Navigating Opioid Use Disorder in Long-Term Care Facilities

Treatment, Screening, & Education (Part 2)

Jean Storm DO, CMD, CHCQM

Medical Director Quality Insights

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Objectives

- List the medications used to treat opioid use disorder
- Describe successful processes involved in treating residents with opioid use disorder in the facility

Treatment	
Buprenorphine	• Partial mu-opioid receptor agonist • Suppresses and reduces cravings for opioids • Can be prescribed by any clinician with a current, standard DEA registration with Schedule III authority, in any clinical setting
Methadone	• Full mu-opioid receptor agonist • Reduces opioid cravings and withdrawal and blunts or blocks the effects of opioids • Can only be provided for OUD through a SAMSHA-certified opioid treatment program
Naltrexone	• Opioid receptor antagonist • Blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria • Should be started after a minimum of 7 to 10 days free of opioids to avoid precipitation of severe opioid withdrawal • Can be prescribed by any clinician with an active license to prescribe medications

https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html

Schedule of Controlled Substances

Schedule	Definition	Examples
I	No accepted medical use with a lack of accepted safety. High abuse potential. Cannot be prescribed for medical use.	Heroin, LSD, ectasy
II	High abuse potential.	Morphine, oxycodone, fentanyl, hydrocodone, methadone
III	Abuse potential less than schedule I or II medications	Tylenol with codeine, ketamine, testosterone, **buprenorphine**
IV	Abuse potential less than schedule III	Benzodiazpeines (lorazepam, diazepam)
V	Abuse potential less than schedule IV	Pregabalin, Phenergan with codeine

https://www.dea.gov/drug-information/drug-scheduling

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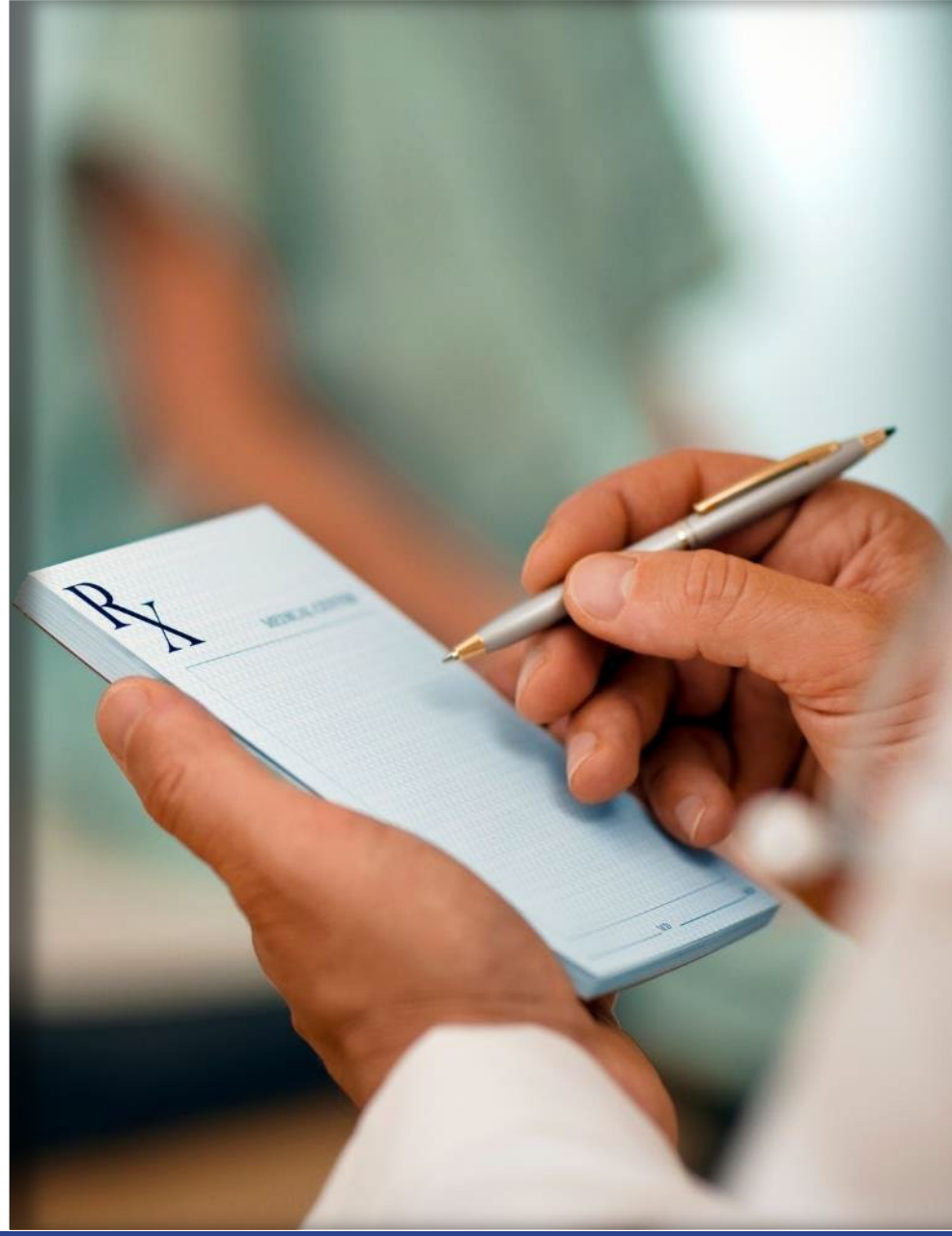
Methadone

- Long-acting opioid agonist, reduces opioid craving and withdrawal and blocks the effects of opioids
- Available in liquid, powder, and diskettes
- Methadone may be dispensed only by specially certified providers in particular facilities
- Patients taking methadone to treat OUD must initially receive the medication under the supervision of a practitioner.



https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone

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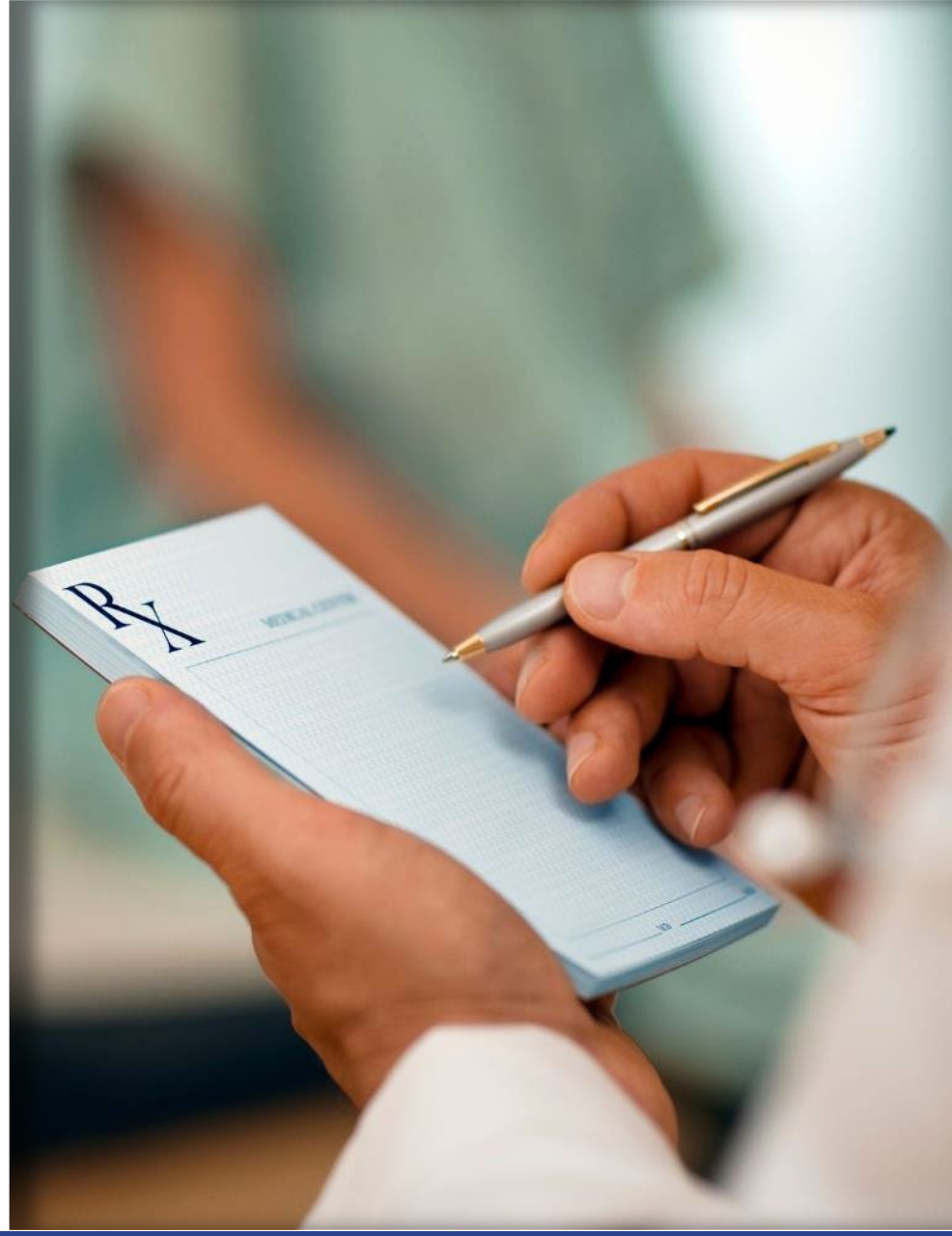
Buprenorphine

- Partial opioid agonist that diminishes the effects of physical dependency to opioids, such as withdrawal symptoms and cravings
- Available as sublingual tablet, sublingual/buccal film, implant, or extended-release injection
- Does produce euphoria and respiratory depression, but these effects are weaker compared to other opioids
- Increased safety for overdose



https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine

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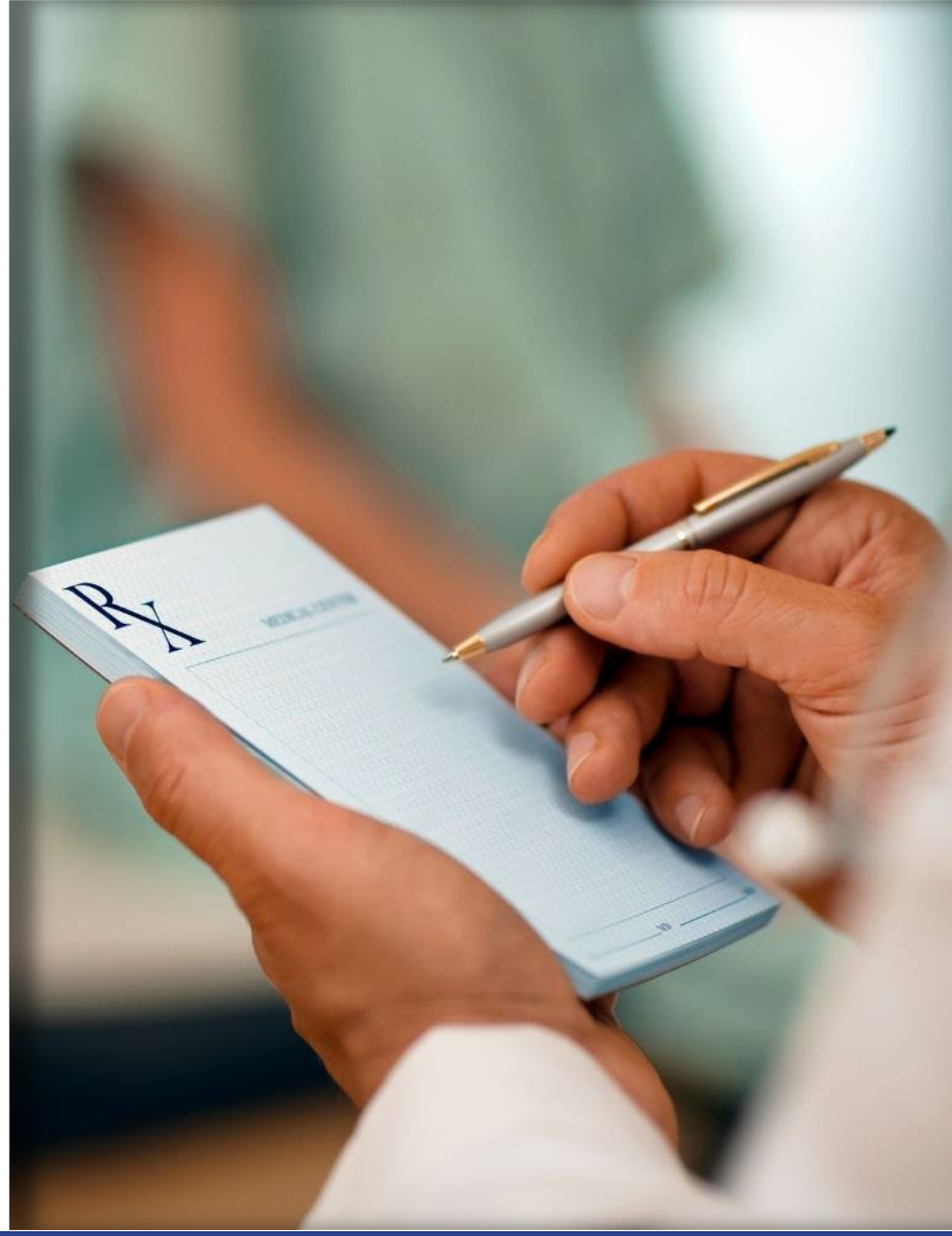
Naltrexone

- Not an opioid, blocks the euphoric and sedative effects of opioids
- No abuse and diversion potential
- Reduces and suppresses opioid cravings
- The long-acting injectable formulation is FDA approved as a medication for OUD
- Patients have to wait at least 7 days after their last use of short-acting opioids and 10 to 14 days after taking long-acting opioids, before starting naltrexone



https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone

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Buprenorphine Initiation

- It is important to understand that individuals have to stop opioids prior to initiating buprenorphine, so they will experience some degree of withdrawal symptoms.
- It may take several dose adjustments to find the appropriate dose for each individual.
- Once an individual is on maintenance buprenorphine, everything should be done to continue this treatment to facilitate successful recovery.

Clinical Opiate Withdrawal Scale (COWS)

Symptom	Highest Score (Most Severe)
Resting pulse rate	Pulse greater than 120
Sweating	Sweat streaming off face
Restlessness	Unable to sit still
Pupil size	Only the rim of iris is visible
Bone of joint aches	Unable to sit still due to discomfort
Runny nose or tearing	Nose constantly running/tears streaming down face
GI upset	Multiple episodes of vomiting or diarrhea
Tremor	Gross tremor or muscle twitching
Yawning	Several times a minute
Anxiety or irritability	Participation in assessment is difficult
Gooseflesh	Prominent

https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

Transitions

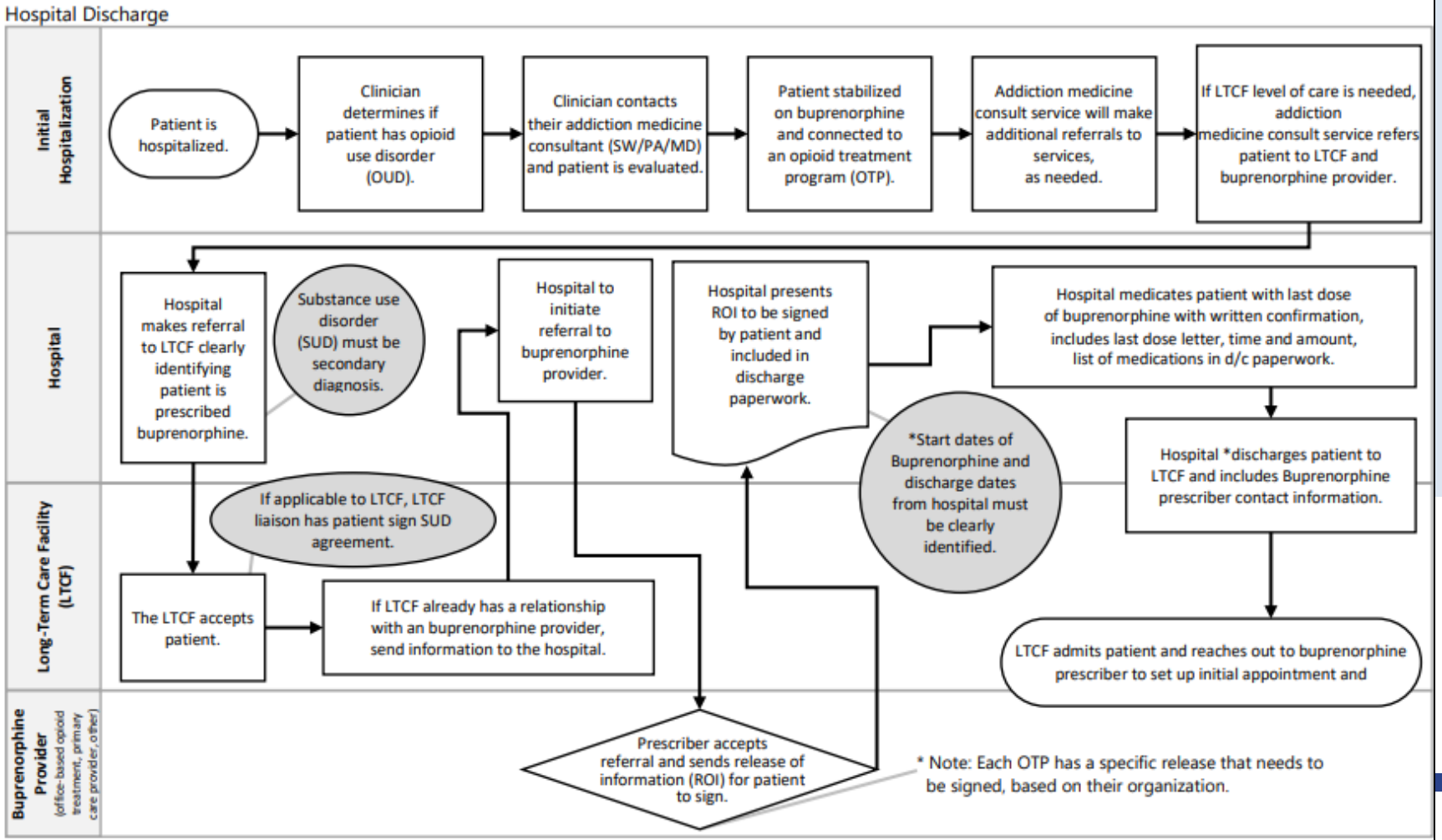
- Communication is essential at all steps.
- A buprenorphine prescriber must be identified prior to discharge from the hospital to the long-term care facility.
- All agreements required by prescriber should be completed prior to discharge from the hospital.
- Start dates should be clearly identified.
- Substance use disorder must be secondary diagnosis

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

Massachusetts Department of Public Health
Bureau of Health Care Safety & Quality
www.mass.gov/dph/bhcsq

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 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

https://www.mass.gov/orgs/bureau-of-health-care-safety-and-quality

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Steps for Success

- Once LTC facility accepts resident, liaison should attempt to have resident sign SUD agreement
- Hospital initiates referral to buprenorphine provider (if LTC facility has established relationship with provider)
- Discuss policy and procedures with your medical director (physicians are required to obtain 8 hours of training which allows them to prescribe buprenorphine for OUD)

Policy Considerations

- Referral/acceptance process (who is reviewing and deciding?)
- Who is the prescriber?
- Will the resident sign an agreement for OUD treatment in the facility?
- How will the resident receive counseling services?
- Naloxone
- Stigma prevention
- Discharge process

Buprenorphine Drug Interactions

- Benzodiazepines
- Ketoconazole
- Clarithromycin
- Verapamil
- Phenytoin
- Phenobaribitol
- Antidepressants (serotonergics)
- Antiretrovirals

Alert consultant pharmacist to be on the lookout for drug interactions with medications added to regimen!

https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/020733s024,022410s034lbl.pdf

Staff OUD Education

Older adults with OUD is a knowledge gap for staff in SNFs. An evidence based curriculum was provided by a geriatrician and all available staff were invited to attend at a pilot facility.

Topics included:

1) Defining addiction as a medical disease
2) Describing specific medications for OUD
3) Incorporating non-stigmatizing language
4) Recognizing overdose signs/symptoms

Lau-Ng, R., Kang, S., & Day, H. (2022). Implementation of an Educational Curriculum on Care of Older Adults with Opioid Use Disorder in Long-Term Care. In Journal of the American Medical Directors Association (Vol. 23, Issue 3, pp. B8–B9). Elsevier BV. https://doi.org/10.1016/j.jamda.2022.01.047

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Education

- The educational modules were offered 12 times at 3 SNFs
- A total of 159 staff attended including individuals from nursing, administration, activities, housekeeping, maintenance, kitchen, therapy, and social work.
- Pre- and post-tests were administered in order to assess knowledge

Lau-Ng, R., Kang, S., & Day, H. (2022). Implementation of an Educational Curriculum on Care of Older Adults with Opioid Use Disorder in Long-Term Care. In Journal of the American Medical Directors Association (Vol. 23, Issue 3, pp. B8–B9). Elsevier BV. https://doi.org/10.1016/j.jamda.2022.01.047

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Results

- Mean post-test scores assessing confidence regarding learning objectives increased compared to pre-test scores
- Post-test scores also increased in specific learning objectives about defining addiction, medication for OUD, appropriate language around OUD, and recognizing overdose.

Lau-Ng, R., Kang, S., & Day, H. (2022). Implementation of an Educational Curriculum on Care of Older Adults with Opioid Use Disorder in Long-Term Care. In Journal of the American Medical Directors Association (Vol. 23, Issue 3, pp. B8–B9). Elsevier BV. https://doi.org/10.1016/j.jamda.2022.01.047

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Education Opportunities

- Staff orientation training for opioid use disorder toolkit
- About Addiction Science
- SUD for the Healthcare Team
- Medication-Assisted Treatment Improves Outcomes for Patients with OUD

Creating a Culture Without Stigma

1. Incorporate harm-reduction principles throughout your facility and within your existing policies (National Harm Reduction Coalition).
2. Incorporate a section on OUD 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.
3. Develop an assessment of staff perceptions of OUD and MOUD.
4. Post anti-stigma posters for staff, residents, and family to view (Words Matter Campaign).

https://www.mass.gov/info-details/the-care-of-residents-with-opioid-stimulant-use-disorders-in-long-term-care-settings-toolkit

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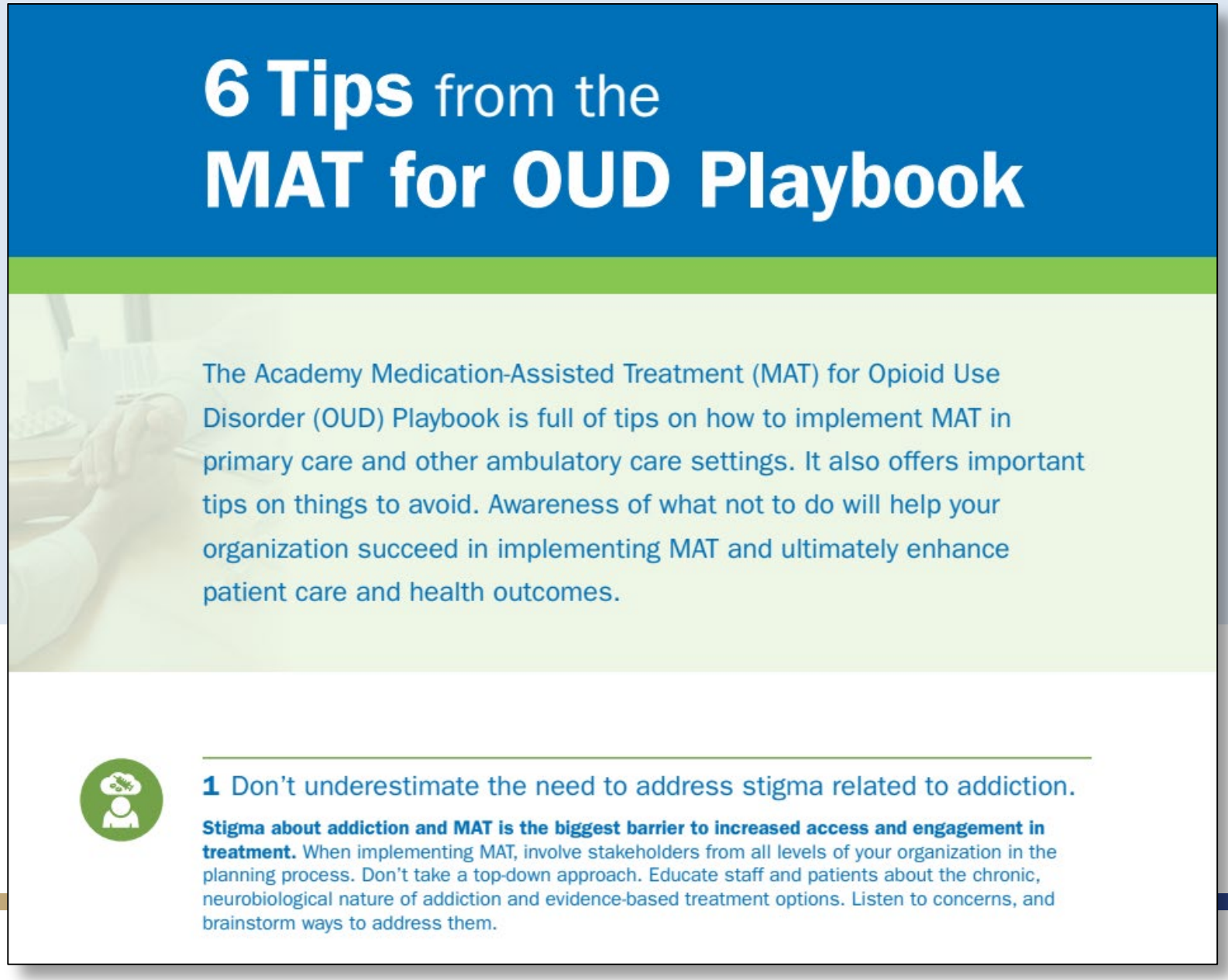

https://integrationacademy.ahrq.gov/sites/default/files/2021-02/ahrq-whatnottodo-infographic.pdf

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Resident Perspectives on Substance Use Disorders and Opioid Use Disorders in the Nursing Home

- Residents with SUD/OUD admitted into nursing homes generally view their stay as a positive influence on their use disorder.
- Residents' positive experiences may stem from: stable housing, being in an environment removed from daily stressors and being in an environment where substances are less accessible
- Areas identified for further improvement include increased access to more counseling services for substance use disorder management

Yang, Meredith, Kimberly Beiting, and Stacie Levine. "Patient Perspectives on Substance Use Disorders (SUD) and Opioid Use Disorders (OUD) in the Nursing Home." *Journal of the American Medical Directors Association* 23.3 (2022): B19.

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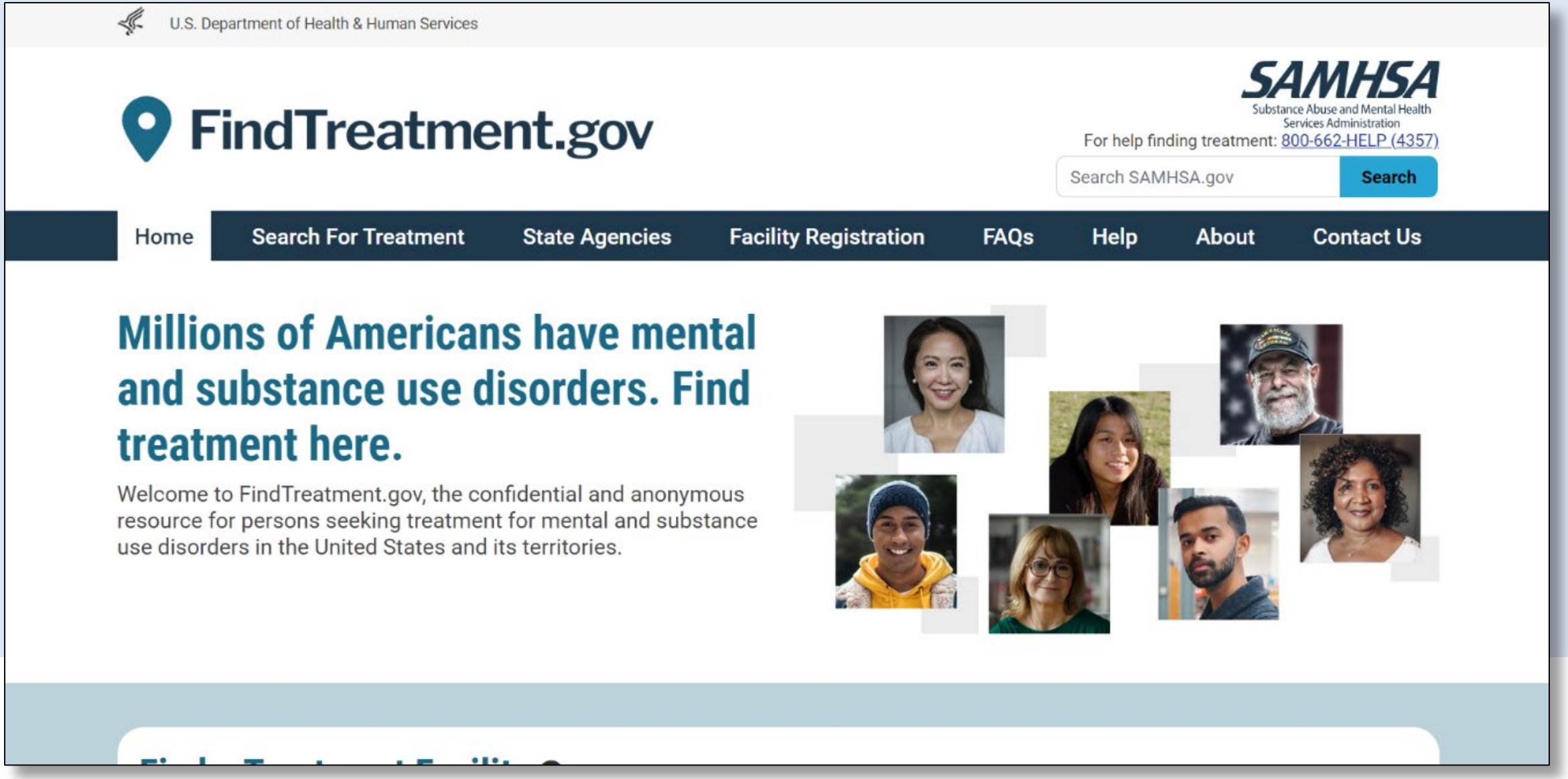

https://findtreatment.gov/state-agencies

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Engagement of Family and Caregivers

- Ensure the resident agrees to sharing information with family regarding OUD prior to disclosing this information with family
- Family and caregivers play a vital role in the recovery process
- Share a list of prohibited items (e.g., drugs, drug contraband) with residents, families, and caregivers to ensure their safety (this step may seem obvious, but it is necessary)
- Organize family focus groups for support: Working with Patients and Families as Advisors

Signs of Overdose

- Small, constricted “pinpoint pupils”
- Falling asleep or losing consciousness
- Slow, weak, or no breathing
- Choking or gurgling sounds
- Limp body/unresponsive
- Cold and/or clammy skin
- Discolored or blue skin (especially in lips and nails)

https://www.cdc.gov/stopoverdose/naloxone/index.html

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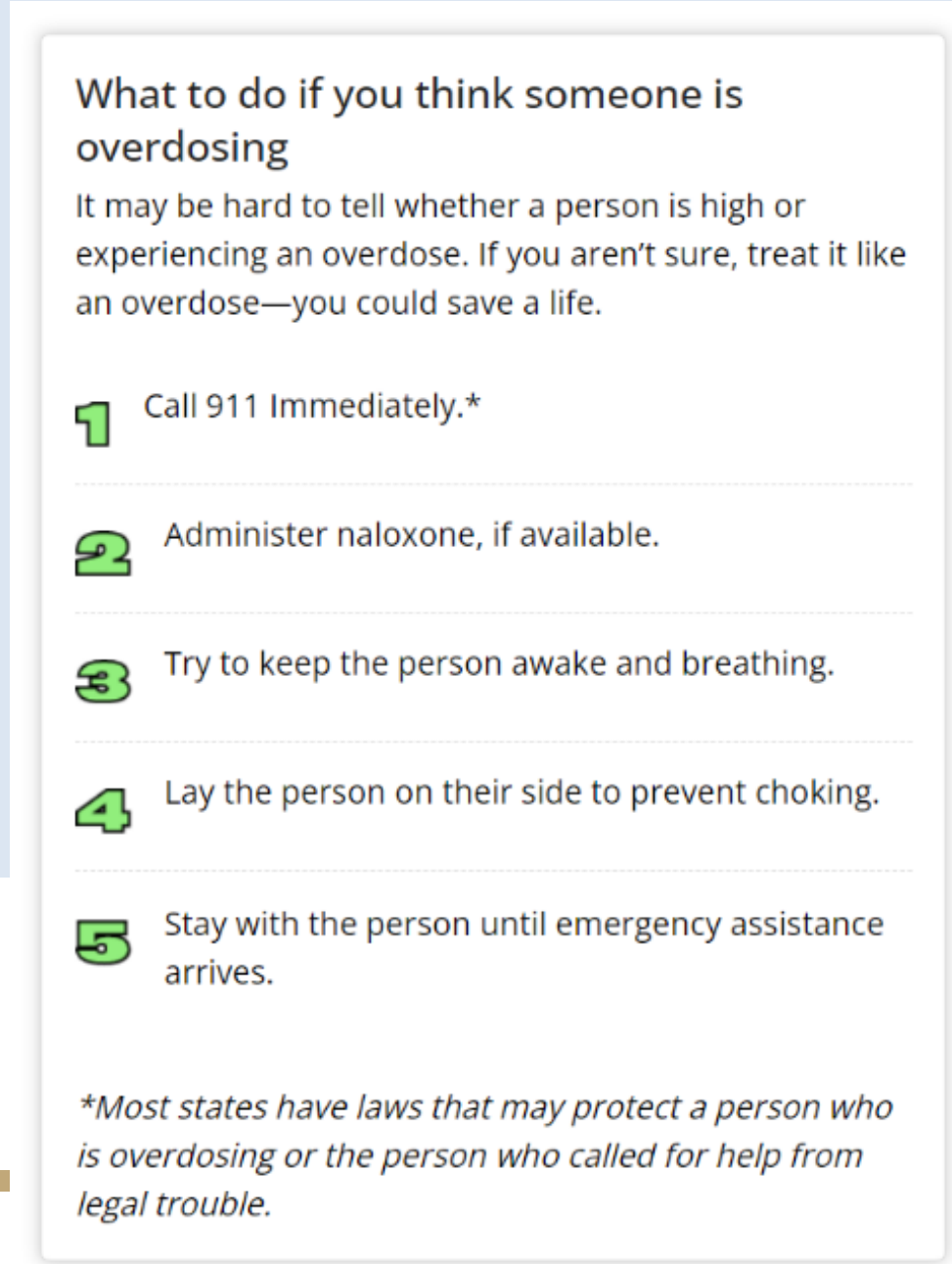

Fentanyl and fentanyl analogs have a higher potency compared to that of heroin. Larger doses of naloxone may be required to reverse the opioid-induced respiratory depression from a fentanyl-involved overdose.

https://www.cdc.gov/stopoverdose/naloxone/index.html

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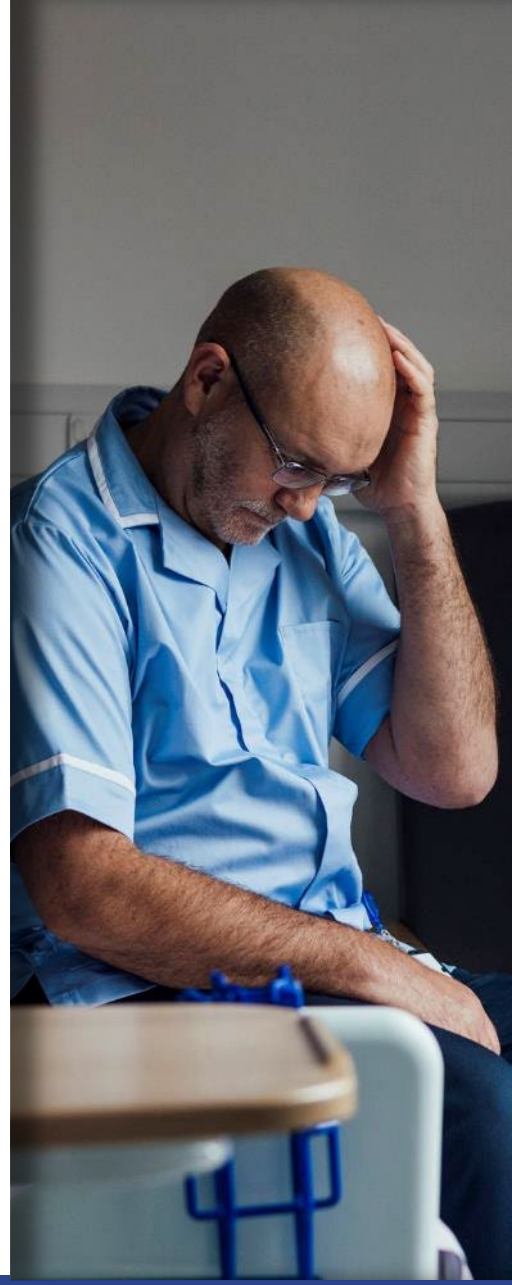
Treating Pain

- Individuals receiving MOUD who develop acute pain should be treated.
- Always ensure multimodal, non-opioid measures are in place (pharmacologic and non-pharmacologic).
- As needed opioids may be needed for a short period of time to manage pain (and at a higher dose), but should be only used to treat acute pain.

Case

A 58-year-old with a diagnosis of OUD successfully being treated with buprenorphine/naloxone sublingual film 16mg/4mg per day is admitted to the hospital following a fall with hip fracture. Surgical repair is done and hydromorphone is added for acute pain control post-operatively and is eventually weaned off.

Recommendations are made for rehab prior to discharge home and accepting physician at skilled nursing facility agrees to prescribe buprenorphine/naloxone for the resident. Nursing facility faxes OUD agreement to hospital for resident to sign and it is returned to facility. Hospital creates flowsheet for buprenorphine/naloxone information (start date, last dose, etc.) and faxes to nursing facility on discharge.



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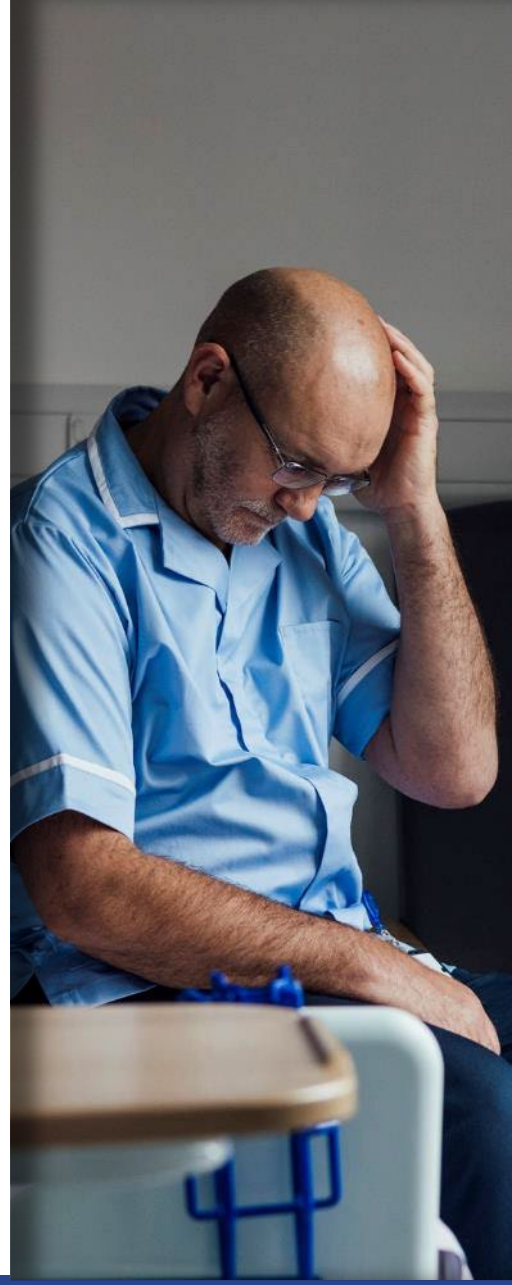
Case (Continued)

Resident arrives at skilled nursing facility and attending physician arrives to assess resident and write prescription for buprenorphine/naloxone at maintenance dose. Attending physician also writes order for consultation with psychologist for ongoing counseling and support for resident. Pharmacy delivers 2-week supply of buprenorphine/naloxone and the resident continues on therapy during rehab.

The resident discharges home in 2 weeks and is discharged with a prescription for buprenorphine/naloxone with enough supply to last until the resident's appointment with the regular prescriber in 4 days.



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Take-Home Points

- Opioid use disorder prevalence has been increasing in the long-term care population.
- Medications to treat opioid use disorder can suppress cravings and reduce risks of overdose.
- Long-term care facilities should adopt educational programs to help staff understand the best ways to care for individuals with opioid use disorder.
- Screening tools are an essential part of opioid use disorder prevention and treatment.

Questions?

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Contact

JEAN STORM, DO, CMD

Medical Director, Quality Insights

EMAIL ADDRESS

jstorm@qualityinsights.org

ONLINE

qualityinsights.org/qin

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