Domain 5: Family and Community

Establish meaningful connections involving the resident, their family or family of choice and friends, and the community stakeholders to better support residents with opioid use disorder (OUD).

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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 5. Family and Community

Goal:

Establish meaningful connections involving the resident, their family or family of choice and friends, and the community stakeholders to better support residents with opioid use disorder (OUD).

Objectives:

1. Consider how long-term care facilities (LTCFs) can be the catalyst for the four dimensions of recovery.
2. Define the roles of community based Opioid Treatment Programs (OTPs) and prescribers of Medication for Opioid Use Disorder (MOUD) in supporting LTCF residents with OUD.
3. Identify common community resources (e.g. mutual help groups, peer recovery) and community-based programs (e.g., gyms, social encounters, sports, community activities) to support residents during their stay and after discharge.
4. Identify ways to engage residents' families and caregivers in support of their care plan, when appropriate.

Description:

The Family & Community domain centers around inclusion and opportunities for families and community partners to work together for the benefit of the resident with OUD and to support the organization's efforts.

Building and Strengthening Communities for Residents with OUD

To offer perspective on the breath of the opioid crisis as it relates to discharge, a recent analysis looked at 459,763 hospitalized patients with OUD.

"Of these, patients aged < 65 years and those dually enrolled in Medicaid comprised the majority (59.1%). OUD and opioid overdose were primary diagnoses in 14.3% and 6.2% of analyzed hospitalizations, respectively. We found that 70.3% of hospitalized patients with OUD were discharged home, 15.8% to a skilled nursing facility (SNF), 9.6% to a non-SNF institutional facility, 2.5% home with home health services, and 1.8% died in-hospital. Within 30 days of hospital discharge, rates of readmissions and mortality were 29.7% and 3.9%; respectively, with wide variation across post-acute locations".[1]

These staggering statistics offer insight into the importance of community for residents with OUD and is of critical importance in the context of their healing and hope for recovery. Substance Abuse and Mental Health Services Administration (SAMHSA) shares that the process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life,

[1] Moyo P, Eliot M, Shah A, Goodyear K, Jutkowitz E, Thomas K, Zullo AR. Discharge locations after hospitalizations involving opioid use disorder among medicare beneficiaries. Addict Sci Clin Pract. 2022 Oct 8;17(1):57. doi: 10.1186/s13722-022-00338-x. PMID: 36209151; PMCID: PMC9548174.

resilience becomes a key component of recovery. Recovery includes four dimensions to support a healthy life. These include health, home, purpose, and community.

SAMHSA's Working Definition of Recovery:
https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf[2]

The LTCF may be the first place to help a resident with OUD start acquiring health, home, purpose, and community. Beginning the recovery process within this setting can help support the transition back to the community after discharge.

Partnering with community organizations is not new for LTCFs but, they are less likely to have partnered with organizations that treat and support those with OUD and other substance use disorders (SUD). Below you will find a wide array of organizations that can help LTCFs in caring for those with OUD.

LTCF Residents and Medication for Opioid Use Disorder (MOUD)

Residents in the LTCF that have OUD may be receiving, or be interested in receiving, MOUD such as Buprenorphine or Methadone (see Domain 3: Care Practices for more information). MOUD are controlled substances designed to help control opioid use by reducing withdrawal symptoms and cravings.[3] Methadone can only be prescribed by Opioid Treatment Programs (OTPs) and other medications such as buprenorphine can be prescribed by a licensed independent practitioner with a DEA license. Some residents may already be connected to a specific health care facility or provider to receive their MOUD. Additionally, some residents may be able to obtain 14- or 28-days' worth of their methadone at a time and would only need to visit the OTP for refills or to receive integrated support services (e.g. behavioral health services).

What are Opioid Treatment Programs (OTPS)?

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 Domain 3: Care Practices). OTPs generally administer medication on-site but can provide take-home medication (pre-poured doses) on a case-by-case basis.

What other providers can prescribe MOUD?

Prescribing clinicians are no longer required to obtain a Drug Addiction Treatment Act (DATA) waiver to prescribe MOUD. This change expands access to MOUD treatment.

Telehealth

Telehealth is "the use of electronic communication and information technologies to provide or

[2] SAMSHA (2012). Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from: https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf
[3] National Harm Reduction Coalition (Accessed 2024). Medication for Opioid Use Disorder (MOUD) Overview. Retrieved from: https://harmreduction.org/issues/facts/

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." Telehealth services may grow in popularity because they are accessible, convenient, and cost-effective.

Federal and CT regulations now allow clinicians to initiate buprenorphine through telehealth.[4]

How can LTCFs help their residents access MOUD?

There are a few ways that LTCFs can help residents access MOUD while they are in their care. See Domain 4: Leadership for more information.

At admission: During the admission process LTCF staff should be discussing any health issues the resident has, including whether they have OUD. If a resident has OUD, the LTCF staff should ask if the resident is receiving, or interested in receiving, MOUD during their stay. If they are, then this should be included in the resident's care plan. If a resident is already receiving MOUD, the LTCF should discuss with the resident how often they will need to see their MOUD prescriber (e.g. for doses/refills or to access integrated support services) and whether they will need assistance with transportation. If a resident is interested in starting MOUD, the LTCF should help connect the resident with local OTPs or MOUD prescribers.

During their stay: While the resident is at the facility the LTCF staff should support MOUD use as they would any other part of the resident's care plan. This could include reminding the resident to take their MOUD (if they have a multi-day supply) and/or helping to coordinate transportation for the resident's appointments with their MOUD prescriber.

At discharge: If a resident has been receiving MOUD during their stay or expresses interest in beginning MOUD once they are discharged, this should be included in the discharge plan.

Community Resources to Support Residents with OUD

Community-based organizations can support LTCF residents with OUD both during their time in the facility and once they are discharged. Some residents may already be working with one or more of these groups when they are admitted. As part of the admission process, ask residents if they are working with any of these types of organizations and whether there are ways to help them maintain connections while they are receiving care. These are also organizations that LTCFs should reach out to and build connections with. They may be able to provide resources or programs to help care for and support residents with OUD. Establishing relationships with these organizations may also assist with discharge planning.

Warm Lines

Warm Lines are telephone support services staffed by people who have experience/expertise with mutual support. These lines are not crisis lines and the days/hours of operation vary.

Directory of Warm Lines: https://portal.ct.gov/DMHAS/Programs-and-

[4] Federal Register (accessed 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#h-12

Services/Advocacy/Warm-Lines

Recovery and Support Organizations

Recovery and support organizations 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 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.

- *Advocacy Unlimited* https://advocacyunlimited.org/
- *Connecticut Community for Addiction Recovery* https://ccar.us/
- *National Alliance on Mental Illness-CT* https://namict.org/
- *Recovery Innovations for Pursuing Peer Leadership and Empowerment* https://rockingrecovery.org/

DHMAS's real-time SUD and Mental Health bed websites:

- *CT Mental Health Services DMHAS* - https://www.ctmentalhealthservices.com/
- *CT Addiction Services DMHAS* https://www.ctaddictionservices.com/

Virtual Support Meetings

Virtual support meetings allow residents to stay connected to the recovery community no matter where they are. The Connecticut Community for Addiction Recovery (CCAR) has a calendar of virtual meetings that residents can participate in without having to leave the facility and they can continue to participate after discharge.

CCAR Virtual Support Meeting Calendar: https://ccar.us/programs/virtual-support-meetings/

Emergency Department Recovery Coach Services

A peer recovery coach is an integral member of the interdisciplinary care team, bringing a unique and invaluable perspective to the team. These individuals have lived experience in overcoming SUD. Their role is to guide and support others on their recovery journeys by drawing from their firsthand experiences. Peer recovery coaches assist others in initiating and maintaining their recovery by promoting self-actualization, community engagement, civic engagement, and overall wellness. They collaborate with individuals to create personalized recovery plans and pathways, providing a range of support tailored to individual needs. This support may include emotional support, sharing information on health and wellness resources, offering guidance on concrete matters such as housing or employment, and facilitating connections to recovery communities, activities, and events.

Connecticut began piloting a program in 2017 to connect on-call recovery coaches with emergency departments in Connecticut hospitals. As of 2024, all hospital emergency departments have recovery coaches on site. The recovery coaches assist people who are

admitted with opioid overdose and other alcohol or drug-related medical emergencies and, if they are interested, connect them to treatment and other recovery support services. Harm reduction supplies and services may also be offered. See Appendix 1 for more information or visit here: https://portal.ct.gov/DMHAS/Initiatives/DMHAS-Initiatives/Emergency-Department-Recovery-Coach-Services.

Patient Navigators

A patient navigator is a person who works with local health care systems. A patient navigator helps guide a patient or resident through the healthcare system and its other services. These services may be valuable resources once a patient is discharged to home. Patient navigators 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.[5] 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 the resident's healthcare.
  Community resource providers (including insurance companies, employers, case managers, lawyers, and social services)

Treatment and Recovery Services for Women and Families:

https://portal.ct.gov/dmhas/programs-and-services/women/womens-and-childrens-programs

Community-Based Programs to Support Residents After Discharge

Residents with OUD may have different needs when they are being discharged. There are programs and resources available for individuals with OUD that may help with developing discharge plans for residents with OUD. Residents with OUD may need housing or employment assistance secured as part of their discharge plan.

Sober Living Homes and Certified Sober Living Homes

Residents with OUD being discharged may be interested in living in a Sober Living Home. There are two types of entities that refer to themselves as Sober Living Homes:

Sober Living Homes: These are residences where adults choose to live together and agree to remain sober. They are not monitored, certified, or overseen by the Department of Mental Health and Addiction Services.

Certified Sober Living Homes: These are Sober Living Homes that are certified as recovery residences by an affiliate of the National Alliance for Recovery Residences (NARR) or another organization recognized by the Department of Mental Health and Addiction Services.

[5] 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/

Location, contact information, and bed availability for Certified Sober Living Homes is available online: https://www.ctaddictionservices.com/.

Employment Support

Residents with OUD may need assistance in finding employment at discharge. As part of a comprehensive discharge plan provide residents with resources and support. Connecticut offers various programs designed to assist residents in recovery with developing job training and finding employment opportunities.

The CT DMHAS website has a whole section dedicated to supported employment services including agencies across Connecticut that provide employment and education services.

Engaging Residents' Family and Caregivers

Residents can benefit from supporting interactions with individuals from their personal support network. This support system can extend beyond family members and can include friends, colleagues, neighbors, and community organizations with which they are involved. Identifying a resident's support system and engaging those individuals in their care while at your facility is important. It enhances their well-being and supports in planning for a successful discharge back into the community. Identifying a resident's support system and engaging those individuals as part of the care team can be beneficial for all parties, depending on the circumstances. If appropriate, social connections can enhance well-being and support the discharge planning process. Residents with OUD may have difficult or limited relationships with their family members and loved ones. There are resources to support the family members and loved ones of people with OUD.

Opioid Family Education Support Groups (OEFS)

Adults and young adults (16 and older) who have a family member or loved one with OUD can attend OFES groups in Connecticut. These groups, run by the Community Renewal Team (CRT) provide support, education, and Narcan training. For more information, visit www.crtct.org.

Additional Resources for Family and Caregivers

- Connecticut Mental Health Network: https://portal.ct.gov/dmhas/programs-and-services/finding-services/finding-services
- Milford Prevention Council: https://milfordprevention.org/
- Women's and Children Services: https://portal.ct.gov/dmhas/programs-and-services/women/womens-and-childrens-programs
- NAMI: https://namict.org/your-journey/family-members-and-caregivers/
- LiveLoud- Life with Opioid Use Disorder: https://liveloud.org/