Domain 3: Care Practices

Assist long term care facilities (LTCF) in implementing person-centered care practices that address the complex needs of residents with opioid use disorder (OUD) to meet their individual health goals.

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The toolkit outlines six domains to help LTCFs care for residents with Opioid Use Disorder (OUD). Administrators, directors of nursing (DON), medical directors, social workers, nurses, and certified nursing assistants (CNA) can all use these resources. Each domain can be used on its own when implementing. Below is Domain 1: Workplace Practice.

Throughout the domains there are links to educational resources, including links to brief learning management modules to aid in understanding of key topic areas. In the appendices you will find sample template forms and tools to help guide development of LTCFs policies and procedures.

Toolkit Domains:

Contents

Domain 3: Care Practices

"An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment."

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) Arlington, VA, American Psychiatric Association, 2013

Goal:

Assist long term care facilities (LTCF) in implementing person-centered care practices that address the complex needs of residents with opioid use disorder (OUD) to meet their individual health goals.

Objectives:

1. Summarize the spectrum of OUD (and co-occurring substance use) including level of disease severity, biological effects, and how residents present.
2. Develop care plans that integrate interventions, including medication for opioid use disorder (MOUD) and non-pharmacological approaches, that support LTCF residents with OUD.
3. Employ empathy and trauma-informed care (TIC) as foundational components of all care practices.

Description:

Care practices describe the art of caring. It includes the ways in which residents, staff, families, and caregivers are cared for physically, mentally, spiritually, and emotionally. Included in this domain is a person-centered approach to caring for individuals with OUD. Topics include OUD as a chronic condition, harm reduction principles, medication used for OUD, non-pharmacological approaches, care plan considerations and trauma-informed care practices.

Understanding Opioid Use Disorder

OUD has been a major public health challenge for many years. Progress is being made in supporting those with OUD. Like other substance use disorders (SUD), OUD is a chronic medical condition caused by the recurrent use of opioids, including prescription drugs such as oxycodone and hydrocodone, and illicit substances such as heroin or fentanyl. It is a chronic brain disease in which people continue to use opioids despite the harm and/or consequences caused by their use. Sadly, the mortality rate of individuals who use opioids can be up to thirty times higher than the rate of individuals who do not.[1] Though OUD is a

[1] Drug Topics (2023). Age, Food Security, And Financial Situation All Common Factors in OUD Cases. Retrieved from https://www.drugtopics.com/view/age-food-security-and-financial-situation-all-important-for-maintaining-responsible-opioid-use

chronic, long-term disease, it is treatable. Medications and behavioral therapies can help people with OUD to stop using opioids and support them in their recovery.[2]

Prescription opioids are meant to be used to treat acute pain (such as recovering from injury or surgery), chronic pain, cancer treatment, palliative care, and end-of-life care.[3] Many people rely on prescription opioids to help manage their conditions under the care of a physician. These drugs interact with opioid receptors in the body and brain to reduce the perception of pain; however, they also stimulate the reward pathway in the brain, which can cause a feeling of well-being and happiness known as euphoria.

This activation of the reward pathway makes opioids addictive for some people. Continued use of the drugs causes changes in the brain that lead to tolerance of the drug. This means that a larger dose of opioids is needed to get the same level of pain relief or euphoric high.

Opioid use or misuse can produce a wide spectrum of symptoms. In addition to reducing the perception of pain, opioids can also cause euphoria, drowsiness, confusion, nausea, constipation and at higher doses can slow breathing which may lead to overdose and possible death.

Opioid treatment for pain is associated with increased risk for OUD, particularly if opioids are prescribed for more than 90 days.[4]

Problematic use of opioids in older adults is associated with several adverse effects, including sedation, cognitive impairment, falls, fractures and constipation. In 2023, older adults aged 55 and older represented 33% of all opioid related deaths in Connecticut with Fentanyl being present in 90% of these deaths.[5] There are also additional older adults experiencing pain, comorbid chronic conditions, concurrent alcohol use disorder and /or depression are more at-risk for developing problematic opioid use.[6] It is important to note that co-occurring substance use (i.e., alcohol, stimulants, benzodiazepines) is common, which may increase the complexity of treatment for OUD. It is vital to take all risks into consideration when developing and implementing individualized care plans for residents with OUD.[7]

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[2] Yale Medicine (2020). Opioid Use Disorder. Retrieved from https://www.yalemedicine.org/conditions/opioid-use-disorder

[3] American Psychiatry Association (2022). Opioid Use Disorder. Retrieved from https://www.psychiatry.org/Patients-Families/Opioid-Use-Disorder

[4] CDC (2023) Opioid Use Disorder: Preventing and Treating. Retrieved from https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html

[5] Connecticut Department of Public Health (2024). Drug Overdose Deaths in Connecticut Data Dashboard, 2015 to 2024 | Tableau Public. Retrieved from https://public.tableau.com/app/profile/heather.clinton/viz/SUDORS_Dashboard_final2/OverdoseDashboard

[6] Dufort A, Samaan Z. Problematic Opioid Use Among Older Adults: Epidemiology, Adverse Outcomes and Treatment Considerations. Drugs Aging. 2021 Dec;38(12):1043-1053. doi: 10.1007/s40266-021-00893-z. Epub 2021 Sep 7. PMID: 34490542; PMCID: PMC8421190.

[7] Yale Medicine (2020). Opioid Use Disorder. Retrieved from https://www.yalemedicine.org/conditions/opioid-use-disorder

The Spectrum of Opioid Use Disorder

How an individual is diagnosed with OUD:

To best care for those with OUD, it is important to understand the behaviors associated with the disorder while ensuring resident safety throughout the process. It is also important to take a holistic approach by employing MOUD with counseling, cognitive behavioral therapy, and other evidence based best practices for residents.

OUD is manifested by at least two out of eleven defined criteria occurring within a year. Severity of OUD is determined based on the number of criteria met. See Appendix 5: Opioid Use Disorder Diagnostic Criteria.

Opioid Use Disorder: Diagnostic Criteria

- Taking opioids in larger amounts or over a longer period than intended.
- Having a persistent desire or unsuccessful attempts to reduce or control opioid use.
- Spending excess time obtaining, using, or recovering from opioid use.
- Craving opioids.
- Continued opioid use causing inability to fulfill work, home, or school responsibilities.
- Continuing opioid use despite having persistent social or interpersonal problems.
- Lack of involvement in social, occupational, or recreational activities.
- Using opioids in physically hazardous situations.
- Continuing opioid use despite awareness of persistent physical or psychological problems.
- Exhibiting tolerance symptoms, as defined by either of the following: *
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
  - Markedly diminished effect with continued use of the same amount of an opioid.
- Exhibiting withdrawal symptoms, as manifested by either of the following: *
  - The characteristic opioid withdrawal syndrome, or
  - Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Severity
Mild: 2-3 criteria
Moderate: 4-5 criteria
Severe: greater than or equal 6 criteria

**Tolerance and withdrawal are not considered to be met for those taking opioids solely under appropriate medical supervision. This is available here:* Opioid Use Disorder: (cdc.gov)[8]

[8] CDC (2023) Opioid Use Disorder: Preventing and Treating. Retrieved from https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html

Presenting with Opioid Use Disorder:
LTCFs care for a wide array of people using opioids, not all of whom have OUD; however, providers seek to ensure that residents receiving care do not develop OUD. The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for OUD among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of developing OUD. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.[9]

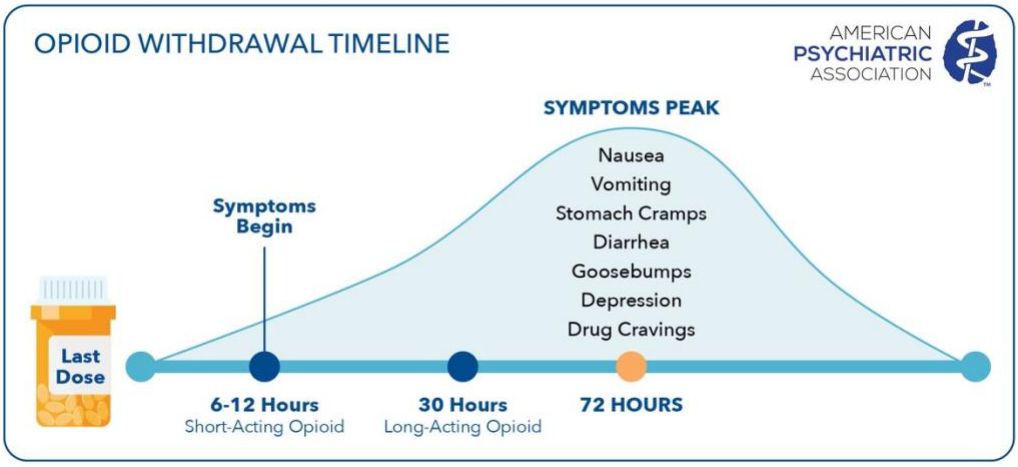
An Opioid Risk Assessment Tool should be administered to residents prior to admission and readmission. An ORT example is provided in Appendix 6.[10]

Guidance:
- Low risk of opioid use disorder:
    - If opioids are prescribed, utilize standard screening.
- Moderate risk of opioid use disorder:
    - Consider alternatives to opioids; if opioids are prescribed, avoid dose escalation.
    - Monitor behaviors closely along with standard screening.
- High risk of opioid use disorder:
    - Avoid prescribing opioids.
    - If opioids are prescribed, limit order to a few days and monitor behaviors closely.

Symptoms of Opioid Use Disorder Withdrawal:
Individuals with OUD may experience cravings, withdrawal, or difficulty in controlling pain. In some cases, residents with OUD will already be on MOUD upon admission to Long Term Care (LTC). The resident's plan of care may require additional evaluation and collaboration between the LTC and community providers (i.e. OTP for Methadone) for dose adjustments. Other residents may have been undiagnosed or diagnosed with OUD but have other indications for acute opioid analgesia; monitor these residents for drowsiness, sedation, and overdose. (See **Domain 1, Workplace Practice for overdose prevention and Naloxone use**).

Opioids can lead to physical dependence within a short time and the body will eventually become dependent on opioids and will have difficulty functioning without opioids. With chronic use, abruptly stopping use of opioids leads to withdrawal symptoms, including generalized pain, chills, cramps, diarrhea, dilated pupils, restlessness, anxiety, nausea, vomiting, insomnia, and very intense cravings.[11]

[9] National Institute on Drug Abuse. Opioid Risk Tool. Retrieved from https://nida.nih.gov/sites/default/files/opioidrisktool.pdf
[10] Quality Insights (2024). Opioid Risk Assessment Tool (fillable). Retrieved from https://www.qualityinsights.org/qin/resources#opioid-risk-assessment-tool-fillable
[11] Psychiatry.org - Opioid Use Disorder. Retrieved from https://www.psychiatry.org/patients-families/opioid-use-disorder



The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids.[12]

Use the COWS (Appendix 4) to determine the stage or severity of opiate withdrawal. The COWS score will help determine the next steps in caring for the resident. Add a decision tree into your LTCF policy based on mild, moderate, moderately severe, or severe withdrawal. Always communicate with the resident's physician (if they have one) or LTCF medical director, Opioid Treatment Program (OTP) and interdisciplinary care team regarding suspected withdrawal symptoms and COWS score to determine the next steps and/or if the resident should go to a higher level of care.

Harm Reduction Principles:

Harm reduction is a critical, evidence-based approach that facilitates engaging with individuals who use drugs. It equips them with lifesaving tools and information, enabling positive change in their lives and potentially saving lives. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy.[13] Several resources on harm reduction can be found on the CT Department of Mental Health and Addition Services website at Opioid Services (ct.gov).

Harm reduction approaches promote safety while reducing risk of deaths from overdoses, prevention of relapse and infectious disease, reduction of Emergency Department visits and offers individuals a connection to substance use disorder (SUD) treatment in settings free of stigma.[14]

Examples of Harm Reduction Strategies include:

[12] Clinical Opiate Withdrawal Scale (2003). Retrieved from https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf
[13] SAMHSA (2023). Harm Reduction. Retrieved from https://www.samhsa.gov/find-help/harm-reduction
[14] National Institute on Drug Abuse (NIDA) (2023). Harm Reduction. Retrieved from https://nida.nih.gov/research-topics/harm-reduction

- Safe syringe Programs: sterile syringes and injection equipment, access to proper disposal of syringes
- Naloxone Kits for treatment of suspected overdose
- Drug checking: Harmful substances such as Fentanyl and Xylazine can be mixed into drugs without a person knowing, increasing the risk for overdose and other harms. Methods such as Fentanyl test strips may be used for detection of this harmful drug.

How can Harm Reduction be incorporated into Long Term Care?

1. Partner with a Harm Reduction Resource center in your region. See CT-Harm-Reduction-Resources-Flyer-2022.pdf
2. Educate residents with OUD about harm reduction.
3. Educate caregivers of residents with OUD about harm reduction.
4. Provide access for proper disposal of syringes and other drug paraphernalia.
5. Provide free testing strips for Fentanyl and Xylazine.
6. Have Naloxone kits readily available.
7. Include harm reduction in the resident care plan.

Similar to other residents, individuals with OUD frequently leave the facility for a leave of absence (LOA). During this time away, they are vulnerable to exposure to illegal drugs, acquaintances, or environments where drug use is prevalent. Prior to the leave, provide the resident with tools for success, such as education about harm reduction, and a contact person and phone number at the facility if/when the resident chooses or is thinking of making a choice to use. Let the resident know it is okay to return to the facility.

Individuals with OUD, as with any other medical condition, have the right to refuse treatment and/or medication, thus may not accept medication for OUD. Individuals who make a choice to decline MOUD still reserve their right to receive adequate and appropriate care, access to available services and to continue participation in their own assessment, care planning, treatment, and discharge.[15]

Care Plan Considerations for Residents with OUD:

As with other medical conditions and diagnoses, the nursing process, an interdisciplinary team approach and an individualized care plan are all imperative for residents with OUD. An effective care plan includes a comprehensive assessment, goals, outcomes, and interventions by all team members. The care plan for OUD includes person-centered principles and practices that involve a focus on the person's experience and to what extent the support and care are responsive to the resident's needs, goals, and unique circumstances. Care plans should be developed in partnership with each resident, reflecting their autonomy, and self-determination and an expectation of positive outcomes. Staff and leaders need to cultivate a focus on recovery potential, not pathology.

[15] Your Rights as a Resident of a Long-Term Care Facility (ct.gov). Retrieved from https://portal.ct.gov/LTCOP/Content/Resident-Rights/Your-Rights-as-a-Resident-of-a-Long-Term-Care-Facility

Trauma Informed Care:

In 2016, the Center for Medicare and Medicaid Services issued revisions to the requirements for nursing home communities that participate in Medicare and Medicaid programs. Among the many changes finalized in this rule are policies designed to strengthen the provision of person-centered care to residents. This includes the provision of trauma informed care (TIC).

Trauma results from an event, series of events, or set of circumstances that are physically or emotionally harmful or life threatening and has lasting adverse effects on an individual's well-being.[16] Examples of trauma include but are not limited to experiencing or witnessing physical, emotional, or sexual abuse, having a family member with a mental health or substance use disorder, natural disasters; car, train and airplane crashes; combat; becoming a refugee; homelessness; medical trauma; violent crime; bias and discrimination; and hate crimes and hate speech, witnessing violence, poverty and/or systemic discrimination.

Numerous research studies confirm the link between traumatic experiences in childhood and addictive behaviors in adulthood. One of the most notable studies was conducted by Felitti and Colleagues (1998) titled Adverse Childhood Experiences ACEs included traumatic experiences within the first 18 years of life such as physical, emotional, and sexual abuse, neglect, loss of a parent, witnessing intimate partner violence, and living with a family member with a mental illness. Researchers, Felitti et al found that more ACEs increase the risk of alcohol and other drug use in adulthood.[17]

TIC is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumas and avoiding re- traumatization. A trauma informed framework acknowledges and anticipates that a resident may have a history of trauma and that the environment and interpersonal interactions can exacerbate manifestations of trauma. Under (CMS requirement) F 699 TIC, the facility must ensure that trauma survivors receive trauma-informed, culturally competent care accounting for residents' experiences and preferences to avoid triggers leading to re-traumatization.

Staff need to assess residents on admission for a history of trauma and identify triggers to avoid re-traumatization. Triggers may include a sound, smell, physical touch, or uncomfortable situations. Like universal precautions for infection control, providing TIC for all residents is best practice. Offering training to staff to help them understand what TIC is, how it affects individuals, and strategies that can be used to avoid trauma can help organizations to become sensitive. The trauma-informed approach is guided by four assumptions, known as the "Four R's": *Realization* about trauma and how it can affect people and groups, *recognizing* the signs of trauma, having a system which can *respond* to trauma, and *resisting* re-traumatization. Offer case stories that reflect real life situations to enhance staff awareness. Examples include startling noises that affect someone with Post Traumatic Stress (PTS), intimate situations or procedures that might negatively impact a resident who has experienced sexual abuse, or protective responses about one's possessions for someone who has lived on the streets.

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[16] Psychology Today (2024). Trauma. Retrieved from https://www.psychologytoday.com/us/basics/trauma
[17] Psychology Today (2021). Why Trauma Can Lead to Addiction. Retrieved from https://www.psychologytoday.com/us/blog/understanding-addiction/202109/why-trauma-can-lead-to-addiction

A national community-based survey found that between 55% and 90% of the population has experienced at least one traumatic event. And some individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes.[18]

In addition to requirement F699 trauma informed care, CMS also adds F656 Comprehensive Care Plan, which is for the inclusion of culturally competent and TIC.

Please see **Appendix 2** for 10 Fast Facts about Trauma Informed Care.

A care plan for the resident who has experienced trauma requires the same structure as all resident care plans. It has an identified issue, a goal, and interventions.

Here is an example:

Issue:

- Residents have expressed a need for privacy while bathing as a result of past trauma.

Goal:

- Offer the resident privacy and support to ensure their need for privacy is met.

Interventions:

- Resident will be afforded resources that will maximize their privacy, such as robes, towels, and curtains.
- Resident will be encouraged to coach staff on their personal need for privacy.
- Resident's needs will be shared across shifts to ensure consistency.

A Person-Centered Care Plan is the Key to Trauma Informed Care.

How do we know if the care plan is "Person Centered"?

Here are some examples:

- Residents are actively involved in making decisions and refining goals.
- Services and supports reflect the individual choices of the resident.
- People who are important in the lives of residents with OUD are encouraged to be involved.
- Staff and Leaders caring for residents with OUD are knowledgeable about the strengths and abilities of the residents with OUD.
- Staff and Leaders have positive expectations for the resident.[19]

Other Care plan considerations for people with OUD:

Issue Priorities:

- Ensure safety and monitor for withdrawal symptoms.
- Monitor for signs and symptoms of active use and/or overdose.
    - Be prepared to respond to an overdose.
- Facilitate access to appropriate treatment.

[18] Community Connections (2009). Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol. Retrieved from https://children.wi.gov/Documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

[19] NCAPPS (2019). National Environmental Scan: Indicators. Retrieved from https://ncapps.acl.gov/docs/NCAPPS_Indicators%20Scan%20_191202_Accessible.pdf

- Address any co-occurring mental and physical health issues.
- Encourage participation in activities.

Assess for:

- Behavioral changes such as mood swings, irritability, changes in sleep patterns.
- Observable signs of intoxication or withdrawal, including tremors, sweating, restlessness, or agitation.
- Neglect of personal hygiene or a decline in grooming habits.
- Strained or damaged relationships with loved ones due to substance use.
- Reports from family members, friends, or other caregivers regarding the resident's substance use or related behaviors.

Goals:

- The resident and caregivers will demonstrate their command of OUD as a chronic condition by exercising their knowledge, skill, and attitude.
- The resident and caregivers will demonstrate active participation in their care plan and develop mutual goals with the interdisciplinary care team.
- The resident will accept a mutual (no harm) agreement for safety while residing in the facility.

Interventions:

- Educate the residents and caregivers about MOUD.
- Utilize Telehealth -Virtual Support Meetings - CCAR.
- Offer Peer Recovery Support Services.
- Invite residents to participate in recreational activities of interest offered within the facility.
- Maintain a safe environment.
- Include non-pharmacological approaches for pain management.

The above care plan considerations are undoubtedly not a comprehensive list, however, meant to provoke thought into care planning for residents with OUD.

Successful long-term outcomes for residents with OUD relies on collaborative work and partnerships with community providers. Solicit the assistance of community providers to promote fluid transition in and out of the facility.

Discharge Planning

Residents with OUD who have healed (or stabilized) from their primary admission diagnosis are likely to need support in finding suitable lodging. Social Workers are frequently enlisted to help find lodging. In some cases, After Care specialists are also part of the discharge planning team. After Care Specialists have connections with halfway or sobriety houses and other community-based supports (See Domain 1: Workplace for information Aftercare Specialist). Upon discharge, a resident is not left to navigate the system alone. The LTCF will need to help:

- Coordinate a discharge plan with the resident and Opioid Treatment Program (OTP) when indicated.
- Partner with a harm reduction center.
- Explore Telehealth options for group sessions and/or other support services (i.e., Narcotics Anonymous, Peer Support).
- Connect with community-based organizations and programs that help address health-related social needs.
- Review money follows the person to see if applicable to the resident at discharge (https://portal.ct.gov/dss/health-and-home-care/money-follows-the-person-program/money-follows-the-person-program).

Education and Alternative Strategies for Treating Pain:

Educating residents on the risks of opiate addiction, along with decreasing prescription rates, can affect the misuse of prescription opiates. However, decreased prescriptions will leave some residents dealing with real pain. To help improve their overall quality of life, these residents could be offered non-opiate drug options that include:

- ✓ Topical analgesics
- ✓ Non-steroidal anti-inflammatory drugs (NSAIDs)
- ✓ Acetaminophen
- ✓ Antidepressants or anticonvulsants that are used for neuropathic pain.
- ✓ Nerve blocks with local anesthetics.

Non-drug therapies that can help ease pain include: (See Domain 1 Workplace & Domain 2: Environment)

- ✓ Physical or occupational therapy to increase range of motion.
- ✓ Deep breathing and meditation techniques to relieve stress.
- ✓ Diet and exercise to release natural endorphins.
- ✓ Massage and acupuncture to decrease muscle tension.
- ✓ Individual counseling or group therapy to treat depression and anxiety that are often associated with chronic pain.

Understanding Medication for Opioid Use Disorder:

Like other chronic diseases, medications are central to the treatment of OUD. People with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment.

Medications discussed in this section include:

Medication to treat OUD:

- Methadone
- Buprenorphine

- Buprenorphine/Naloxone
- Naltrexone

Medication to prevent/treat overdose:

- Naloxone

Buprenorphine, methadone, and naltrexone are used to treat OUD to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These medications are safe to use for months, years, or even a lifetime. As with any medication, a resident's provider or the LTCF's medical director should be consulted before discontinuing use.[20]

Methadone:
Diversion risk: High

Point to Ponder:
A resident with Hypertension on an antihypertensive medication would not have that medication discontinued once the blood pressure returned to normal. It remains beneficial as long as the blood pressure remains stable. The same holds true for residents with a chronic condition of OUD on MOUD.

Mechanism of action: Methadone is a full agonist. This drug fully activates and occupies the opioid receptors of the brain. It is a long acting, synthetic opioid. Methadone reduces opioid withdrawal and craving and blunts or blocks the euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.[21]

Uses: Methadone is used in medically supervised withdrawal as well as during the maintenance phase. It reduces withdrawal symptoms and prevents relapse. General guidance offered by SAMHSA indicates that stable patients can continue OUD medication such as Methadone indefinitely if it is beneficial to them. Residents who have stabilized on Methadone are in recovery.[22] Note: Withdrawal management is not the role of the LTCF.

Availability: Methadone necessitates closer observation of new residents to ensure that initial doses do not exceed an individual's tolerance for the medication.

In Connecticut, Methadone is available only through an Opioid Treatment Program (OTP) or a mobile OTP unit.

LTCFs should determine a model of service delivery that works for the facility's organizational structure and supports person centered care. It is highly recommended by the Connecticut Department of Public Health that skilled nursing and other long term care facilities have on-

[20] SAMHSA (2024). Medications, Counseling, and Related Conditions. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions
[21] Drugs.com (2024) Methadone: Uses, Dose, Side Effects, Retrieved from https://www.drugs.com/methadone.html
[22] American Addiction Centers (2024). Methadone Withdrawal Symptoms, Timeline, and Detox Treatment. Retrieved from https://americanaddictioncenters.org/withdrawal-timelines-treatments/methadone

site methadone maintenance services to avoid the need to transport medically vulnerable patients off-site to receive services. LTCFs will need to work closely with an OTP to secure those arrangements. By reducing the burden on residents to visit the OTP daily, this flexibility may reduce stigma and create a more efficient and fluid plan of care.

Refer to *Guidance for Onsite Methadone Maintenance Service Delivery for Nursing Homes That are a Satellite to an Opioid Outpatient Treatment Program (OTP) in* Domain 4 Leadership

Care team considerations:

- Communicate with the hospital and OTP prior to discharge so LTCF doses are available at the time of discharge.
- If resident is newly inducted in the hospital, ensure that there is an appropriate hand-off to an OTP that can manage resident after discharge from the hospital.
- Opioid withdrawal is not required for initiation of Methadone. The dose can be gradually increased to suppress cravings and prevent withdrawal, and there is no maximum dose.
- Methadone does not appear in Prescription Drug Monitoring Programs (PMP) when used for OUD; however, in CT, individuals will have the option to "opt in" for methadone dosing information to be entered into the PMP.
- Clinically significant interactions with medications that are metabolized by CYP450 enzymes can occur, leading to increased or decreased effects of methadone. C- heck for drug interactions.[23]
- Avoid the use of Benzodiazepines (i.e., Alprazolam, Lorazepam, Clonazepam, Diazepam) with Methadone. Combining Benzodiazepines with Methadone can be dangerous and may cause drowsiness, respiratory suppression, and possible death.

Indication: Methadone is typically indicated for individuals with OUD who are physiologically dependent on opioids and meet federal criteria for OTP admission.[24]

Restrictions have been changed whereby an individual no longer needs to meet a one-year addiction requirement.

Restrictions: Methadone is a schedule II drug. It is only available at federally certified OTPs, mobile OTP units, and acute –in-resident hospital settings for OUD treatment.[25] Methadone is available from the pharmacy for pain management in the LTCF.

Form(s): Although available in oral tablet, liquid, or wafer forms, OTP's only dispense liquid formulations.

[23] NIH National Library of Medicine (2009). Drug interactions involving methadone and buprenorphine - Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK143177/ https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines

[24] Code of Federal Regulations (2024). Retrieved from: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8/subpart-C/section-8.12

[25] SAMHSA (2024). Statutes, Regulations, and Guidelines for Medicated-Assisted Treatment. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines

Dosing:

The OTP manages dosing for Methadone.

Other Clinical Considerations:

- ✓ Monitor for side effects:
  - Constipation
  - Diaphoresis or flushing
  - Nausea and/or vomiting
  - Dry mouth
  - Respiratory depression
  - Sedation
  - QT prolongation
  - Sexual dysfunction
  - Severe hypotension including orthostatic hypotension and syncope.[26]

- ✓ Monitor the resident for misuse.
- ✓ Add Orthostatic Vital signs to the resident care plan.

Buprenorphine (Belbuca, Butrans, Sublocade, Brixaldi):
Diversion risk: Intermediate

Mechanism of action: Buprenorphine is a partial agonist. It activates the opioid receptors but not to the same extent as a full agonist.

Buprenorphine has a ceiling effect, meaning the drug's impact on the body plateaus and thus lowers the risk of misuse, dependency, and side effects. It is a long-acting synthetic opioid.

Buprenorphine reduces opioid withdrawal and craving and blunts or blocks the euphoric effects of self- administered illicit opioids through cross-tolerance and opioid receptor occupancy.[27]

Uses: This drug is used in medically supervised withdrawal and for the maintenance phase. Buprenorphine reduces withdrawal symptoms and prevents relapse. Note: Withdrawal management should not be occurring in the LTCF.

Availability: Buprenorphine can be prescribed by any provider with a Drug Enforcement Agency (DEA) license and availability should be confirmed with the LTCFs' partner pharmacy. Recent changes allow for the use of audio-visual or audio-only telehealth platforms to assess new residents who will be treated with Buprenorphine.

[26] Boston Medical Center (2021). Massachusetts Nurse Care Manger Model of Office Based Addiction Treatment: Clinical Guidelines. Retrieved from https://www.addictiontraining.org/documents/resources/22_2021_Clinical_Guidelines_1.12.2022_fp_th%2528003%2529.29.pdf

[27] Drugs.com (2024). Buprenorphine. Retrieved from https://www.drugs.com/search.php?searchterm=buprenorphine

Telehealth can be an effective tool in integrating care and extending the reach of specialty providers to those with OUD.

There are no significant differences between telehealth and in-person Buprenorphine induction in the rate of continued substance use, retention in treatment or engagement in services.[28]

Care team considerations: Opioid withdrawal is typically required before for standard initiation with this drug.[29]

A provider can prescribe low dose initiation of Buprenorphine with the continuation and tapering of opioids to avoid precipitated withdrawal.

High-dose may be started with an initial dose of > 8 mg and rapid up-titration within 1 day.

Avoid use of benzodiazepines, alcohol, and other Central Nervous Symptom (CNS) depressants.

As indicated, clinicians should provide adjunctive medications to relieve specific symptoms of acute opioid withdrawal. A table of these recommendations may be found Here under Buprenorphine/Naloxone.

Indication: Typically, Buprenorphine is for individuals with OUD who are physiologically dependent on opioids.

Restrictions: Buprenorphine is a Schedule III drug. No waiver is needed. Any provider with a DEA number can prescribe Buprenorphine.

Buprenorphine does require any new or renewing DEA registrants, starting June 27, 2023, to have at least one of the following:

- Eight hours of training on OUD or other SUD from certain organizations.
- Board certification in addiction medicine or addiction psychiatry.
- Graduated within 5 years and status in good standing from medical, APRN or PA school that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours.[30]

Form(s): Sublingual tablet, buccal, sublingual film, or transdermal patch (off label for OUD)

Dosing:

Induction: Day 1: Initiate with 2-4 mg in 2–4-hour increments until withdrawal symptoms are managed. The provider may titrate up to 8mg in total.

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[28] Federal Register (2024). Medications for the Treatment of Opioid Use Disorder. Retrieved from https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder

[29] American Society of Addiction Medicine (2023). DEA Education Requirements. Retrieved from https://www.asam.org/education/dea-education-requirements

[30]

Day 2: Give Day 1 dose and an additional 2-4 mg up to 16mg total.

Normal dosing range is 16-24mg/day.

Residents who are opioid-dependent do not typically experience euphoria at this dosage. If they do, this very mild euphoria resolves within a few days.

The maximum recommended dose is 32mg/day. Doses of Buprenorphine up to 32 mg daily may be indicated to relieve opioid craving and promote treatment retention, particularly in individuals with chronic fentanyl exposure.[31]

Residents with chronic fentanyl exposure or other risk factors for precipitated withdrawal may benefit from low-dose Buprenorphine induction with opioid continuation (LDB-OC), in which full opioid agonists can be continued until a therapeutic level of Buprenorphine is achieved. It is essential to discuss with the resident and document the risks of ongoing, non-prescribed, full opioid agonist use, and the strategies to maximize safe use.

LDB-OC, previously known as microdosing or micro-induction)**:**

- **Initial Buprenorphine dose:** 0.25 mg to 0.5 mg while resident continues taking full opioid agonist.
- **Titration:** Increase with low dose increments of Buprenorphine over 7 days to reach therapeutic level; discontinue full opioid agonist.
- Does *not* require opioid withdrawal and can be an alternative for patients who may not be able to tolerate standard initiation.[32]

What is the SUBLOCADE REMS (Risk Evaluation and Mitigation Strategy)?
A REMS is a strategy to manage known or potential risks associated with a drug and is required by the Food and Drug Administration (FDA) to ensure the benefits of the drug outweigh its risks. SUBLOCADE is administered monthly only by subcutaneous injection in the abdominal region by a healthcare provider and is only available through a restricted distribution program called the SUBLOCADE REMS. SUBLOCADE must never be dispensed directly to the patient and must only be administered by a healthcare professional. The goal of the REMS is to mitigate the risk of serious harm or death that could result from intravenous self-administration.
Sublocade REMS - Home

Form: Injectable

Restrictions: Injectable Sublocade is available through the Risk Evaluation and Mitigation Strategies (REMS) program only and administered only by health care providers in a health care setting.

[31] Grande LA, Cundiff D, Greenwald MK, Murray M, Wright TE, Martin SA. Evidence on Buprenorphine Dose Limits: A Review. J Addict Med. 2023 Sep-Oct 01;17(5):509-516. doi: 10.1097/ADM.0000000000001189. Epub 2023 Jun 16. PMID: 37788601; PMCID: PMC10547105.
[32] New York State Department of Health AIDS Institute (2024). Substance Use Care, Clinical Guidelines Program, Opioid Use Disorder Treatment. Retrieved from https://www.suguidelinesnys.org/guideline/treatment-of-opioid-use-disorder/?mytab=tab_2&mycollection=substance-use/#table-2

Prescribers are NOT required to be certified in the SUBLOCADE REMS to prescribe and obtain Sublocade. More information about the Sublocade REMS program can be found here: Sublocade REMS Fact Sheet.[33]

DOSING For Injectables

The recommended dose for long-acting Buprenorphine injection (XR Buprenorphine, currently available brand name Sublocade**,** is 300mg subcutaneously once monthly for the first 2 months, followed by a maintenance dose of 100mg/month.

Residents need to be stabilized on a sublingual buprenorphine or buprenorphine/naloxone for at least seven days before treatment with Sublocade.

Doses should be given no less than 26 days apart.

Weekly injectable XR-Buprenorphine (Sublocade) can be used to initiate treatment in individuals who are not already taking Buprenorphine. Injections should be initiated immediately after a test dose of sublingual Buprenorphine to demonstrate tolerance without precipitated withdrawal.[34]

Brixadi is approved in both weekly and monthly subcutaneous injectable formulations at varying doses, including lower doses that may be appropriate for those who do not tolerate higher doses of extended-release buprenorphine that are currently available.

The weekly doses are 8mg, 16 mg, 24 mg, 32 mg; and the monthly doses are 64 mg, 96 mg, 128 mg. The approved weekly formulation in various lower strengths offers a new option for people in recovery who may benefit from a weekly injection to maintain treatment adherence.[35]

Other Clinical Considerations:

✓ Monitor for side effects:
- Constipation
- Headache
- Nausea and/or vomiting
- Excessive sweating
- Insomnia
- Pain
- Dry mouth
- Dizziness
- Peripheral edema

[33] Sublocade REM. Retrieved from https://www.sublocaderems.com/#Main/Home
[34] Boston Medical Center (2021). Massachusetts Nurse Care Manger Model of Office Based Addiction Treatment: Clinical Guidelines. Retrieved from https://www.addictiontraining.org/documents/resources/22_2021_Clinical_Guidelines_1.12.2022_fp_th%252800%2529.29.pdf
[35] Braeburn (2023). About BRIXADI. Retrieved from https://www.brixadihcp.com/about-brixadi/

- Respiratory depression (particularly combined with benzodiazepines or other CNS depressants)

✓ For residents receiving sublingual/buccal doses, assess for oral numbness, tongue pain and/or mucosal erythema.
✓ Monitor the resident for misuse.
✓ Assess the potential for, educate residents about, and have a clear protocol for managing precipitated withdrawal.

Buprenorphine/Naloxone (e.g., Suboxone, Zubsolv, Bunavail)

Diversion risk: Yes

Mechanism of action: This drug is a combination of partial agonist combined with antagonist. It reduces opioid withdrawal and craving and blunts or blocks euphoric effects of self- administered illicit opioids through cross-tolerance and opioid receptor occupancy.

This drug is less likely to be misused due to the combination with Naloxone (antagonist).

Uses: Buprenorphine/Naloxone (BUP/NLX) is used in medically supervised withdrawal, for the maintenance phase, and reduces withdrawal symptoms and prevents relapse.

Availability: BUP/NLX is available through OTPs

Care team considerations: To minimize risk of precipitated withdrawal, clinicians should advise residents to wait for the onset of mild to moderate opioid withdrawal before starting BUP/NLX.

Indication: This drug is typically prescribed for individuals with OUD who are physiologically dependent on opioids.

Restrictions: Buprenorphine is a Schedule III drug. No waiver is needed. Any provider with a DEA number can prescribe Buprenorphine.

Buprenorphine does require any new or renewing DEA registrants, starting June 27, 2023, to have at least one of the following:

- Eight hours of training on OUD or other SUD from certain organizations.
- Board certification in addiction medicine or addiction psychiatry.
- Graduated within 5 years and status in good standing from medical, APRN or PA school that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours.

Form(s): Sublingual BUP/NLX, oral tablet or buccal film.

Dosing: Dosing per day for BUP/NLX is as prescribed by OTP or other provider.

Normal dosing range is 16-24mg/day. Opioid-dependent residents do not typically experience euphoria at this dosage. If they do, this is a very mild euphoria and resolves within a few days. The maximum recommended dose is 32mg/day.

BUP/NLX is initiated after the onset of mild to moderate opioid withdrawal symptoms and titrated in incremental doses. The goal is to reach a dose that will control a resident's opioid cravings, reduce, or prevent withdrawal symptoms, and support the resident's treatment goals.

Residents with chronic fentanyl exposure or other risk factors for precipitated withdrawal may benefit from low-dose BUP with opioid continuation (LDB-OC), in which full opioid agonists can be continued until a therapeutic level is achieved. It is essential to discuss with the resident and document the risks of ongoing, non-prescribed, full opioid agonist use, and the strategies to maximize safe use.[36]

Other Clinical Considerations:

- ✓ Monitor for side effects:
  - Constipation
  - Headache
  - Nausea and/or vomiting
  - Excessive sweating
  - Insomnia
  - Pain
  - Dry mouth
  - Dizziness
  - Peripheral edema
  - Respiratory depression (particularly combined with benzodiazepines or other CNS depressants)[37]
- ✓ For residents receiving sublingual/buccal doses, assess for oral numbness, tongue pain and/or mucosal erythema Monitor the resident for misuse.
- ✓ Assess the potential for, educate residents about, and have a clear protocol for managing precipitated withdrawal.

✓ Resource: Buprenorphine Quick Start Guide (samhsa.gov)[38]

Naltrexone (e.g., ReVia, Vivitrol)

Diversion risk: No

Mechanism of action: Naltrexone is an antagonist and blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy and does not cause opioid effects.

[36] New York State AIDS Institute (2024). Treatment of Opioid Use Disorder. Buprenorphine/Naloxone. Retrieved from https://www.suguidelinesnys.org/guideline/treatment-of-opioid-use-disorder/
[37] Braeburn (2023). About BRIXADI. Retrieved from https://www.brixadihcp.com/about-brixadi/
[38] Samhsa (2023). Buprenorphine Quick Start Guide. Retrieved from: https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

Uses: Naltrexone prevents relapse following medically supervised withdrawal.

Availability and Restrictions: Any prescriber can prescribe it, and no waiver is needed.

Care team considerations: The risk of overdose among participants receiving XR Naltrexone in the U.S. randomized controlled trial discussed above was nearly 4 times higher than the risk of overdose among those receiving BUP/NLX.[39]

Indication: This drug is typically for residents 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.[40]

Form(s): Oral tablet or extended release (XR) injectable.

Dosing: Before administering XR naltrexone, clinicians should administer a NLX (or low-dose Naltrexone) to challenge and confirm that residents do not react to ensure that opioids have been cleared from the system. [41]

Administer the extended release injectable every 4 weeks or once a month as a 380 mg IM gluteal injection**.**

Other Clinical Considerations:

- ✓ Monitor for side effects:
  - Nausea
  - Anxiety
  - Insomnia
  - Precipitated opioid withdrawal
  - Hepatotoxicity
  - Vulnerability to opioid overdose
  - Depression and/or suicidality
  - Muscle cramps
  - Dizziness and/or syncope
  - Somnolence or sedation
  - Decreased appetite or other appetite disorders
  - **Intramuscular:** Pain, swelling, induration (including some cases requiring surgical intervention).[42]
- ✓ Add depression and suicidal ideation screening to the resident care plan.

[39] Ajazi, et al. 2022. Revisiting the X:BOT Naltrexone Clinical Trial Using a Comprehensive Survival Analysis. Journal of Addiction Medicine 16(4):p 440-446, 7/8 2022. | DOI: 10.1097/ADM.0000000000000931
[40] SAMSHA (2024). Naltrexone. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone
[41] Boston Medical Center (2021). Massachusetts Nurse Care Manger Model of Office Based Addiction Treatment: Clinical Guidelines. Retrieved from https://www.addictiontraining.org/documents/resources/22_2021_Clinical_Guidelines_1.12.2022_fp_th%2528003%2529.29.pdf
[42] SAMSHA (2024). Naltrexone. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone

Naloxone

Diversion risk: No

Mechanism of action: Naloxone is an opioid antagonist. 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.

Uses: Naloxone is used for opioid overdose reversal.

Availability and Restrictions: Naloxone is widely available through pharmacies and other agencies.

Care team considerations: Educating LTCF staff on recognizing signs of overdose and appropriate actions to take if a resident has overdosed is a best practice. See Domain 1- Workplace Practice

Indication: Persons overdosing from opioids.

Form(s):

- IM, IV or SC injection.
- Auto-injector
- Nasal Spray

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.

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.[43]

Other Clinical Considerations:

Naloxone works to reverse opioid overdose in the body for only 30 to 90 minutes. But many opioids remain in the body longer than that. Because of this, it is possible for a person to still experience the effects of an overdose after a dose of naloxone wears off. Residents who are

[43] Drugs.com (2024). Naloxone Dosage. Retrieved from https://www.drugs.com/dosage/naloxone.html#Usual_Adult_Dose_for_Opioid_Overdose

given naloxone should be monitored for 2 hours after the last dose of naloxone is given to make sure breathing does not slow or stop.[44]

Side effects:

Naloxone seldom causes side effects, but some individuals may experience allergic reactions to the medication. Overall, Naloxone is a safe medicine; however, it only reverses an overdose in people with opioids in their systems and will not reverse overdoses from other drugs like cocaine or methamphetamine. When residents awaken, they should be responded to with empathy and respect, reassuring them the care team will help them through the reactions of naloxone reversal.

Contrary to common assumptions, withdrawal symptoms and anger following naloxone administration may be unrelated phenomena. Anger was less likely to be reported when care givers communicated positively with the person who had overdosed by talking to them, explaining what had happened, and/or trying to calm them down. In contrast, anger was more likely to be reported when the participant communicated negatively with the person who had overdosed by criticizing, berating, or chastising them during the resuscitation process. Research findings have suggested positive or reassuring communication style may lessen anger post overdose.[45]

For more information about responding to an opioid overdose, please visit Domain 1: Workplace Practices.

A word on Buprenorphine Initiation

Before initiating buprenorphine treatment, individuals must discontinue opioid use. They may experience withdrawal symptoms during this process, and it could take several dose adjustments to find the appropriate buprenorphine dosage. Once an individual is stabilized on maintenance buprenorphine, a plan should be developed to continue this treatment and facilitate successful recovery. Another option would be that a provider can prescribe low dose initiation of Buprenorphine with the continuation and tapering of opioids to avoid precipitated withdrawal.

Buprenorphine for Pain

Buprenorphine for Pain: A Transition Guide from Full Agonist Opioid Prescriptions is a tool intended to aid clinicians in switching patients off of full opioid agonists to buprenorphine, a partial mixed opioid agonist for pain management. More information about this guide can be found at Buprenorphine for Pain: A Transition Guide from Full Agonist Opioid Prescriptions – IPRO QIN-QIO Resource Library.

[44] National Institute on Drug Abuse (2022). Naloxone Drug Facts. Retrieved from https://nida.nih.gov/publications/drugfacts/naloxone

[45] Neale J, Kalk NJ, Parkin S, Brown C, Brandt L, Campbell ANC, Castillo F, Jones JD, Strang J, Comer SD. Factors associated with withdrawal symptoms and anger among people resuscitated from an opioid overdose by take-home naloxone: Exploratory mixed methods analysis. J Subst Abuse Treat. 2020 Oct;117:108099. doi: 10.1016/j.jsat.2020.108099. Epub 2020 Aug 5. PMID: 32811629; PMCID: PMC7491601.

Transitions

Effective communication is crucial at all stages. Care coordination and warm handoffs are necessary for residents requiring continuation of MOUD. Prior to discharge from the hospital to the long-term care facility, a buprenorphine prescriber must be identified. All agreements required by the prescriber should be completed before hospital discharge, and the treatment start date should be clearly established.