care for your residents with OUD and the co-occurring use of stimulants. Administrators, directors of nursing (DON), medical directors, social workers, nurses, and certified nursing assistants (CNA) can all use these resources. This toolkit will help you comply with state and federal policies and provide evidence-based care to residents with OUD and StUD. Each tip has a list of suggested policies, processes, and educational resources to help your LTCF be better prepared to work with and provide continuity of care to those residents. Finally, in the appendices you will find a table of pharmacotherapy options, process maps for transitions of care, and template forms.

**Tip 1: Understanding Opioid Use Disorder and Stimulant Use Disorder**

**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**

# Tip 1: Understanding Opioid and Stimulant Use Disorders

## Description

The National Institute on Drug Abuse (NIDA) defines addiction as a "complex but treatable condition."[30] LTCFs can create supportive care environments by better understanding OUD and StUD by considering the stigmas and myths, how they present, symptoms of withdrawal, and how to manage the conditions appropriately.

## Goal

This section aims to help LTCF staff create a supportive care environment by understanding OUD and StUD and how dispelling stigmas and myths can foster better care for residents.

## Objectives

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

- Understand OUD and StUD, the underlying causes, spectrum of disease severity, the biological effects, and how residents present clinically.
- Recognize the stigma of addiction.
- Dispel misconceptions about persons with OUD and StUD.

## Policies

- Incorporate harm-reduction principles throughout your organization and in existing policies.
- Incorporate a section on OUD and StUD into your internal discrimination policy to reduce stigma and foster a positive culture that ensures staff sees 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.
- Understand and differentiate between opioid withdrawal and the symptoms and effects of stimulant withdrawal to support the resident.
- Develop policies regarding naloxone administration.

## Presentation, Diagnosis, and Symptoms of Withdrawal

To best care for those with OUD and StUD, it is important to understand the presenting behaviors associated with these two disorders while ensuring resident safety throughout the process.

It is also essential to understand that some residents may have a co-occurrence of both OUD and StUD. While treatment for each of these disorders is different, it is important to take a holistic approach. For example, employing MOUD with counseling and cognitive behavioral therapy and other evidence-based best practices is critical for residents with co-occurring OUD and StUD.

## Opioid Use Disorder

### Diagnosing Opioid Use Disorder

To be diagnosed with an OUD, a person must have experienced two or more of the following criteria within a 12-month period.

| Criteria for OUD Diagnosis: | |
|---|---|
| **1.** | Opioids are often taken in larger amounts or over a longer period than was intended. |
| **2.** | There is a persistent desire or unsuccessful efforts to cut down or control opioid use. |
| **3.** | A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects. |
| **4.** | Craving, or a strong desire or urge to use opioids. |
| **5.** | Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home. |
| **6.** | Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. |
| **7.** | Important social, occupational, or recreational activities are given up or reduced because of opioid use. |
| **8.** | Recurrent opioid use in situations in which it is physically hazardous. |
| **9.** | Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. |
| **10.** | Exhibits tolerance (*note: alone, not enough to diagnose an OUD. Not considered to be met for individuals taking opioids solely under appropriate medical supervision*). |
| **11.** | Exhibits withdrawal (*note: alone, not enough to diagnose an OUD. Not considered to be met for individuals taking opioids solely under appropriate medical supervision*). |

Source: American Psychiatric Association (on. (n.d.). Retrieved from Opioid Use Disorder Diagnostic Criteria

### Presenting with Opioid Use Disorder

Opioids are a class of drugs, including pain relievers available legally by prescription, the illegal drug heroin, and synthetic opioids such as fentanyl. These drugs bind to and activate opioid receptors on cells located in the brain, spinal cord, and other regions in the body. When opioids attach to the receptors, they block pain signals sent from the brain to the body and release large amounts of dopamine. Opioids make people feel relaxed or "high." They also cause drowsiness, confusion, nausea, constipation, euphoria, and slowed breathing.[31]

Residents presenting with an OUD may appear acutely intoxicated, in opioid withdrawal, or show no acute effects related to their opioid use.[32] If a patient is in active withdrawal, LTCF staff should follow the regulatory restrictions outlined in 105 CMR Section 150.003: Admissions, Transfers, and Discharges on managing active withdrawal. Many health-related consequences may accompany residents presenting with OUD, including infection, opioid-induced bowel syndrome, opioid-induced hyperalgesia, motor-vehicle accidents, opioid amnestic syndrome, overdose, and possibly death.[33]

## Symptoms of Opioid Use Disorder Withdrawal

Individuals with OUD may experience cravings, withdrawal, or difficulty in controlling pain. Most of your facility's residents with OUD will already be on MOUD, but they will require additional evaluation by the appropriate provider for dose adjustments. Other residents may have been undiagnosed or diagnosed OUD but have other indications for acute opioid analgesia; monitor these residents for drowsiness, sedation, and overdose. Ask residents about symptoms in non-judgmental ways and develop person-centered plans to optimize resident safety and reduce harm.

To do this, your behavioral health services (contracted or non-contracted) should conduct an assessment, then conference with the physician and physician assistant to determine the appropriate care plan. If the resident connects with an OTP or OBOT/OBAT, include them in the conversation and development of the care plan.

Symptoms of opioid withdrawal can include:[34]

- Nausea, vomiting, diarrhea
- Anxiety
- Insomnia
- Hot and cold flushes
- Perspiration
- Muscle cramps
- Watery discharge from eyes and nose

Use the COWS to determine the stage or severity of opiate withdrawal (Exhibit 2). The COWS score will help determine the next steps in caring for your resident. Add a decision tree into your LTCF policy based on COWS scores (5-12= mild; 13-24= moderate; 25-36= moderately severe; 36= severe withdrawal). Always communicate with the resident's physician, OTP, or OBOT/OBAT regarding suspected withdrawal symptoms and COWS score to determine the next steps and when or if the resident should go to a higher level of care.

**Exhibit 2: Clinical Opiate Withdrawal Scale**

**Resting Pulse Rate:** _____ beats/minute
*Measured after patient is sitting or lying for one minute*

- **0** pulse rate 80 or below
- **1** pulse rate 81-100
- **2** pulse rate 101-120
- **4** pulse rate >120

**GI Upset:** *over last 1/2 hour*

- **0** no GI symptoms
- **1** stomach cramps
- **2** nausea or loose stool
- **3** vomiting or diarrhea
- **5** multiple episodes of diarrhea or vomiting

**Sweating:** *over past 1/2 hour not accounted for by room temperature or patient activity.*

- **0** no report of chills or flushing
- **1** subjective report of chills or flushing
- **2** flushed or observable moistness on face
- **3** beads of sweat on brow or face
- **4** sweat streaming off face

**Tremor:**
*observation of outstretched hands*

- **0** no tremor
- **1** tremor can be felt, but not observed
- **2** slight tremor observable
- **4** gross tremor or muscle twitching

**Restlessness:** *Observation during assessment*

- **0** able to sit still
- **1** reports difficulty sitting still, but is able to do so
- **3** frequent shifting or extraneous movements of legs and/or arms
- **5** unable to sit still for more than a few seconds

**Yawning Observation** *during assessment*

- **0** no yawning
- **1** yawning once or twice during assessment
- **2** yawning three or more times during assessment
- **4** yawning several times per minute

**Pupil Size**

- **0** pupils pinned or normal size for room light
- **1** pupils possibly larger than normal for room light
- **2** pupils moderately dilated
- **5** pupils so dilated that only the rim of the iris is visible

**Anxiety or Irritability**

- **0** none
- **1** patient reports increasing irritability or anxiousness
- **2** patient obviously irritable or anxious
- **4** patient so irritable or anxious that participation in the assessment is difficult

**Bone or Joint Aches:**
*If patient was having pain previously, only the additional component attributed to opioid withdrawal is scored*

- **0** not present
- **1** mild diffuse discomfort
- **2** patient reports severe diffuse aching of joints or muscles
- **4** patient is rubbing joints or muscles and is unable to sit still because of discomfort

**Gooseflesh Skin:**

- **0** skin is smooth
- **3** piloerection of skin can be felt, hairs standing up on arms
- **5** prominent piloerection

**Runny Nose or Tearing:**
*Not accounted for by cold-symptoms or allergies*

- **0** not present
- **1** nasal stuffiness or unusually moist eyes
- **2** nose running or tearing
- **4** nose constantly running, tears streaming down cheeks

**Total Score** _____
*The total score is the sum of all 11 items*
Initials of person completing assessment: _____

**Score:**

- **5-12** = mild
- **13-24** = moderate
- **25-36** = moderately severe
- ➢ **36** = severe withdrawal

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

## Signs of Opioid Overdose and What to Do if You Suspect an Overdose

Signs of an overdose include:

- Nonresponsive to voice or sternal rub
- Pulse slow, erratic, or absent
- Breathing slow, irregular, or has stopped
- Grey or lighter lips and fingertips for dark skinned individuals, blue lips and fingertips for light skinned individuals
- Limp and pale
- Small, pin-point pupils

If you suspect a resident has overdosed, follow guidelines from the SAMHSA Opioid Overdose Prevention Toolkit.[35]

Residents cannot go through acute withdrawal in LTCFs. Transfer resident to hospital after administering naloxone.

| DO | DON'T |
|---|---|
| Attend to the person's breathing and cardiovascular support needs by administering oxygen or performing rescue breathing and/or chest compressions. This is the most critical step and should be continued until Emergency Medical Services (EMS) arrives. | Slap or forcefully try to stimulate the person; it will only cause further injury. If you cannot wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, the person may be unconscious. |
| Administer naloxone and use a second dose if no response to the first dose. | Put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock. |
| Put the person in the "recovery position" on the side, if you must leave the person unattended for any reason. | Inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is naloxone. |
| Stay with the person and keep the person warm. | Try to make the person vomit drugs that may have been swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury. |

# STOP AN OVERDOSE

## TAKE THESE STEPS:

1. Check for overdose
2. Call 9-1-1
3. Give Narcan®
4. Give breaths
5. Stay until help arrives

## 1 CHECK FOR OVERDOSE

Signs of overdosing:
- Not breathing well
- Turning blue/gray
- Not reacting when you rub your knuckles on their chest

## 2 CALL 9-1-1

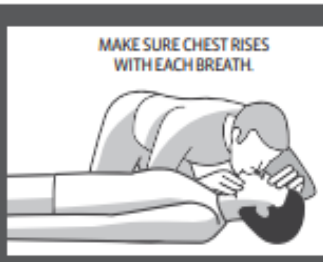
- Call 9-1-1
- Say "someone isn't breathing" and/or "I think it's an overdose"
- Stay until help arrives, even if they seem better*

## 3 GIVE NARCAN®

- Push pump only after tip is in nose
- Go to Step 4
- If no response in 3 minutes, give another dose

## 4 GIVE BREATHS/CPR

- Make sure mouth is clear
- Tilt head back, lift chin, pinch nose
- Give 1 breath every 5 seconds
- Try CPR if you've been trained




## 5 STAY UNTIL HELP ARRIVES

- If breathing well, put on side
- If not breathing well, repeat Steps 3 and 4
- Stay until help arrives*

**HelplineMA.org**
800-327-5050

**mass.gov/narcan**

*Good Sam Law protects people who overdose or seek help for someone overdosing from being charged or prosecuted for simple drug possession.

Source: www.mass.gov/narcan, visit for Spanish version

## Case Study: Opioid Use Disorder

Managing residents who have OUD requires attentive care from physicians and other providers due to the complexity of their disorders. An individualized treatment plan is necessary to provide the resident with a patient-centered approach to proper care. Below we present a case example of a man prescribed opioids for a back injury (adapted from CDC Guidelines for Prescribing Opioids for Chronic Pain[36]). Following the scenario is a set of questions for you to consider.

### Identifying DSM-5 OUD Criteria Scenario 1: Resident Chart

Nelson, John, DOB: 4/11/1984

- Medical history: Lower back pain that began after a fall at work three years ago; lifting heavy objects at work exacerbated the injury; currently takes extended-release morphine 45 milligrams twice daily to treat pain.
- Prescription drug monitoring program (PDMP) data does not show any additional controlled substance prescriptions other than the extended-release morphine prescription described above.
    - [Doctor] Hi John, it's nice to meet you. I see you recently moved to the area, and you are looking to establish care. Can you tell me what is going on?
    - [Resident] Well, I had a fall at work a few years ago and I've been taking pain medications for it, but they've run out. Since I ran out, I've had some really bad nausea and diarrhea, and I feel really achy. I've run out of my pain medications before, and I felt the same way. I have tried to cut down on the amount of pills I take so that I can get to my next refill, but I need more pills to make these symptoms go away.
    - [Doctor] Okay, can you tell me more?
    - [Resident] I am currently taking 45 milligrams of extended-release morphine twice a day, but it doesn't seem to be working and I feel I need a bigger dose. In fact, I've had to skip work several times because my symptoms get so bad after running out of my medicine.
    - [Doctor] Have you tried any methods for pain relief that didn't involve opioids?
    - [Resident] My prior doctor recommended I try working some regular exercise into my day and even try things like yoga and acupuncture, but that's just not for me so I haven't done it. Ibuprofen just didn't cut it either.

### Identifying DSM-5 OUD Criteria Scenario 1: Check Your Knowledge

Based on the information shared so far, is it correct to suspect John meets the criteria for OUD?

- Yes
- No

Yes, based on the information John shared, OUD should be suspected. He has met two or more of the DSM-5 criteria within a year:

- He has taken the opioids longer than intended.
- He has tried unsuccessfully to cut down or control opioid use.
- His opioid use seems to be resulting in his being unable to function at work.

*In this scenario, not all the OUD criteria were assessed. Further discussion at this appointment and during future visits should assess whether he meets additional criteria suggesting moderate (4-5 criteria) or severe (6 or more criteria) OUD.*

## Stimulant Use Disorder

### Diagnosing Stimulant Use Disorder

Diagnosis of a StUD is based on the occurrence of at least two of the following within a 12-month period.[37]

| Criteria for StUD Diagnosis: | | | |
|---|---|---|---|
| **1.** | Taking more stimulants than intended. | | |
| **2.** | Failing to cut down or control use of stimulants, despite wanting to do so. | | |
| **3.** | Spending excessive amounts of time in activities surrounding stimulant use. | | |
| **4.** | Experiencing urges and cravings for stimulants. | | |
| **5.** | Failing to meet the obligations of home, school, or work. | | |
| **6.** | Continuing to take stimulants, even if it has led to relationship or social problems. | | |
| **7.** | Giving up or reducing important recreational, social, or work-related activities because of stimulant use. | | |
| **8.** | Using stimulants in situations in which it is physically hazardous. | | |
| **9.** | Continuing to use stimulants even if there is an awareness that it is causing or worsening a physical or psychological problem. | | |
| **10.** | Experiencing an increase in tolerance to stimulants. | | |
| **11.** | Having withdrawal symptoms when not taken. | | |
| ***Severity Scale:*** | *Mild if 2-3 symptoms* | *Moderate if 4-5 symptoms* | *Severe if >6 symptoms* |

### Presenting with Stimulant Use Disorder

Stimulants are substances that affect the central nervous system through their ability to cause an increase in dopamine throughout the body.[38] When consumed, stimulants have the effect of causing a sense of euphoria, make a person more alert, and may increase one's energy.[39] Furthermore, stimulants can also affect a person's physiological processes by causing an increase in heart rate, breathing, and blood pressure.[40] Typical and prominent stimulants include cocaine, methamphetamine, and prescription stimulants (amphetamine, methylphenidate).[41]

Residents who have used stimulants may exhibit behavior changes, agitation, paranoia, increased energy, and fast breathing. For illegal stimulants, like other substances, there are different modes of administration. Residents who inject stimulants may present with skin or bacterial infections. Residents who snort stimulants may present with sinus infections or nosebleeds. Residents who smoke stimulants may present with chronic coughing, wheezing, or shortness of breath. The symptoms and effects of stimulants may present differently depending on the person.[42] To optimize resident safety and reduce harm, ask residents about their symptoms in non-judgmental ways, and develop person-centered plans.[43]

### Symptoms of Stimulant Use Disorder Withdrawal

If a resident is in active withdrawal, LTCF staff should follow the regulations outlined in 150.003: Admissions, Transfers, and Discharges, on managing active withdrawal. In stimulant withdrawal, the resident may experience fatigue, insomnia, depression, and anxiety, or minimal effects related to their stimulant use.[44]

People using stimulants for a sustained period may become distressed or agitated, which may progress to include symptoms that resemble psychosis. Acute stimulant intoxication may result in the person presenting as a danger to themselves or others.[45] Symptoms may include auditory, visual, and hallucinations, delusions, and paranoia.[46] Physical symptoms may include rapid heart rate, elevated body temperature and shortness of breath. There is no validated withdrawal scale.[47] Taking more stimulants than the body can handle can result in cardiac arrest or stroke.

Care should focus on comfort and de-escalation. De-escalation starts with ensuring a safe, calm space, and safety. Designate one person to interact with the resident calmly and reassuringly.

| ***Ten Domains of De-escalation*** | |
|---|---|
| 1. Respect personal space | 6. Listen actively and respond appropriately |
| 2. Do not be provocative | 7. Agree or agree to disagree |
| 3. Establish verbal contact | 8. Lay down the law and set clear limits |
| 4. Be concise | 9. Offer choices and optimism |
| 5. Identify wants and feelings | 10. Debrief the patient and staff. |

Source: Richmond JS, Berlin JS, Fishkind AB, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med. 2012;13(1):17-25.

When danger to self or others persists despite de-escalation efforts, involve psychiatric crisis services if applicable or transfer the patient to the emergency room.[48]

To do this, have an assessment conducted by your behavioral health services (contracted or non-contracted), who should then conference with a provider to determine the appropriate care plan. If the resident works with a behavioral health program, include it in the coordination of the care plan. Some of the most common stimulant withdrawal side effects and symptoms include:

- Fatigue and increased need for sleep
- Increased appetite
- Anhedonia
- Slowed reaction and movement
- Aches and pains
- Mood lability
- Depression
- Suicidal ideation

Like opioid withdrawal, if you suspect a resident is experiencing stimulant withdrawal, communicate with the resident's physician or other providers to determine the next steps, if or when the resident should go to a higher level of care.

## Signs of Stimulant Overamping and What to Do if You Suspect Overamping[49]

Overamping is a term used to describe an overdose of a stimulant, such as cocaine, speed, and methamphetamine. Overamping can occur regardless of amount used or length of use. Overamping can happen when the body feels run down, sleep deprivation, or when stimulant is taken with other drugs.

Signs and symptoms of overamping[50] include:

- Paranoia, anxiety, panic
- Hallucinations
- Psychosis
- Increased heartrate/chest pain
- Increased sensory awareness
- Hyperthermia
- Dilated pupils
- Grinding jaw or spastic movements

If you suspect a resident is experiencing stimulant overamping:

- Assess the scene
- Assess the resident
- Call 911
- Attempt to de-escalate the resident, if appropriate
- Stay with the resident until help arrives
- Should the resident become unresponsive, perform CPR until help arrives

## Case Study: Stimulant Use Disorder

An individualized treatment plan is required to provide the resident with person-centered care.

Below, we present a case example of a scenario, followed by a set of discussion questions.

**Case Study-Stimulant Use Disorder[51]**

43 year-old female patient presents to urgent care complaining of three to four week history of shortness of breath, fatigue, restlessness at night, and chest "pressure" that has been unrelenting for the past 12-hours.

Admitted from urgent care to the cardiovascular care unit for evaluation.

Day 1: Cardiac enzymes were cycled, and she ruled-out for an acute coronary syndrome. Echocardiogram (EKG) was performed.

Day 2: She underwent diuresis with furosemide infusion and was asymptomatic. Angiotensin-converting-enzyme (ACE)-inhibitor and beta-blocker therapies were started using lisinopril and carvedilol.

Day 3: Patient was clinically opti-volemic. Heart failure (HF) management program evaluated patient. Aldosterone antagonist therapy started with spironolactone. HF education was started and included discussion of methamphetamine use as cause of her cardiomyopathy. HF nutrition counseling provided by registered dietician.

Psychiatric/addictions care also evaluated patient. She refused inpatient and outpatient addiction treatment.

Day 4: Discharged to home in care of her son. To follow up in the heart failure clinic (HFC) in four days.

### Case Study-Stimulant Use Disorder[51]

#### Subsequent HFC Follow Up

- Patient seen weekly for next six weeks.
- Carvedilol titrated to 25 mg BID.
- Furosemide decreased to 40 mg daily overtime.
- Remained abstinent from methamphetamine (UDS negative) but started smoking again after eight weeks.
- Three months after HFC therapy was initiated, EKG was repeated: LV systolic function NORMAL. EF 72%.
- Two months after the echocardiogram, patient failed follow up with HFC.
- She did return for one visit at which she admitted that she used methamphetamine one time in the previous week after the death of her grandmother. She again refused addictions treatment/counseling.
- She has not returned to HFC since that visit.
- Multiple attempts have been made to locate and contact patient via telephone and mail. She has moved and all her emergency contacts reported not to know her whereabouts.

#### Discussion

- Consider methamphetamine (and cocaine) use when a person presents with new-onset heart failure associated with significant hypertension.
- Refusal to participate in clinical addictions recovery and counseling programs is common in people with SUD.
- Several studies have documented adverse effects of beta-blockade in patients with ongoing cocaine or amphetamine use. The hazard lies in the potential for deadly ventricular arrhythmias with unopposed beta-blockade concomitantly with amphetamine agents. Though no large-scale randomized studies exist, using alpha and beta-blocking agents (such as carvedilol) is widely felt to reduce this population's potential for adverse cardiac events.
- Methamphetamine-induced cardiomyopathy can be successfully treated with significant improvement in systolic function with a combination of abstinence from the drug and a medication regimen of beta-blocker, ACE-inhibitor, and aldosterone antagonist.
- The disease of addiction cannot be ignored. There is great potential for relapse. As addiction research shows, people with SUD are at risk of relapse and interruptions to therapeutic medication regimens.

## Opioid Use Disorder and Stimulant Use Disorder

### Prescribing Opioids and Stimulants

Physicians prescribe opioids for short durations to treat severe pain, often after surgery or an injury.[52] Prescription opioids increase the activity of dopamine in the brain.[53] People misuse opioids by taking more than prescribed, taking someone else's prescription, or taking the medication to become intoxicated.[54] They may also take the medication by crushing a pill to smoke, snort, or inject to get immediate effects.[55] Take particular caution when a person is prescribed an opioid and a benzodiazepine together. Taking both an opioid and a benzodiazepine can be unsafe because both medications have sedative properties that suppress breathing and impact cognitive functions.[56] And may lead to dependence, SUD, and other health issues, including hypoxia and neurological effects.

Patients diagnosed with attention deficit hyperactivity disorder (ADHD) and narcolepsy are commonly prescribed stimulant medications. Prescription stimulants increase the activity of dopamine and norepinephrine in the brain as well as alertness, attention, and energy.

People misuse stimulant medications by taking more than prescribed, taking someone else's prescription, or taking the medication to become intoxicated. They may also take the medication by crushing a pill to smoke, snort, or inject to get immediate effects. Stimulants increase alertness and create enhanced focus and can improve mental performance. There is prevalent use in teens and college students to improve focus, and productivity; older people may use stimulants to enhance memory or to lose weight. Dependence, SUD, and other health issues such as psychosis and heart problems may develop.

Some residents who develop OUD and/or StUD initially were prescribed these medications for medical needs such as pain, ADHD, and narcolepsy—balancing the approach to address the medical need while managing addiction can be challenging. Identifying alternative treatment methods (e.g., acupuncture or non-opioid medications) to care for residents should be part of the care plan.

## Talking with Residents about Opioid and Stimulant Use Disorders

Review the following videos from Boston Medical Center's Grayken Center for Addiction[57]:

- Challenging Patient Conversations
- Intersection of Pain and Addiction

Also consider using statements such as:

- "Trouble controlling opioid medication use makes it unsafe. The long-term risk, over time, is substantial."
- "The medicine prescribed to you for [pain, ADHD, or narcolepsy] became a problem. You developed a complication of therapy that we should not ignore."
- "Continuing the current medication is not a safe option due to the risks, but there are options for treating what we call OUD."
- "Sometimes people become too comfortable with medications and start to take them for reasons other than pain."
- "You meet the criteria for OUD, also known as OUD. It's helpful to put a name on it because it opens up a variety of approaches to help with your specific circumstance."
- "You developed what we call OUD and/or StUD. We have treatment for these conditions that can be integrated with your other healthcare needs."
- "Stimulants may be helpful for many people, but they can also cause harm in some individuals."

## Specific Strategies to Help Residents Understand Their Diagnosis

**Communication strategies**, approach residents with compassion, use statements such as:

- "Sometimes the medications that we use to treat one condition may cause issues in other ways. It is difficult to anticipate who will develop a SUD, but it can happen to anyone."
- "SUD is common, and long-term recovery is possible for everyone."
- "SUD can develop for a variety reasons: genetic differences, environmental factors, and differences in brain chemistry. They are not moral failings, but rather chronic medical conditions that can be treated. We can help you."
- "You are not alone. All kinds of people can have problems with stimulants."

**Relationship-building skills** include reflective listening and empathetic statements to destigmatize OUD and StUD diagnoses. Use statements such as:

- "I understand you have been struggling and know that discussing change can be distressing."
- "It is our goal to partner with you to become the healthiest you, as you see yourself in the long term."
- "Getting help for this is like getting help for any other chronic medical condition."
- "I want you to have the best possible care, and this difficult, but productive, conversation is a first step."

**Explain 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."

## Strategies for Managing Difficult Reactions

The table below provides examples of specific strategies to manage difficult reactions from residents with OUD or co-occurring OUD and StUD. Also please review Tip 3 for a trauma-informed care approach.

| Reactions | Management Strategy |
|---|---|
| The resident is anxious, agitated, or panicking. | • Approach the resident in a calm and confident manner.<br>• Reduce the number of people attending to the resident.<br>• Carefully explain any interventions and what is going on.<br>• Minimize the risk of self-harm. |
| The resident is confused or disoriented. | • Ensure the resident is frequently supervised.<br>• Explain to the resident where they are and what is happening. |
| The resident is experiencing hallucinations. | • Create a safe space and de-stimulate the environment (e.g., dimming lights and limiting noise pollution).<br>• Protect the resident from harming him or herself and others. |
| The resident exhibits anger or behavior that appears aggressive or agitated. | • Ensure that staff and other residents are protected and safe.<br>• When interacting with the resident remain calm and reassuring.<br>• Listen to the resident.<br>• Use the resident's name to personalize the interaction.<br>• Use calm open-ended questions.<br>• Use a consistent, even tone of voice, even if resident becomes hostile and shouts.<br>• Acknowledge the resident's feelings.<br>• Do not challenge the resident.<br>• Remove source of anger if possible. |

Source: World Health Organization. (2009). Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings, Table 2

## Address Stigma

The misconception that addiction is a choice poses challenges to effective care delivery. A Johns Hopkins University research study suggests people are more likely to have a negative attitude towards those with a drug addiction than those with a mental illness.[58] It is important to be aware of how stigma influences treatment of your residents. The Anti-Stigma Project characterizes stigma as a "pervasive and damaging influence on the quality of services, treatment outcomes, and therapeutic, professional, and personal relationships."[59]

On an organizational level, recognizing stigma and dispelling misconceptions of persons with OUD and StUD is an important first step in creating a supportive care environment. Examples of reducing stigma include changing language used at the facility, launching a campaign to raise awareness of the damaging effect of stigmatizing language, and suggesting alternative language. The table below provides examples of appropriate language to reduce stigma.

## 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, or in recovery |
| "Dirty" (Referring to a person} | In a period disease exacerbation or relapse |
| "Shooting up" | Injection |
| "Shooter" | Person who injects drugs |
| "Tweaker" | Person under the influence of methamphetamine |
| "Aggressive" | Person experiencing protective behaviors |
| "Delusional" | Person experiencing altered perception of reality |

Source: Adapted from the Boston Medical Center Grayken Center for Addiction, Reducing Stigma.

Resources to help reduce stigma among providers, staff, residents, families and resident representatives include:

- Impact of stigma videos:
  - Watch Stephanie's Story to see the impact of stigma on treatment (1 minute)[60]
  - Review "Misperceptions and the Misused Language of Addiction: Words Matter" (1 hour)[61]
- A Guide to Reducing Addiction-Related Stigma – Anti-Stigma Toolkit[62]
- Challenge myths associated with MOUD, infographic & videos (Figure 3)[63]

Many false assumptions also exist about MOUD that put residents with OUD at risk. Examples include methadone or other opioid agonists as a crutch, MOUD trades one addiction for another, and medications should be discontinued as soon as possible (Figure 3).

However, MOUD bridges the biological, and behavioral components of addiction and research has shown that persons on MOUD for at least one to two years have highest rates of long-term success.[64] It is important to recognize that "addiction is a chronic disease similar to other chronic diseases, such as type II diabetes, cancer, and cardiovascular disease."[65] Adapted from the National Council, Figure 3 illustrates common challenges to myths related to MOUD (formerly called medication-assisted treatment, MAT).

*Figure 3: Challenging the Myths Associated with Medication-Assisted Treatment (MAT)*

| | | |
|---|---|---|
| **MAT trades one addiction for another**<br>MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery. | **MAT is only for the short term**<br>Research shows that patients on MAT for at least one to two years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT. | **My patient's condition is not severe enough to require MAT**<br>MAT utilizes a multitude of different medication options (agonists, partial agonists, and antagonists) that can be tailored to fit the unique needs of the patient. |
| **MAT increases the risk for overdose in patients**<br>MAT helps prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. After detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. | **Providing MAT will disrupt and hinder recovery process**<br>MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery. | **There isn't any proof that MAT is better than abstinence**<br>MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, SAMHSA, National Institute on Alcohol Abuse and Alcoholism, CDC, and other agencies emphasize MAT as first-line treatment. |

## Harm-Reduction

"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on belief in, and respect for, the rights of people who use drugs."[66]

Below are examples adapted from the Harm Reduction Coalition of principles central to harm reduction practice. Organizations can implement harm reduction specific to individual, LTCF, and community needs tailored to the cultural and linguistic needs of the residents.

## Example: Harm-Reduction Principles

| This Facility… | | |
|---|---|---|
| Accepts drug misuse is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them. | Understands drug use is 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. |
| Ensures residents have a real voice in the creation of programs and policies designed to serve them. | Empowers people who use substances 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. |

Source: Harm Reduction Coalition. (2019). Retrieved from Principles of Harm Reduction

## Education and Resources

- GE Foundation and RIZE Massachusetts Foundation: Opportunities to Increase Screening and Treatment of OUD Among Healthcare Professionals Report[67]
- Harm Reduction Coalition: Harm-Reduction Principles[68]
- Boston Medical Center: Words Matter Pledge[69]
- World Health Organization: Clinical Guidelines for Withdrawal Management [70]
- American Psychiatric Association: Opioid Use Disorder[71]
- American Hospital Association and Centers for Disease Control and Prevention: Factsheet[72]
- American Academy of Family Physicians: Opioid Addiction[73]
- National Alliance on Mental Illness Anti-Stigma: Resources[74]
- Boston Medical Center: OBAT T/TA Training Calendar[75]
- SAMHSA Treatment for Stimulant Disorders: Manifestations of Stimulant Withdrawal/Abstinence[76]
- Harm Reduction Coalition: Stimulant Overamping Basics[77]
- Here to Help: Stigma and Discrimination[78]
- Appendix 13: Additional Resources

## Implementation: Key Points

| Tip 1: | Understanding Opioid Use Disorder and Stimulant Use Disorder |
|---|---|
| **Policies** | 1. Incorporate harm-reduction principles throughout your organization and within your existing policies.<br>2. Incorporate a section on OUD and StUD into your internal discrimination policy to reduce stigma and foster a positive culture that strives to ensure that staff see addiction as a medical condition.<br>3. Integrate COWS to identify opioid withdrawal and guide the care of residents.<br>4. Develop policies regarding naloxone administration. |
| **Interventions** | ***Topic and Potential Staff*** |
| *Addressing Stigma* | ☐ **Director of Nursing or Administrator**<br>▪ Develop an assessment of staff perceptions of OUD, MOUD, and StUD.<br>▪ Post anti-stigma posters for staff, residents, and family to view.<br>☐ **All Staff**<br>▪ Show Stephanie's Story.<br>▪ Review Misperceptions and Misused Language of Addiction: Words Matter (1 hour).<br>▪ Review myths associated with OUD, MOUD, and StUD. |
| *Harm-Reduction Principles* | ☐ **Director of Nursing, Administrator, or Champion**<br>▪ Develop and incorporate harm-reduction principles that are relevant to your organization. Visit the National Harm Reduction Coalition for help.<br>☐ **All Staff**<br>▪ Review potential scenarios with staff, see page 14 and page 17 for information. |
| *Understanding how OUD and StUD Presents and Screening* | ☐ **All Staff:**<br>▪ Review American Psychiatric Association criteria.<br>▪ Review SAMHSA Treatment for StUD criteria.<br>▪ Review CDC case example.<br>▪ Review BMC videos to learn how to talk with a resident about OUD. |
| *Recognize Symptoms of Withdrawal* | ☐ **Clinical Nurse or Director of Nursing**<br>▪ Use COWS score to determine state or severity.<br>▪ Assess stimulant use and withdrawal severity.<br>▪ Follow organization protocols and alert hospital.<br>▪ Communicate with OTP or OBOT/OBAT. |
| *Managing Difficult Reactions* | ☐ **Nurse, Certified Nursing Assistant, or Activities Coordinator**<br>▪ Review World Health Organization Clinical Guidelines. |
| *What to do for a Suspected Overdose* | ☐ **All Staff**<br>▪ Review how to identify an opioid related overdose.<br>▪ Review emergency response for OUD and StUD.<br>▪ Responding to overamping.<br>☐ **Director of Nursing or Trainer**<br>▪ Conduct naloxone training with all staff. |
| **Regulatory Considerations** | Residents cannot go through acute withdrawal in LTCFs. The resident needs to be transferred to a hospital after naloxone administration. See page 10 and page 15 for information. |

# Tip 2: Creating a Therapeutic Environment

## Description

In today's environment, healthcare facilities are designed to give quality care through medicine and safety and fully accept the resident, family, and caregivers in a supportive therapeutic environment. The LTCF environment affects resident outcomes, satisfaction, safety, and staff efficiency, staff satisfaction, and organizational outcomes. In addition to the physical environment, facilities should consider the social climate, linguistic needs, and cultural aspects. It is important to develop a culture that accepts all residents and for LTCF staff to implement individualized, person-centered approaches to resident care.[79] See this short video on the Holistic Approach to Transformation Change (5 minutes). [80]

## Goals

This section aims to identify several interventions LTCF staff can implement to foster a therapeutic environment that meets both the linguistic and cultural needs of the residents.

## Objectives

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

- Define and interpret a therapeutic environment.
- Develop action steps to work towards implementing a therapeutic environment that is culturally and linguistically appropriate for all residents including those with OUD or StUD.
- Identify non-pharmacological approaches that support residents experiencing OUD and StUD.

## Policies

- Incorporate the development of a therapeutic environment into your existing orientation policies, including your residents' linguistic and cultural needs.
- Develop a policy on creating and involving a patient and family advisory council.

## Process

### Developing a Therapeutic Environment

Many LTCFs have already implemented a therapeutic environment in caring for residents with dementia. Therapeutic settings recognize and support all residents as individuals, regardless of their diagnosis. They also acknowledge that residents with dementia are particularly vulnerable to chaotic environmental influences, so they strive to minimize environmental stressors such as unnecessary noise, clutter, and chaos.

Any individual in your facility, including individuals with SUD, can apply this same principle. By focusing on individualized, flexible designs to support differing functional levels and approaches to care, you can provide a philosophy of care that puts the resident's needs and interests at the center. Organizational framework, care goals, and values shape an environment. Philosophies of care occupy a spectrum, from less help and intervention to more technical intervention.[81] Developing boundaries between staff and with residents is part of the therapeutic environment.

Examples of boundary setting include ensuring that staff limit the personal information shared with residents, avoid emotional reactions toward residents, avoid terms of endearment or nicknames with residents, manage their tone of voice, and refrain from favoritism towards residents.[82] See Tip 3 for details on how to develop your framework to support residents with OUD and StUD, such as developing mission and vision statements, staff training, and understanding the impact of trauma on residents.

Developing an environment that promotes well-being for residents with OUD and StUD include involvement of family (chosen, adopted, and biological), friends, and other caregivers, reduction of environmental stressors, development of a wellness orientation, reduction of stigma, and dispelling myths associated with OUD, StUD, and addiction treatment.

***Involve Family and Caregivers:***

- Providers should be cautious about disclosing information to the family or other caregiver. Title 42 Code of Federal Regulations (CFR), Part 2 limits what SUD information providers can tell families or caregivers. Without expressed signed consent, it is illegal to provide information about the relationship of a resident with an OTP or OBOT/OBAT to a family member or caregiver regardless of their relationship with the patient. Although you may have a signed release to speak with a family member, it is not lawful to share this information if the release doesn't include instructions explicitly related to SUD care.
- Families and caregivers play a vital role in recovery and support of individuals with OUD and StUD. Organize family focus groups and a Patient and Family Advisory Council (PFAC) to be an active part of the process. Utilizing a PFAC will enable you to understand the specific needs of residents and the overall population and community.
- Draft plans to ensure that families and caregivers are used to enhance overall improvement efforts, educational material development, and processes.
- The following resources include helpful information for developing a PFAC.
    - American Medical Association – Forming a Patient and Family Advisory Council[83]
    - Institute for Patient and Family-Centered Care – Creating Patient/Family Councils [84]
    - Agency for Healthcare Research and Quality – PFAC Implementation Guide[85]

***Keep Caregivers Informed and Families Involved***

- Share contact information of community OTP and OBOT/OBAT organizations and community-based recovery support groups with families provided you have received a signed release from the resident specific to OUD care (see Tip 5 for community resources). Families and caregivers may benefit from a warm handoff to or participation in a local support group.
- Share a list of prohibited items (e.g., drugs, drug contraband) with residents, families, caregivers, and staff to ensure their safety. Notify them of steps your facility takes if prohibited items are found, such as confiscation, referral for drug testing, and, if necessary, contacting law enforcement.
- It is a federal and state regulation to translate information shared with residents into their preferred language. For more detail, visit the Health and Human Services Office of Civil Rights[86] and the Massachusetts DPH Office of Health Equity.[87]

***Reduce or Eliminate Environmental Stressors***

- Foster inclusion by arranging spaces so that each resident can see and interact with others (e.g., non-fixed seating, round tables, etc.). Such areas facilitate positive social behaviors and the development of interactive social groups.
- Work with residents to identify environmental stressors specific to them. Once identified, work to change the situation by assisting the resident with avoiding the stressor, alter the stressor, adapt to the stressor, or accept the stressor (unnecessary noise, alarms, clutter, etc.).
- Incorporate positive distractions such as colorful pictures of nature or music.
- Ensure that you are working to minimize odors. Odors that are objectionable or perceived as medical can create stress.
- Cluttered rooms can cause stress. Work with residents to reduce belongings that take up space and may contribute to clutter.
- Soften noise and reduce the appearance of chaos.

*Figure 4: Eight Dimensions of Wellness*

***Wellness Orientation***

By nature, a therapeutic environment is one that fosters well-being. The WHO defines wellness as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." For residents with OUD and StUD focusing on wellness can improve their quality of life. Culture and spiritual beliefs impact one's perception of wellness and are not the same for everyone. However, ensuring adequate sleep, opportunities to personalize daily schedules, access to nutritious food, and opportunities to engage in purposeful activities are ways LTCFs can heighten a sense of wellness. SAMHSA's Wellness Initiative supports focus on the Eight Dimensions of Wellness to achieve an improved quality of life.[88]

The Eight Dimensions of Wellness[89] (Figure 4) include emotional, financial, social, spiritual, occupational, physical, intellectual, and environmental.

Providers can work with residents to ensure that their well-being continues to be a priority and their cultural and linguistic needs are met. This means not only physical status, but mental and spiritual condition as well.

- A healthy lifestyle goes hand-in-hand with a healthy diet – which means eating a wide variety of foods in the right proportions and consuming the right amount of food and drink to achieve and maintain a healthy body weight. Work with residents and your dietitian to identify goals that can support a healthy diet, such as reduction of processed foods, sugar intake, and refined carbohydrates.
- Investigate whether your facility fosters a positive sleep environment. Do you have soft lighting? Are lights off, hallway included? Is your facility an alarm-free? Providing a positive sleeping environment is linked to improved health outcomes such as reduced falls, improved immune system, and better wound healing. The body heals during stage 3 sleep, so individuals who get proper sleep are more refreshed.[90]
- Offer evidence-based programming and meaningful daily activities. The transition to LTCF can be traumatic, especially for those who will remain in long-term care. Work with your residents and PFAC on identifying person-centered activities and engage the resident in personal interests.

***Positive Engagement Strategies (Ensure that these are culturally and age appropriate)***

- Person-centered care is especially relevant to residents with OUD and StUD, as the concepts embedded in that care are also key drivers of recovery.[91]
- Create a schedule of daily tasks, individual, and group activities to help residents have a sense of purpose and form good habits.
    - "When I first came, I didn't want to go to any groups. I found real fast that boredom is a trigger for me; and so, I try to stay active all day. It's important for me now."[92] This quote was captured from an individual attending a recovery group session.
- Offer light jobs and responsibilities such as mail delivery, teaching a class, attend a peer support meeting, working in the garden, helping prepare the dining room, raking leaves, or preparing the outdoor fire pit.
- Utilize residents' talents and skills. Invite them to contribute their gifts and talents to the community.
- Provide all residents, particularly those with OUD and StUD, information to empower them to be partners in their care. Communication techniques include asking open-ended questions, not interrupting the resident and engage in active listening.
- Examples of ways facilities can create a positive environment:
    - Views of nature or nature pictures in resident rooms, lobby, waiting, and other high stress areas, access to nature, healing gardens, trails, etc.
    - Chapel, meditation room, and meditation gardens
    - Artwork depicting nature, including back-lit photographs of nature
    - Music (live music in a public area, recorded music in resident room when programmed specifically to create a healing environment, personal playlists with headphones)
    - Physical exercise (corridors, public spaces, and gardens that invite walking when appropriate)
    - Pets and other activities or elements that allow for a sense of stimulation that help nurture a resident's sense of positive well-being
    - Privacy and control (e.g., control over radio, TV, reading light, night light)

## Education and Resources

- Institute for Health and Recovery: Publications[93]
- Institute for Patient- and Family-Centered Care: Partnering with to Address the Opioid Epidemic[94]
- Tribal Law and Policy Institute: Tribal Healing to Wellness Court Series[95]
- SAMHSA: Resources for Families Coping with Mental and Substance Use Disorders[96]
- SAMHSA: Creating a Healthier Life: A Step-by-Step Guide to Wellness[97]
- SAMHSA: Recovery and Recovery Support Resources[98]
- New England Region of Narcotics Anonymous: Narcotics Anonymous Website[99]
- Nar-Anon Family Groups: Nar-Anon 12-Step Program[100]
- SMART Recovery®: Free Mutual Support Meetings[101]
- The Phoenix: Massachusetts Locations[102]
- Appendix 13: Additional Resources

## Implementation: Key Points

| Tip 2: | Creating a Therapeutic Environment |
|---|---|
| **Policies** | 1. Incorporate development of a therapeutic environment into your existing orientation policies, including linguistic and cultural needs of your residents.<br>2. Develop a policy on creating and/or involving a patient and family advisory council. |
| **Interventions** | ***Topic and Potential Staff*** |
| *Involve Family, Caregivers, Support Persons* | ☐ **Leadership Support and Identify a Champion or Staff Liaison**<br>▪ Create a PFAC:<br>○ Identify opportunities for PFAC.<br>○ Prepare leadership and staff to work with advisors.<br>○ Recruit potential members.<br>○ Implement and coordinate meetings to involve PFAC members.<br>▪ Review AHRQ PFAC Implementation Guide.<br>☐ **Leadership**<br>▪ Offer an information brochure to family members about community resources and what not to bring to the facility.<br>☐ **Case Management, Social Work, Leadership**<br>▪ Partner with OTP and OBOT/OBAT to create a brochure.<br>▪ Disseminate addiction-related support resources:<br>○ Peer Recovery Support Centers<br>○ Massachusetts Substance Use Helpline<br>○ Massachusetts Consultation Service for Treatment of Addiction and Pain (MCSTAP) |
| *Reduce or Eliminate Environment Stressors* | ☐ **Leadership or Champion**<br>▪ Arrange spaces to facilitate social behaviors and development of social groups.<br>▪ Identify potential environmental stressors.<br>☐ **Housekeeping**<br>▪ Reduce objectionable or medicinal odors; reduce clutter.<br>☐ **All Staff**<br>▪ Eliminate noise when possible. |
| *Wellness Orientation* | ☐ **Dietician or Appropriate Staff**<br>▪ Develop healthy diet and identify goals in partnership with resident.<br>☐ **Champion**<br>▪ Foster positive sleep environment.<br>☐ **Activities Staff**<br>▪ Create spaces for exercise and physical activity. |
| *Positive Engagement Strategies* | ☐ **Activities Staff**<br>▪ Offer evidence-based training and daily activities.<br>▪ Create or suggest light jobs and invite residents to contribute to the community.<br>▪ Provide rooms or spaces with nature, healing gardens, if you have available space to do so.<br>▪ Create space for chapel, meditation, etc. |
| **Regulatory Considerations** | Federal regulations already require a resident council and, if family requests, a family council must provide the space. Licensed space is regulated by state regulations (e.g., dining rooms, activity space). Ensure that you are in compliance with those regulations. |

# Tip 3: Organizational and Workforce Approaches to Person-Centered Care

## Description

The Centers for Medicare & Medicaid Services (CMS) defines person-centered care as 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."[103] This can represent a major shift in how processes, routines, and priorities are organized and may be a departure from the typical approach of many clinicians and staff in the health care and long-term care systems.[104] Approach OUD and StUD like any other chronic disease or health condition. After OUD and StUD are recognized and treated, individuals can stabilize, their symptoms can go into remission, and they can make strides towards recovery.[105] Person-centered care is especially relevant to residents with OUD and StUD, as the concepts embedded in that care are also key drivers of recovery.[106] Person-centered care means trying to identify and understand a resident's goals for recovery and identifying appropriate interventions, with those goals in mind, to ensure safety and maximum quality of life.

To develop a culture of person-centered care, staff should review their overall mission and vision statements, cultural competency of the organization, and approaches to staff training. As you establish a person-centered approach to care, specifically for residents with OUD and StUD, it is important to review your vision and mission statements. Consider revising them to reflect a person-centered orientation. Ensure they fit the needs of your residents both culturally and linguistically. Vision is a mental image of the ideal state an organization wishes to achieve, both inspirational, and aspirational. Mission is a concise explanation of an organization's reason for existence, describing purpose and overall intention.[107]

Tips for Vision and Mission Statements[108] is a helpful resource to assist in crafting or revising your vision and mission statements.

Taking steps to ensure the adoption of trauma-informed care practices throughout the organization is vital to fully integrating person-centered care. Tip 2 discusses the importance of a therapeutic approach by using PFACs and developing more wellness activities; this Tip will look at a more organizational-wide approach. Here are some helpful websites for more information on person-centered care:

- Action Pact [109]
- Developing Trauma-Informed Organizations[110]
- Institute for Person-Centered Care[111]
- PioneerNetwork[112]
- Planetree[113]
- The Green House Project[114]

## Goal

This section aims to help LTCF staff establish a multi-layered, interdisciplinary, person-centered approach to supporting residents with OUD and StUD that meets residents' linguistic and cultural needs.

## Objectives

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

- Ensure vision and mission statements reflect a person-centered approach embedded into your policy and practice.
- Recognize key components of trauma-informed care, the effects of trauma on one's life, and how to individualize care through a trauma-informed care lens.
- Understand how to reflect and incorporate Culturally and Linguistically Appropriate Services (CLAS) concepts in policies, language, practices into overall operations.

## Policies

- Review and incorporate a person-centered approach into existing policies and procedures.
- Develop a policy around training staff on trauma-informed care.
- Integrate CLAS into policies and procedures.

## Person-Centered Approach - Changing Your Culture

### *Engage Resident*

It is important to establish a positive relationship with your residents. Discovering your resident's habits, beliefs, passions, preferences, and health goals will help foster the partnership. Some ideas:

- Think about their room, their first day, their first encounters with others.
- What can you do to positively impact their time with you?
- What are the snacks they like? What is the one thing they can't live without? Coffee or tea?
- Who are their supportive people?
- What do they need at their bed stand that brings them comfort?

### *Engage Staff*

Stepping back to discuss what person-centered care means to your staff provides opportunities to engage in this crucial part of organizational culture. Involvement of front-line staff members is powerful, providing them with key opportunities to review how person-centered care helps support residents with OUD and StUD. Additionally, bolstering staff engagement helps reduce staff turnover, thus providing consistency and continuity for residents and many other positive effects.[115] Some ideas:

- 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 resonate with staff members.
- Identify a champion who will assist in creating culture change.

### *Staff Recruitment*

When recruiting and interviewing staff, introducing person-centered care questions into the process will enable you to set expectations for necessary values and culture. It will also help you strategically bring individuals on board who already possess the required person-centered orientation.

Recruitment efforts may prioritize building a diverse workforce or reflective of the community, especially regarding CLAS considerations around language and culture.

See sample person-centered care interview questions for recruiting. These questions are behavior-based, focusing on teamwork, patient care, adaptability, time management, communication style, motivation, and core values. It is positive to see applicants share examples of difficult past conflicts with colleagues and focusing on what they learned from the experiences. Applicants should also be prepared to share what motivates them and share situations in which they took the initiative to start a project or complete a project.[116]

- Sample Interview Questions (Appendix 3)

### *Staff Training*

It is beneficial to focus on crucial areas supporting a person-centered approach to care and areas specifically relevant to the care of residents with OUD and StUD. The list below offers training tools and resources to help staff members and residents.

Training should include education on OUD, MOUD, StUD and the skills and awareness required to best support residents (see Tip 4 for staff competencies). Training should also include education around co-occurring OUD and StUD, identifying skills necessary to support these residents. In addition, it will be helpful to set up ongoing case reviews or staff member peer-sharing to address potential stress, isolation, or negative feelings.

- MOUD approach and efficacy[117]
- Empathy Techniques (Appendix 2)
- Changing the Conversation: The Importance of Language[118]
- Providers Clinical Support System[119]
- Partners in Calm Cooperative De-escalation[120]
- Review Addressing Stigma in Tip 1

## Trauma-Informed Care

Individuals and residents with OUD and StUD benefit from trauma-informed care. The impact of trauma on individuals, families, and communities can be dramatic and impact physical and psychiatric health. Establishing and promoting trauma-informed care as part of organizational culture aligns with a person-centered approach.

Research shows a link between OUD, StUD, and other risky health behaviors and traumatic experiences.[121] Discussions around trauma-informed care can accompany the vision and mission review. Core principles of trauma-informed care include safety, trustworthiness, choice, collaboration, and empowerment.[122] The following short videos and kit are helpful resources:

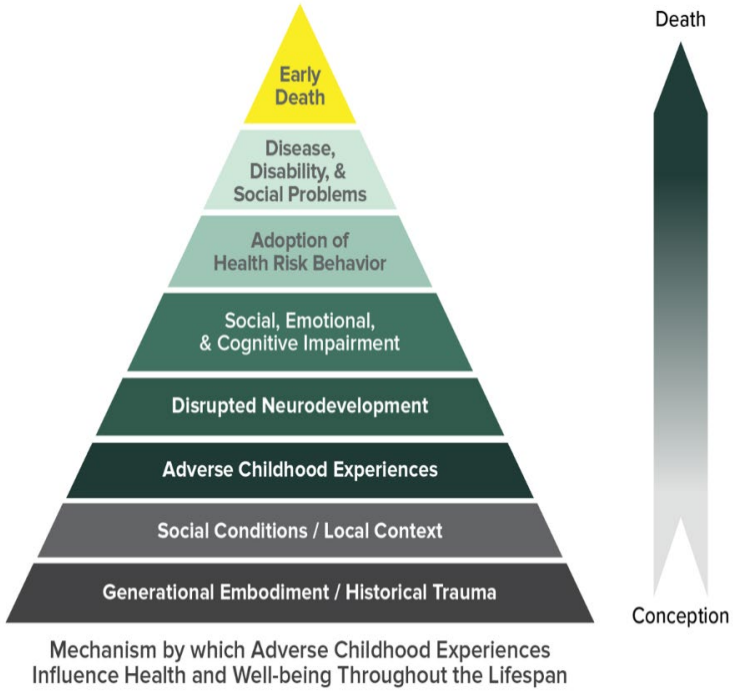
- What is Trauma-Informed Care?[123] (3 minutes)
- What is Trauma?[124] (2 minutes)
- Relationships between trauma and addiction[125] (11 minutes)
- Developing Trauma-Informed Organizations[126]

The change package indicated below provides resources and guidance on trauma-informed care focusing on person-centered care. Phase 2 details how to educate staff on trauma-informed care foundational principles.

- Trauma-Informed Care: Change Package for Nursing Centers[127]

Adverse childhood experiences (ACEs), have been connected to specific health risk behaviors (such as OUD[128]), chronic health conditions, and early death.[129] (Figure 5).

*Figure 5*




Source: CDC-Kaiser ACE Study, https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/

Many individuals with SUD experienced traumatic events that contributed to the development of a SUD and are associated with many negative health outcomes, including cardiovascular disease, pulmonary disease, addiction, cancer, and premature death. Universal trauma precautions are important to exercise because trauma often precedes addiction. Once someone develops a SUD, risk of new trauma also increases. It is important to train staff to recognize ACEs as part of the person-centered care approach. The following resources can help with this:

- Take the ACE Quiz — And Learn What It Does and Doesn't Mean[130]
- Finding your ACE Score[131]

***Engagement of Family and Caregivers***

As mentioned in Tip 2, engagement with the resident's family, caregiver, or friends is an important step. If possible, provide information on family and caregiver support resources available within the community. Often, taking advantage of support resources will help the family or caregivers develop healthy boundaries with the resident, which can help support their recovery through reinforcement of acceptable behaviors and interactions.

As a result of the ACEs study, we learned many residents come from chaotic or traumatizing households. These households have a history of instability or trauma; therefore, it is important to recognize that family is not always a source of support for residents. Healthy boundaries can also protect the family or caregiver's mental and emotional health.[132] Staff must obtain a signed release by the resident, explicitly addressing SUD care, before staff can share information with family or other caregivers.

There are a variety of groups available for support of the family, caregiver, or friends. Notably, Learn to Cope[133] operates throughout Massachusetts, with weekly meetings, online support, education, and training. Familiarize yourself with these resources and offer or guide families to them.

- Learn to Cope: 508-738-5148[134]
- Allies in Recovery (AIR)[135]
- Center for Motivation and Change[136]
- Massachusetts Helpline: 800-327-5050[137]

***Non-pharmacological Approaches***

While medications help with the physical symptoms, including cravings and withdrawal, many residents with OUD and StUD may have other psychological, behavioral, and social needs that staff should address. Currently, there are no evidence-based medications to support the physical symptoms for residents with StUD that are FDA approved. However, residents with OUD and StUD should have access to behavioral health services as needed, medical care, and addiction counseling. They should also have access to recovery support services to supplement medications.[138] As previously mentioned, care for residents with OUD and StUD is similar to care for residents with other chronic conditions.

A wide range of providers—social workers, counselors, peer recovery support specialists, outreach workers, physicians, nurses, and advanced practice professionals—can deliver non-pharmacological therapy. Some will require connection to external resources, while others perform therapy onsite via facility staff or with an integrated or collaborative care model. Local providers and community-based organizations are key partners. See Tip 5 for further details.

- Careers of Substance[139] offers staff training resources, an event calendar, and a training calendar.

With the goal of supporting the treatment of a resident with OUD in a person-centered way, it is important to review approaches in addition to MOUD and understand how and when to utilize them. Other approaches include counseling, psychiatry, and peer support. MOUD, in combination with these other therapy approaches, provides a "whole-person" approach to the treatment of OUD. Staff can combine the following therapeutic approaches with MOUD for holistic treatment:

- Counseling/therapy (individual, group) should be included in the residents' care plan, which is developed in partnership with the OTP or OBOT/OBAT
- Psychiatry, if applicable
- Peer support or peer recovery coaching are good resources to connect a resident to upon discharge
- Mutual help group programs
- Contingency management

There are many evidence-based non-pharmacological therapies for StUD treatment. However, staff can use contingency management across genders, ages, races, and ethnicities in individual and group settings. [140]

Other therapeutic approaches to the treatment of StUD include motivational interviewing, exercise supported recovery, trauma-informed care seeking safety, community reinforcement approach, and cognitive behavioral therapy. Different residents will have different needs. It is important to stay away from a "one-size-fits-all" approach. Consider the resident's preferences on how they want to receive support and treatment. While some residents may benefit from individual therapy, a group therapy approach may work better for others. A group approach incorporates peer feedback and an opportunity to use reflective listening.

As part of the resident's care plan, the resident and team should discuss the most appropriate, effective approach to supporting the resident's recovery process. Tip 5 offers further details and a discussion of online or telehealth options.

The relationship built between residents and staff can be a powerful tool for change and recovery. One effective technique to aid relationship-building is motivational interviewing (MI). MI is a counseling style and way of interacting with residents throughout their recovery process. MI is collaborative, goal-oriented, and activates the resident's inherent capacity for positive change in an accepting, compassionate manner.[141]

Here are some MI resources:

- The Bureau of Substance Addiction Services (BSAS)-funded resource: Massachusetts Screening, Brief Intervention, and Referral to Treatment Training and Technical Assistance (MASBIRT TTA) will offer MI training in-person for 15-20 people.
- Motivational interviewing
  - Cheat Sheet[142]
  - Quick Reference Sheet[143]
  - Resource Guide[144]
  - Network of Trainers[145]

## Culturally and Linguistically Appropriate Services

The National CLAS Standards in Health Care establish principles an organization can "provide effective, equitable, understandable and respectful quality care and services, responsive to diverse cultural health beliefs and practice, preferred languages, health literacy, and other communication needs."[146] Cultural identity includes race, ethnicity, language, education, health literacy, gender, religion, sexual orientation, disability status, and access to care. The principle behind cultural competence is providing person-centered care.[147]

The MDPH Office of Health Equity created a guide for providing CLAS. Making CLAS Happen: Six Areas for Action divides the standards into six chapters:[148]

- Foster cultural competence
- Build community partnerships
- Collect and share diversity data
- Benchmark: plan and evaluate
- Reflect and respect diversity
- Ensure language access

## Education and Resources

- SAMHSA: Cultural Competence for Clinicians Manual[149]
- SAMHSA: KAP KEY for Clinicians Manual[150]
- U.S. Department of Health & Human Services (HHS): Think Cultural Health[151]
- HHS: Office of Minority Health[152]
- Appendix 13: Additional Resources

## Implementation: Key Points

| **Tip 3:** | **Organizational and Workforce Approaches to Person-Centered Care** |
|---|---|
| **Policies** | 1. Incorporate a person-centered approach into existing policies.<br>2. Develop a policy around training staff on trauma-informed care.<br>3. Integrate CLAS into policies and procedures. |
| **Interventions** | ***Topic and Potential Staff*** |
| *Developing Mission and Vision Statements* | ☐ **Corporate or Leadership**<br>▪ Review Tips for vision and mission statements. Incorporate a person-centered approach.<br>☐ **All Staff, Residents, Families, and Caregivers**<br>▪ Engage staff in creating vision and mission. Identify a champion to assist with development. |
| *Staff Recruitment and Training* | ☐ **Leadership**<br>▪ As part of staff recruitment, review sample interview questions (Appendix 3).<br>▪ Make sure to include the following as part of staff training:<br>○ The Medication Assisted Treatment (MAT) Tool Box<br>○ Tip 1: review of stigma, OUD and StUD overview, managing difficult behaviors, what to do in case of overdose or withdrawal<br>○ Empathy Techniques (Appendix 2)<br>○ The Importance of Language<br>○ De-escalation: Partners in Calm Cooperative De-escalation<br>▪ Train staff on trauma-informed care. |
| *Trauma-Informed Care* | ☐ **All Staff**<br>▪ Watch videos: What Is Trauma? and What is Trauma-Informed Care?<br>▪ Review Trauma-Informed Care Change Package and follow steps.<br>▪ Review Institute for Health and Recovery.<br>▪ Take the ACE Quiz.<br>☐ **Case Management, Social Work, or Nursing**<br>▪ Incorporate non-medication approaches, including exercise supported recovery and cognitive behavioral therapy.<br>▪ Incorporate the following resources into the residents' care plan, in partnership with OTP or OBOT/OBAT and community resources:<br>▪ Counseling<br>▪ Peer Support/Peer Recovery<br>▪ Mutual Help Group Programs<br>▪ Train staff on motivational interviewing to build relationships with residents |
| *CLAS* | ☐ **Leadership**<br>▪ Conduct a CLAS Standards Needs Assessment.<br>▪ Implement annual mandatory cultural competence trainings.<br>☐ **All Staff**<br>▪ Develop cultural competence by completing annual cultural competence trainings. |
| **Regulatory Considerations** | Review CMS federal requirements on trauma-informed care in Phase 3. |

# Tip 4: Demonstrated Competencies

## Description

A competency is the ability to apply knowledge, skills, or attitudes (KSAs) successfully or efficiently to perform critical job functions. One needs to practice a competency to use it effectively in various appropriate situations and times. When working with residents with OUD and StUD, there are important KSAs that your staff should possess to care for residents safely.

This toolkit is based on a set of OUD, StUD, and treatment core competencies. As a result, many of the concepts presented in Tip 4 also appear throughout the toolkit. Tip 4 is designed to consolidate the list of essential core competencies under one Tip.

## Goals

The goal of this section will be to help LTCF staff identify key competencies they should demonstrate and understand to better care for residents with OUD and StUD.

## Objectives

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

- Learn how to care for individuals with OUD and StUD in LTCF effectively.
- Understand special considerations across the age spectrum for LTCF residents with OUD and StUD.

## Policies

- Incorporate the following competencies into staff training policy
  - Understanding OUD and StUD
  - How to care for individuals with OUD and StUD
  - Preventing opioid and stimulant use overdose
  - What to do in case of an overdose

## Process

### Knowledge About Understanding Opioid and Simulant Use Disorders

LTCF clinicians and staff must develop knowledge, skills, and attitudes about OUD and StUD to effectively care for individuals with this chronic, relapsing medical condition.

***Ethical and Legal Guidelines When Caring for People with Stimulant and Opioid Use Disorders***[153,154,155]
**Understanding of 42 CFR:**[156] Federal Drug and Alcohol Confidentiality regulation (42 CFR Part 2) protects the confidentiality of residents' alcohol and SUDs. It protects residents' identities, diagnoses, prognoses, and treatment plans in record documents maintained in connection with federally assisted programs or activities about substance abuse education, prevention, training, treatment, rehabilitation, or research. This ensures patients receiving treatment are not made more vulnerable than individuals with a SUD who do not seek treatment.

- This applies to federally-assisted alcohol and drug abuse programs. Obtain patient consent before sharing information from a program subject to 42 CFR Part 2. After information disclosure, do not disclose further information without patient's express consent or unless otherwise permitted.

- Limited exceptions for disclosure without consent:
  - Medical emergencies
  - Scientific research
  - Audits and evaluations
  - Child abuse reporting
  - Crimes on program premises or against personnel
  - Court order
  - Communications with a qualified service organization (QSO) of information needed by the organization to provide services to the program

***Stigma: Dispelling Misconceptions***

- According to the WHO, stigma is a major cause of discrimination and exclusion, and it contributes to human rights abuse. When a person experiences stigma, they are seen as less than because of their real or perceived health status or characteristic. Residents with OUD and StUD are no different than any other residents with chronic health conditions.[157,158,159,160] (See Tip 1.)

***Implicit Bias***

- Implicit biases are attitudes and stereotypes that are inaccessible to conscious awareness or control. These unconscious attitudes create quick assumptions and associations between people with certain characteristics and certain behaviors or evaluations. For example: if you imagine a scientist and you see a male rather than a female. Everyone carries these implicit assumptions, but it is important that you are aware of the assumptions that you make and how they can influence your care of residents.
- You can take the Implicit Association Test.[161]
- Complete the Addressing Bias module.[162]

***Distinction Between Use, Dependence, And Use Disorder***

- Identity and discuss stigma and misconceptions of OUD and StUD.[163,164,165] Also, identify and understand the distinction between use, dependence, and use disorder. (See Tip 1 for more information on stigma.)
- Substance dependence is not synonymous with a use disorder, but rather a physical state in which the body adapts to ongoing use of a substance.
- When people use the word dependence, they typically refer to a physical dependence on a substance. Dependence includes symptoms of tolerance and withdrawal. An individual can have opioid dependence without having an OUD.[166]
- Definitions
  - "Substance abuse and dependence are caused by multiple factors, including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems." [167]
  - "SUD is a mental disorder affecting a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications."[168]
  - "OUD is a medical condition defined by not being able to abstain from using opioids, and behaviors centered around opioid use that interfere with daily life. However, people can misuse opioids and not have physical dependence. When a person has physical dependence, it can be particularly hard to stop taking opioids, and that dependence can interfere with daily routines, including personal relationships or finances."[169]

***Trauma-Informed Care***

- "Trauma-informed care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize."[170] (See Tip 3 for information regarding the effects of trauma.)
- Screening and assessing suicide risk: Patient Health Questionnaire-9 (PHQ-9) is a LTCF screening tool used by social workers to measure depression severity in residents. View universal suicide risk screening information.[171]

***Recognize and Manage Intoxication, Withdrawal, or Overdose.***[172,173]

- Managing acute treatment (detoxification): LTCF cannot accept residents with primary diagnosis is SUD for detox. Instead, an appropriate outpatient, acute care, or rehabilitation facility should treat residents for detoxification before admission to LTCF. (See 150.003 Admissions, Transfers, and Discharges D (5)).
- Communicate with the OTP or OBOT/OBAT providers regarding abrupt discontinuation of opioids after long-term intense use, which may produce withdrawal symptoms.[174] (See Tip 1 for symptoms of withdrawal). The most effective method for treating a resident who has withdrawal is to prescribe a long-acting oral opioid (usually methadone or buprenorphine) to relieve symptoms and then gradually reduce the dose to allow the resident to adjust to the absence of an opioid. Medically supervised withdrawal can also involve the use of non-opioid medications that can help control symptoms; this should only be done under the supervision of the residents' clinicians at their OTP or OBOT/OBAT.[6]

***Special Considerations Across the Age Spectrum for Long-Term Residents with Opioid and Stimulant Use Disorder***[175]

- Typically, LTCF residents are thought of as an older, medically-complex population. However, LTCFs also have a population of younger adults who are admitted for short-term rehabilitation, are medically compromised, and need the level of care provided in a LTCF. All residents, regardless of age, require safety considerations when managing OUD and StUD.[176]
- When LTCF residents receive MOUD through an OTP or OBOT/OBAT or receive StUD treatment, clinicians manage treatment by considering the following:
    - Medical co-morbidities
    - Psychiatric co-morbidities
    - Managing acute and chronic pain and OUD[177]
    - Effective treatment
    - Polypharmacy and drug interactions
- View BSAS guidelines for practice with older adults[178] and family approach[179] to treatment.
- If you have any questions regarding addressing complex needs of patients with chronic pain, SUD, or both, call MCSTAP for a free consultation 833-PAIN-SUD (833-724-6783).

## Long-Term Care Facility Residents' Social Environment[180]

- The rules and expectations in LTCF for residents with OUD and/or StUD:
    - LTCFs have rules that apply to all residents, including those with OUD and StUD.
    - Set appropriate boundaries for residents, staff, and visitors in collaboration with residents to provide a safe, supportive environment.
    - Prepare staff to manage resident reactions associated with OUD and StUD. (See Tip 1.)
    - Staff should be aware of resources and strategies to optimize resident and staff safety.

## Caring for Individuals Treated with Medication for Opioid Use Disorder in Long-Term Care Facilities

Individuals with OUD can be treated with MOUD while residing in a LTCF, though these facilities are not designated as OTPs or OBOTs/OBATs.[181]

- Goals of MOUD (see introduction and MOUD Comparison chart)
- Treatment modalities include:
  - Methadone, buprenorphine, buprenorphine, naloxone, or naltrexone (MOUD comparison chart)
  - Counseling
  - Recovery support/peer support-coaching
- Effective assessments and person-centered care plans (see Tip 3)
- Communication with treatment programs (see Tip 5 and Tip 6 for additional information on treatment programs and communication)
- Protocols for medication changes and needs
- Arranging transportation (see Tip 6)
- Discharge planning, including continuity of care and resources (see Tip 6)
- Preventing an overdose (see Tip 1)
- Competency with naloxone to reverse opioid overdose (see Tip 1) and Five Steps for First Responders[182]
- Harm-reduction strategies (see Tip 1)
- Storing, dispensing, and transporting medications for MOUD (see Tip 6)
- Record-keeping, see your internal policies
- LTCF reporting requirements for overdose events, typically DPH[183]

## Caring for the Caregivers (see **Tip 2** and **Tip 3** Regarding Resources for Families and Caregivers)

- Setting personal and professional boundaries
- Recovering from traumatic events (i.e., overdose event or unexpected resident death)
- Debriefing after a crisis
- Recognizing and preventing caregiver burnout

## Education and Resources

- American Addiction Centers National Rehabs Directory: Check Your Blind Spot: Understanding Implicit Bias[184]
- SAMHSA Recover Month: Road to Recovery Discussion Guide[185]
- Appendix 13: Additional Resources

## Implementation: Key Points

| Tip 4: | Demonstrated Competencies |
|---|---|
| **Policies** | **1.** Incorporate competencies into staff training: understanding OUD and StUD, how to care for individuals with OUD and StUD, prevent overdose, and what to do in case of an overdose. |
| **Checklist of Competencies** | ***Competencies: Knowledge, Skill, or Attitude*** |
| *Understanding OUD and StUD* | ☐ **Knowledge and/or Attitude**<br>▪ Implicit bias: take the implicit association tests.<br>▪ Dispelling the stigma and misconception of OUD and StUD.<br>▪ Trauma-informed care approach.<br>▪ Recognize and manage intoxication, withdrawal, or overdose.<br>▪ Ethical and legal guidelines.<br>☐ **Knowledge and Skill**<br>▪ Distinction between use, dependence, and use disorder. |
| *Special Considerations Across the Age Spectrum* | ☐ **Knowledge**<br>▪ Medical comorbidities<br>▪ Psychiatric comorbidities<br>▪ Acute/chronic pain and OUD along with StUD<br>▪ Effective treatment as determined by OTP or OBOT/OBAT<br>▪ Polypharmacy and drug interactions |
| *Residents' Social Environment* | ☐ **Knowledge and Skill**<br>▪ Expectations for residents with OUD and StUD: Resources and strategies for resident and staff safety |
| *Caring for Individuals with OUD Treated with MOUD* | ☐ **Knowledge**<br>▪ Goals of MOUD<br>▪ Treatment modalities<br>▪ Protocols for medication changes and needs<br>▪ Arranging transportation<br>▪ Harm reduction<br>▪ Record-keeping<br>☐ **Skill**<br>▪ Effective assessment and care plans<br>▪ Communication with treatment programs<br>▪ Discharge planning<br>▪ Competency with naloxone<br>☐ **Knowledge and Skill**<br>▪ Preventing overdose<br>▪ Storing, dispensing, transportation of MOUD |
| *Caring for the Caregivers* | ☐ **Knowledge and/or Skill**<br>▪ Setting personal and professional boundaries<br>▪ Recovering from traumatic events<br>▪ Debriefing after a crisis<br>▪ Recognizing and preventing burnout |
| **Regulatory Considerations** | Federal regulations on Patients' Rights related to visitations, room searches, etc.<br>150.003 Admissions, Transfers and Discharges |

# Tip 5: Community Wide Resources and Partnerships

## Description

According to SAMHSA, patients experiencing OUD and StUD should "have access to mental health services as needed, medical care, and addiction counseling, as well as recovery support services, to supplement treatment with medication."[186] LTCFs may have some resources available internally. Many resources will come from partnerships with local facilities, such as OTPs and OBOTs/OBOTs, or community groups assisting those with OUD or StUD. Staff within your facility must be generally aware of the types of resources available—what they are, what they do, and how to find them.

## Goal

The aim of this section is to help LTCFs become familiar with and learn how to connect with treatment partners and community resources to better care for residents with OUD and StUD.

## Objectives

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

- Define the roles of OTPs and OBOTs/OBATs.
- Recognize the potential uses of telehealth.
- Identify common community resources.

## Policies

- Incorporate a communication strategy within policies and develop a plan of how you'll use community-wide resources in the care of residents with OUD and StUD.
- Develop a Qualified Service Organization Agreement (QSOA) with an OTP or OBOT/OBAT. (See Tip 6: Transitions of Care for more detail.)

## Process

- Review the education section below and related resources.
- Integrate the use of community resources and partnerships in your facility.

### Opioid Treatment Programs and Office-Based Opioid Treatment or Office-Based Addiction Treatment Programs

OTPs and OBOTs/OBATs are the main providers of MOUD. SAMHSA regulates OTPs and the request from providers at the OBOT/OBAT for the Drug Enforcement Agency (DEA) Drug Addiction Treatment Act of 2000 (DATA) waiver. BSAS also regulates OTPs and OBOTs/OBATs, but each has its own set of governing rules. Because the service requirements of each treatment provider vary, it is important to establish a clear understanding of the LTCF's relationship with the OTP or OBOT/OBAT upon admission of a resident with OUD. (See Tip 6: Transitions of Care for more detail.)

### *Opioid Treatment Program*

An OTP is an outpatient program that provides services to treat and manage OUD in a clinical setting. Only federally certified and licensed OTPs may dispense methadone for the treatment of OUD. OTPs may also dispense or administer other medications, including buprenorphine, buprenorphine/naloxone, or naltrexone on-site (see MOUD Comparison Chart). OTPs generally administer medication on-site but can provide take-home medication (pre-poured doses) on a case-by-case basis.

In response to COVID-19, BSAS received a blanket exemption from SAMHSA on behalf of OTPs for take-home doses of MOUD in June 2021.[187] SAMHSA has allowed the following: up to 28 days of take-home medications for all patients and up to 14 days of take-home medication for those patients who are unstable, but the OTP believes they can safely administer this level of take-home medication.[188] OTPs are also required to provide integrated emotional, social, and behavioral health services, including counseling, treatment, and education about diversion control.[189] SAMHSA regulates OTPs and maintains a directory of clinics by state.[190]

### *Office-Based Opioid Treatment or Office-Based Addiction Treatment*

An OBOT/OBAT provider is another outpatient treatment program in which specific primary care or general health care practitioners are permitted to administer or prescribe certain medications to treat OUD after obtaining a waiver.[191]

The DATA Waiver permits practitioners, who meet certain qualifications, to treat opioid addiction with Schedule III, IV, and V narcotic medications specifically approved by the FDA for that indication. Qualified practitioners include physicians, nurse practitioners, physician assistants clinical nurse specialists, certified registered nurse anesthetist, and certified nurse-midwives.

Current practice guidelines permit qualified practitioners to treat up to 30 patients without the DATA Waiver training if they meet the following criteria:

- Must be a licensed provider with DEA registration
- Must register a letter of intent with SAMHSA and DEA registration
- Must be waivered to prescribe buprenorphine

MDPH and the BSAS encourage providers to take The DATA Waiver training, training options include:

- Boston Medical Center: OBAT Training and Technical Assistance + (OBAT TTA+)
- Providers Clinical Support System Waiver Training for Physicians

OBOTs/OBATs may prescribe buprenorphine, buprenorphine, or naloxone as take-home prescriptions and administer naltrexone on-site (see MOUD Comparison Chart). OBOTs/OBATs are required to provide integrated emotional, social, and behavioral health services, if they are licensed by BSAS. If they are not licensed by BSAS, they are strongly encouraged to refer patients to relevant resources or medical sub-specialties, as needed.[192]

SAMHSA administers DATA waivers[193] and maintains a public database of aggregate waiver data,[194] an online waiver check tool for pharmacists,[195] and a map you can filter to find a "buprenorphine physician."[196]

You can connect with local OTPs and OBOTs/OBATs through the Massachusetts Substance Use Helpline, 1-800-327-5050,[197] or SAMHSA's National Helpline, 1-800-662-HELP (4357).[198]

***At-a-Glance: Opioid Treatment Programs versus Office-Based Opioid Treatment or Office-Based Addiction Treatment Programs***

| | OTPs | OBOTs/OBATs |
|---|---|---|
| **Are they allowed to offer…** | | |
| On-site treatment | Yes | Yes |
| Take-home treatment | Yes (based on the OTPs provider decision per individual patient, as required by federal regulations) | Yes |
| Methadone | Yes | No |
| Buprenorphine | Yes | Yes |
| Buprenorphine/naloxone | Yes | Yes |
| Buprenorphine extended release injection | Yes (on-site only) if patient is eligible | Yes |
| Naltrexone | Yes | Yes (on-site only) |
| **Are they required to provide…** | | |
| Counseling | Yes | Yes, if licensed by BSAS (referral encouraged) |
| Treatment | | |
| Planning and diversion control | | |
| **Can I find them…** | | |
| In an online database https://helplinema.org/ | Yes | Yes (SAMHSA, but physicians can opt out) |
| By calling a hotline1-800-327-5050 | Yes | Yes |

## Telehealth

Telehealth is "the use of electronic communication and information technologies to provide or support clinical care at a distance. The delivery of services through telehealth involves the use of secure interactive audio and video telecommunications systems that permit two-way, real-time communication between a patient/resident and a provider."[199] Telehealth services may grow in popularity because they are accessible, convenient, and cost-effective.[200]

Federal law requires a complete physical evaluation before admission to an OTP, limiting the option of telehealth to admit a new patient with OUD to an OTP. However, concerning new patients treated with buprenorphine, SAMHSA decided to exercise its authority to exempt OTPs from the requirement to perform an in-person physical evaluation for any patient the OTP will be treated with buprenorphine. A program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, can determine whether one can accomplish an adequate evaluation of the patient via telehealth.

This exemption will continue for the period of the national emergency declared in response to the COVID-19 pandemic and applies exclusively to OTP patients treated with buprenorphine.[201] The practitioner must have a valid DEA registration to prescribe or dispense medications in the appropriate Controlled Substances Schedule. LTCFs may be able to utilize telehealth services for residents with OUD where transportation issues are a hindrance. Providers can use telehealth in place of an in-person visit for prescribing certain medications for OUD[202] or as a delivery method for behavioral health services.[203]

To date, reimbursement policies have been a barrier to the widespread use of telehealth.[204] However, in response to COVID-19, new rules are expanding reimbursement of telehealth services during the pandemic. Tele-Behavioral Health services (TeleBH). MassHealth (Massachusetts' Medicaid Program) recently revised their policy[205,206] to reimburse TeleBH "at same rates as in-person visits." [207]

These new policies exclude reimbursement for the physical devices and infrastructure (tablets, high-speed internet, upkeep of technology), which may burden the facility. If an OTP is treating a resident, it is the OTP's responsibility to provide counseling services for a resident diagnosed with OUD. Therefore, telehealth could be a potential delivery method. Be sure to include a note in your QSOA if OTP will provide the counseling via telehealth. (See Tip 6: Transitions of Care for more details.)

Another way to use telehealth to care for residents is through provider support and consultation services. Providers can participate in a teleECHO clinic [208] or the Providers Clinical Support System (PCSS) Clinical Mentoring Program,[209] free of charge.

For a real-time phone consultation on safe prescribing and managing care for adults with chronic pain, SUDs, or both, call MCTSAP – a free service to Massachusetts providers – at 1-833-PAIN-SUD (1-833-724-6783), Monday to Friday, 9 a.m. – 5 p.m.

- Telemedicine and prescribing buprenorphine for the treatment of OUD, statement.
- Use of telemedicine while providing medication-assisted treatment (MAT), information brief

## Community Supports

LTCFs may coordinate with local community supports for individuals with OUD and StUD. Some forms of support that these groups can offer include helping patients stop using opioids and stimulants, managing recurrent use, and helping with necessary lifestyle changes. Just like OTPs and OBOTs/OBATs, you can get connected to these local services through the Massachusetts Substance Use Helpline, 1-800-327-5050,[210] or SAMHSA's National Helpline, 1-800-662-HELP (4357).[211]

## Additional Support Types

### *Mutual Help Group Programs*

Mutual-help groups assist individuals (or families and friends of individuals) seeking to obtain or maintain sobriety through peer connections. Groups offer social and emotional support, structured tools and techniques, motivation, and accountability through shared experiences.

- "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."[212]

In Massachusetts, groups for individuals with OUD and StUD include:

- Narcotics Anonymous (NA)[213]
- Nar-Anon[214]
- SMART Recovery®[215]
- Dual Recovery Anonymous[216]
- Massachusetts Organization for Addiction Recovery (MOAR)[217]
- Recovery Binder[218]
- The Phoenix[219]

***Recovery Centers***

Recovery support centers offer individuals recovery education and peer support to help prevent relapse and promote sustained recovery from alcohol and other drugs. Recovery centers also conduct community outreach. They also link families to relapse prevention support and counseling, alcohol- and other drug-free social events, life skills training and education, and career exploration. They offer assistance with housing, employment, public assistance, emergency relief, benefits and entitlements, legal services, educational and job applications, financial aid, vocational rehabilitation and training, recovery networking, and advocacy and empowerment of individuals in recovery.

***Peer Recovery Coaches***

A peer recovery coach is part of the interdisciplinary care team. They combine the lived experience of recovery with training and supervision to assist others in initiating and maintaining their recovery through self-actualization, community and civic engagement, and overall wellness.

Peer recovery coaches help people create recovery plans and pathways by providing different types of support, including emotional support, information (support health and wellness resources), concrete support (housing or employment), and connections (recovery community supports, activities, and events). If appropriate, reach out to your community OTP or OBOT/OBAT to connect residents to a recovery coach. MassHealth covers recovery coach services. Current research shows that people receiving peer recovery support experience reductions in substance use or improvements in recovery outcomes, on a small to moderate scale.[220]

- "Peer support helped me see I was not hopeless. It gave me my voice back, bolstering my self-worth."[201]

***Patient Navigators***

A patient navigator is a person who works in conjunction with local health care systems. A patient navigator helps guide a patient or resident through the healthcare system and support services. These services may be valuable resources once a patient is discharged to home. Patient navigators help identify patient needs and direct patients to emotional, financial, administrative, legal, social, or cultural support. Patient navigators improve access to care through advocacy and care coordination. They also work to reduce disparities and barriers to care rooted in language and cultural differences.[221] Insurance does not typically cover navigators. A patient navigator works with:

- The individual and family or other caregivers to help them learn to self-navigate
- Members of the health care team to facilitate patient healthcare
- Community resource providers (including insurance companies, employers, case managers, lawyers, and social services) who may have an effect on an individual's healthcare needs[222]

Some areas have patient navigators specializing in OUD and StUD. For example, in Guilford County, North Carolina, a program provides a navigator to visit individuals who experienced an overdose within 72-hours of being revived by EMS. The navigator "screens for risk of repeat overdose, assesses current SUD, discusses treatment options, provides education about harm reduction, and distributes and provides training on the use of naloxone."[223] One of their navigators commented:

- "We meet people where they are and build relationships. Then they realize we're safe. We're there to spread love, not hurt them."[224]

While community health workers (CHWs) are typically not associated with LTCFs, they can be valuable to residents upon discharge. CHWs often help people communicate with healthcare providers and connect them to community resources, including social service agencies. CHWs are frontline agents of change, helping reduce health disparities in underserved communities."[225] CHWs provide education and support, including mutual-help programs, crisis counseling, referrals, and relapse-prevention plans.[226] More specifically, CHWs provide interpretation and translation services, culturally appropriate health education and information, assistance in accessing healthcare services and resources, informal counseling on health behaviors, advocacy for individual and community health needs, and some preventive services (such as blood pressure screenings).[227]

- "I learned how to assist members in becoming self-sufficient with their health care. They make and keep appointments, have effective transportation, and ability to overcome social barriers as they arrive. Members look forward to my pleasant face and smile when they have clinic appointments."[228]

## Education and Resources

- The Massachusetts Substance Use Helpline: 1-800-327-5050, English Website;[229] Spanish Website[230]
- SAMHSA: Federal Guidelines for Opioid Treatment Programs[231]
- SAMHSA: Opioid Treatment Program Directory[232]
- Massachusetts Health Policy Commission: Integrating Telemedicine for Behavioral Health: Practical Lessons from the Field[233]
- RIZE Massachusetts Foundation: Health Resources in Action[234]
- S.A.F.E. Project: Community Playbook[235]
- S.A.F.E. Project NA and Persons Receiving Medication-Assisted Treatment: Pamphlet for Practitioners[236]
- Narcotics Anonymous National Helpline: 1-800-662-4357 or Website[237]
- Gavin Foundation: Devine Recovery Center[238]
- Appendix 13: Additional Resources

## Implementation: Key Points

| **Tip 5:** | **Community-Wide Resources and Partnerships** | |
|---|---|---|
| **Policies** | 1. Incorporate in policies how you plan to utilize community-wide resources in care of residents with OUD and StUD.<br>2. Develop a QSOA with the OTP or OBOT/OBAT. | |
| **Awareness** | ***Community-Wide Resource*** | ***Information*** |
| *OTP* | ☐ On-site treatment and take-home treatment<br>☐ Currently offer methadone<br>☐ Future plans to offer- buprenorphine, naloxone, naltrexone<br>☐ Counseling required, treatment, planning and diversion control | • OTP Treatment Directory<br>• Massachusetts Substance Use Helpline: 1-800-327-5050<br>• SAMHSA National Helpline: 1-800-662-HELP (4357) |
| *OBOT/OBAT* | ☐ On-site treatment and take-home treatment<br>☐ Buprenorphine, naloxone, naltrexone<br>☐ Referrals to counseling, treatment, planning and diversion | • Treatment Map<br>• Massachusetts Substance Use Helpline: 1-800-327-5050<br>• SAMHSA National Helpline: 1-800-662-HELP (4357) |
| *Telehealth* | ☐ Counseling Services: facilities can be reimbursed by MassHealth and Medicare<br>☐ Include in QSOA<br>☐ MCSTAP consultations available for free | |
| *Mutual Health Group Programs* | ☐ NA: 12-step recovery program<br>☐ Nar-Anon: 12-step recovery program for family and friends<br>☐ SMART Recovery: recovery program for addictive behaviors focus on self-regulation<br>☐ Dual Recovery Anonymous: 12-step recovery and emotional or psychiatric illness | • New England Region: NAs<br>• Nar-Anon: Find a meeting<br>• SMART Recovery<br>• Dual Recovery |
| *Peer Recovery* | ☐ Reach out to local peer recovery support centers or contact the helpline. | • Peer Recovery Support Centers<br>• Reach out to OTP/OBOT for services<br>• Contact MassHealth for coverage options |
| *Patient Navigators* | ☐ Works in conjunction with local health care systems helps guide a patient through the healthcare system and patient support services. | • Currently may not be covered under insurance |
| **Regulatory Considerations** | None | |

# Tip 6: Transitions of Care

## Description

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

## Goal

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

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

## Objectives

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

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

## Policies

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

## Process

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

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

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

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

#### *Developing Qualified Service Organization Agreement*

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

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

#### *Obtaining Release of Information*

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

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

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

***Arranging Transportation of Person to Opioid Treatment Program***

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

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

***Arranging Transportation of Methadone to the Long-Term Care Facility***

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

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

***Managing Pre-Poured Methadone***

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

***Self-Administration***

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

***Discharge Planning***

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

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

***Arranging Connections to Behavioral Health Programs***

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

## Education and Resources

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

## Implementation: Key Points

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

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

# Appendices

## Appendix 1: Comparison Chart: Medication for Opioid Use Disorder

| Comparison Chart: Medication for Opioid Use Disorder | | | |
|---|---|---|---|
| **Methadone Diversion Risk – Yes** | | | |
| ***Mechanism of Action*** | ***Uses*** | ***Side Effects*** | |
| **Full Agonist**<br>Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy. | Used in medically supervised withdrawal and for maintenance phase; reduces withdrawal symptoms; prevents relapse. | Constipation, hyperhidrosis, respiratory depression, sedation, QT prolongation, sexual dysfunction, severe hypotension including orthostatic hypotension and syncope, misuse potential. | |
| ***Forms*** | ***Restrictions*** | ***Appropriate Patients*** | ***Dosing*** |
| Oral tablet or liquid. | Schedule II; only available at federally certified OTPs and acute inpatient hospital settings for OUD treatment. | Typically patients with OUD who are physiologically dependent on opioids and meet federal criteria for OTP admission. | Dosing as **prescribed by OTP.**<br><br>Daily dosing at a methadone treatment program (narcotic treatment program):<br>- Taken orally<br>- Common starting dose 20-30mg<br>- Titration up by 1-3mg. Every few days<br>- Data shows typically need at least 60mg; titrate to control without sedation<br><br>Average maintenance dose:<br>- 60-90mg, but the range can be broad<br>- Peak dose in 4hrs |

| Comparison Chart: Medication for Opioid Use Disorder | | | |
|---|---|---|---|
| **Buprenorphine (e.g., Subutex, Belbuca, Probuphine, Sublocade) Diversion Risk – Yes** | | | |
| ***Mechanism of Action*** | ***Uses*** | ***Side Effects*** | |
| **Partial agonist**<br>Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self- administered illicit opioids through cross-tolerance and opioid receptor occupancy. | Used in medically supervised withdrawal and for maintenance phase; reduces withdrawal symptoms; prevents relapse. | Constipation, nausea, precipitated opioid withdrawal, excessive sweating, insomnia, pain, peripheral edema, respiratory depression (particularly combined with benzodiazepines or other CNS depressants), misuse potential.<br>- **Implant:** Nerve damage during insertion/removal, accidental overdose or misuse if extruded, local migration or protrusion.<br>- **Subcutaneous:** Injection site itching or pain, death from intravenous injection. | |
| ***Forms*** | ***Restrictions*** | ***Appropriate Patients*** | ***Dosing per Day*** |
| Oral tablet, buccal film, extended-release implant, or subcutaneous injection. | Schedule III; requires waiver to prescribe outside OTPs. Prescribed in any setting with appropriate waiver. OTPs do not need a waiver but can prescribe and dispense.<br>- **Implant:** Prescribers must be certified in the Probuphine Risk Evaluation and Mitigation Strategy (REMS) Program. Providers who wish to insert/ remove implants are required to obtain special training and certification in the REMS Program.<br>- **Subcutaneous:** Healthcare settings and pharmacies must be certified in the Sublocade REMS Program and only dispense the medication directly to a provider for administration. | Typically for patients with OUD who are physiologically dependent on opioids. | Normal dosing range is 16-24mg/day.<br><br>Opioid-dependent patients do not typically experience euphoria at this dosage. If they do, this very mild euphoria resolves w/in a few days. Maximum recommended dose is 32mg/day.<br><br>Sublocade recommended dose is 300mg SC once monthly for the first 2 months, followed by a maintenance dose of 100mg/month. Patients need to be stabilized on a sublingual buprenorphine or buprenorphine/naloxone for at least seven days before treatment with Sublocade. |

## Comparison Chart: Medication for Opioid Use Disorder

### Buprenorphine/naloxone (e.g., Suboxone, Zubsolv, Bunavail) Diversion Risk – Yes

| *Mechanism of Action* | *Uses* | *Side Effects* | |
|---|---|---|---|
| **Combination of Partial Agonist/Antagonist** | Used in medically supervised withdrawal and for maintenance phase; reduces withdrawal symptoms; prevents relapse. | Constipation, nausea, precipitated opioid withdrawal, excessive sweating, insomnia, pain, peripheral edema, respiratory depression (particularly combined with benzodiazepines or other CNS depressants), misuse potential. | |
| ***Forms*** | ***Restrictions*** | ***Appropriate Patients*** | ***Dosing per Day*** |
| Oral tablet or buccal film. | Schedule III; requires waiver to prescribe outside OTPs. Prescribed in any setting with appropriate waiver. OTPs do not need a waiver but can prescribe and dispense. | Typically for patients with OUD who are physiologically dependent on opioids. | Dosing per day as prescribed by OTP/OBAT.<br><br>Normal dosing range is 16-24mg/day — opioid-dependent patients do not typically experience euphoria at this dosage. If they do, this very mild euphoria resolves within a few days. Maximum recommended dose is 32mg/day. |

### Naltrexone (e.g., ReVia, Vivitrol) Diversion Risk – No

| *Mechanism of Action* | *Uses* | *Side Effects* | |
|---|---|---|---|
| **Antagonist**<br>Blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy. Causes no opioid effects. | Prevents relapse following medically supervised withdrawal. | Nausea, anxiety, insomnia, precipitated opioid withdrawal, hepatotoxicity, vulnerability to opioid overdose, depression, suicidality, muscle cramps, dizziness or syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders.<br>- **Intramuscular:** Pain, swelling, induration (including some cases requiring surgical intervention). | |
| ***Forms*** | ***Restrictions*** | ***Appropriate Patients*** | ***Dosing per Day*** |
| Oral tablet or extended-release injectable. | Any prescriber can prescribe, No waiver needed/noted. | Typically for patients with OUD who have abstained from short-acting opioids for at least 7–10 days and long-acting opioids for at least 10–14 days. | Administer the extended release injectable every 4 weeks or once a month as a 380 mg IM gluteal injection**.** |

## Comparison Chart: Medication for Opioid Use Disorder

**Naloxone** **Diversion Risk – No**

| *Mechanism of Action* | *Uses* | *Side Effects* |
|---|---|---|
| **Opioid antagonist**<br>It attaches to opioid receptors and reverses and blocks the effects of other opioids. It is used for the complete or partial reversal of opioid overdose, including respiratory depression. | For opioid overdose reversal**.** | Side effects from naloxone are rare, but people might have allergic reactions to the medicine. Overall, naloxone is a safe medicine. But it only reverses an overdose in people with opioids in their systems and will not reverse overdoses from other drugs like cocaine or methamphetamine. Important to note that patients will awaken in withdrawal, could be aggressive. Patients should be monitored after reversal as opioid may have longer half-life than naloxone. |

| *Restrictions* | *Appropriate Patients* | *Forms* |
|---|---|---|
| Widely available through pharmacies and EMT and other agencies. | Persons overdosing from opioids. | - IM, IV or SC injection.<br>- Auto-injector (Evzio).<br>- Nasal Spray (naloxone). |

***Dosing***

**Initial dose:** 0.4 mg to 2 mg IV; alternatively, may give IM or subcutaneously.

- If desired response is not obtained, doses should be repeated at 2-3 minute intervals.
- If no response is observed with a total dose of 10 mg, the diagnosis of opioid-induced or partial opioid-induced toxicity should be questioned.

**Auto-injector**: For emergency use in the home or other non-medical setting.

- Administer 0.4 mg (1 actuation) IM or subcutaneously into the anterolateral aspect of the thigh (through clothing if necessary).
- If desired response is not achieved, a second dose may be administered after 2-3 minutes. Additional doses may be administered every 2-3 minutes until medical assistance arrives.

**Nasal Spray:**

- Administer 1 spray (intranasal) into 1 nostril.
- If desired response is not achieved after 2 or 3 minutes, give a second dose (intranasal) into alternate nostril; additional doses may be administered every 2 to 3 minutes in alternating nostrils until emergency medical assistance arrives.

## Appendix 2: Empathy Techniques

Empathy is the capacity to understand and relate to someone's experience and emotions. It colors most of our relationships, in every setting, and can be very important for residents who are working towards recovery from OUD and STUD.[1] Here are some examples staff can use to express empathy towards residents.[2]

| Technique | Examples (may overlap) |
|---|---|
| Naming | "It seems like you are feeling…"<br>"I wonder if you are feeling…"<br>"Some people would feel… in this situation."<br>"I can see that this makes you feel…" |
| Understanding | "I can understand how that might upset you."<br>"I can understand why you would be… given what you are going through."<br>"I can imagine what that would feel like."<br>"I can't imagine what that would feel like."<br>"I know someone who had a similar experience. It is not easy."<br>"This has been a hard time for you."<br>"That makes sense to me." |
| Respecting | "It must be a lot of stress to deal with…"<br>"I respect your courage to keep a positive attitude in spite of your difficulties."<br>"You are a brave person."<br>"I am impressed by how well you handled this." "It sounds like a lot to deal with."<br>"You have been through a lot." |
| Supporting | "I want to help in any way I can."<br>"Please let me know if there is anything I can do to help."<br>"I am here to help you in any way I can."<br>"I will be with you in this difficult time."<br>"I will be with you all the way." |
| Exploring | "Tell me more about what you were feeling when you were sick."<br>"How are you coping with this?"<br>"What has happened since we last met?" |

[1] Juergens, J. (2016, July 14). How Empathy in Addiction Treatment Helps You Heal. Retrieved from Addiction Center: https://www.addictioncenter.com/community/empathy-in-addiction-treatment/

[2] M. Jawad Hashim, M. (2017). Patient-Centered Communication: Basic Skills. American Family Physician, 29-34.

## Appendix 3: Sample Person-Centered Care-Related Interview Questions for Recruiting and Interviewing Staff (Tip 3)

### Teamwork

- Describe a situation when you had to work closely with a difficult coworker. How did you handle the situation? Were you able to build a relationship with this person?
- Talk about a conflict within your team. What was the conflict and how did you handle it?
- Describe a time when you were particularly proud of your team. What was your role in this situation?
- Tell me about a time you stepped into a leadership role.

### Patient Care

- Tell me about a time when a resident's family was dissatisfied with your care. How did you handle that situation?
- What approach do you take in communicating with people who do not know medical jargon? Give an example of a time you explained medical terminology to someone who is not medically trained.
- Describe a time you provided effective family and caregiver education.
- Talk about a time a resident or their family was particularly pleased and appreciative of your care.
- Give an example of a time you had to interact with a hostile resident. How did you handle the situation and what was the outcome?
- Describe a time you were faced with a resident who chose not to communicate or disclose important information. How did you handle the situation and what was the outcome?
- How would you handle resident abuse either observed by you or reported by a resident?

### Adaptability

- Tell me about a time you were under a lot of pressure. What was going on, and how did you get through it?
- Describe a time when your facility was undergoing some change. How did that impact you, and how did you adapt?
- Tell me about a time when you didn't know the answer to something at work. How did you go about finding the information?
- Give me an example of an awkward situation at work. How did you handle the situation?
- Tell me about a time you failed. How did you deal with this situation?
- Describe a time when you anticipated potential problems with a resident and initiated preventive measures.

### Time Management

- Talk about a time you worked in a fast-paced setting. How do you prioritize tasks while maintaining excellent care?
- Describe your experience with a resident who required a lot of your time. How did you manage this resident's care while ensuring your other residents were adequately cared for?
- Talk about a time when you felt overwhelmed with your workload. What did you do?
- Give an example of an important goal you set for yourself. Did you accomplish that goal? How did you ensure that you accomplished it?

## Communication Style

- Give an example of a time when you were able to successfully persuade a resident to agree to something. How did you persuade this person?
- Tell me about a time when you had to rely on written communication to explain yourself to your team or to a resident/family/caregiver.
- Talk about a time when you had not communicated well. How did you correct the situation?
- Describe a time when you received negative feedback and turned it into something positive.

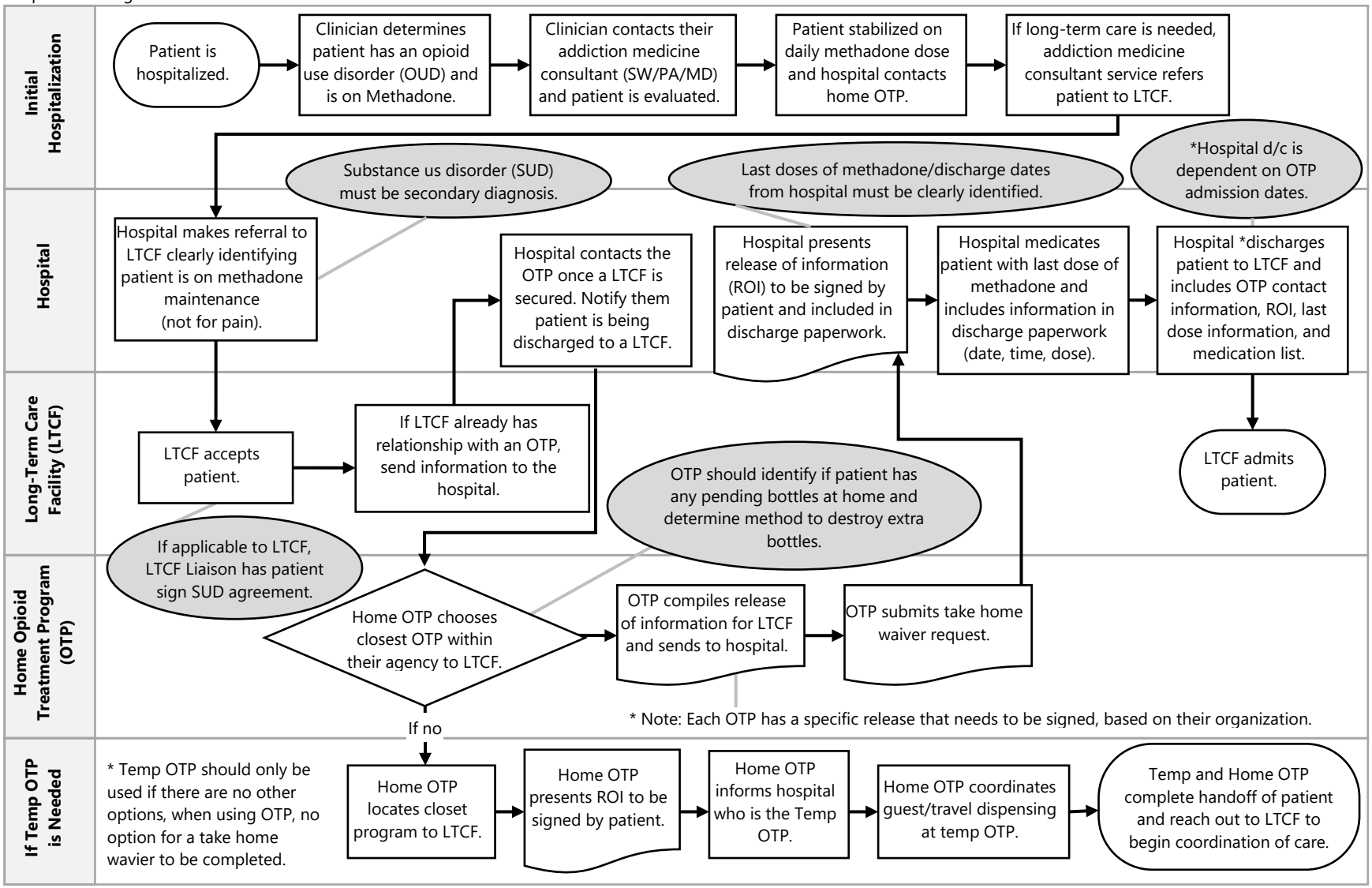
## Motivation and Core Values

- What is one professional accomplishment you are most proud of and why?
- What does a person-centered approach mean to you? Provide a concrete example of how this shows in your work, how you live your values.
- Talk about a challenging situation or problem where you took the lead to correct it instead of waiting for someone else to do it.
- Have you ever felt dissatisfied with your work and/or role? What could have been done to make it better?
- Describe a time when you went over and above your job requirements. What motivated you to put forth the extra effort?
- Give an example of a mistake you've made. How did you handle it?
- What do you find most difficult about your role? How do you overcome this difficulty?
- What motivates you the strongest in your role? What brought you into the field, and what sustains your interest and energy in this work?

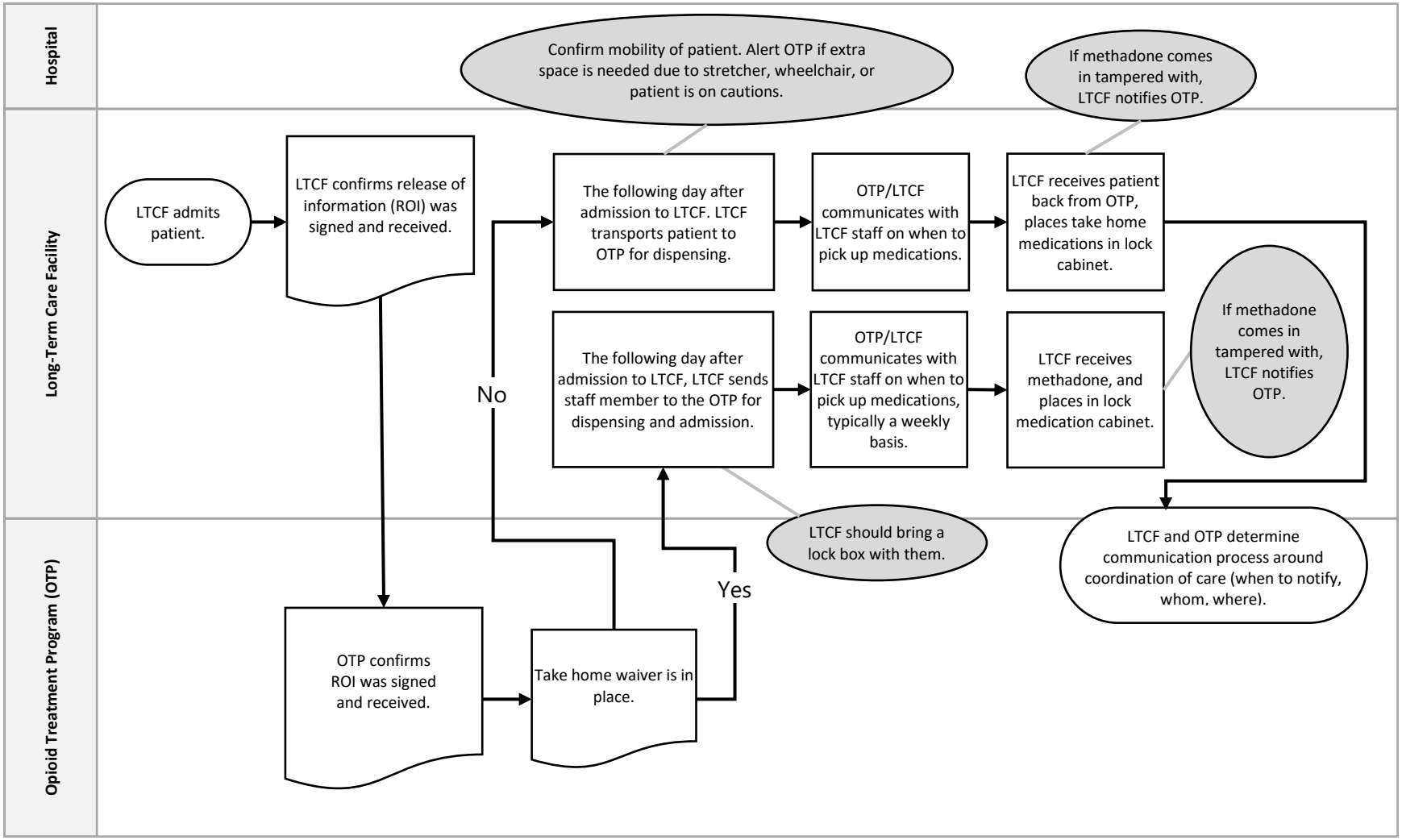
Adapted from:
https://www.beckershospitalreview.com/workforce/31-interview-questions-for-nurses-and-how-to-answer-them.html

## Appendix 4: Flow Diagram of Resident on Methadone Maintenance Discharged from Hospital to Long-Term Care Facility

**Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF)** (*Only for patients on methadone maintenance*)
Hospital Discharge Process



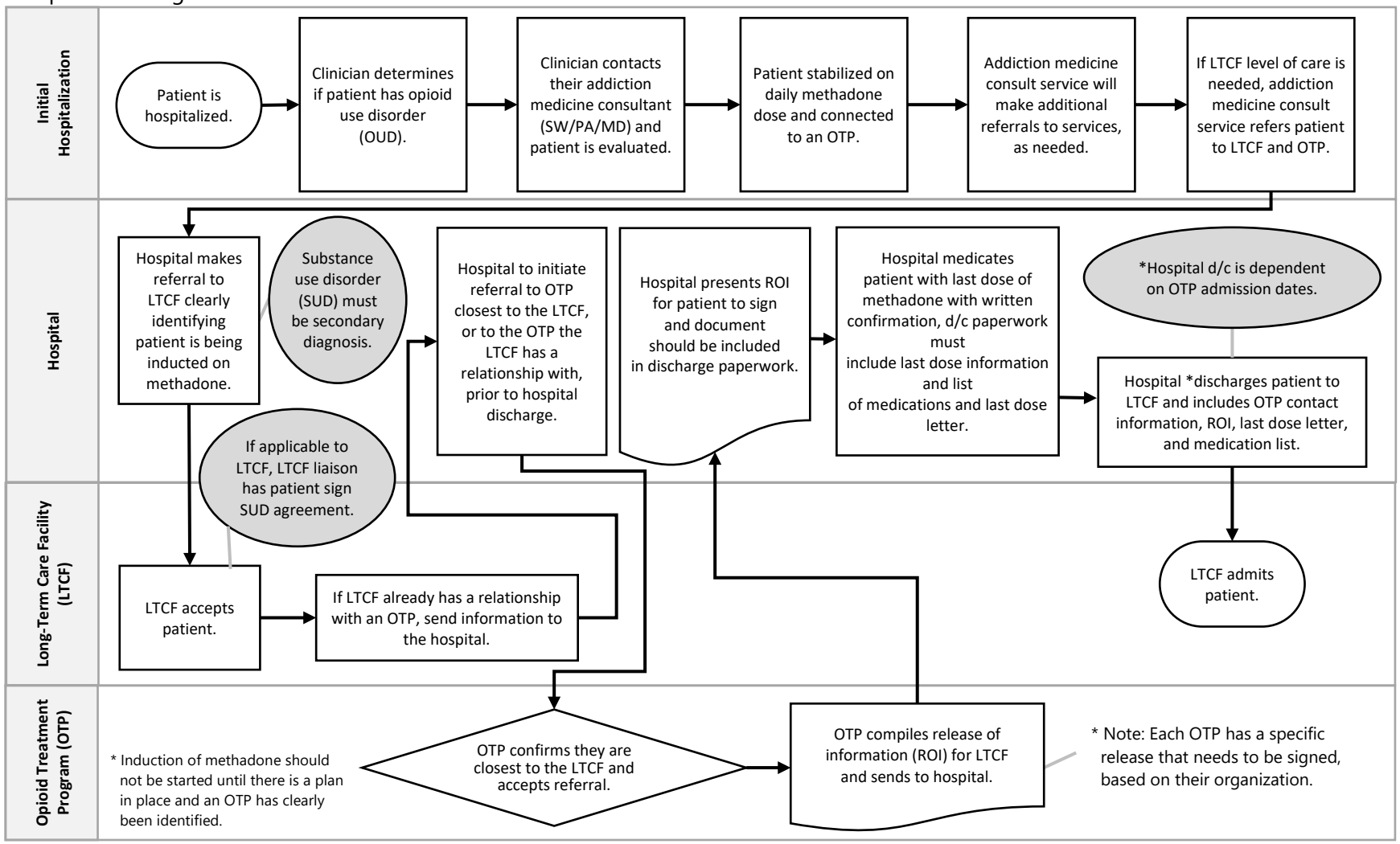
**Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF)** (*Only for patients on methadone maintenance*)
Transition of Care Between LTCF and opioid treatment program (OTP)



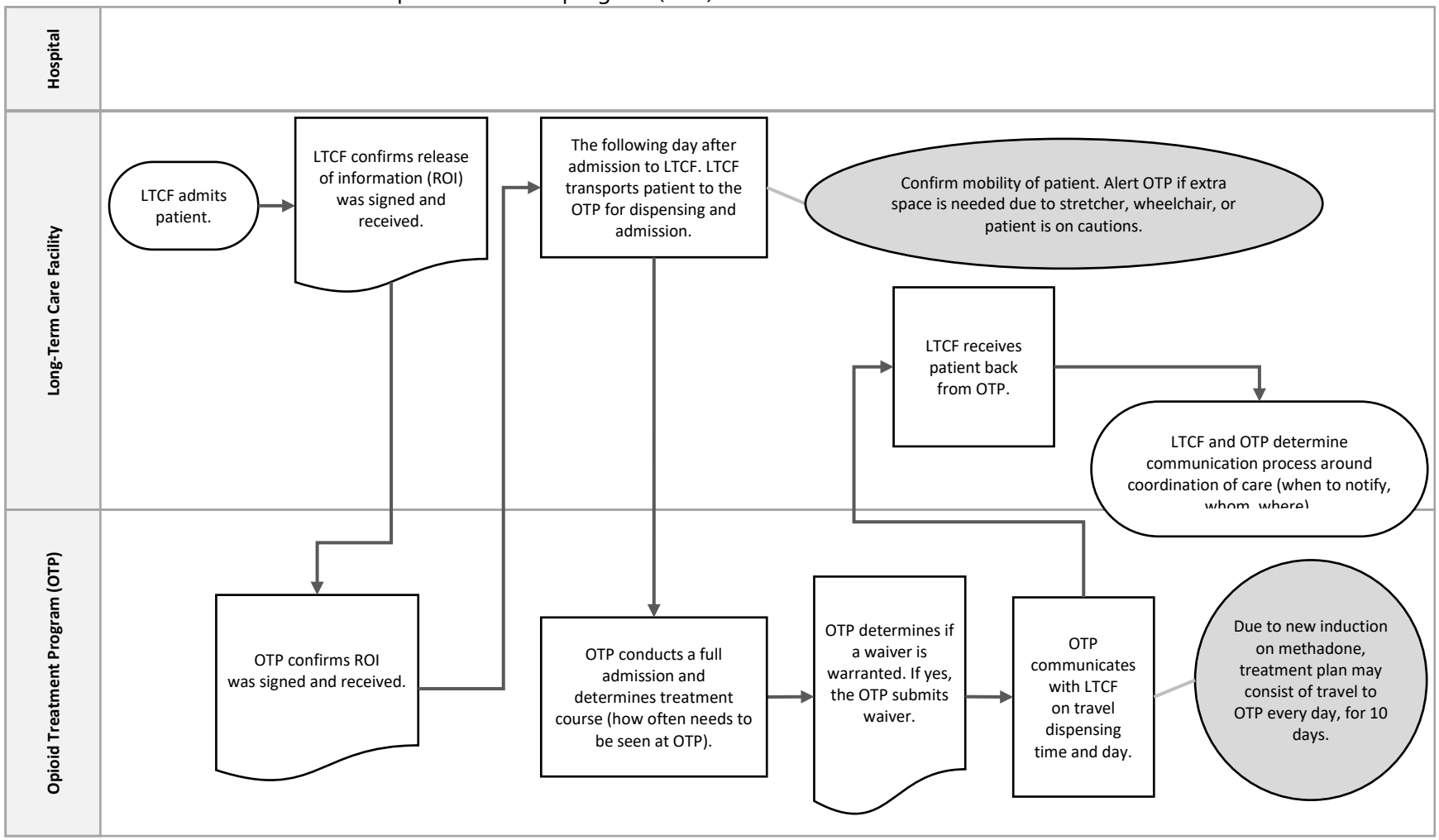
## Appendix 5: Flow Diagram of Resident who is Newly Inducted on Methadone who is Discharged from the Hospital to Long-Term Care Facility

**Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF)** (*Only for newly inducted patients on methadone*)

Hospital Discharge



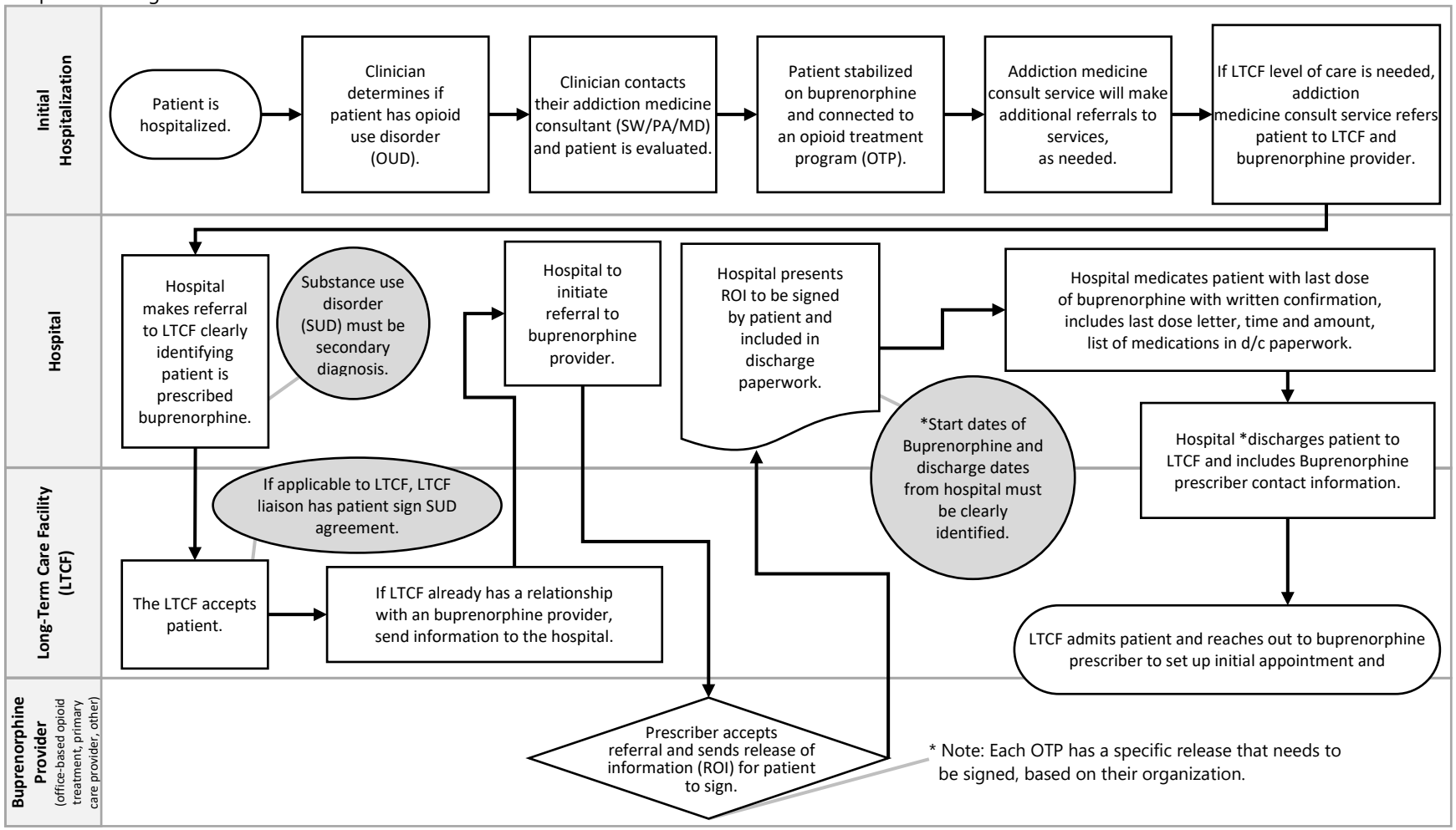
**Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF)** (*Only for newly inducted patients on methadone*)
Transition of Care Between LTCF and opioid treatment program (OTP)



## Appendix 6: Flow Diagram of Resident on Buprenorphine who is Discharged from the Hospital to a Long-Term Care Facility

**Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF)** (*Only for patients newly inducted or prescribed buprenorphine*)

Hospital Discharge




* Hospital needs to determine appropriateness of buprenorphine and should not be started until there is a plan in place and bridge clinic/prescriber has clearly been identified

## Appendix 7: Example of Qualified Service Organization Agreement

LEGAL ACTION CENTER

FORM 6: SAMPLE QUALIFIED SERVICE ORGANIZATION/ BUSINESS ASSOCIATE AGREEMENT (QSO/BA AGREEMENT)

QUALIFIED SERVICE ORGANIZATION / BUSINESS ASSOCIATE AGREEMENT (BA/QSO AGREEMENT) XYZ Service Center ("the Center") and the ABC Alcohol/Drug Program (the Program") hereby enter into an agreement whereby the Center agrees to provide _____.

(Nature of services to be provided to the program)

Furthermore, the Center:

1. Acknowledges that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from the Program identifying or otherwise relating to the patients in the Program ("protected information"), it is fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164;
2. Agrees to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
3. Agrees that it will not use or disclose protected health information except as permitted or required by this Agreement or by law;
4. Agrees that, when the Center uses, discloses, or requests protected health information, it will limit the use, disclosure, or request to the minimum necessary;
5. Agrees that if the Center enters into a contract with any agent, including a subcontractor, the agent will agree to comply with 42 C.F.R. Part 2 and HIPAA, and, if the Center learns of a pattern or practice by the agent that is a material breach of the contract with the Center, to take reasonable steps to cure the breach or terminate the contract, if feasible;
6. Agrees to comply with HIPAA's security provisions with regard to electronic protected health information, and to use appropriate safeguards (can define with more specificity) to prevent the unauthorized use or disclosure of the protected information;
7. Agrees to report breaches of protected information to the Program;
8. Agrees to report to the Program any use or disclosure of the protected information not provided for in this Agreement of which it becomes aware (insert negotiated time and manner terms);
9. Agrees to ensure that any agent, including a subcontractor, to whom the Center provides protected information received from the Program, or creates or receives on behalf of the Program, agrees to the same restrictions and conditions that apply through this Agreement to the Center with respect to such information;

10. Agrees to provide access to the protected information at the request of the Program, or to an individual as directed by the Program, in order to meet the requirements of 45 C.F.R. § 164.524 which provides patients with the right to access and copy their own protected information (insert negotiated time and manner terms);

11. Agrees to make any amendments to the protected information as directed or agreed to by the Program pursuant to 45 C.F.R. § 164.526 (insert negotiated time and manner terms);

12. Agrees to make available its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of protected information received from the Program, or created or received by the Center on behalf of the Program, to the Program or to the Secretary of the Department of Health and Human Services for purposes of the Secretary determining the Program's compliance with HIPAA (insert negotiated time and manner terms);

13. Agrees to document disclosures of protected information, and information related to such disclosures, as would be required for the Program to respond to a request by an individual for an accounting of disclosures in accordance with 45 C.F.R. § 164.528 (insert negotiated time and manner terms);

14. Agrees to provide the Program or an individual information in accordance with paragraph (9) of this agreement to permit the Program to respond to a request by an individual for an accounting of disclosures in accordance with 45 C.F.R. § 164.528 (insert negotiated time and manner terms);

**Termination**

1. The Program may terminate this Agreement if it determines that the Center has violated any material term.
2. Upon termination of this Agreement for any reason, the Center shall return or destroy all protected information received from the Program or created or received by the Center on behalf of the Program. This provision shall apply to protected information that is in the possession of subcontractors or agents of the Center. The Center shall retain no copies of the protected information.
3. In the event that the Center determines that returning or destroying the protected information is infeasible, the Center shall notify the Program of the conditions that make return or destruction infeasible (insert negotiated time and manner terms).
4. Upon notification that the return or destruction of the protected information is infeasible, the Center shall extend the protections of this Agreement to such protected information and limit further uses and disclosures of the information to those purposes that make the return or destruction infeasible, as long as the Center maintains the information.

Executed this ____ day of _____, 20___.

_____

President
XYZ Service Center
[address]

_____

Program Director
[Name of the Program]
[address]

## Appendix 8: Example Release of Information

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Subject to the notices printed on the back, I hereby authorize to disclose and or receive my health care information, including but not limited to substance use disorder information, Confidential HIV/AIDS, and psychiatric or behavioral health information (unless otherwise specified below), to/from the following individuals and/or entity listed below:

1. Name of entity or name of provider with whom I have a treating provider relationship (e.g., hospital, medical practice, physician, etc.):

   Name: _____

   Address: _____

   Phone: _____

   If you would like to limit the disclosure to the above-named entity, please specify the name of the individual(s) with whom you have a treating provider relationship (e.g., physician) below:

   _____ _____

   How would you like us to send your health information to the above individual or entity?

   ☐ U.S. mail ☐ Fax ☐ Encrypted e-mail ☐ Telephonic ☐ Encrypted CD

2. Individual with whom I do not have a treating provider relationship (e.g., attorney, probation officer) *:

   Name: _____

   Address: _____

   Phone: _____

   How would you like us to send your health information to the above individual?

   ☐ U.S. mail ☐ Fax ☐ Encrypted e-mail ☐ Telephonic ☐ Encrypted CD

*Please note that when there is no treating provider relationship, the name of an individual recipient must be specified (e.g., Naming a law firm or school is not sufficient). *

I authorize the following of my health care information to be disclosed: Place an X by those items to be disclosed.

- ☐ Intake Document
- ☐ Attendance Record
- ☐ Discharge Summary
- ☐ Urine Drug Screens
- ☐ Outside Lab Results
- ☐ Medical/Physical Exams
- ☐ Diagnostic Studies
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Psychiatric Evaluation
- ☐ Entire Medical Record
- ☐ Other:

_____

(Please provide an explicit description of what substance use disorder information may be disclosed)

Please specify the time period during which you wish the information described above to be disclosed:

- ☐ All information maintained by; or
- ☐ Information maintained: From: ___/___/_____ To: ___/___/_____

Please specify the purpose(s) of the disclosure:

- ☐ Coordinate treatment;
- ☐ Comply with court order;
- ☐ Provide to probation officer;
- ☐ Referral;
- ☐ Maintain employer involved/informed;
- ☐ Arrange transportation;
- ☐ Coordinate medication or prescriptions;
- ☐ At my request;
- ☐ Consecutive Missed Medication/Inclement Weather
- ☐ Dual enrollment
- ☐ Emergency Contact
- ☐ Other:

_____

(Please describe the purpose of the disclosure; as specific as possible)

This consent, if not revoked before, will expire twelve (12) months after I have completed my treatment at; or please specify an earlier date, event, or condition upon which this consent expires as stated herein:

_____

I understand that I may revoke this consent at any time by notifying in writing as set forth in the Notice of Privacy Practices, except to the extent that action has been taken in reliance on it (e.g., provision of treatment services in reliance on a valid consent to disclose information to a third-party payer).

I understand that The Hartford Dispensary may not condition my treatment on my signing this consent form. Upon request, I understand that I may receive a copy of this consent form after signing.

_____

Print Name of Patient or Personal Representative

_____ _____

Patient Signature (or Personal Representative) Date

For staff use only: If not signed by the patient, please describe legal authority to sign for patient:

_____

STATEMENTS REGARDING CONFIDENTIAL INFORMATION

Any information released by a program to authorized persons is subject to the following notices:

Psychiatric Information: In the event that information released constitutes confidential psychiatric information protected under state law:

"The confidentiality of this record is required under chapter general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes."

Substance Use Disorder Information: In the event that information released is protected by the U.S. Department of Health and Human Services Confidentiality of Substance Use Disorder Patient Records regulations (42 C.F.R. part 2):

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

HIV-Related Information: In the event that information released constitutes confidential HIV-related information protected under state law:

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Consent for Release of Information Revised 1/18/2018

## Appendix 9: Medical Necessity form

MASSHEALTH MEDICAL NECESSITY FORM FOR NONEMERGENCY AMBULANCE/WHEELCHAIR VAN TRANSPORTATION

MassHealth pays only for medically necessary nonemergency ambulance and wheelchair van transportation. The transportation provider is responsible for the completeness of this form and must retain the form for six years from the date of service. Pursuant to 130 CMR 450.205, the transportation provider must provide completed forms if the MassHealth agency requests them. The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. Please complete each section and field relevant to the service being provided. Fields that are not applicable to the service provided may be left blank.

**1. Trip Information**

Number of trips requested _____

Transportation requested: ☐ Wheelchair Van ☐ Nonemergency Ambulance

Date(s) of service (recurring transportation can only be authorized for up to a 30-day period, beginning with the date of the first trip): _____

Medical service provided to member at destination _____

**2. MassHealth Member Information**

Name _____

MassHealth ID Number _____ Date of Birth ___ /___ /____ Gender M F

**3. Pick-up Location**

Is pick-up location member's residence? ☐ Yes ☐ No

Is pick-up location a health care facility? ☐ Yes ☐ No

Facility Name (if pick-up location is a health care facility, including a facility at which member resides)

Street Address _____

City _____ State_____ Zip _____

**4. Destination Information**

Is destination member's residence? ☐ Yes ☐ No Is destination a health care facility? ☐ Yes ☐ No

Facility Name (if destination is a health care facility, including a facility at which member resides)

_____

Street Address _____

City _____ State _____ Zip _____

**5. Transportation Provider Information**

Name _____

NPI or PIDSL _____Tel. # _____ Fax # _____

**6a. Medical Necessity Information—Wheelchair Van Requests Only**

- ☐ Member resides in an institutionalized setting and uses a wheelchair
- ☐ Member resides in an institutionalized setting and has a severe mobility impairment preventing member from using other transportation
- ☐ Member resides in an institutionalized setting and needs to be carried up or down stairs (because member is unable to walk up or downstairs or cannot walk without the assistance of two persons)
- ☐ Member resides in the community and needs mobility assistance from transportation provider personnel to exit his or her residence or to move from his or her residence to the vehicle
- ☐ Member is being discharged from an inpatient psychiatric hospital to a community-based behavioral health program and requires supervision during transportation. PT-1 transportation is unavailable or inappropriate.

**6b. Medical Necessity Information—Ambulance Requests Only**

- ☐ Member is continuously dependent on oxygen.
- ☐ Member is continuously confined to bed.
- ☐ Member is classified as an American Heart Association Class IV patient with a disease of the heart.
- ☐ Member is receiving intravenous treatment.
- ☐ Member requires transportation after cardiac catheterization.
- ☐ Member has uncontrolled seizure disorders.
- ☐ Member has a total body cast.
- ☐ Member has hip spicas or other casts that prevent flexion at the hip.
- ☐ Member is in an isolette (incubator).
- ☐ Member is in need of restraints because the member is possibly harmful to himself or herself or others. (This includes persons transported under M.G.L. c. 123, § 12 for temporary hospitalization by reason of mental illness.)
- ☐ Member is heavily sedated.
- ☐ Member is comatose.
- ☐ Member has the following medical condition making ambulance transportation necessary.

**7. Requesting Provider Attestation**

NOTE: The requesting provider must 1) have adequate knowledge of the member's condition to attest to the information contained in the form; 2) be one of the provider types identified below; and 3) be enrolled in MassHealth (or, in the case of a physician designee, be a registered nurse supervised by a physician who is enrolled in MassHealth).

**ATTESTATION:** I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider identified below. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature _____ Date _____

Print name_____

NPI (if applicable) _____Tel. # _____ Fax # _____

Provider Type:

☐ Dentist

☐ Managed care representative

☐ Nurse midwife

☐ Nurse practitioner

☐ Physician

☐ Physician assistant

☐ Physician designee (Registered Nurse)

☐ Psychologist

Physician designees only: Provide the following information for supervising physician.

Name _____

NPI _____ Tel. # _____ Fax # _____

## Appendix 10: Methadone Chain of Custody

Methadone Chain of Custody:

Authorizing Pick-up and Administration for A Homebound or Long-Term Care Facility (LTCF) Client by a Nurse

To be filled out by [**OTP NAME**] Nurse before receipt is signed by LTCF/Visiting Nurse picking up Methadone

I am the SNF/Visiting Nurse for: _____ agree as follows:
(Name of Client, ID # and DOB)

The client is unable to come to [**OTP NAME]** for methadone treatment because:

_____

_____

I received _____sealed bottles of methadone from [**OTP NAME]** along with a Methadone Administration Record. (Initials-visiting nurse) _____

I agree that I am responsible to keep the methadone in a secure place so that only LTCF/Visiting Nurses have access to the methadone.

The LTCF/Visiting Nurse will give a bottle of methadone with the correct date, daily at about the same time.

Each LTCF/Visiting Nurse will date and initial on the Methadone Administration Record when the client is given the methadone and the LTCF/Visiting Nurse will have the client initial that he/she received the methadone.

The LTCF/Visiting Nurse will complete a nursing assessment (attached) prior to administering the methadone. The LTCF/Visiting Nurse will not administer the methadone if any abnormalities are detected during the assessment and will contact the [**OTP NAME**] program physician.

The LTCF/Visiting Nurse will return the completed Methadone Administration Record, the empty methadone bottles, and any unused methadone to [**OTP NAME**].

The LTCF/Visiting Nurse will immediately report the discharge of the client to [**OTP NAME**].

By signing below, I affirm that I fully understand the information above and have had all my questions answered.

_____ _____
Signature of LTCF/Visiting Nurse Date

_____
Printed Name of LTCF/Visiting Nurse

*Adapted from Spectrum Health Systems Chain of Custody form

## Appendix 11: Methadone Chain of Custody Administration Record

Methadone Chain of Custody and Administration Record
[**OTP NAME**} Nurse to fill in Client Name, ID Number and DOB.

Client Name: _____ ID Number: _____

Date of Birth: _____

Methadone should be given to the client daily at approximately the same time, unless there is a medical reason to alter this practice. **The bottles are dated for each day.**

The nursing assessment will be completed by the Visiting Nurse or Long-Term Care Facility (LTCF) Nurse prior to administering methadone. If any abnormalities are detected the Nurse will NOT administer the methadone without first contacting a [**OTP NAME**].

| Date bottle given to client | Initials of Visiting Nurse or LTCF Nurse | Initial of Client |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |
| | | |

Please note below if a dose of methadone was altered or not given or disposed of, and if so, when and for what reason.

_____

_____

I, the client, will notify [**OTP NAME**] immediately if the methadone seems altered in any way, and I understand that in order to pick-up refills, I will have the Visiting Nurse/LTCF Nurse return to [**OTP NAME**] the Methadone Administration Record and the empty methadone bottles.

_____ _____

Client Signature Date

_____

Client Name Printed

*Adapted from Spectrum Health Systems Chain of Custody and Administration form

## Appendix 12: Medication for Opioid Use Disorder Self-Administration Sheet

MEDICATION MANAGEMENT INSTRUMENT FOR DEFICIENCIES IN THE ELDERLY

| What a Person Knows About Their Medications | YES | NO |
|---|---|---|
| **1. Name all the medications taken each day including prescription and over-the counter medications (including milk of magnesia, nutritional supplements, herbs, vitamins, Tylenol, etc. | | |
| **2. State the time of day for each prescription medication to be taken | | |
| **3. Can you tell me how the medications should be taken (by mouth, with water, on skin, etc.) | | |
| **4. State why he/she is taking each medication | | |
| **5. Tell me the amount of each medication to be taken at each time during the day | | |
| 6. Identify if there are problems after taking the medication (i.e., like dizziness, upset stomach, constipation, loose stool, frequent urination, etc.) | | |
| 7. Does the resident get medication help from anyone? If YES, by whom? Type of help? | | |
| 8. What other medications do you have on hand or available? (i.e., eye drops, creams, lotions, or nasal sprays that are outdated, unused or discontinued) | | |
| If a Person Knows <u>How To Take Their</u> Medications | | |
| **1. Can fill a glass with water | | |
| **2. Can remove top from medication container (vial, bubble pack, pill box, etc.) | | |
| **3. Can count out required number of pills into hand or cup | | |
| **4. Can put hand with medication in it to open mouth; put hand to eye for eye drops; hand to mouth for inhaler; draw up insulin, or place a topical patch. | | |
| **5. Sip enough water to swallow medication | | |
| Record how the medications are currently being stored: | | |
| If a Person Knows <u>How to Get</u> Their Medications | | |
| **1. Identify if a refill exists on a prescription | | |
| **2. Identify who to contact to get a prescription refilled | | |
| **3. Do you have resources to obtain the medication? (Can arrange transportation to pharmacy, pharmacy delivers, daughter picks it up, etc.) | | |
| 4. After getting a new refill, do you look at the medication before you take it to make sure it is the same as the one you finished? | | |
| 5. Do you have a prescription card? YES, NO<br>Do you use your prescription card? YES, NO<br>If YES : specify type:_____ | | |
| 6. Are there medications that you need that you cannot obtain? YES, NO<br>If YES, ask resident to explain. | | |

** If NO, it is counted as a 1 in the Deficiency Score

**TOTAL DEFICIENCY SCORE: _____ (sum of three deficiency scores: maximum total score=13)**

| MEDICATION NAME | DOSAGE | TIME (S) of Day Taken | EXPIRATION DATE | PHYSICIANS NAME/PHONE | PHARMACY NAME/PHONE |
|---|---|---|---|---|---|
| | | | | | |
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Reference: Orwig D. Brandt N. Gruber-Baldini AL. (2006) Medication Management Assessment for Older Adults in the Community. Gerontologist. 2006; 46:661-668. Please contact author(s) prior to using this form at respective numbers (410) 706-8951 or (410) 706-1491 or via email dorwig@epi.umaryland.edu or nbrandt@rx.umayland.edu. Copyright 2002, University of Maryland, Baltimore 06/23/11

## Appendix 13: Additional Resources

Below is a list of additional resources, some of which were mentioned in the toolkit, that you may find informative and helpful in working with resident with OUD. This is not a comprehensive list of all available resources, but some that have been found helpful.

- The SAMHSA Treatment Improvement Protocols (TIP) Series:
  - TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment
  - TIP 54: Managing Chronic Pain in Adults with or in Recovery from Substance Abuse
  - TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse
  - TIP 57: Trauma-Informed Care in Behavioral Health Services Disorders
  - TIP 59: Improving Cultural Competence
  - TIP 63: Medications for Opioid Use Disorder
  - TIP 45: Detoxification and Substance Use Treatment

- The SAMHSA
  - Treatment of Stimulant Use Disorders

- Center for Health Care Strategies
  - Trauma-Informed Care

- Camden Coalition and The National Center for Complex Health and Social Needs
  - Medications for Addiction Treatment

- Cultural Competence for Clinicians:
  - This manual for clinicians describes the influence of culture on the delivery of substance use and mental health services. It discusses racial, ethnic, and cultural considerations, and presents the core elements of cultural competence.

- Grayken Center for Addiction: Boston Medical Center
  - Employer Resource Library

- Harm Reduction Coalition
  - Principles of Harm Reduction

- Institute for Healthcare Improvement
  - Quality Improvement Essential Toolkit

- KAP KEY for Clinicians:
  - This manual for professional care providers and administrators describes the influence of culture on the delivery of substance use and mental health services. It discusses racial, ethnic, and cultural considerations, and presents the core elements of cultural competence.

- Implicit Bias Resources:
  - Addressing Bias
  - Check Your Blind Spot: Understanding Implicit Bias
  - Recovery Among Diverse Population Video with a Discussion Guide

- Office-Based Addiction Treatment Training and Technical Assistance (OBAT TTA):
  - Providers
  - Patient and Family Resources
  - Better Understanding Addiction

- Providers Clinical Support System
  - Evidence-Based Training and Resources to Treat Patients with OUD

- RIZE Massachusetts
  - An Initiative to End the Opioid Epidemic

- SAFE Project
  - Community Playbook: Step-by-Step Guide

## Citations

[1] Center for Behavioral Health Statistics and Quality. (2020). *2019 National Survey on Drug Use and Health: Methodological summary and definitions*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[2] Ibid.

[3] Massachusetts Department of Public Health. (2021, May). Data Brief: Opioid-related overdose deaths among Massachusetts residents. Retrieved from https://www.mass.gov/lists/current-opioid-statistics#updated-data-%E2%80%93-as-of-may-2021-.

[4] Schieber LZ, Guy GP Jr, Seth P, Losby JL. Variation in Adult Outpatient Opioid Prescription Dispensing by Age and Sex: United States, 2008-2018. MMWR Morb Mortal Wkly Rep 2020;69:298-302. DOI: http://dx.doi.org/10.15585/mmwr.mm6911a5external icon

[5] Ibid.

[6] 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.

[7] National Center for Health Statistics, Centers for Disease Control and Prevention. (2021, April). Co-involvement of Opioids in drug overdose deaths involving cocaine and psychostimulants. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db406.htm.

[8] O'Brien, P., Henke, RM, Schaefer, M. B., et al. (2020). Utilization of treatment by Medicaid enrollees with opioid use disorder co-occurring substance use disorders. Drug and Alcohol Dependence, 271. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0376871620304269.

[9] Siefried KJ, Acheson LS, Lintzeris N, Ezard N. Pharmacological Treatment of Methamphetamine/Amphetamine Dependence: A Systematic Review. CNS Drugs. 5th ed. 2020;34(4):337-365. DOI:10.1007/s40263-020-00711-x. PubMed PMID:32185696; PubMed Central PMCID:PMC7125061.

[10] Figure 2: KFF analysis of Centers for Disease Control and Prevention (CDC). (2021). National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database.

[11] Massachusetts Department of Public Health Press Release. (2021, May 12). Retrieved from https://www.mass.gov/news/opioid-related-overdose-deaths-rose-by-5-percent-in-2020.

[12] O'Donnell J, Galdden M, Mattson C, Hunter C, Davis N. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants – 24 States and the District of Columbia, January-June 2019. MMWR Morb Mortal Wkly Rep 2020;69:1189-1197.

[13] Connolly B, Doyle S, Baaklini V. More Outpatient Treatment Needed for Opioid Use Disorder. PEW. April 30, 2020.

[14] 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. Retrieved from https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

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

[16] Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality. Ann Intern Med. 2018;169(3):137. doi:10.7326/M17-3107

[17] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357. doi:10.1136/bmj.j1550

[18] Larochelle MR, Bernson D, Land T, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality. Ann Intern Med. 2018;169(3):137. Doi:10.7326/M17-3107.

[19] Camden Coalition. The National Center for Complex Health & Social Needs. (2019, September). Medications for addiction treatment. Providing best practice care in a primary care clinic. Retrieved from https://camdenhealth.org/wp-content/uploads/2019/09/Medications-for-addiction-treatment-FINAL-9.20.19.pdf

[20] Partnership to End Addiction [Video]. (2013, June 17). Medication-Assisted Treatment Overview: Naltrexone, Methadone & Suboxone. Retrieved from https://www.youtube.com/watch?v=tMusvDyoIRI

[21] qtpie20121 [Video]. (2008, September 15). Addiction: HBO Video About Medication Assisted Treatment. Retrieved from https://www.youtube.com/watch?v=c8r1BbrTjTQ

[22] Ronsley C, Nolan S, Knight R, Hayashi K, Klimas J, Walley A, et al. (2020) Treatment of stimulant use disorder: A systematic review of reviews. PLoS ONE 15(6): e0234809.

[23] MDPH. (2020, February). Data Brief Trends in Stimulant-Related Overdose Deaths.

[24] SAMHSA. (2020, June). Evidence-Based Resource Guide Series: Treatment of Stimulant Use Disorders. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-001_508.pdf

[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Ibid.

[29] Addressing Opioid Use Disorder among LGBTQ Populations. Health Resources and Services Administration. (June

2018). Retrieved June 2021. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/06/OpioidUseAmongLGBTQPopulations.pdf

[30] National Institute on Drug Abuse. (2018). Drugs, Brains, and Behavior: The Science of Addiction: Drug Misuse and Addiction. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

NIDA. "Prescription Opioids DrugFacts." National Institute on Drug Abuse, 1 Jun. 2021, https://www.drugabuse.gov/publications/drugfacts/prescription-opioids. Accessed 3 Aug. 2021.

[32] Strain, E. M. (2019). UpToDate. Retrieved from Opioid use disorder: Epidemiology, pharmacology, clinical manifestations, course, screening, assessment, and diagnosis: https://www.uptodate.com/contents/opioid-use-disorder-epidemiology-pharmacology-clinical-manifestations-course-screening-assessment-and-diagnosis

[33] National Institute on Drug Abuse. (2005, June). Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. Retrieved from https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease

[34] World Health Organization. (2009). Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Retrieved from *National Center for Biotechnology Information: Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings.*

[35] SAMHSA (2019). Opioid Overdose Prevention Toolkit. Retrieved from https://store.samhsa.gov/system/files/sma18-4742.pdf

[36] Centers for Disease Control and Prevention. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

[37] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020

[38] NIDA. Methamphetamine DrugFacts. National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/drugfacts/methamphetamine. June 16, 2020 Accessed June 28,2020., NIDA. Cocaine DrugFacts. National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/drugfacts/cocaine. June 16, 2020 Accessed June 28, 2020.

[39] Ibid.

[40] Ibid.

[41] Ibid.

[42] Alcohol and Drug Foundation (ADF). (2021). Stimulants. Retrieved June 2021. https://adf.org.au/drug-facts/stimulants/

[43] Alcohol and Drug Foundation (ADF). (2021). Stimulants. Retrieved June 2021. https://adf.org.au/drug-facts/stimulants/ Integration of Care for People Who Use Stimulants into Substance Use Treatment Services. Bureau of Substance Addiction Services, 2021. Retrieved June 2021. https://www.mass.gov/doc/stimulant-use-disorder-treatment-guidance-pdf/download

[44] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020

[45] Ibid.
[46] Ibid.
[47] Ibid.
[48] Integration of Care for People Who Use Stimulants into Substance Use Treatment Services. Bureau of Substance Addiction Services, 2021. Retrieved June 2021. https://www.mass.gov/doc/stimulant-use-disorder-treatment-guidance-pdf/download
[49] National Harm Reduction Coalition (2020), https://harmreduction.org/issues/overdose-prevention/overview/stimulant-overamping-basics/recognizing-stimulant-overamping/
[50] Ibid.
[51] Methamphetamine Case Study, y Ruth "Missy" Jensen, MSN, FNP, American Association of Heart Failure Nurses, https://cdn.ymaws.com/www.aahfn.org/resource/resmgr/Docs/casestudies/Meth_Case_Study.pdf
[52] What are prescription opioids? National Institute on Drug Abuse (NIH). (June 2021). Retrieved June 2021. https://www.drugabuse.gov/publications/drugfacts/prescription-opioids
[53] Ibid.
[54] Ibid.
[55] Ibid.
[56] https://www.drugabuse.gov/drug-topics/opioids/benzodiazepines-opioids
[57] OBAT TTA. (2020). Resources. Retrieved from Videos from Our Experts: https://www.bmcobat.org/resources/?category=8
[58] Morrow, S. D. (2014). Drug addiction viewed more negatively than mental illness, Johns Hopkins study shows. Johns Hopkins Magazine.
[59] Stark County Mental Health & Addiction Recovery. (2019). Heroin and Opiate Help. Retrieved from https://starkmhar.org/help/stark-countys-heroin-epidemic/understanding-opiate-addiction/

[60] Curated Library about Opioid Use for Decision-makers (CLOUD). (2021). Retrieved from CLOUD Stories of Stigma: Stephanie's Story: https://www.opioidlibrary.org/video/2241/
[61] UMass Medical School. (2017). Retrieved from National Network of Libraries of Medicine New England Region: https://escholarship.umassmed.edu/ner/48/
[62] Landry, M. (2012). Anti-Stigma Toolkit. Retrieved from https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf
[63] National Council for Behavioral Health. (2019). Medication-Assisted Treatment. Retrieved from https://www.thenationalcouncil.org/mat/
[64] Aaron M. Williams, M., Jordan Hansen, M. L., & Ashel Kruetzkamp, M. R. (2017, June). Identifying and Lifting Barriers to Integrating MAT with 12 Step Modalities. *Retrieved from The National Council for Behavioral Health*: https://www.thenationalcouncil.org/wp-content/uploads/2017/06/MAT-with-12-Steps-slide-deck.pdf
[65]National Institute on Drug Abuse. (2005, June). Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. Retrieved from https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease
[66] Harm Reduction Coalition. (2019). Retrieved from Principles of Harm Reduction: https://harmreduction.org/about-us/principles-of-harm-reduction/
[67]Shatter Proof. (2019). Retrieved from In It Together: Opportunities to increase screening and treatment of opioid

use disorder among Massachusetts healthcare professionals: https://rizema.org/wp-content/uploads/2019/07/GE-Rize-Shatterproof-White-Paper-Final.pdf

[68]Harm Reduction Coalition. (2019). Retrieved from Principle of Harm Reduction: https://harmreduction.org/about-us/principles-of-harm-reduction/

[69]Grayken Center for Addiction and Boston Medical Center. (2019). Retrieved from I Pledge to stop stigma associated with addiction: https://development.bmc.org/wp-content/uploads/2018/09/Grayken-Center-for-Addiction-at-Boston-Medical-Center-Words-Matter-Pledge.pdf

[70]Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Geneva: World Health Organization; 2009. 4, Withdrawal Management. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK310652/

[71]American Psychiatric Association. (2019). Retrieved from Addiction and Substance Use Disorder: https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder/opioid-use-disorder

[72]Centers for Disease Control and Prevention. (2019). Retrieved from Opioid Factsheet: https://www.cdc.gov/drugoverdose/pdf/AHA-Patient-Opioid-Factsheet-a.pdf

[73] Familydoctor.org. (2019). Retrieved from Opioid Addiction: https://familydoctor.org/condition/opioid-addiction/

[74] NAMI. (2019). Stigmafree. Retrieved from https://www.nami.org/stigmafree

[75] Boston Medical Center Office-Based Addiction Treatment, Training, and Technical Assistance. (n.d.). https://www.bmcobat.org/training/register/

[76] SAMHSA. https://www.ncbi.nlm.nih.gov/books/NBK64323/#A57812

[77] National Harm Reduction Coalition (2020), https://harmreduction.org/issues/overdose-prevention/overview/stimulant- overamping-basics/recognizing-stimulant-overamping/

[78] HeretoHelp 2019, https://www.heretohelp.bc.ca/stigma-and-discrimination

[79] *Maintaining a Therapeutic Environment*. (n.d.). Retrieved from ATrain Education: https://www.atrainceu.com/course-module/3511837-200_adrd3-module-08 Ron Smith, A. A. (2016, September 22). *Therapeutic Environments*. Retrieved from Whole Building Design Guide: https://www.wbdg.org/resources/therapeutic-environments

[80] Healthcentric Advisors. (2015). Holistic Approach to Transformational Changes. https://www.youtube.com/watch?v=DtRnzz4ztbk

[81] *Maintaining a Therapeutic Environment*. (n.d.). Retrieved from ATrain Education: https://www.atrainceu.com/course-module/3511837-200_adrd3-module-08 https://www.atrainceu.com/course-module/3511837-200_adrd3-module-08

[82] Tom Medlar, M. L. (n.d.). Inter-Generations. Retrieved from Role Boundaries in the Long-Term Care Setting: http://www.intergens.com/featurearticle-35.html

[83] Martin J. Hatlie, JD; Knitasha Washington, DHA, MHA, FACHE, Forming a Patient and Family Advisory Council (PFAC), 2016, https://edhub.ama-assn.org/steps-forward/module/2702594

[84] Institute for Patient and Family Centered Care. (2019). Retrieved from https://www.ipfcc.org/resources/Advisory_Councils.pdf

[85] AHRQ. (2018). Retrieved from Working with Patient and Families as Advisors: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf

[86] U.S. Department of Health and Human Services (HHS). Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient

Individuals. U.S. Department of Health and Human Services. Office of Civil Rights. http://hhs.gov/ocr/civilrights/resources/specialtopics/lep

[87] Torres, Brunilda. 2001. Best Practice Recommendations for Hospital-Based Interpreter Services. Massachusetts Department of Public Health. Massachusetts Department of Public Health. Office of Health Equity, https://www.mass.gov/files/documents/2016/07/vq/chapter-6-ensure-language-access.doc

[88] Swarbrick, M. (2006). A wellness approach. Psychiatric Rehabilitation Journal, 29(4), 311-314

[89] Adapted from Swarbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, 29(4), 311-314

[90] National Institute of Neurological Disorders and Stroke. (2019). Brain Basics: Understanding Sleep. Retrieved from https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Understanding-Sleep#2

[91] Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from https://store.samhsa.gov/system/files/pep12-recdef.pdf

[92] MARS Maryland Quality Improvement Project, On Our Own, n.d. https://onourownmd.org/wp-content/uploads/mars-md-quality-improvement-project-rec.pdf

[93] Institute for Health Recovery. (n.d.). Retrieved from http://www.healthrecovery.org/publications/

[94] Institute for Patient and Family Centered Care. (2018). Retrieved from Partnerships to Address the Opioid Epidemic: https://www.ipfcc.org/bestpractices/opioid-epidemic/index.html

[95] Bureau of Justice Assistance U.S. Department. (2014). Tribal Healing to Wellness Courts: The Key Components. http://www.wellnesscourts.org/files/Tribal%20Healing%20to%20Wellness%20Courts%20The%20Key%20Components.pdf

[96] SAMHSA. (2019). Retrieved from Resources for Families Coping with Mental and Substance Use Disorders: https://www.samhsa.gov/families

[97] SAMHSA. (2016). Creating a Healthier Life: A Step-by-Step Guide to Wellness: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4958.pdf

[98] SAMHSA. (n.d.). Retrieved from Recovery and Recovery Support: https://www.samhsa.gov/find-help/recovery

[99] New England Region of Narcotics Anonymous (2019). Home. Retrieved October 2019, from https://nerna.org/

[100] Nar-Anon Family Groups (2019) Home. Retrieved October 2019, from https://www.nar-anon.org/naranon/

[101] SMART Recovery (2019). Home. Retrieved October 2019, from https://www.smartrecovery.org/

[102] The Phoenix. (n.d.). Massachusetts: https://thephoenix.org/locations/massachusetts/

[103] Centers for Medicare and Medicaid Services. (2017). State Operations Manual Appendix PP - Guidance to Surveyors for Long-Term Care Facilities.

[104] Tellis-Nayak, V. (2007). A Person-Centered Workplace: The Foundation for Person-Centered Caregiving in Long-Term Care. Journal of the American Medical Directors Association, 46-54.

[105] National Quality Forum. (2019). National Quality Partners Playbook: Enhancing Access to Medication-Assisted Treatment. Washington, DC: National Quality Forum.

[106] Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from https://store.samhsa.gov/system/files/pep12-recdef.pdf

[107] Q&As, H. (2018, March 5). Mission & Vision Statements: What is the difference between mission, vision and values statements? Retrieved from Society of Human Resource Management: https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/isthereadifferencebetweenacompany%E2%80%99smission,visionandvaluestatements.aspx

[108] Community Tool Box. (2019). Retrieved from https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/vision-mission-statements/main

[109] Action Pact. (2019). Retrieved from http://www.actionpact.com/

[110] Institute for Health and Recovery. (2012). Developing Trauma-Informed Organizations: A Tool Kit: https://healthrecovery.org/images/products/30_inside.pdf

[111] Institute for Patient and Family Centered Care. (2019). Retrieved from https://www.ipfcc.org/resources/Advisory_Councils.pdf

[112] Pioneer Network. (2019). Retrieved from Changing the Culture of Aging in 21st Century: https://www.pioneernetwork.net/

[113] Planetree International. (2019). Retrieved from Person-Centered Care: http://www.planetree.org/

[114] The Green House Project. (2019). Retrieved from https://www.thegreenhouseproject.org/

[115] Baldoni, J. (2013, July 4). Employee Engagement Does More than Boost Productivity. Retrieved from Harvard Business Review: https://hbr.org/2013/07/employee-engagement-does-more

[116] Becker's Hospital Review. (2021). Retrieved from https://www.beckershospitalreview.com/workforce/31-interview-questions-for-nurses-and-how-to-answer-them.html

[117] Connecticut State Department of Mental Health and Addiction Services. (2019). Retrieved from https://portal.ct.gov/DMHAS/Initiatives/DMHAS-Initiatives/MAT-Learning-Collaborative

[118]Dardess, P. D. (2018). Partnering with Patients and Families to Strengthen Responses to the Opioid Epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care.

[119] Providers Clinical Support System. (2020). PCSS Mentoring Program. Retrieved June 2021. https://pcssnow.org/mentoring/

[120] Bioxcel Therapeutics. (2021). Cooperative De-escalation. Retrieved July 2021. https://www.partnersincalm.com/cooperative-de-escalation/?msclkid=4d0507e4ad24107cfc34672e9ca139f9&utm_source=bing&utm_medium=cpc&utm_campaign=M%20%7C%20UB%20%7C%20HCP%20%7C%20Cooperative%20De-escalation&utm_term=de%20escalation%20technique&utm_content=Cooperative%20De-escalation%20Ph

[121] SAMHSA. (2019). Trauma and Violence. https://www.samhsa.gov/trauma-violence

[122] Healthcentric Advisors. (2018). Trauma-Informed Care: Change Package for Nursing Centers. Trauma-Informed Care: Change Package for Nursing Centers. Providence, RI.

[123]Center for Healthcare Strategies. (2019). Retrieved from What is Trauma-Informed Care? https://www.youtube.com/watch?v=fWken5DsJcw

[124] National Council for Behavioral Health. (2018). https://www.youtube.com/watch?v=uraDbhfFvsk

[125] Trauma and Addiction: Crash Course Psychology #31 (2014). https://www.youtube.com/watch?v=343ORgL3kIc

[126] https://healthcentricadvisors.org/wp-content/uploads/2019/10/TIC-FINAL-2019OCT.pdf

Institute for Health and Recovery. (2012). Developing Trauma-Informed Organizations. Retrieved from https://healthrecovery.org/images/products/30_inside.pdf

[127] Healthcentric Advisors. (2019). Retrieved from Trauma-Informed Care: https://healthcentricadvisors.org/wp-content/uploads/2019/10/TIC-FINAL-2019OCT.pdf

[128] Garland EL, R. S. (2019). Adverse childhood experiences predict autonomic indices of emotion dysregulation and negative emotional cue-elicited craving among female opioid-treated chronic pain patients. Development and Psychopathology, 1101-1110.

[129] Prevention, C. f. (2019, April 9). About Adverse Childhood Experiences. Retrieved from CDC Injury Center:

https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html

[130] https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean

[131] http://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

[132] Robeznieks, A. (2018, August 22). Opioid-use Disorder: Treat the family, not just the patient. Retrieved from American Medical Association: https://www.ama-assn.org/delivering-care/opioids/opioid-use-disorder-treat-family-not-just-patient

[133] Learn to Cope: 2019 https://www.learn2cope.org/

[134] Learn to Cope: 2019 https://www.learn2cope.org/

[135] Allies in Recovery. (2019). Retrieved from https://alliesinrecovery.net/

[136] Center for Motivation & Change. (2019). Retrieved from https://motivationandchange.com/family-services/what-is-craft/

[137] Massachusetts Substance Use. (2019). Retrieved from Helpline: https://helplinema.org/

[138] National Quality Forum. (2019). National Quality Partners Playbook: Enhancing Access to Medication-Assisted Treatment. Washington, DC: National Quality Forum.

[139] Careers of Substance. (2019). Retrieved from https://careersofsubstance.org/

[140] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020

[141] Substance Abuse and Mental Health Services Administration. (2013). Enhancing Motivation for Change in Substance Abuse Treatment. Rockville, MD: US Department of Health and Human Services.

[142] Center for Addiction and Mental Health. (2019). Retrieved from Motivational Interviewing Basics: http://thehub.utoronto.ca/family/wp-content/uploads/2016/12/MI-Cheat-Sheet-copy.pdf

[143] University of Virginia. (2012). Retrieved from MI Quick Reference Sheet: https://www.med-iq.com/files/noncme/material/pdfs/XX183_ToolKit_%20QuickReferenceSheet.pd f

[144] Community Care of North Carolina. (n.d.). Retrieved from CCNC Motivational Interviewing (MI): https://www.communitycarenc.org/media/files/mi-guide.pdf

[145] Motivational Interviewing Network of Trainers. (2020) Welcome to the Motivational Interviewing Network of Trainers (MINT): https://motivationalinterviewing.org/

[146] CLAS Standard 1, HHS, Office of Minority Heath, CLAS and CLAS Standards: https://www.thinkculturalhealth.hhs.gov

[147] Making CLAS Happen: Six Areas for Action. Retrieved from Massachusetts Department of Health, Culturally and Linguistically Services (CLAS) Initiative https://www.mass.gov/lists/making-clas-happen-six-areas-for-action#introduction-&-chapters-1-6-

[148] Ibid.

[149] SAMHSA. (2016). Quick Guide for Clinicians: Based on Tip 59 – Improving Cultural Competence https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf

[150] SAMHSA. (2016). KAP Keys for Clinicians: Based on Tip 59 – Improving Cultural Competence https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf

[151] HHS. (n.d.). Think Cultural Health: https://thinkculturalhealth.hhs.gov/about

[152] HHS. (n.d.). Office of Minority Health: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=1

[153] O'Reilly, 10 New Ways the New Opioid Law Could Help Address the Epidemic, American Medical Association, n.d. https://www.ama-assn.org/delivering-care/opioids/10-ways-new-opioids-law-could-help-address-epidemic

[154] Untangling the Medical Ethics of Prescribing Opioids (2018, August 10), https://www.ama-assn.org/delivering-care/ethics/untangling-medical-ethics-prescribing-opioids

[155] Office-Based Addiction Treatment Training and Technical Assistance, OBAT Clinical Guidelines, www.bmcobat.org/resources/?category=1

[156] Substance Abuse Confidentiality Regulations, SAMHSA, www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

[157] Shaming the Sick: Addition and Stigma. (n.d.). Lauren Villa, Retrieved from Drugabuse.com: https://drugabuse.com/addiction/stigma/

[158] https://www.acponline.org/system/files/documents/about_acp/chapters/ma/ge-rize-shatterproof-white-paper_final.pdf

[159] Olsen, Y., Sharfstein, J.M., 2014. Confronting the Stigma of Opioid Use Disorder—and Its Treatment. JAMA 311, 1393. https://doi.org/10.1001/jama.2014.2147

[160] "Changing Language to Change Care" https://cf8b2643ab1d3c05e8f6-d3dc0d8f838e182b6b722cea42bb6a35.ssl.cf2.rackcdn.com/aaap_eb20f80a7ec0c1713978ba2b069091f7.pdf

[161] Signs of Opioid Abuse, Johns Hopkins Medicine n.d. https://www.hopkinsmedicine.org/opioids/signs-of-opioid-abuse.html

[162] National Center for Cultural Competence, Georgetown University Center for Child and Human Development. (n.d.). Conscious & Unconscious Biases in Health Care: https://nccc.georgetown.edu/bias/

[163] Opportunities to Increase Sceening & Treatment of OUD Among Healthcare Professionals, 2019, https://www.acponline.org/system/files/documents/about_acp/chapters/ma/ge-rize-shatterproof-white-paper_final.pdf

[164] Olsen, Y., Sharfstein, J.M., 2014. Confronting the Stigma of Opioid Use Disorder—and Its Treatment. JAMA 311, 1393. https://doi.org/10.1001/jama.2014.2147

[165] MAT Training https://cf8b2643ab1d3c05e8f6-d3dc0d8f838e182b6b722cea42bb6a35.ssl.cf2.rackcdn.com/aaap_eb20f80a7ec0c1713978ba2b069091f7.pdf

[166] Signs of Opioid Abuse, Johns Hopkins Medicine n.d. https://www.hopkinsmedicine.org/opioids/signs-of-opioid-abuse.html

[167] Ibid.

[168] Substance Use and Co-Occurring Mental Disorders. National Institute of Mental Health. (2021). Retrieved June 2021. https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health/

[169] Signs of Opioid Abuse, Johns Hopkins Medicine n.d. https://www.hopkinsmedicine.org/opioids/signs-of-opioid-abuse.html

[170] University at Buffalo. (2021, August). What is Trauma-Informed Care? Retrieved from http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

[171] The Columbia Lighthouse Project (2019): Identify Risk. Prevent Suicide. http://cssrs.columbia.edu/

[172] Signs of Opioid Abuse, Johns Hopkins Medicine n.d. https://www.hopkinsmedicine.org/opioids/signs-of-opioid-abuse.html

[173] Marc A. Schuckit, M. (2016, July 28). *Treatment of Opioid-Use Disorders*. Retrieved from The New England Journal

of Medicine:
https://www.nejm.org/doi/10.1056/NEJMra1604339

[174] What is Trauma-Informed Care?, Buffalo Center for Social Research, n.d. http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

[175] Louis A. Trevisan, M. (n.d.). *Substance Use Disorders in Older People* . Retrieved from Providers Clinical Support System: https://cf8b2643ab1d3c05e8f6-d3dc0d8f838e182b6b722cea42bb6a35.ssl.cf2.rackcdn.com/aaap_986d7d138b9fc49bcf0f61d6ba0392c9.pdf

[176] There are pediatric LTCFs in Massachusetts but this is not the focus of our work. Information for pediatric LTCFs can be found at https://www.mass.gov/medical-review-team.

[177] Alford, D. P. (n.d.). *Managing Acute & Chronic Pain with Managing Acute & Chronic Pain with Medication-Assisted Treatment (MAT)*. Retrieved from Providers Clinical Support System for Medication-Assisted Treatment: http://pcssnow.org/wp-content/uploads/2015/12/Alford-Acute-Chronic-Pain-MAT-FINAL2-12-22-15.pdf

[178] BSAS Practice Guidelines (2015): https://www.mass.gov/files/documents/2016/07/vp/care-principles-guidance-older-adults.pdf

[179] BSAS Practice Guidelines (2015): https://www.mass.gov/files/documents/2016/07/op/practice-guidance-engaging-young-adults-and-their-families.docx

[180] Celeste Shawler, R. G. (2001, October 01). *Analysis of Key Decision-Making Incidents in the Life of a Nursing Home Resident*. Retrieved from The Gerontologist: https://academic.oup.com/gerontologist/article/41/5/612/596559

[181] Circular Letter: DHCQ 16-11-662 - Admission of Residents on Medication-Assisted Treatment for Opioid Use Disorder, Eric Sheehan, JD, Director, Bureau of Health Care Safety and Quality, November 15, 2016 https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted

[182] Opioid Overdose Prevention Toolkit - Five Essential Steps for First Responders, 2018 https://store.samhsa.gov/system/files/five-essential-steps-for-first-responders.pdf

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

[184] American Addiction Centers National Rehabs Directory. (2019, November 4). Check Your Blind Spot: Understanding Implicit Bias: https://rehabs.com/pro-talk/check-your-blind-spot-understanding-implicit-bias/

[185] SAMHSA. (2017, December 18). The Road to Recovery Discussion Guide: 2018 Television and Radio Series: https://www.recoverymonth.gov/sites/default/files/roadtorecovery/r2r2018-july-discussion-guide-508.pdf

[186] 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

[187] COVID-19 Medication Dosing in Opioid Treatment Programs. Executive Office of Health and Human Services – Department of Public Health, The Commonwealth of Massachusetts. June 10, 2021. Retrieved June 2021. https://search.mass.gov/?_ga=2.254905544.1385348170.1624814791-1677852464.1614185120&page=1&q=OTP%20SAMHSA%20blanket%20waiver

[188] Ibid.

[189] Federal Opioid Treatment Standards. (2015, June 18). 42 CFR §8.12(h)(4)(i). Retrieved from https://www.ecfr.gov/cgi-

bin/retrieveECFR?gp=4&SID=fd009293990433d2961852b541ef0305&ty=HTML&h=L&mc=true&r=SECTION&n=se42.1.8_112

[190] U.S. Department of Health & Human Services. Opioid Treatment Program Directory. SAMHSA. Retrieved October 2019, from https://dpt2.samhsa.gov/treatment/directory.aspx

[191] Administering or Dispensing of Narcotic Drugs. (2005, June 23). 21 CFR §1306.07. Retrieved from https://www.ecfr.gov/

[192] U.S. Department of Health & Human Services. (n.d.). Office-Based Opioid treatment (OBOT). Indian Health Services. Retrieved October 2019, from https://www.ihs.gov/opioids/recovery/obot/

[193] U.S. Department of Health & Human Services. (2019, September 19). Medication-Assisted Treatment: Statutes, Regulations, and Guidelines. SAMHSA. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines

[194] U.S. Department of Health & Human Services. (Updated Daily). Practitioner and Program Data. SAMHSA. Retrieved October 2019 from https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data

[195] U.S. Department of Health & Human Services. (n.d.). Buprenorphine Pharmacy Lookup. SAMHSA. Retrieved October 2019 from https://www.samhsa.gov/bupe/lookup-form

[196] U.S. Department of Health & Human Services. (updated annually). Find Treatment: Locator Map. SAMHSA. Retrieved October 2019 from https://findtreatment.samhsa.gov/locator

[197] Health Resources in Action. (2019). Retrieved from The Massachusetts Substance Use Helpline: https://helplinema.org/

[198] S U.S. Department of Health & Human Services. (2019, August 05). SAMHSA's National Helpline. SAMHSA. Retrieved October 2019, from https://www.samhsa.gov/find-help/national-helpline

[199] Commonwealth of Massachusetts (2019, January) MassHealth All Provider Bulletin 281. Retrieved October 2019, from https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf

[200]U.S. Department of Health & Human Services. (2019, April 16). Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021. Centers for Medicare & Medicaid Services. Retrieved October 2019, from https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-06822.pdf.

[201] Substance Abuse and Mental Health Services Administration (2020, April) FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency. Retrieved June 2021, from https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

[202]U.S. Department of Justice. (2018, September) Use of Telemedicine While Providing Medication-Assisted Treatment (MAT). Retrieved October 2019, from https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-dea-final-508compliant.pdf

[203] Wicklund, E. (2019, March 11). Telemedicine Helps SNFs Connect Patients to Mental Health Services. mHealth Intelligence. Retrieved October 2019, from https://mhealthintelligence.com/news/telemedicine-helps-snfs-connect-patients-to-mental-health-services

[204] Wicklund, E. (2018, December 11). Reimbursement Barriers Still Plague Telemental Health Expansion. mHealth Intelligence Retrieved October 2019, from https://mhealthintelligence.com/news/reimbursement-barriers-still-

plague-telemental-health-expansion

[205] Commonwealth of Massachusetts (2019, January) MassHealth All Provider Bulletin 281. Retrieved October 2019, from https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf

[206] Commonwealth of Massachusetts (2019, January) MassHealth Managed Care Entity Bulletin 10. Executive Office of Health and Human Services Office of Medicaid. Retrieved October 2019, from https://www.mass.gov/files/documents/2019/01/23/managed-care-entity-10.pdf

[207] Massachusetts Health Policy Commission (2019, May) Integrating Telemedicine for Behavioral Health: Practical Lessons from the Field. Retrieved October 2019, from https://www.mass.gov/files/documents/2019/05/28/TeleBH%20brief_final.pdf

[208] University of New Mexico School of Medicine. (n.d.) About ECHO. Retrieved October 2019, from https://echo.unm.edu/

[209] Providers Clinical Support System. (n.d.) PCSS Mentoring Program. Retrieved October 2019, from https://pcssnow.org/mentoring/

[210] Health Resources in Action. (2019). The Massachusetts Substance Use Helpline. Retrieved October 2019, from https://helplinema.org/

[211] U.S. Department of Health & Human Services. (2019, 08 05). SAMHSA's National Helpline. SAMHSA. Retrieved October 2019, from https://www.samhsa.gov/find-help/national-helpline

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

[213] New England Region of Narcotics Anonymous (2019). Home. Retrieved October 2019, from https://nerna.org/

[214] Nar-Anon Family Groups (2019) Home. Retrieved October 2019, from https://www.nar-anon.org/naranon/

[215] SMART Recovery (2019). Home. Retrieved October 2019, from https://www.smartrecovery.org/

[216] Dual Recovery Anonymous. (2009). Welcome to the DRA Online Resource Center. Retrieved October 2019, from http://draonline.qwknetllc.com/index.html

[217] Massachusetts Organization for Addiction Recovery. (2020). Retrieved June 2021, from https://www.moar-recovery.org/resources

[218] Recovery Binder. (2020). Recovery Binder – Recovery Support Centers. Retrieved June 2021, from https://www.recoverybinder.org/resources/recovery-support-centers

[219] The Phoenix. (2021). The Phoenix – Rise, Recover, Live. Retrieved June 2021, from https://thephoenix.org/about-us/

[220] SAMHSA. (2017). Peers Supporting Recovery from Substance Use Disorders. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

[221] Natale-Pereira, A., Enard. K., Nevarez, L., and Jones, A. (2011, July 20). The Role of Patient Navigators in Eliminating Health Disparities. Cancer, 117 (15 0), 3543-3552. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121958/

[222] University of Colorado. (2008). Module 3: Patient Navigator Roles and Responsibilities. Retrieved from Patient Navigator Training: http://www.patientnavigatortraining.org/course1/module3/roles.htm

[223] Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). Partnering with patients and families to strengthen approaches to the opioid epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care. Retrieved from https://ipfcc.org/bestpractices/opioid-epidemic/IPFCC_Opioid_White_Paper.pdf

[224] Institute for Patient- and Family-Centered Care. Retrieved from https://ipfcc.org/bestpractices/opioid-epidemic/IPFCC_Opioid_White_Paper.pdf

[225] US Department of Health and Human Services National Institutes of Health (2014, June). Role of Community Health Workers. Retrieved from https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm

[226] US Department of Health and Human Services Agency for Healthcare Research and Quality (2016, December). Technical Brief Number 28: Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings. Retrieved from National Institutes of Health https://www.ncbi.nlm.nih.gov/books/NBK402352/pdf/Bookshelf_NBK402352.pdf

[227] US Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions (2007, March). Community Health Worker National Workforce Study: An annotated Bibliography. Retrieved from https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/communityhealthworkforcebibliography.pdf

[228] Johns Hopkins Medicine (n.d.) Community Health Partnership Success Stories www.hopkinsmedicine.org/community_health_partnership/share_your_journey_stories.html

[229] Massachusetts Substance Use. (2019). Retrieved from Helpline :https://helplinema.org/

[230]Massachusetts Substance Use Languages. (2019). Retrieved from Helpline: https://helplinema.org/?lang=es

[231] SAMHSA. Federal Guidelines for Opioid Treatment Programs (2015) https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP

[232] SAMHSA. Opioid Treatment Program Directory (2020) https://dpt2.samhsa.gov/treatment/directory.aspx

[233] Massachusetts Health Policy Commission. Integrating Telemedicine for Behavioral Health (2019) https://www.mass.gov/files/documents/2019/05/28/TeleBH%20brief_final.pdf

[234] RIZE Massachusetts. Employer and Employee Resources (2019) https://rizema.org/resources/

[235] SafeProject. Safe Community Playbook (2019) https://www.safeproject.us/playbook/

[236] Narcotics Anonymous. Persons Receiving MAT (2016) www.na.org/admin/include/spaw2/uploads/pdf/pr/2306_NA_PRMAT_1021.pdf

[237] SAMHSA. National Helpline: https://www.samhsa.gov/find-help/national-helpline

[238] Gavin Foundation. (n.d.). Devine Recovery Center: http://www.gavinfoundation.org/programs/devine-recovery-center

[239] American Medical Directors Association (AMDA). Transitions of Care in the Long-Term Care Continuum: Clinical Practice Guideline. Columbia, MD: AMDA, 2010. Accessed May 29, 2014. http://www.amda.com/tools/clinical/toccpg.pdf.

[240] Coleman EA, Boult C; American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc*. 2003;51(4):556-557.

[241] Shamji, H., Baier, R., Gravenstein, S., Gardner, R. (2014, July). Improving the Quality of Care and Communication During. *The Joint Commission Journal on Quality and Patient Safety*, 40(7), 319-324.

[242] Duber, H. e. (2018, October). Identification, Management, and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department. *The Practice of Emergency Medicine/Review Article*, 72(4), 420-431.

[243] Substance Abuse and Mental Health Services Administration. (2019, April 18). Substance Abuse Confidentiality Regulations. Retrieved from Frequently Asked Questions (FAQs) and Fact Sheets: https://www.samhsa.gov/about-

us/who-we-are/laws-regulations/confidentiality-regulations-faqs

[244] Health Resources in Action. (2019). The Massachusetts Substance Use Helpline. Retrieved October 2019, from https://helplinema.org/

[245] National Alliance on Mental Illness (NAMI). (n.d.). NAMI Connection Recovery Support Groups. https://namimass.org/nami-connection-recovery-support-groups/

[246] Massachusetts Behavioral Health Access (MABHA). (n.d.). Substance Use Disorder Services. https://www.mabhaccess.com/SUD.aspx

[247] New England Region of Narcotics Anonymous (2019). Home. Retrieved October 2019, from https://nerna.org/

[248] SMART Recovery (2019). Home. Retrieved October 2019, from https://www.smartrecovery.org/

[249] Commonwealth of Massachusetts. (n.d.). Peer Recovery Support Centers. Retrieved from https://www.mass.gov/info-details/peer-recovery-support-centers?utm_source=google&utm_campaign=rsc21&utm_medium=search&utm_term=text&utm_content=ad2

[250] Institute for Healthcare Improvement. (2018). Retrieved from Situation-Background-Assessment-Recommendation. Retrieved from http://www.ihi.org/Topics/SBARCommunicationTechnique/Pages/default.aspx

[251] Healthcentric Advisors. (2018). Safe Transitions Best Practices Measure Guides. Retrieved from https://healthcentricadvisors.org/insights/#bps

[252] Healthcentric Advisors. (2019). RED Re engineered Discharge. Retrieved from https://www.youtube.com/watch?v=JAZY7ONtJZc&feature=youtu.be

[253] Healthcentric Advisors. (2019). After Care Plan. Retrieved from https://healthcentricadvisors.org/wp-content/uploads/2019/08/AfterCarePlan.pdf

[254] DEA Office of Diversion Control. (2014). Disposal Act: LTCF Fact Sheet. Retrieved from https://www.adldata.org/wp-content/uploads/2015/07/disposal_public.pdf

[255]Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. https://store.samhsa.gov/system/files/pep15-fedguideotp.pdf