Strategies for Supporting Residents with Opioid Use Disorder in Long Term Care

CONNECTICUT
Public Health

CONNECTICUT
Mental Health & Addiction Services

Healthcentric Advisors

The Connecticut Women's Consortium
Improving Behavioral Health Services for Women

This toolkit was made possible by funding from the Connecticut Department of Mental Health and Addiction Services. We would also like to thank representatives from Connecticut Department of Mental Health and Addiction Services, Connecticut Department of Public Health, and the Connecticut Women's Consortium for their contributions in the development and review of this toolkit and the adjunctive training and implementation of this initiative.

Table of Contents

How to Use the Toolkit

This toolkit outlines six domains to help your LTCF 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.

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.

This toolkit is a live document. We are open to feedback on what may be missing or needs to be covered in more detail. Please reach out to sbaker@healthcentricadvisors.org to provide recommendations.

Toolkit Domains:

Introduction

Re-Tool, Realign, Re-Imagine

The urgency for Strategies for Supporting Residents with Opioid Use Disorder in Long Term Care Toolkit has never been more pressing. This comprehensive toolkit represents the first in a series of resources designed to assist Long Term Care Facilities (LTCFs) in their initiatives to provide high-quality, person-centered care for individuals with opioid use disorder (OUD). As the opioid crisis continues to impact communities across the nation, equipping LTCFs with the necessary tools and resources is paramount to ensuring the well-being and successful recovery of residents with an OUD.

There are several contributing factors that have led to the increase of those in need of a sub-acute level of care due to opioid dependency. The opioid crisis in the United States has reached such sizable proportions that it has permeated various aspects of communal life, including LTCFs. Escalation of fentanyl has caused a rapid increase in overdose deaths and medical complications, the need for prolonged IV antibiotic therapy, aftereffects from surviving an overdose, and recovery from severe injuries while under the influence, requires hospitals to find safe and healing environments where recovery from a primary diagnosis can take place. As a result, LTCFs have become the downstream setting for care.

A retrospective study conducted at Brown University offers perspective on the breath of the opioid crises as it relates to discharge, a recent analysis included 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. They 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.[1]

An analysis conducted by Healthcentric Advisors identifies substance use disorder (SUD) diagnoses using all Part A hospital claims (admission, emergency Department, observation) for Medicare FFS beneficiaries admitted to a nursing home in Connecticut, shows that OUD accounted for 1.04% of the top 25 SUD diagnosis of 136 residents. (*See Figure 1. CT: Nursing Home Residents by SUD Diagnosis*).

[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.

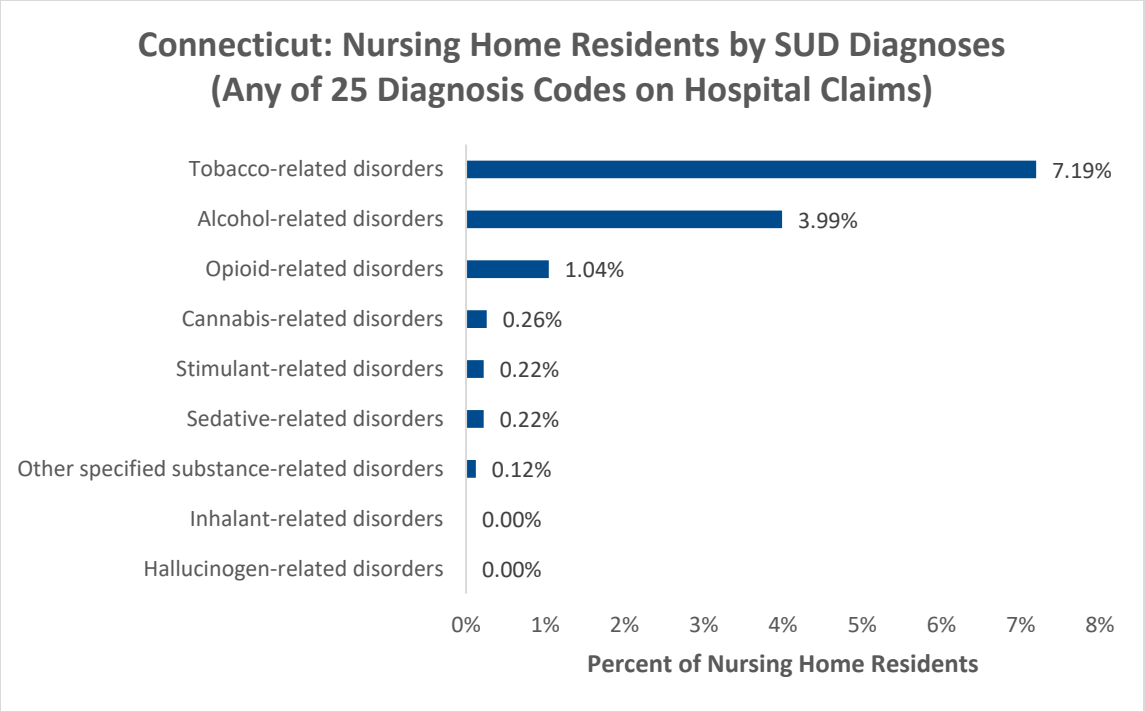


Figure 1: CT: Nursing Home Residents by SUD Diagnosis

LTCFs are expected to accept residents who meet nursing home level of care with OUD. LTCFs that have declined face scrutiny. As highlighted in a recent article by Grebbin, the rising prevalence of SUD has placed a growing demand on LTCF operators to provide comprehensive care within the continuum of healthcare services. Federal and state enforcement agencies, bolstered by anti-discrimination laws, have issued warnings, and taken actions against SNFs refusing admission to individuals in treatment for SUD.[2] In 2022, in Massachusetts, a Connecticut-based long-term care management company operating nursing homes across southern New England agreed to pay $1.75 million and adopt a series of critical compliance measures in a settlement reached by Attorney General Maura Healey's Office. The settlement resolves a series of allegations, including that the company failed to meet the needs of nursing home residents experiencing SUD.[3]

Offering specialized care for individuals with OUD requires LTCFs to enhance their skillset and capabilities to meet the unique demands and care needs of this population. Transitioning from a historically elder-focused workforce to accommodate the needs of a younger group of residents will necessitate a significant cultural shift and extensive education across all levels, from medical directors to nursing assistants. Comprehensive training is essential in areas such as OUD, stigma and bias, trauma-informed care, mood and behavior disorders, de-escalation

[2] Grebbin, Shelby (2024). Avoiding Legal Risks Posed by Nursing Home Admissions of Substance Use Disorder Patients. Skilled Nursing News. Retrieved from: https://skillednursingnews.com/2024/01/avoiding-legal-risks-posed-by-nursing-home-admissions-of-substance-abuse-disorder-patients/

[3] MA DPH (2022). AG Healey Secures $1.75 Million Resolution with Nursing Home Chain Over Failure To Meet the Needs of Residents With Substance Use Disorder. Press Release. Retrieved from: https://www.mass.gov/news/ag-healey-secures-175-million-resolution-with-nursing-home-chain-over-failure-to-meet-the-needs-of-residents-with-substance-use-disorder

techniques, withdrawal symptom management, overdose response, harm reduction, Medications for Opioid Use Disorder (MOUD), and tailored activities. Furthermore, systems, policies, and operational accountability measures will require refinement to ensure the provision of high-quality care for residents with OUD.

To effectively address the needs of residents with OUD, numerous LTCFs have introduced new roles and fostering partnerships. These include employing behavioral health technicians, aftercare specialists, Licensed Clinical Social Workers with expertise in behavioral health, Peer Counselors, and, in some cases, on-site security. New roles will need development of clear job descriptions and requirements for hire, including licensure and/or specialized training. Partnerships with community-based organizations (CBOs) such as federally certified Opioid Treatment Programs (OTPs), agencies providing substance use residential and outpatient services, first responders, such as, but not limited to, EMS, fire/police departments and mobile crisis units, sober houses, and other recovery organizations, not previously on the list of LTCFs stakeholders, will be necessary. Furthermore, survey teams and ombudsmen acknowledge the need to refresh regulatory systems to better serve the community of individuals with OUD. Additionally, communities are beginning to envision and reimagine entirely different facility designs that better accommodate the unique needs of a younger population seeking and/or are in recovery from OUD.

Strategies for Supporting Residents with Opioid Use Disorder in Long Term Care was developed to provide insights for those who are caring for people with OUD. The team developing this resource has been working closely with those pioneering organizations who care for this vulnerable population and finding new and improved ways to approach their care. Their stories and unique insights help to inform both care practices and policy so that interventions for residents with OUD will be increasingly person-centered and effective.

Strategies for Supporting Residents with Opioid Use Disorder in Long Term Care was designed using the HATCh Model. The Holistic Approach to Transformational Change (HATCh®) is a person-centered approach used by health care organizations to transform their culture from institutional to individualized care. HATCh® realigns care and delivery systems to revolve around the needs and input of residents and patients– centering people at the heart of all care and positively affecting quality of life and satisfaction. The model ensures improvement strategies are carefully considered through the lens of the six HATCh® domains so that the resulting changes fully support a person-centered approach and encourages development of more meaningful relationships between patients/residents and their health care providers. "Knowing the person" receiving care means providers are more understanding of needs and interests, and systems are adjusted to revolve around people. Our research demonstrates that the six domains of HATCh® - Workplace Practice, Environment, Care Practices, Leadership, Family & Community, and Regulatory & Stakeholders lead to personal, and organizational systems changes, all of which are necessary for a transformation from institutional to person-centered care.

Domain 1: Workplace Practice

Goal:

Enhance the understanding, skills, and inclusive mindset of all staff to provide thoughtful and expert care to individuals with an opioid use disorder (OUD), using a person-centered approach.

Objectives:

1. Employ specific strategies for recruiting and onboarding new staff and ongoing training about OUD.
2. Define key skills related to OUD for professional and frontline staff.
3. Assess the need for new and expanded competencies to support long-term care facility (LTCF) residents with OUD.

Description:

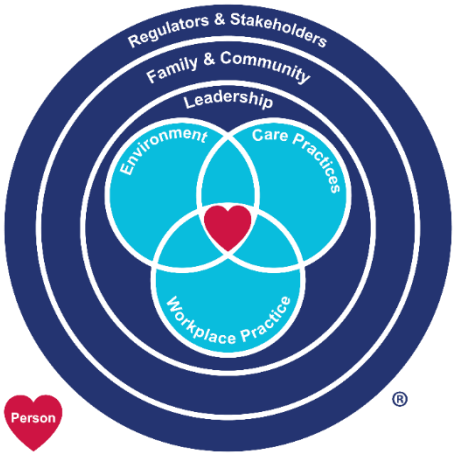
The workforce domain refers to the high engagement and performance of all those whose labor and efforts impact residents. It calls on leaders of LTCFs to create a culture of continuous learning. Within this domain are ways to enhance person-centered care and develop competencies to provide more effective support for individuals with OUD. It addresses best practices in hiring, strategies for onboarding new staff members, and ongoing training around key skills and competencies (e.g. such as a trauma- informed care, reducing or eliminating stigma and bias, de-escalation techniques, and motivational interviewing). Also, for consideration, there are ways to expand/enhance staff roles to create a resilient, competent workforce.

Changing Demographics

As the opioid crises in America grows, the healthcare system is responding to increasing encounters with those with an OUD. Many individuals living with OUD experience a wide array of comorbidities and frequently need compassionate care to bring them back to baseline. A significant number of individuals recover from injuries, drug events, and complications from comorbidities in local LTCFs following hospital stays. Consequently, LTCFs frequently find themselves caring for notably younger residents. This trend is compelling LTCFs to reevaluate and reimagine certain aspects of their operations and care delivery. They are transitioning from an elder care model to one that embraces and supports younger residents with vastly different needs and healthcare goals. Providers are learning to adjust to the changing demographics by reinventing their services to include more social service support, behavioral health counselors, support groups that address substance use disorder (SUD), and a much more fluid activity calendar.

Additional roles could include an aftercare specialist. Aftercare specialists are responsible for providing support to individuals with OUD, and/or mental health needs. Aftercare specialists are being employed to assist with discharge placement ensuring that individuals have a safe setting from which they can continue their path to recovery. Recognizing that some newly admitted residents with active SUD may have been using substances as part of their daily routine prior to admission requires new levels of competency, care, system knowledge of behavioral health and OUD, and support on the part of staff.

Person-Centered Approach



Person-centered care, an approach that puts the resident at the heart or center of care with services encompassing their needs, is especially relevant to residents with OUD, as the concepts embedded in that care are also key drivers of recovery.[4] The Centers for Medicare & Medicaid Services (CMS) defines person-centered care as "integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together."[5]

Continuous growth and education focused on person-centered care, provides all staff with an opportunity to become increasingly competent. Leaders and managers who "model the way" and inspire a shared vision are likely to accelerate the staff's understanding of person - centered care. Watching leaders handle situations that offer dignity, respect, kindness and empathy with residents will ensure that staff emulate these skills. Involvement of staff members in "just in time" discussions based on behaviors they have witnessed, escalations they have encountered, or other uncomfortable episodes is powerful, providing them with key opportunities to review how person-centered care helps support any resident but also those with OUD. Bolstering staff engagement in these types of discussions and experiences helps them to gain confidence and competence and even goes a long way in helping to reduce staff turnover, thus providing consistency and continuity for residents and many other positive effects.[6] This is an opportunity to build the knowledge, skills, and attitudes of staff to help create and sustain a person-centered culture.

Some ideas:

- Encourage staff in the early days of a resident's admission to learn more about the resident, explore their likes and dislikes, daily routine, and goals the resident might have and share them with other team members during huddles or reports, so that staff can support the resident.
- Consider applying the 'it takes a village' approach.
- Educate staff in such a consistent and ongoing way that the organization experiences a notable positive shift in the culture and care for residents.
- Identify champions who can work on specific goals and performance improvement projects that will assist in creating a high performing, uniquely caring environment for people with OUD.[7]

---

[4] 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
[5] Centers for Medicare & Medicaid Services. (2024). CMS Innovation Center Key Concepts. Retrieved from https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care
[6] 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
[7] 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

Here is an example of person-centered care:

Tyler is a 42-year-old male who has experienced unsheltered homelessness for the last four years. After experiencing a concussion, and a fracture to his occipital lobe with lacerations caused by a recent drug overdose, he was discharged to a local nursing home after spending two days in the hospital. It is the first time he has ever been to a nursing home. The home makes a special effort to support Tyler's need to construct his own daily schedule. Staff identify that Tyler doesn't usually sleep "in a bed" and frequently wanders around at night downtown until he gets tired. He has a few safe places that he frequents to sleep and sometimes stays on the couch at his cousin's house. He eats late and as a result, he tends to sleep a bit longer in the morning (or until it gets light out or he hears the traffic moving around him). The team discusses with Tyler the best ways they can make him comfortable. They offer him a room close to the patio so he can walk at night. There, he can relax. They buy snacks that he particularly enjoys which are left in his drawer and have made accommodations so that a meal will be available to him late at night. Tyler was delighted when the team offered him a recliner (a donated item from a former resident) that was put in his room. He thought this would be better than the bed and it would give him a place to take a nap. The team got a "Do not disturb" sign for the door so when he wanted to nap, no one would enter. They gave him a calendar so he could see the day's activities, but he said he just likes to listen to music. The team connected him with a radio as part of the Music & Memory program and downloaded a playlist of his favorite songs.

Staff Recruitment

LTCFs are starting to recognize a growing need to offer screening questions addressing candidate's biases, level of empathy, safety needs and de-escalation competencies. This is important and reflects a shift in competencies. When recruiting and interviewing staff, introducing person-centered care questions into the process will set expectations that reflect the values and culture of the organization. It will also strategically bring individuals on board who already possess the required person-centered orientation.

Recruitment efforts may prioritize building a diverse workforce that is reflective of the community, especially regarding culturally linguistically appropriate services (CLAS) considerations around language and culture (**See Domain 4: Leadership for more information on CLAS).**

When interviewing potential staff describe the culture of the organization as an empathetic, bias and stigma-free environment where we assist all people to reach their highest practicable potential. After helping them understand what makes the culture unique, begin to ask questions that help the candidate share their values.

Here are some potential questions to add to existing interview guides:

- What does a person-centered approach mean to you? Provide a concrete example of how this shows in your work, or how you act on your values.
- Our culture relies on empathy. Can you give an example of a time you showed empathy to another person.

- How would you approach a resident who is behaving aggressively?
- Are you familiar with person-first language? If no, would you be willing to adopt it?
- Are you aware of the psychological signs that someone might be experiencing addiction?
- 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?

What motivates you most in your role? What brought you into the field, and what sustains your interest and energy in this work?

Staff Training

A staff training plan should incorporate an interdisciplinary, person-centered approach. Training should enhance staff competencies in the following areas (*click on each competency below to be directed to the section of the toolkit that covers them in more detail*):

1. Understanding of LTCFs mission and vision statements to develop a culture of person-centered care.
2. Clear knowledge and understanding of OUD as a chronic disease.
3. Overdose prevention and naloxone use.
4. Recognizing signs of withdrawal, utilizing the Clinical Opiate Withdrawal Scale (COWs).
5. Stigma and bias training and use of person first language.
6. Understanding of what Harm Reduction is (see Domain 3: Care Practices).
7. How to engage residents to establish a positive relationship including de-escalation and empathy techniques.
8. Understanding of the six stages of behavioral change.
9. Trauma-informed care and addressing underlying trauma.
10. Use of motivational interviewing
11. Training in recreation therapy to meet the needs of younger residents and programs to support recovery.

Education on OUD and Medication for Opioid Use Disorder (MOUD)

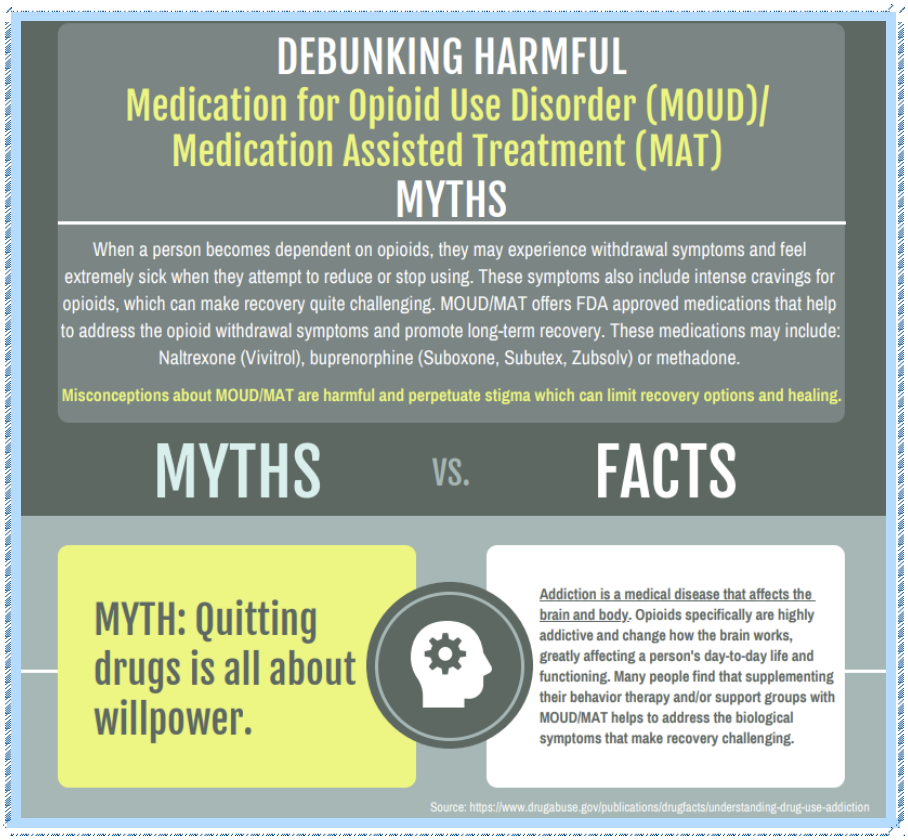
Training should include education on OUD and MOUD, and the skills, attitudes and awareness required to best support residents. Training should also include education around co-occurring substance use disorder (SUD). Furthermore, the organization should prioritize implementing ongoing case reviews, overdose drills, or peer-sharing sessions for staff members to address potential stress, feelings of isolation, or negative emotions. Review **Domain 3: Care Practices for a full understanding of OUD and MOUD.**

Review the learning management module on the Opioid Epidemic here: https://learningforquality.org/courses/strategies-for-supporting-residents-with-opioid-use-disorder-in-long-term-care/

There are many false assumptions that exist about MOUD that put residents with OUD at risk. Persistent myths include "methadone or other opioid agonists are a crutch, or MOUD trades one addiction for another and medications should be discontinued as soon as possible". The messages that staff need to hear are as follows: MOUD bridges the biological, and behavioral

components of addiction and research has shown that individuals on MOUD, for at least one to two years, have the highest rates of long-term success.[8] 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."[9]

Review with LTCF staff the myths that are associated with MOUD that can be harmful. Download and share the infographic from the Department of Mental Health and Addiction Services (DMHAS) debunking harmful MOUD myths. See Domain 3: Care Practices for additional information on the types of MOUD, buprenorphine and methadone and regulatory requirements.



Signs of Overdose and Use of Naloxone

Educating LTCF staff on recognizing signs of overdose and appropriate actions to take if a resident has overdosed is a best practice.

Review the information on the Connecticut Department of Public Health (CT DPH) website on opioids and drug overdose prevention for more information, and include in staff training the following naloxone training video and the Naloxone + Overdose Response App (NORA):

[8] 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

[9] 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

- Review the DMHAS Opioid Services website for the most up-to-date information on Naloxone (Narcan) use: https://portal.ct.gov/dmhas/programs-and-services/opioid-treatment/naloxone
- NORA App[10]

Additionally, the CT Department of Mental Health and Addiction services has many resources on how to obtain Naloxone: https://portal.ct.gov/dmhas/programs-and-services/opioid-treatment/naloxone

Signs of Overdose:

- Unconscious/not responsive
- Pinpoint/very small pupils
- Gurgling/uneven snoring
- Shallow/slowed abnormal/irregular breathing
- Not breathing
- Foaming from the mouth and nose
- Blue lips, nails, or blue/grayish skin color
- Signs of drug use (needles, pills, etc.)

Here are the steps to follow if overdose is suspected:

1. Call 911 right away.
2. Check for a response. If the person can respond, hold off on giving naloxone.
3. Check the person's mouth and throat to ensure that there is nothing blocking the airways.
4. If you need to leave the area, roll them onto their side.
5. Check for a pulse. If you cannot feel a pulse, start cardiopulmonary resuscitation (CPR).
6. If the person is still breathing but not responding, administer naloxone.

[10] CT State Department of Public Health (2019). Naloxone + Overdoes Response App. Retrieved from https://egov.ct.gov/norasaves/#/HomePage

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.

Consider running a suspected overdose response drill:
(pulled from the IPRO QIN-QIO Naloxone Toolkit)[11]

Procedure

1. Plan a time and location for the drill. Inform staff, residents and visitors in the area about the plan.
2. Conduct drill.
3. Complete a post drill review to capture successes and develop an action plan that incorporates lessons learned.

Before the Drill

1. Develop the overdose drill scenario.
   - When will the drill occur (choose a location where an overdose may occur)?
   - How will the alarm be called and what will it sound like?
   - Designate a staff member to play the role of the person who has overdosed and explain their role (unresponsive to intervention attempts).
   - Plan how to proactively communicate the date, time, location, and purpose of the drill (e.g., to staff, residents around the drill location, and visitors). Include how you will proactively reassure observers during the drill.
2. Review drill with the LTCF's Medical Director to ensure that they are involved in the planning and implementation.
3. Prepare staff for the drill.

[11] IPRO Quality Innovation Organization- Quality Improvement Organization. (2023). Nursing Home Naloxone Policy & Procedure Toolkit. Retrieved from https://qi-library.ipro.org/2023/07/31/nursing-home-naloxone-policy-and-procedure-toolkit/

- Notify all staff, including administration and security, of the date, time and location of the drill, and review the overdose response plan.
- Assign specific staff to roles and orient them to their task(s). Each task can be assigned to a different person.
  Roles to be assigned:
  - Discoverer of an individual with a suspected overdose.
  - Individual experiencing the overdose.
  - Obtain naloxone training device/verbalize location and how to obtain actual naloxone and how to identify expiration date of naloxone.
  - Obtain crash cart/emergency supplies (e.g., CPR board, oxygen).
  - Individual who would Call 911.
  - Meet fire/EMS at the door.
  - Use Ambu bag to support respiration, as needed.
  - Administer naloxone.
  - Provide crowd control.
  - Observer- to review and observe any gaps of care seen during the drill.
  - Person to facilitate and complete the Suspected Overdose Response Drill Debrief Form
- Review "***Tips for Overdose Reversal Using Naloxone"*** *(see Appendix 4)*

4. Gather equipment.
   - Naloxone training kit.
   - CPR doll and board to be used to simulate administration of naloxone.

Conduct the Drill

Conduct the drill as planned and in accordance with the Naloxone Use for Opioid-Induced Respiratory Depression Policy and Procedures.

After the Drill (Fill out the: ***Suspected Overdose Response Drill Form***) (see Appendix 3)

- Debrief with the team and the person playing the overdose role together.
  - What went well?
  - What would you do differently?
  - What needs improvement?
  - Who will be responsible for follow-up actions, and by when?
- Develop/modify your Suspected Overdose Response plan.
- Provide additional education as needed.

Recognize Symptoms of Withdrawal

Opioids can lead to physical dependence within a short time and the body will become dependent on opioids so that it has 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.[12] The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician (see Appendix 7). 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.[13] The COWS score will

[12] American Psychiatric Association (2024). Opioid Use Disorder. Retrieved from https://www.psychiatry.org/patients-families/opioid-use-disorder

[13] Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9. Retrieved from: https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

help determine the next steps in caring for the resident. Review the LTCF's policy based on mild, moderate, moderately severe, or severe withdrawal and communicate with the resident's physician or LTC 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. See Domain 3 Care Practice for additional information on withdrawal symptoms and the COWs scale.

Addressing Stigma and Bias

Johns Hopkins University conducted a research study that suggests people are more likely to have a negative attitude towards those with OUD than those with a mental illness.[14] Stigma and biases can influence how residents are cared for within LTCFs. Training staff on how to recognize personal stigma/bias and dispel misconceptions is an important step in creating a healthy healing environment. The National Institute on Drug Abuse defines stigma as "a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with OUD might include inaccurate or unfounded thoughts like they are dangerous, incapable of managing treatment, or at fault for their condition."[15]

Launch a campaign to raise awareness of the damaging effects of stigmatizing language and suggest alternative language as part of ongoing culture change and staff training efforts to reduce stigma. Start with having facility leaders and staff "Take the Pledge" to empower person-first language. Shatterproof's National Movement to End Addiction Stigma states that "Person-first language places emphasis on people rather than their diagnosis or condition (e.g. "person with schizophrenia" vs. "schizophrenic", "person with a substance use disorder" vs. "addict"). This type of language can shift the way people with substance use disorders are viewed."[16] The table below provides examples of appropriate language to reduce stigma.

[14] Morrow, S. D. (2014). Drug addiction viewed more negatively than mental illness, Johns Hopkins study shows. Johns Hopkins Magazine.
[15] National Institute on Drug Abuse. (2024). Opioid-Overdose Reduction Continuum of Care Approach. (2023). Retrieved from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education.
[16] Shatter Proof (2023) https://www.shatterproof.org/our-work/ending-addiction-stigma/pledge-to-reduce-stigma

Avoid Stigmatizing Language		
Non-Stigmatizing Language	Stigmatizing Language	Rationale
• Person with an opioid use disorder • Person with a substance use disorder	• Substance abuser or drug abuser • Alcoholic • Addict • User • Abuser • Drunk • Junkie	Neutral, non-judgmental language. Several studies compare "abuser/ abuse" to "person with substance use disorder" and confirm that person-first language is less stigmatizing.
• Substance use disorder or addiction • Use, misuse • Risky, unhealthy, or heavy use	• Drug habit • Abuse • Problem	Neutral, non-judgmental language
• Person in recovery or person in long-term recovery • Abstinent • Not drinking or taking drugs	• Ex-addict, former/ reformed addict • Clean	Neutral, non-judgmental language. Several studies compare "abuser/ abuse" to "person with substance use disorder" and confirm that person-first language is less stigmatizing.
• Treatment or medication for addiction • Medication for Opioid Use Disorder/Medication for Alcohol Use Disorder • Positive, negative (toxicology screen results)	• Substitution or replacement therapy • Clean, dirty	Treatments for other diseases are not labelled "medication assisted treatment," so substance use disorder should not be treated differently. "Replacement" suggests that patients are trading one substance use disorder for another.
• Adherent • Non-adherent	• Compliant • Non-compliant	Neutral, non-judgmental language.
Adapted from: Boston Medical Center Grayken Center for Addiction, Reducing Stigma and Shatter Proof Addiction Language Guide		

Resources to help assist training staff, residents, families, and resident representatives include:

- Shatter Proof- Addiction Language Guide[17]
- Harm Reduction Coalition- Respect to Connect Undoing Stigma Resource[18]
- Videos to show during training on Stigma:
  - Review the Stigma and Bias learning management module
- DMHAS/Shatterproof Stigma Reduction Webinar: Addressing Addiction Stigma in Connecticut: The Impact Public Stigma has on Social Isolation, Seeking Help and Employment (60mins)

[17] Shatterproof (2021). Shatterproof Addiction Language Guide. Retrieved from: (https://www.shatterproof.org/sites/default/files/2023-02/Stigma-AddictionLanguageGuide-v3.pdf

[18] Harm Reduction Coalition (2020). Respect to Connect: Undoing Stigma. Retrieved from: https://portal.ct.gov/-/media/DMHAS/Opioid-Resources/Resource-HarmReductionBasics-UndoingStigma.pdf

Trauma Informed Approach

The requirements of participation and final rule in the fall of 2016 established the need for LTCFs to provide regular Trauma Informed Care (TIC) training to staff to better support their care needs. Establishing and promoting TIC as part of organizational culture aligns with a person-centered approach. Taking steps to ensure the adoption of TIC practices throughout the LTCF is vital, especially for residents with an OUD. People who have experienced four or more adverse childhood events (ACEs) have more than ten times the risk of having problematic substance use compared to people without any ACEs. Research shows a link between OUD and other risky health behaviors and traumatic experiences.[19] The experience of childhood trauma has a detrimental effect on how individuals see the world and their place in it. Traumas that result from acts such as abuse, and neglect create a negative self-image. People who have suffered childhood trauma may struggle with self-esteem.[20] They may also see the world around them as a hostile place. Childhood traumas can teach us that the places and situations we should associate as safe, and comforting could be seen as hostile environments. Survivors of trauma may seek relief from their emotional pain and stress. With this information in mind, training that develops or enhances staff empathy is essential for providing TIC.

Domain 3: Care Practices discusses the importance of an organization-wide approach to workplace training and development in TIC. This domain examines the importance of TIC, providing therapeutic approaches, and utilizing resident and family advisory councils.

Begin with emphasizing the six foundational principles of TIC: safety, trustworthiness and transparency, collaboration, empowerment, cultural humility and responsiveness, and resilience and recovery.[21] All staff, volunteers, board members, and administrative staff should receive foundational training about trauma and its impact. The primary goal of this training is to sensitize them to trauma-related dynamics and avoid re-traumatization. Education about trauma and TIC for all staff should be included in orientation and ongoing training.

The following short videos are helpful resources to incorporate in staff training:

- What is Trauma-Informed Care?[22] (3 minutes)
- What is Trauma?[23] (2 minutes)
- Relationships between trauma and addiction[24] (11 minutes)

Additional resources to help build LTCF staff training:

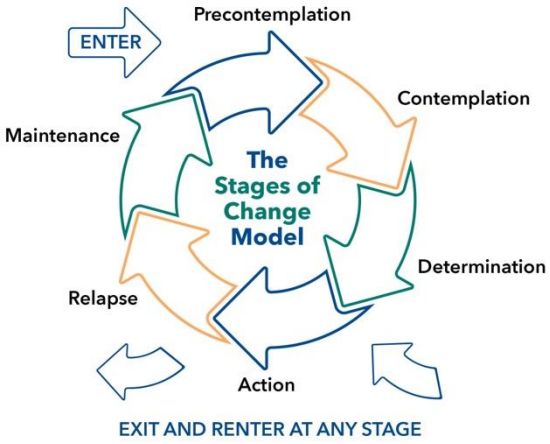
[19] SAMHSA. (2019). Trauma and Violence. https://www.samhsa.gov/trauma-violence
[20] Safe & Sound Treatment- Drug & Alcohol Treatment Center (2024). Childhood Trauma and Addiction: The Connection Explained. Retrieved from: https://safesoundtreatment.com/childhood-trauma-and-addiction/
[21] CA Bridge. (2021). Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches. https://bridgetotreatment.org/wp-content/uploads/CA-BRIDGE-TOOL-Trauma-Informed-Care-for-Opioid-Use-Disorder-April-2021.pdf
[22] Center for Healthcare Strategies. (2019). Retrieved from What is Trauma-Informed Care? https://www.youtube.com/watch?v=fWken5DsJcw
[23] National Council for Behavioral Health. (2018). https://www.youtube.com/watch?v=uraDbhfFvsk
[24] Trauma and Addiction: Crash Course Psychology #31(2014). Retrieved from: https://www.youtube.com/watch?v=343ORgL3kIc.

- Adverse Childhood Experience Questionnaire for Adults[25]
- Implementing Trauma Informed Care: A Guidebook by Leading Age[26]
- Toolkit by CA Bridge: Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches.[27]

Six Stages of Behavioral Change

The Transtheoretical Model (also called the Stages of Change Model) was developed by Prochaska and DiClemente in the late 1970s. For each stage of change, different intervention strategies are needed to effectively move the resident to the next stage of change and subsequently through the model. The model is a process by which residents make an intentional change, but also the support from themselves and others that can help. The focus is on enhancing intrinsic motivation, which comes from within (rather than on providing the resident with extrinsic motivation, like rewards). By training LTC staff on the stages, they can assist residents in developing and understanding their intrinsic motivations and help them see "where they are" versus "where they want to be." Meeting the resident where they are encourages autonomy so that they can make the choices that meet their goals about changing their behaviors. The stages of change provide a guide for how to help residents depending on where they are in the model.

Six stages of readiness experienced by a resident attempting to change[28]:



- **Precontemplation** – Residents in the precontemplation stage typically do not consider their behavior to be unhealthy. This may be because they have not yet

[25] ACES Aware (2020). Adverse Childhood Experience Questionnaire for Adults. Retrieved from: https://www.acesaware.org/wp-content/uploads/2022/07/ACE-Questionnaire-for-Adults-Identified-English-rev.7.26.22.pdf
[26] LeadingAge Maryland. (2019). Implementing Trauma-Informed Care: A Guidebook. https://leadingage.org/wp-content/uploads/drupal/RFA%20Guidebook.pdf
[27] CA Bridge (2021). Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches. Retrieved https://bridgetotreatment.org/wp-content/uploads/CA-BRIDGE-TOOL-Trauma-Informed-Care-for-Opioid-Use-Disorder-April-2021.pdf
[28] Boston University School of Public Health (2022). Behavioral Change Models. Retrieved from: https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/index.html#headingtaglink_1

experienced any negative consequences of their behavior, or it may be a result of denial about the negativity or severity of the consequences they have experienced.

- **Contemplation** – A resident at the contemplation stage is generally more open to receiving information about the possible consequences of their behavior. They may be open to learning about different harm reduction strategies or what recovery could look like for them, without committing to a specific approach or even promising to make a change.
- **Preparation** – During the preparation stage, a resident might plan the kind of change to be made, determine how to make the change, obtain necessary resources, remove triggers, and put the needed supports in place.
- **Action** – The action stage is the stage at which behavior change starts happening. The action stage may be stressful, but with adequate preparation, it can also be an exciting time that gives way to new options.
- **Maintenance** – The maintenance stage is concerned with continuing to achieve the progress that began in the action stage. For residents with substance use disorders, this means upholding the intentions made during the preparation stage and the behaviors introduced in the action stage. Maintenance can be difficult when faced with the stress of life. This is why it is important to learn new ways of coping with stress during the action stage so that alternative strategies are available during the maintenance stage.
- **Termination/Relapse**- In any behavior change, relapses are a common occurrence and can happen at any time. When a resident goes through a relapse, they might experience feelings of failure, disappointment, and frustration. The key to success is to not let these setbacks undermine their self-confidence. If a resident relapses back to an old behavior, support them through the process of understanding why it happened. What triggered the relapse? What can be done to avoid or manage these triggers in the future? Relapses can be difficult, but they are an expected part of the recovery process and can be managed.

It is important to note that resident's behavior through earlier stages may not be linear. Instead, it occurs in cycles; they may revisit or relapse to prior stages before moving on to the next. Being in certain situations can trigger previous trauma, which may lead to substance use. High-risk situations vary across residents. There are also a range of other factors that fluctuate over time that can influence behavior. For example, being around individuals who are consuming substances could be triggering.

There are several factors which impact change, such as one's ability to focus on personal strengths and their understanding of where different behaviors will lead (e.g. closer or further away from their goals).

Helpful resources to enhance training on the six stages of change:

- Boston University School of Public Health: The Transtheoretical Model (Stages of Change)[29]

[29] Boston University School of Public Health (2022). Behavioral Change Models. Retrieved from: https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/index.html#headingtaglink_1

- The 6 Stages of Change: Worksheets For Helping Your Clients[30]
- SAMHSA TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment[31]

Motivational Interviewing

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 collaborative and goal-oriented technique that activates the resident's inherent capacity for positive change in an accepting, compassionate manner.[32] MI 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 one or multiple sessions.

MI resources that could be utilized in LTCF staff training:

- CT Department of Mental Health and Addiction Services (DMHAS) Motivational Interviewing[33] (includes self-paced training, webinars, a podcast, and toolkits)
- MI: Talking with Somone Struggling with OUD from Providers Clinical Support System[34]
- MI Quick Reference Sheet[35] from University of Virginia
- Motivational Interviewing Network of Trainers (MINT)[36]

How to Engage a Resident (or Residents)

It is important to establish secure, consistent and genuine relationships with residents to build trust. Discovering residents' habits, beliefs, passions, preferences, and health goals will also help foster rapport.

Here are some tips to include in trainings on how to engage:

- Think about their room, their first day, their first encounters with others. Ask- How they have adjusted to the new room and meeting others.
- What can you do to positively impact their time with you?
- What are their favorite snacks? Do they prefer coffee or tea?
- Who are their supportive people?
- What do they need at their bed stand that brings them comfort?

---

[30] Sutton PhD, Jermey (2020). The 6 Stages of Change: Worksheets for Helping your Clients. Retrieved from: https://positivepsychology.com/stages-of-change-worksheets/

[31] SAMHSA (2019). TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment. Retrieved from: https://store.samhsa.gov/sites/default/files/tip-35-pep19-02-01-003.pdf

[32] 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.

[33] CT Department of Mental Health and Addiction Services. (2024) Motivational Interviewing: https://portal.ct.gov/DMHAS/Initiatives/Evidence-Based/Motivational-Interviewing

[34] Provider Clinical Support System (2021). Retrieved from Motivational Interviewing: Talking with Someone Struggling with Opioid Use Disorder: https://pcssnow.org/courses/motivational-interviewing-talking-with-someone-struggling-with-oud/

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

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

De-escalation

De-escalation is a technique that can be used in any situation where there is potential for conflict or aggressive behaviors, with the goal of diffusing tension, promoting understanding, and preventing further escalation.

Review the Center of Excellence for Behavioral Health in Nursing Facilities De-escalation toolkit which is organized in three parts:

1. How to conduct a self-check to determine one's feelings, triggers, and biases.
2. Tips to de-escalate challenging behaviors.
3. Debriefing tips to allow the team to review what happened, identify areas for improvement, and devise a plan to manage situations more effectively in the future.[37]

Another resource to consider using in training is from the Crisis Prevention Institute, Inc., CPI's Top 10 De-Escalation TIPS. Included in this resource are tips to help respond to different behaviors.[38]

- Tip 1: Be empathic and nonjudgemental.
- Tip 2: Respect personal space.
- Tip 3: Use nonthreatening nonverbals.
- Tip 4: Avoid overreacting.
- Tip 5: Focus on Feelings
- Tip 6: Ignore challenging questions.
- Tip 7: Set limits.
- Tip 8: Choose wisely what you insist upon.
- Tip 9: Allow silence for reflection.
- Tip 10: Allow time for decisions.

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 or are in recovery. For more detailed information on Empathy as a Care Practice see **Domain 3: Care Practices**.

Review these two videos:

- Empathy: The Human Connection to Patient Care (4 mins) from the Cleveland Clinic.[39]
- RSA Short: Empathy (3 mins) from Brene' Brown[40]

---

[37] Center of Excellence for Behavioral Health in Nursing Facilities De-escalation toolkit. (2024). Retrieved from https://nursinghomebehavioralhealth.org/wp-content/uploads/2024/01/COE-De-escalation-Toolkit-12-27-23_508.pdf

[38] Crisis Prevention Institute. Top 10 De-escalation tips. Available at https://institute.crisisprevention.com/De-Escalation-Tips.html/?ref=branded. Accessed February 16, 2024.

[39] Cleveland Clinic (2020): Empathy: The Human Connection to Patient Care.https://www.youtube.com/watch?v=dYhpxn81xus

[40] Brene' Brown (2013). Empathy. Retrieved from: https://brenebrown.com/videos/rsa-short-empathy/

Here are some examples staff can use to express empathy towards residents.[41]

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

Enhancing Staff Roles

To enhance retention and person-centered care, LTCFs may want to look at enhancing or adding staff positions to help support residents. Below are some examples of how some LTCFs have enhanced and/or developed new roles.

Aftercare Specialists

The Aftercare Specialist is responsible for providing support to individuals with substance use disorder, and/or mental health needs (or mental illness). This role provides care for those with OUD in a safe and therapeutic environment. Potential responsibilities could include coordination with community organizations to identify and address the needs of residents, provide interventions, and support services, and assist residents in a successful discharge to the community. The ideal staff person has a solid

[41] 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/

understanding of the recovery process and has excellent connections with community organizations, and strong communication and interpersonal skills.

Specialist responsibilities and qualifications could include:

- Develop and implement individualized discharge plans for residents, including goals and objectives, in collaboration with interdisciplinary team.
- Connect clients to appropriate community resources and services prior to discharge.
- Provide education and resources to residents and families.
- Facilitate weekly support groups.
- Maintain accurate records and documentation.
- Coordinate with other staff to ensure continuity of care.
- Recovery Specialist credentials.
- Bachelor's degree in a related field.
- Minimum 2 years of experience working in a recovery setting.
- Knowledge of substance use disorders, mental health, and physical health recovery services.
- Excellent communication and interpersonal skills.
- Able to work independently and as part of a team.
- Able to multitask and prioritize efficiently.

Recreation Therapy

In some cases, residents in need of care due to an OUD might be considerably younger than the typical nursing home resident. Many homes are dedicated to reimagining their programs to provide recreational therapy to a younger population.

Recreation therapy includes participation in healthy leisure activities, team problem solving and trust exercises. Those who have been living with a substance use disorder for some time may feel unwelcome and awkward in certain social settings due to fear of stigma and being misunderstood or disrespected, for example. Recreation therapy can offer a non-judgmental approach with failure-free leisure activities to help promote overall wellness and build self-esteem and self-confidence. Some of these activities might take place in the community, such as at a local gym.

Some recreation therapy activities include:

- Social activities such as 'Pop Ups!' These are unique, spontaneous events (often to get people outside). One example may be a baseball opening day event with hot dogs and hamburgers grilled outside.
- Leisure education and lectures
- Spiritual programs
- Team sports
- Team-building activities
- Trust activities that might be available in the local area such as ropes courses, climbing walls giant's ladder, zip line and multi-vine features.
- Fitness center activities with cardiovascular machines, universal circuit machines, free weights, and space to follow aerobic and yoga videos.
- Nine-hole disc golf course
- Music therapy

- Nature activities
- Relaxation and stress management
- Arts and crafts

Resident Ambassador program

The Resident Ambassador program is focused on providing high-level customer service through companionship and engagement in meaningful and individualized leisure pursuits. The Ambassadors partner with a resident to become a vital support, friend and/or sounding board. They serve as an advocate for residents and ensure any needs that are brought to their attention are passed along to the appropriate department.

The program is an integral part of resident care. Each Ambassador works with all departments to ensure the residents' physical, emotional, social, spiritual, and intellectual needs are met. Though they aren't medically certified, part of their duties also includes providing safety reminders for residents, supervision, assisting with everyday tasks and non-clinical psychosocial support and companionship. Review this video to learn more: https://youtu.be/JNpEhIAOMOI

Substance Use Disorder (SUD) Counselors/Social Worker

SUD Counselors/Social Workers can help provide direction and work collaboratively with the care team to guide the best possible care for residents with SUD. SUD Counselors/Social Workers should be familiar with the latest treatment methods and collaborate with other mental health care specialists. Candidates have excellent clinical knowledge and demonstrable counseling experience.

Potential SUD Counselor/Social Worker Responsibilities:

- Managing all aspects of a case from admission to date of discharge.
- Evaluating residents' physical and mental behaviors.
- Collaborating with the care team in the development of care plans.
- Facilitating individual and group therapy sessions.
- Monitoring residents over time to assess progress towards their goals.
- Collaborating with doctors, nurses, social workers, and others.

SUD Counselor/Social Worker requirements could include:

- Associate degree in chemical dependency counseling, or a bachelor's degree with coursework in chemical dependency.
- Master's degree in counseling (or social work)
- LCSW licensed clinical social worker or LCP licensed clinical psychologist or LADC licensed Alcohol and drug counselor.
- Previous experience with the treatment of SUD.
- Familiarity with electronic health record systems.
- Experience with co-occurring physical and mental health needs.
- Application of the Substance Abuse and Mental Health Services' (SAMHSA) best practice indicators.
- In-depth knowledge of drug and alcohol testing to monitor treatment plans and medical instructions.
- Exceptional interpersonal skills and a compassionate nature.
- Ability to teach staff and support their ability to provide behavioral interventions.
- Knowledge of harm reduction best practices.

Domain 2: Environment

Goal:

Identify several interventions long term care facilities (LTCF) can implement to foster a therapeutic environment that meets diverse needs of the residents to promote wellness.

Objectives:

1. Define and implement a therapeutic environment, including the eight dimensions of wellness, in the LTCF.
2. Develop action steps to offer culturally and linguistically appropriate services (CLAS) for all residents with opioid use disorder (OUD).
3. Implement evidence-based programing and meaningful daily activities that are inclusive of the resident's diverse needs, abilities, and interests.

Description:

The environment domain describes the commitment to confronting environmental challenges whether physical, social, or cultural that limit a resident's ability to thrive. This domain helps organizations work to establish a place of respect, safety, peace, and trust delivering on its ability to be therapeutic. Content includes the eight dimensions of wellness, how to develop CLAS for residents and how to offer a stimulating environment with choices that meet resident's interest and are age appropriate.

Developing a Therapeutic Environment

A therapeutic environment supports stabilization of chaotic environmental influences and aims to minimize environmental stressors; however, a therapeutic environment is far more than a physical setting. A therapeutic environment takes on a holistic approach addressing physical, social, and/or cultural factors.

Wellness Orientation

By nature, a therapeutic environment is one that fosters well-being. The World Health Organization (WHO) defines wellness as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." **Quality of care-seeks the highest practicable physical, mental, and psychosocial well-being" for each resident.** Focusing on wellness can improve quality of life and decrease risk factors leading to premature death among individuals with behavioral health conditions. Substance Abuse Mental Health Services Administration's (SAMHSA) Wellness Initiative focuses on the Eight Dimensions of Wellness to achieve an improved quality of life. The Eight Dimensions of Wellness include emotional, financial, social, spiritual, occupational, physical, intellectual,

and environmental.[42] These dimensions are interconnected, one dimension building upon another. Also, wellness has different meanings within different cultures, and one's cultural and spiritual beliefs or values may influence one's perspectives on health. Providers and staff can meet residents where they are to ensure that their well-being continues to be a priority and their cultural and linguistic needs are met. This means delivering physical care and meeting the mental and spiritual needs of all residents, regardless of their beliefs, backgrounds, or values. Approaching each resident with curiosity about their culture, language and social needs can assist staff with learning more about diverse perspectives and how to best meet residents' needs.

Review the CLAS flyer and action plan[43] for information on CLAS to aid in implementation.

Physical Wellness (Includes Medical Wellness)

The physical wellness dimension includes promoting a healthy body, making personal choices, and taking steps to help strengthen and care for the body.

- A healthy lifestyle goes hand-in-hand with a healthy diet. Work with residents and a dietitian to identify personal food choices and goals that can support a healthy diet. For some residents with OUD, eating habits may be challenging. Eating habits that have been documented among persons with OUD include eating less than two meals a day, fasting to boost or prolong an opioid high, skipping meals, and consuming few fruits and vegetables.[44]
- Hold a skills class about healthy eating.
- Investigate whether the LTCF fosters a positive sleep environment or "Wake at Will" program. More than 75 percent of people with OUD have sleep problems, such as irregular sleep schedules, not sleeping enough, and/or having a sleep disorder (e.g., insomnia, sleep apnea).[45] Examine the facility lighting. Are the lights off during the night, hallway included? Is the facility alarm-free? Providing a positive sleeping environment is linked to improved health outcomes such as reduced falls, improved immune system, and better wound healing.[46]
- Does programming incorporate physical activity into the residents' day? Are there choices based on age and ability? Is it fun? Does programming and the calendar of

[42] Swarbrick, M. (2006). A wellness approach. Psychiatric Rehabilitation Journal, 29(4), 311–314. https://doi.org/10.2975/29.2006.311.314

[43] IPRO Quality Innovation Organization- Quality Improvement Organization (2023). Culturally and Linguistically Appropriate Standards (CLAS) Resources. Retrieved from: https://qi-library.ipro.org/2023/02/15/culturally-and-linguistically-appropriate-standards-clas-resources/

[44] Rigg, K., Chavez, M. (2020). 4 Connections Between Opioid Addiction and Nutrition. Psychology Today.

[45] Eckert, D. , Yaggi, H.K. (2022). Opioid Use Disorder, Sleep Deficiency, and Ventilatory Control: Bidirectional Mechanisms and Therapeutic Targets. Am J Respir Crit Care Med, 206(8), 937-949. doi: 10.1164/rccm.202108-2014CI

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

events denote activities for the spirit, mind, and body? Are there opportunities for private, quiet space where a resident can experience privacy and peace?
- Are residents educated about their medications, intended purpose and possible adverse effects? ABCD's of your medicine is a helpful tool to give to residents to help ask questions about their medications.
- Are residents educated about preventative care as it relates to acute and/or chronic conditions, including OUD?

Intellectual Wellness

- The intellectual wellness dimension includes activities that enrich the brain. Offer evidence-based programming and meaningful daily activities based on personal interest.
- Consider skill building, education attainment, and passing on lived experiences to others.
- Assess if the resident enjoys:
    - Reading (if books, what genre is preferred; local newspaper; or magazine(s))
    - Playing games (crossword puzzles, mind teasers, cards)
    - Conversation
    - Television, Podcasts

Financial Wellness

The financial wellness dimension includes income, debt, savings, financial processes, and resources. Residents may require assistance and financial literacy awareness. A 2023 study from the Journal of the American Pharmacists Association (JAPHA) examined the link between OUD and social factors. Overall, residents with OUD are twice as likely to encounter financial hardship or food insecurity, which makes them susceptible to continued dangerous opioid use.[47]

- Does the resident express a concern about finances?
- Is the resident aware of available programs and resources (e.g. Money Follows the Person, money management volunteer programs, social security supplemental income or other related options)?
- Are the residents educated about Medicare, Medicaid plans?
- Are there concerns about health-related social needs that must be addressed prior to discharge?

Environmental Wellness

The environmental wellness dimension revolves around residents' sense of emotional and physical safety within their surroundings. For individuals with OUD, avoiding potential triggers. Fostering a therapeutic environment may necessitate avoiding certain people, places, situations, or other environmental factors that could be triggering.

[47] Arsene C, Na L, Patel P, Vaidya V, Williamson AA, Singh S, The Importance of Social Risk Factors for Patients Diagnosed with Opioid Use Disorder, Journal of the American Pharmacists Association (2023), doi: https://doi.org/10.1016/j.japh.2023.02.016

Here are some strategies to help reduce or eliminate environmental stressors and create a positive environment:

- Foster inclusion by arranging spaces so 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 views of nature or nature pictures in resident rooms, the lobby, waiting areas, and other high stress areas. If possible, provide access to nature, healing gardens, trails, etc.
- Work to minimize odors. Odors that are objectionable or perceived as medical can create stress.
- Maintain plenty of living plants inside and out. They add color and liveliness.
- 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 disorder.
- Music (e.g. recorded music in the resident's room that is programmed specifically to create a healing environment or provide personal playlists with headphones-see Music & Memory[48]).
- Physical exercise (corridors, public spaces, and gardens that invite walking when appropriate).
- Chapel, meditation room, and meditation gardens, or a labyrinth.
- 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).
- Make efforts to de-institutionalize the environment.

Spiritual Wellness

Spirituality refers to the broad concept of belief in something beyond the self. It strives to answer questions about the meaning of life, how people are connected to each other, truths about the universe, and other mysteries of human existence. It involves values and practices that help give balance and direction to one's life. Higher spiritual well-being is also shown to reduce relapse and might provide better recovery outcomes and improved mental health status.[49]

- Are there religious or spiritual practices and beliefs that are a source of comfort during life's ups and downs?

[48] Music and Memory. (2024). Retrieved from: https://musicandmemory.org/
[49] Canadian Association of Schools of Nursing & Association for Social Work Education. (2021). Module 6 : Opioid Use Education- Topic A. Identify the spiritual, emotional, mental, and phyiscal effects of opioids. Retrieved from : https://ououd.casn.ca/modules/module-6/topic-6a.html#SpiritualEffectsOpioids

- What is the resident holding on to during a difficult time? Where is their source of comfort?
- Provide time for meditation, relaxation and/or prayer.
- Offer time and/or an area where residents can appreciate the beauty of nature.
- Consider offering yoga classes for different ages and abilities.
- Mutual Help Support groups are becoming a growing trend in LTCF and providing access to these groups is essential.

Social Wellness

The social wellness dimension involves having healthy relationships with friends, family, and/or the community. For those with OUD, a strong social support system serves as a protective factor.[50] Individuals living with OUD may withdraw from social activities to hide their substance use or because of side effects from the opioid use. Self-isolating is a common symptom of depression, and people with OUD may lose interest in activities they once enjoyed. LTCF staff must be aware of these complexities to better support their residents.

- Offer light jobs and responsibilities such as mail delivery, teaching a class, attending a peer support meeting, working in the garden, helping prepare the dining room, raking leaves, or preparing the outdoor fire pit under supervision.
- Hold pop-up events, or spontaneous events that are designed to get people outside.
- Video games and other software might be needed for recreation, especially for younger residents who have grown up with these products.
- Outdoor activities may include cornhole or Velcro darts.
- Invite peer advocates/counselors from the community who are willing to share their lived experience with substance use, harm reduction and/or recovery, so residents can hear from a peer and learn about community resources to support their goals. Utilize residents' talents and skills if they are willing and interested. Invite them to share their gifts with the community.
- Provide all residents, particularly those with OUD, information to empower them to be partners in their care. Communication techniques include asking open-ended questions, not interrupting the resident, and engaging in active listening.
- Involve residents in mutual support groups (e.g. Alcoholics Anonymous (AA), Narcotics Anonymous (NA).
- Connect residents with social activities.
- In some cases, families, families of choice, and/or caregivers play a vital role in supporting individuals with OUD. Where appropriate, organize family focus groups and a resident and family advisory council so residents and their supporters have a voice and opportunity to be heard. Utilizing a resident council will enable an understanding of specific needs of residents and the overall community. Residents who do not have a traditional support system may need assistance from the care team to connect with the right social support (e.g. faith-based community, lesbian, gay, bisexual, transgender (LGBT) support group, or a local cultural center). Draft plans to

[50] Spalding, T.; Meschike, L. (2019). Social Support and OUD Fact Sheets. Retrieved from: https://tnopioid.utk.edu/wp-content/uploads/2019/06/Social-Support-and-OUD-Factsheet.pdf

ensure that families and caregivers are involved in enhancing continuous quality improvement efforts, educational material development, and processes.
- LTCF's should include and collaborate with the Long-Term Care (LTC) Ombudsman program to aid in setting up resident councils.

The transition to LTCF can be traumatic, especially for those who will remain in long-term care. Work with residents and resident councils on identifying person-centered activities and engage the resident in personal interests.

Developing an environment that promotes the well-being for residents with OUD 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, and addiction treatment.[51]

The following resources include helpful information for developing a Resident Council and/or PFAC.

- CT Long Term Care Ombudsman Program- Resident and Family Councils (ct.gov)[52]
- Moving Forward Coalition Strengthening Resident Councils[53]
- American Medical Association – Forming a Patient and Family Advisory Council [54]
- Institute for Patient and Family-Centered Care – Creating Patient/Family Councils [55]
- Agency for Healthcare Research and Quality – PFAC Implementation Guide[56]

Keep caregivers informed and families involved:

- Share contact information of community opioid treatment programs (OTP) and community-based recovery support groups with families, if there is a signed release of information from the resident specific to their OUD care. 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 everyone's safety. Notify them of steps the LTCF takes if prohibited items are found, such as confiscation, referral for drug testing, and, if necessary, contacting law enforcement. Consider incorporating mutual, no harm agreements into the admission process. (**See Domain 4: Leadership**, for more information about policy development).

---

[51] CT Long Term Care Ombudsman Program (2021). Resident and Family Councils. Retrieved from: https://portal.ct.gov/ltcop/resident-and-family-councils.
[52] CT Long Term Care Ombudsman Program (2021). Resident and Family Councils. Retrieved from: https://portal.ct.gov/ltcop/resident-and-family-councils.
[53] Moving Forward Coalition. (2024). Strengthening Residents Councils. Retrieved from: https://movingforwardcoalition.org/wp-content/uploads/2023/10/Strengthening-Resident-Councils_Updated_101023.pdf
[54] American Medical Association (2019). Forming a Patient and Family Advisory Council. Retrieved from: https://edhub.ama-assn.org/steps-forward/module/2702594
[55] Institute for Patient and Family-Centered Care (2022). Creating Patient/Family Councils. Retrieved from: https://www.ipfcc.org/resources/Advisory_Councils.pdf
[56] Agency for Healthcare Research and Quality (2008). PFAC Implementation Guide. Retrieved from: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf

Emotional Wellness

The emotional wellness dimension involves the ability to express feelings, adjust to emotional challenges, cope with life's stressors, and enjoy life. However, research shows that nearly one-third of people with opioid use disorder have a co-occurring mental health disorder, and 48% of people who are dependent on opioids are also diagnosed with depression.[57]

- LTCFs may consider providing formal mental health care including the role of a behavioral health counselor who can support the emotional health of residents and provide education for the staff.
- Develop therapeutic relationships with residents that are secure, consistent, and genuine to help build rapport. A therapeutic relationship that is person-centered and trauma-informed is non-judgmental and provides a safe space for residents to express their feelings and concerns.
- If residents can write and are interested in journaling, provide notebooks so they can write down their thoughts.
- Assist residents with identifying triggers that cause emotional disruption.

Occupational Wellness

The occupational wellness dimension involves participation in activities that provide meaning and purpose, including employment.

The average age of LTC residents has become younger, and many may have potential to be in the workforce or have a desire to re-enter the workforce. Recent research indicates that sustained recovery is significantly tied to meaningful and purposeful work-life balance. Employment is an important element for sustaining recovery and maintaining financial independence.[58]

In the LTCFs setting, consider involving residents in small, meaningful jobs such as mail delivery, assisting with recreational activities, and/or other daily tasks to promote a sense of community and belonging.

- Does the resident have small jobs or activities they look forward to and provide a sense of accomplishment?
- Consider encouraging participation in volunteer opportunities.
- Include more life skills training as part of regular activities. Some examples are as follows:
    - Parenting
    - Literacy
    - Job readiness
    - Soft Skills Training (e.g. interpersonal communication)

---

[57] Solas Health (2024). Understanding Depression and Opioid Use Disorder. Retrieved from: https://solas.health/blog/oud-and-depression/

[58] Substance Abuse and Mental Health Services Administration (2021). Substance Use Disorders Recovery with a Focus on Employment and Education. HHS Publication No. PEP21-PL-Guide-6 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-6.pdf

- Finance/budgeting
- How to access community resources, including organizations that assist with finding employment.

Person-centered care is especially relevant to residents with OUD, as the concepts embedded in that care are also key drivers of recovery.[59]

The strategies outlined above are examples of how facilities can create a welcoming environment using a person-centered approach. Consider reaching out to the CT Department of Labor for assistance (https://portal.ct.gov/dol?language=en_US).

[59] 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

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.[60] Though OUD is a

[60] 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.[61]

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.[62] 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.[63]

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.[64] 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.[65] 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.[66]

---

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

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

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

[64] 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

[65] 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.

[66] 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)[67]

[67] 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.[68]

An Opioid Risk Assessment Tool should be administered to residents prior to admission and readmission. An ORT example is provided in Appendix 6.[69]

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**).

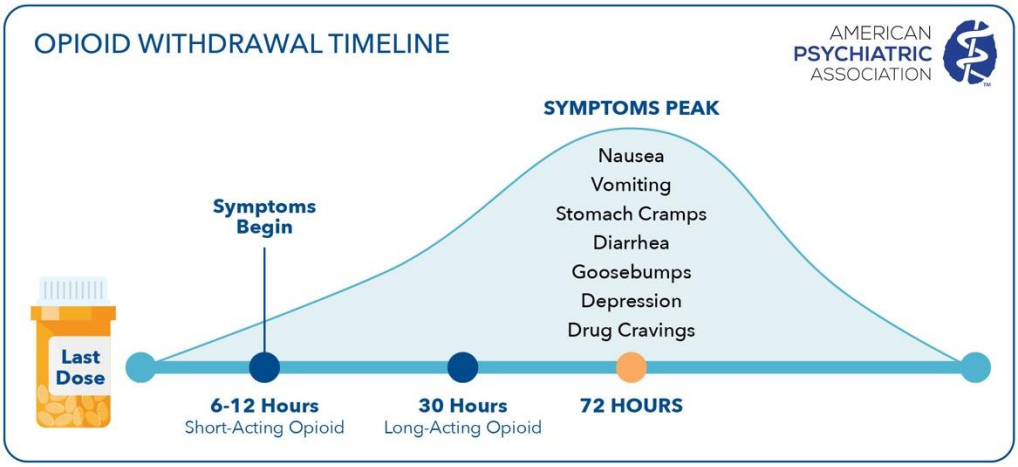
Opioids can lead to physical dependence within a short time and the body will eventually become dependent on opioids and will have difficulty functioning without opioids. With chronic use, abruptly stopping use of opioids leads to withdrawal symptoms, including generalized pain, chills, cramps, diarrhea, dilated pupils, restlessness, anxiety, nausea, vomiting, insomnia, and very intense cravings.[70]

---

[68] National Institute on Drug Abuse. Opioid Risk Tool. Retrieved from https://nida.nih.gov/sites/default/files/opioidrisktool.pdf

[69] Quality Insights (2024). Opioid Risk Assessment Tool (fillable). Retrieved from https://www.qualityinsights.org/qin/resources#opioid-risk-assessment-tool-fillable

[70] 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.[71]

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.[72] 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.[73]

Examples of Harm Reduction Strategies include:

[71] Clinical Opiate Withdrawal Scale (2003). Retrieved from https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf
[72] SAMHSA (2023). Harm Reduction. Retrieved from https://www.samhsa.gov/find-help/harm-reduction
[73] 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.[74]

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.

[74] 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.[75] 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.[76]

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.

---

[75] Psychology Today (2024). Trauma. Retrieved from https://www.psychologytoday.com/us/basics/trauma
[76] 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.[77]

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.[78]

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.

[77] 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

[78] 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.[79]

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.[80]

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.[81] 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-

[79] SAMHSA (2024). Medications, Counseling, and Related Conditions. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions
[80] Drugs.com (2024) Methadone: Uses, Dose, Side Effects, Retrieved from https://www.drugs.com/methadone.html
[81] 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.[82]
- 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.[83]

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.[84] 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.

[82] 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

[83] 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

[84] 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.[85]

- ✓ 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.[86]

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.

[85] 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

[86] 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.[87]

Care team considerations: Opioid withdrawal is typically required before for standard initiation with this drug.[88]

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.[89]

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.

---

[87] 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

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

[89]

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.[90]

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.[91]

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.

[90] 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.
[91] 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.[92]

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.[93]

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.[94]

Other Clinical Considerations:

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

[92] Sublocade REM. Retrieved from https://www.sublocaderems.com/#Main/Home
[93] 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
[94] 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.[95]

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)[96]
- ✓ 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)[97]

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.

[95] 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/
[96] Braeburn (2023). About BRIXADI. Retrieved from https://www.brixadihcp.com/about-brixadi/
[97] 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.[98]

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.[99]

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. [100]

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).[101]
- ✓ Add depression and suicidal ideation screening to the resident care plan.

[98] 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
[99] SAMSHA (2024). Naltrexone. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone
[100] 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
[101] 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.[102]

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

[102] 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.[103]

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.[104]

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.

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

[104] 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.

Domain 4: Leadership

Goal: Model and operationalize an organizational culture that professionally and empathetically responds to the needs of those with an opioid use disorder (OUD) by ensuring safety, and accountability, and advancing the needed skills and attitudes.

Objectives:

1. Design and implement policies, procedures and agreements that support both residents and staff to promote person-centered care.
2. Employ standards of practice that create a safe and respectful environment for long-term care facility (LTCF) residents and staff.
3. Ensure the ongoing and effective education of all staff that demonstrates the skill, knowledge and attitudes required to care for those affected by OUD. These include topics such as trauma-informed care, harm-reduction, and eliminating stigma to foster a positive culture that recognizes OUD as a medical condition.
4. Implement policies for appropriate naloxone use and storage in accordance with state and federal laws and regulations.
5. Define clear steps for access to medication for opioid use disorder (MOUD) and transitions of care from hospital to LTCF to home.

Description:

The leadership domain ensures accountability for creating the kind of culture where residents and staff thrive. It seeks and grows leaders at all levels of the organization and invites the voices and contributions of all people. Exemplary leadership practices are characterized by leading by example, communicating a shared vision that inspires others, seeking innovative processes, empowering others, and celebrating individual and collective achievements (based on the work of Kouzes and Posner)[105]. In this domain, visible leaders create an environment where honest relationships and communication can serve all parties. Throughout this domain there are examples of ways to impact culture, policies and procedures that can be adopted or adapted and then integrated throughout the LTCF.

Establishing a Person-Centered Approach:

As leaders look to establish a person-centered approach to care it is important to review vision, mission, and purpose statements. 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.[106] If a person-centered approach is not already included in vision and mission statements, consider revising them to reflect a person-centered orientation. Include supports provided for residents with OUD, and a commitment to delivering culturally and linguistically appropriate services. Utilizing this guide for developing purpose, guiding principles, and

[105] The Leadership Challenge (2024). The Five Practices of Exemplary Leadership® Model.https://www.leadershipchallenge.com/research/five-practices.aspx

[106] 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

scope for quality assurance and performance improvement (QAPI)[107] could be a helpful resource to assist in crafting or revising vision, mission, and purpose statements.

Leadership Approach to Integrating New Policies and Procedures:

Integrating new policies and procedures into practice requires adapting operational systems and workflows. These new procedures cannot be designed and implemented just by leadership, they should be developed in partnership with residents and others with lived experience, staff, and family and family of choice caregivers.[108] The best practice guide: Engaging People Who Receive Services, is a helpful tool to utilize for the policy development process. The guide gives five strategies on how to directly involve people who receive services in system planning and improvement.[109]

Those strategies are:

1. Authentic Membership
2. Full Participation
3. Effective Communication Supports and Mentors
4. Meaningful Contributions
5. True Influence

All new and existing policies, processes, and procedures should be refined over time based on feedback and updated with new education and resources.

Person-centered Approach: Organizational Self-Assessment

Staff should always take a person-centered approach that ensures resident needs and preferences are respected and included. Review and incorporate a person-centered approach into existing policies throughout the organization. Once new policies are implemented staff should develop procedures on how to measure progress and to make sure implementation of person-centered care is on track and in line with mission and vision. A great tool for this is the Pioneer Networks "Artifacts of Culture Change"[110] Assessment. Quality improvement metrics should include system performance information, experience measures, and person-centered outcomes. Examples of person-centered indicators can be found in the resource Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators.[111]

---

[107] Centers for Medicaid and Medicare Services (Accessed 2024). Guide to Develop Purpose, Guiding Principles, and Scope for QAPI. Retrieved from: https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapipurpose.pdf

[108] Agency for Healthcare Research and Quality (Accessed 2024) Medication-Assisted Treatment for Opioid Use Disorder Playbook. https://integrationacademy.ahrq.gov/products/playbooks/opioid-use-disorder/implement-mat-for-oud

[109] National Center on Advancing Person-Centered Practices and Systems. (2020). Engaging People Who Receive Services. A Best Practice Guide. Retrieved from: https://ncapps.acl.gov/docs/Participant%20Engagement%20Guide%20200904.pdf

[110] Pioneer Network (2024). Artifacts of Culture Change Self-Assessment for Nursing Homes. Retrieved from: https://www.pioneernetwork.net/nursing-homes-overview

[111] National Center on Advancing Person-Centered Practices and Systems. (2019). Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators. https://ncapps.acl.gov/docs/NCAPPS_Indicators%20Scan%20_191202_Accessible.pdf

Here are some policies to consider implementing to meet the goals of a person-centered approach.

- Develop a policy on integrating trauma-informed care (TIC) by integrating it in assessment, treatment planning, and/or operational practices, etc. TIC should be identified in the mission statement or other policy documents. Basic information on trauma should be available and visible to residents, staff, and families. See Domain 5: Family and Community for sample posters to put up. Determine ways of adopting and promoting the principles within the organization.
- Develop a policy on creating and involving a resident and family advisory council. Collaborate with the Long-Term Care (LTC) Ombudsman program to help in development.
- Incorporate harm-reduction principles throughout the LTCF and in existing policies. (See Domain 3: Care Practices)
- Incorporate the development of a therapeutic environment into existing orientation policies, including residents' linguistic and cultural needs. (See Domain 2: Environment)
- Promote person-first language (See Domain 1: Workplace)
- Integrate cultural and linguistical appropriate services (CLAS) into policies and procedures. Below are some helpful resources:

  - The National CLAS Standards in Health Care are a set of 15 action steps to advance health equity, improve quality, and help eliminate health care disparities.[112] The principle behind cultural humility is providing person-centered care.
  - The CT DPH Office of Health Equity includes resources on how to implement National CLAS standards, a glossary of terms, translation services, and resources on Social Determinants of Health (SDOH), etc.[113]
  - The Department of Mental Health and Addiction Services (DMHAS) Multicultural Healthcare Equity OMHE (ct.gov) office also has resources, a strategic plan, training materials and more.[114]
  - The IPRO Quality Innovation Network- Quality Improvement Organization has a Cultural & Linguistic Competency Toolbox that includes resources on evaluation and data collection, among other topics.[115]

[112] CLAS Standard 1, HHS, Office of Minority Heath, CLAS and CLAS Standards: https://thinkculturalhealth.hhs.gov/clas
[113] CT Department of Public Health (accessed 2024). Office of Health Equity: https://portal.ct.gov/DPH/Workforce--Professional-Development/Office-of-Health-Equity/Office-of-Health-Equity.
[114] DMHAS (accessed 2024). Multicultural Healthcare Equity. Office of Multicultural Health Equity. Retrieved from: https://portal.ct.gov/dmhas/divisions/divisions/multicultural-healthcare-equity-omhe
[115] IPRO QIN-QIO (2024) Cultural & Linguistic Competency Toolkit: https://qi.ipro.org/health-equity/cultural-linguistic/

Understanding Opioid Use Disorder:

- Understand opioid withdrawal and the symptoms to support the resident. (See Domain 3: Care Practices)
- Include a section on OUD as part of internal discrimination policies to reduce stigma and foster a culture that recognizes 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 care for residents. (See Domain 3: Care Practices)
- Develop policies regarding Naloxone administration. (See Domain 1: Workplace for more information)

Staff Training:

- Incorporate the following competencies into the staff onboarding and training policy, including how often staff should be re-trained.
    - Understanding OUD
    - How to care for individuals with OUD
    - Preventing opioid overdose
    - What to do in case of an overdose
    - The 10 Domains of De-escalation
    - Trauma Informed Care
    - Administration/chain of custody for Methadone

Creating a Safe Environment for Residents and Staff:

- Limiting harmful substances: mutual agreements and visitor polices
- Chain of Custody of all methadone supplies (see Appendix 10) – DMHAS will review chain of custody policy during Opioid Treatment Program (OTP) monitoring.
- DPH will review the process during licensure, certification, and other inspection activities.

Managing and securing pre-poured methadone.

- The LTCF needs to create an area to manage methadone within a double locked area. The management of pre-poured methadone at the LTCF needs to meet Drug Enforcement Agency (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). Examples include locked in medication room; cabinet within the medication room locked; and resident locked box inside.
- Establish a set-time for self-administration of medications. The process may include having a locked box taken out of the medication room brought to the resident room; resident unlocks and self-administers and relocks box; the nurse then takes the lock box back to the medication room and relocks the drugs in the med cabinet.
- Document administration by having the resident sign an affidavit.
  Notes:

- LTCF may want to buy a lock box and train staff on what to look for regarding diversion.
- Consider having two nurses on every shift with the authority to open the lock box.
- Follow the facility's recommendations on what to include in the narcotics book.
- If a resident leaves Against Medical Advice (AMA), alert the OTP and destroy medications as mandated by federal regulations and per LTCF destruction policies.
- LTCFs must have a supply of naloxone on hand; know the signs of an overdose and how to administer naloxone.

Self-Administration of MOUD (see appendix 11 for sample form)

- The LTCF would need the self-administration form/assessment from the hospital before the resident was admitted. A liaison or Case Manager from the LTCF could do this at the hospital.
- The LTCF should complete a self-administration assessment on admission, quarterly, and with any significant change in condition per guidelines.
- For residents on methadone and receiving end-of-life care, prescribers with expertise in pain management should lead the care provided and prescribe medications. The appropriate provider would need to write an order for comfort care. Methadone for pain management would come from the pharmacy and facility nurses may administer under those circumstances.
- Communicate with the hospital during the discharge process.
- Educate staff on self-administration.

Guidance for Onsite Methadone Maintenance Service Delivery for Nursing Homes that are a Satellite to an Opioid Outpatient Treatment Program (OTP) at Skilled Nursing

With the continuation of the opioid crisis and the increased need for treatment options for people with OUD, it is highly recommended that skilled nursing and other LTCFs make available on-site methadone maintenance services to avoid the need to transport medically vulnerable patients off site. SNFs will need to work closely with an OTP to secure those arrangements. Compliance with regulations that direct an individual's need for a skilled level of care must be followed, specifically regarding the Pre-Admission Screening and Resident Review (PASRR).It is recommended that the skilled nursing facility/LTCF:

- Determine what model of service delivery works for the facility's organizational structure. Two service delivery models exist, (1) the facility supporting the individuals with transportation to the OTP or (2) the OTP delivering and/or administering at the satellite location.
- Identify key leadership roles (such as Ownership, Board of Directors, Medical Director, Administrator, Director of Nurses, and Social Services) who will champion this collaboration as well as a key contact(s) at the local OTP.
- Consider developing a Memorandum of Understanding between the nursing home and the OTP to ensure accountability and quality of care.

- Develop an educational program in collaboration with the OTP, if possible, to provide training for staff on opioid use and other substance disorders and medication assisted treatment; on-going education and training is also strongly recommended. Be advised that the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have partnered to provide resources/training/support to skilled nursing facilities certified with CMS regarding behavioral health, including substance and opioid use disorders. The Center of Excellence is available to improve the quality of life and quality of care for individuals experiencing a variety of behavioral health diagnoses.
- Develop policy and procedures that will address quality of care and quality of life for residents on MOUD, whether it is an onsite model, or the facility is supporting the transportation of medication that will include, but not be limited to:
- Written agreement concerning the process for on-site medication delivery/self-administration for residents requesting the service;
- Treatment planning that addresses the needs of residents with OUD;
- Communication between the nursing home and the OTP that will direct an after- hours call in the event a resident is prematurely discharged and/or transferred to the hospital;
- Discharge planning that includes continuity of care considerations, connection to other case management support, and/or linkages to community-based services;
- Proper storage and security for the methadone;
- Resident ability to self-administer is critical, if not other forms/routes of medication assisted treatment should be considered;
- Transportation for residents who may require an appointment at the main location of the OTP;
- Support of the provision of counseling services, including appropriately confidential locations;
- Provision of resident choice, offering the opportunity for the resident to remain with their existing provider or to access services with the methadone agency that the nursing home has on-site; and
- Collaboration with hospitals to share nursing home expectations for potential patients prior to -hospital discharge.
- Assess adequate secure storage in the facility to store the "methadone take-home bottles" for each resident receiving medication assisted treatment.
- Identify a confidential space in the nursing home for the methadone agency to conduct the clinical assessments and individual or group sessions. It is advised that a back-up space also be designated.
- Ensure the methadone agency contacts the Department of Public Health (DPH) and completes the required forms to add the nursing home as a satellite to the licensed methadone agency. All required forms are available electronically and need to be submitted to DPHFLISLPU@ct.gov.
    - Submission should include:
        - A description of the services offered at the satellite location;
        - A Fire Marshal certificate of inspection for the satellite location;

        - Certificate of Insurance for Worker's Compensation and General Liability indicating that the address of the satellite is insured;
        - Resumes of the key staff providing the services at both the nursing homes and the methadone agency to include, but not be limited to, the physician conducting the intakes, nurse(s), and staff providing counseling services at the nursing home;
        - Policy and procedures from both the nursing home and methadone agency for service delivery, including a procedure for weather or other unexpected disruption of methadone delivery as well as a 24/7 means of immediately accessing OTP staff in the event of an emergency;
    - Provide a floor plan that indicates where the services will be offered at the satellite location; be prepared for DPH inspections. Inspection activities include, but are not limited to the following:
        - Review of the physical space for service delivery, including the area designated for counseling to ensure resident confidentiality;
        - Review of policy and procedures operationalized by both the nursing home and the methadone agency;
        - "Chain of custody" of methadone to include, but not be limited to delivery and storage of take home bottles;
        - Medication reconciliation practices;
        - Review of resident self-administration medication assessment;
        - Observations of the environment;
        - Schedule for delivery of methadone and counseling services;
        - Collaboration with the nursing home/LTCF and the methadone agency/OTP to educate staff and patient/residents regarding the protocols associated with methadone service delivery;
        - Referral process to the methadone agency for an assessment, for the appropriateness of methadone administration;
        - Review of the process for residents who have a relationship with another methadone agency; and
        - Continuity of care considerations and discharge planning/case management/linkages to community-based services when needed.
    - Pursuant to a successful DPH inspection, a license will be issued to the methadone agency designating the nursing home and their physical location as a "satellite" clinic of the agency.

Arranging Transportation of Methadone to the Long-Term Care Facility

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

- Opioid Treatment Exception Request: Eligible residents may receive take-home medication from the OTP and must submit the form for this during their discharge from the hospital.
- The process should be started at the time of admission.
- Diversion trained LTCF Registered Nurse (RN)/Licensed Practical Nurse (LPN) should pick up the methadone with a locked container(s).

- Coordinate with the OTP the best time (typically at the end of dispensing at the OTP, after the first pick-up), for the LPN/RN to bring back empties (look at synchronizing pick-up times if multiple residents have pick-ups).
- Once the LTCF nurse arrives, the OTP nurse will verify the contents before locking up and will confirm the process on the chain of custody form.
- Once the LTCF nurse is back at the facility, document and confirm with the resident that medications are in the box.
- The chain of custody form should stay with the medicine and have initials that both the LTCF and OTP confirmed the medication count in the box. The chain of custody forms should also go back with the empty boxes.
- OTP and LTCF should communicate the best time to pick-up the medication. Chain of custody form needs to be signed by LTCF RN/LPN, OTP RN/LPN, and the resident.
    - Additional considerations:
        - The LTCF should provide protocol training for the diversion RN/LPN about the full process.
        - This process only applies to residents who can self-administer per the OTP (medical take-home waivered residents).
        - As part of the exception, request the destruction of unused methadone according to destruction policy. When the resident leaves AMA from the LTCF, work with the OTP for diversion control, investigation, and sharing of information.
        - Provide lock boxes for each resident, using the resident's own lock box or one from the LTCF.

Arranging Transportation to the Opioid Treatment Program

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

- If available, reach out to Connecticut Non-Emergency Medical Transportation (NEMT), https://www.mtm-inc.net/connecticut/.
- Coordinate with the OTP for the best time for residents to arrive (coordinate scheduling if multiple residents need to go Other potential transportation options:
- Public transportation
- UberHealth as a temporary measure
- LTCF transportation (i.e., facility van)
    - Communication: OTP and LTCF communicate to find the best time to pick up the medication; RN/LPN, OTP RN/LPN, and the resident need to sign the chain of custody form.

Creating a Safe Transitions for Residents:

Qualified Service Organization Agreement (QSOA) *(see appendix 8 for example)*

- A QSOA is a two-way agreement between a SUD program (OTP or prescriber) 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.[116]

- QSOAs should be completed before admission to the LTCF.
- QSOAs should include types of services QSOs provide, such as medical services, counseling services, on-site call coverage, treatment plan, etc.
- Discussions between the LTCF and the OTP/prescriber administrators should occur before admitting residents on MOUD.

Obtaining Release of Information (ROI) (see appendix 9 for example)

- Obtain a 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 a ROI for both the LTCF and OTP or prescriber to sign; the LTCF confirms ROI receipt with the OTP or prescriber.
- The case manager or social worker at the hospital should connect with the liaison/social worker at the LTCF and OTP or prescriber.

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 the 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.
- The case manager or social worker at the hospital should connect with the LTCF liaison.

Incorporate safe transitions of care (from the LTCF to a facility or the community, with connection to OTP or prescriber) into policies.

- Proceed with normal discharge process.
- Alert and involve OTP or prescriber of planned discharge and location.
- For buprenorphine: schedule an appointment at the prescriber's office the day after discharge or plan for the resident to have a script ready before the appointment.
- For methadone: alert OTP that a last dose letter is needed.
- Connect the resident with additional behavioral therapy services, community organizations to address any unmet HRSNs, counseling, support services, etc.

[116] Substance Abuse and Mental Health Services Administration. (2023). 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

Nursing Home Diversion and Transition Program

- The purpose of this program is to ensure that nursing home placements for DMHAS clients (or DMHAS-eligible clients) are necessary, appropriate, and safe. Preadmission Screening Resident Review (PASRR) is an integral part of the program.
- The program focuses on two specific goals: (1) Reducing unnecessary admissions of DMHAS clients to nursing homes; and (2) Transitioning nursing home residents with a mental illness back to the community with support services. To accomplish these goals, DMHAS funds Nurse Clinicians, and Case Managers located at agencies identified below, who work directly with community providers, nursing home staff, and hospital discharge planners. There is ongoing collaboration with the state's Money Follows the Person Demonstration Project and the Medicaid Home and Community-based Waiver for Persons with Serious Mental Illness.
- Brochure and Request form: https://portal.ct.gov/-/media/DMHAS/Publications/NHDTPbrochurepdf.pdf and https://portal.ct.gov/-/media/DMHAS/forms/NHdiversionrequestformpdf.pdf

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".[117]

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,

[117] 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[118]

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.[119] 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

[118] SAMSHA (2012). Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from: https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf
[119] 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.[120]

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.

[120] 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

Directory of Warm Lines: https://portal.ct.gov/DMHAS/Programs-and-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.[121] 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.

[121] 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/

Domain 6: Stakeholders and Regulatory

Goal:

Provide practical strategies to help Long Term Care Facilities (LTCFs) navigate state and federal regulations that may present challenges when caring for residents Opioid Use Disorder (OUD).

Objectives:

- Highlight emerging themes in the state and federal regulations pertinent to providing care for residents with OUD.
- Suggest strategies to support comprehensive and patient-centered care for residents with OUD.

Description:

As known and experienced, nursing homes operate within a highly regulated structure, one considered by many to be among the highest regulated industries in the United States. In this domain strategies will be provided for navigating these regulations in conjunction with meeting the unique needs of residents with OUD.

Strategies for Caring for Residents with Opioid Use Disorder

Survey protocols and interpretive guidelines serve to clarify and/or explain the intent of the regulations. The regulations are intended to provide overarching guidance for a diverse population of people representing a wide variety of clinical needs, races, and ages. Where this becomes challenging for providers is adjusting to the increasing numbers of residents with unique needs associated with OUD and a shift from a traditional population of older residents (85+) to a younger population.

A recent study from the Journal of American Medical Directors Association (JAMDA) analyzed skilled nursing facility (SNF) administrators' perspectives on admissions and care for residents with OUD. Their question was: What do administrators perceive as barriers and facilitators to admitting and caring for residents with OUD in SNFs?

"Participants described active substance use, Medicaid insurance, housing instability, and younger age as potential barriers to SNF admission for individuals with OUD. The lack of formal guidelines for OUD management, staff shortages, facility liability, state regulations, and skills and training deficits among staff were cited among challenges of effectively meeting the needs of residents with OUD. Many participants reported inadequate institutional capacity as a source of negative outcomes for people with OUD yet expressed their concerns by characterizing individuals with OUD as potentially violent, nonadherent, or likely to bring undesirable elements into facilities. Participants also shared strategies they used to better serve residents with OUD, including providing transportation to support group

meetings in the community, delivery in advance of resident arrival of predosed methadone, and telemedicine through the state's hotline to prescribe buprenorphine."[122]

What Connecticut is doing to address these barriers:

1. Interagency partnerships have had a positive impact by the development of tools and resources available to LTCFs and three in-person conferences with over 200 attendees.
2. SUD in LTC Workgroup consists of providers across the continuum working to develop solutions to challenges experienced by LTCFs and partners in caring for residents with an OUD.
3. CT State agencies have staff and resources (websites, toolkit, webinars, etc.) to support initiatives and implementation of MOUD in LTCFs.
4. OTP satellite locations established in several LTCFs across the state.
5. CCAR Pilot- Connecting LTCF residents with a Recovery Coach

Considerations:

Below are series of current scenarios encountered by providers. These are just a few but are reflective of larger systemic issues facing nursing home providers and stakeholders. Among the providers whose experiences have contributed to this toolkit, those that were in close contact with the survey team and ombudsman gained greater input to challenges, collaboration, and expertise through that partnership.

Star Rating	**Background:** For years, the long-term care community has worked tirelessly to reduce the off-label use of antipsychotic drugs. This initiative was framed as a moral imperative denouncing the use of these drugs due to the dangers noted on the black box warning that highlighted the threat to elders. **The Issue:** The CMS Star Rating system is designed to reflect quality of care based on an elaborate scoring system around an array of measures which ultimately provide a star rating. The current quality measures favor those who have low antipsychotic drug rates. In this case, the lower rate contributes (in concert with other measures) to a higher star rating. Higher star ratings offer privileges that include better insurance rates, interest on loans and preferred status both in the community and with other healthcare providers. Providers caring for people with OUD may recognize co-occurring disorders. Some of the individuals diagnosed with co-occurring disorders may require treatment with anti-psychotic medications. Providers may be concerned that by increasing the numbers of people admitted and in need of antipsychotic medication for their treatment that their rating will be affected.

[122] Moyo P, Nishar S, Merrick C, Streltzov N, Asiedu E, Roma C, Vanjani R, Soske J. Perspectives on Admissions and Care for Residents With Opioid Use Disorder in Skilled Nursing Facilities. JAMA Netw Open. 2024 Feb 5;7(2):e2354746. doi: 10.1001/jamanetworkopen.2023.54746. PMID: 38315484; PMCID: PMC10844991.

	Suggestions: State committees compromising industry stakeholders should articulate the complexities of the antipsychotic issues soliciting comments, stories and solutions from providers, trade associations and stakeholders to create awareness and policy changes. The topic or its complexities is not widely known or understood. Taking thoughtful action that leads to advocacy will be the strongest leverage to help in these early days of this culture shift. Star ratings are a science involving math and strategy. A provider's understanding of how it works can mean the difference between hundreds of points left on the table. With the array of measures, providers should consider ways to maximize their scores in as many other areas as possible to offset the antipsychotic drug measure. Your local Quality Improvement Organization (QIO) can help you with that.
Resident Rights Protections	**Background:** For those residents who are active users of opioids, 90% arrive at the LTCF without Medication for Opioid Use Disorder (MOUD) and of those who have an order, most, according to data, are not appropriately managed and are usually being treated with low doses as small as 10mg of suboxone vs 30-40mg affecting their wellbeing. **The Issue:** Providers currently caring for people with OUD recognize that not all residents are ready to move toward sobriety resulting in some residents contacting people outside the facility for their opioid needs. This factor can and has created safety issues for the LTCF that can include exposure to fentanyl and drug paraphernalia, the necessity to search property that causes tension and behavioral escalations between staff and residents. Have residents take active part in the care of the facility usually being assigned jobs, and strongly encourage participation in structured activities, various therapy and support groups run by trained professionals with expertise in the disease. Invariably, they have the good fortune of structuring their setting with the supports, and boundaries as well as skilled practitioners such as psychiatrists, behavioral health professionals and technicians to provide the right care, treatment and setting to positively impact the life of those with OUD. This recipe for success is strengthened by engagement in the community. Having a supportive social or family environment[123] or

[123] Anderson M, Devlin AM, Pickering L, McCann M, Wight D. 'It's not 9 to 5 recovery': the role of a recovery community in producing social bonds that support recovery. Drugs (Abingdon Engl). 2021 Jun 9;28(5):475-485. doi: 10.1080/09687637.2021.1933911. PMID: 34675456; PMCID: PMC8522802.

	living in a recovery-supportive housing facility[124] helps people engage in recovery. Rehabilitation treatment centers recognize these as the best practices to support and care for people with OUD. The current LTCFs, however, are left without the tools and governance to provide satisfactory care and protection for all. Currently, in its effort to create a homelike environment, providing residents with freedom, dignity, choice, and privacy, LTCF faces exposure to an array of challenges, cited above, without the ability to create the necessary structure and boundaries. **Suggestions:** LTCF have recently begun to utilize Mutual Agreements. Through this tool, the parties-resident and administration-lay out the shared expectations of conduct which include: no use of illegal substances, no drug paraphernalia, no drug selling or dealing, no use of drugs while off the property on leave of absence, commitment to creating a safe environment for staff and residents. It further goes on to state that in the event that there is suspicion or knowledge of these things that the organization can take action which includes removal of illegal drugs, drug paraphernalia, a search of the room and property, involvement by law enforcement and the beginning of eviction action. The idea behind the mutual agreement is to show good faith among all parties. It becomes part of a system of transparency that includes the mutual agreement, facility risk assessment, policies & procedures, and documentation in the care plan.

Overall recommendations:

1. Partner with survey team & ombudsman to develop the necessary structures to provide the greatest care for people with OUD.
2. Create state committees compromising industry stakeholders should articulate the complexities of the antipsychotic issues soliciting comments, stories and solutions from providers, trade associations and stakeholders to create awareness and policy changes. The topic or its complexities is not widely known or understood. Taking thoughtful action that leads to advocacy will be the strongest leverage to help in these early days of this culture shift.
3. Talk with other providers to develop and share strong policies and procedures.

[124] Islam MF, Guerrero M, Nguyen RL, Porcaro A, Cummings C, Stevens E, Kang A, Jason LA. The Importance of Social Support in Recovery Populations: Toward a Multilevel Understanding. Alcohol Treat Q. 2023;41(2):222-236. doi: 10.1080/07347324.2023.2181119. Epub 2023 Feb 28. PMID: 37312815; PMCID: PMC10259869.

Appendices

The following appendices are provided only as examples for guidance and do not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.

Appendix 1. CT Harm Reduction Resources

CT HARM REDUCTION RESOURCES

harm reduction
SAVES LIVES

Across the state, Mobile Outreach is available for all of your Harm Reduction needs, with new locations coming soon!

CT Harm Reduction Alliance
www.ghhrc.org
Servicing: Hartford, New Haven, Bristol, River Valley

Bridges
www.bridgesct.org
Servicing: Milford & West Haven

Liberation Programs
www.liberationprograms.org
Servicing: Bridgeport

McCall
www.mccallcenterct.org
Servicing: Torrington

Perceptions
www.perceptionprograms.org
Servicing: Norwich, Willimantic, Jewett City, Danielson, Putnam, Taftville

APEX
www.apexcommunitycare.org
Servicing: Torrington, Winstead, Waterbury, New Milford, Danbury

Yale Community Health Van
www.yale.edu
Servicing: New Haven & Fair Haven

CT Center for Harm Reduction
www.harmreduction-ct.org
Servicing: Hartford

dmhas

To get trained and to obtain FREE Naloxone for you or a loved one, contact your local Regional Behavioral Health Action Organizations (RBHAO)
Naloxone (ct.gov)

Region 1: The Hub
www.thehubct.org
475-282-3521

Region 2: APW
www.apw-ct.org
203-736-8566

Region 3: SERAC
www.secracct.org
860-848-2800

Region 4: Amplify
www.amplifyct.org
860-921-8390

Region 5: Western CT
www.WCTCoalition.org
203-743-7741

Organizations can request through DMHAS directly at: Opioid Services ct.gov

ADDITONAL RESOURCES:
24/7 Access Line:800-563-4086

www.harmreduction.org

How-Can-we-help.pdf (ct.gov)

www.LiveLOUD.org

www.drugfreect.org

SyringeServicesProgram.pdf (ct.gov)

www.norasaves.com

www.smartrecoveryct.org

www.ctclearinghouse.org

www.youthrecoveryct.org

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 2. 10 Fast Facts about Trauma-Informed Care (TIC)

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

10 Fast Facts about Trauma-Informed Care (TIC)

1

What is Trauma?

The 3 Es of trauma:

- **Event -** an event, series of events, or set of circumstances which resulted in actual harm or threat of harm.
- **Experience -** how the individual perceives the event. For some, an event may not result in trauma, but for others it does.
- **Effects -** how the event adversely impacts the person.

2

What is Trauma-Informed Care?

An approach to delivering care that aims to avoid retraumatization. Providers recognize the widespread impact and signs and symptoms of trauma in residents and incorporate knowledge about trauma into policies, procedures, and practices to avoid retraumatization.[1]

3

Tips for Screening and Assessment of Trauma

#1: Identify traumatic events and circumstances by using or developing a screening tool to serve as a guide. Include experiences from:

- Accidents
- Natural disasters
- War
- Physical, emotional, or sexual abuse
- Deaths
- Life events that continue to have an impact
- Substance abuse and addictions of any kind

#2: Identify how the resident currently perceives the trauma. Questions may include:

- Do you have thoughts or memories of a stressful experience from the past?
- Do you currently feel in danger or afraid someone might hurt you?
- How upset do you feel when something reminds you of a stressful experience from the past?
- Are there any triggers that make you feel as if you are reliving the stressful experience?
- What helps you cope with these stressful situations?

 # 3: Be empathetic but straightforward to avoid any confusion while screening for the traumatic event.

4

Apply the Four Keys of Trauma-Informed Care to Care Planning[2]

- **Realization -** Understand what trauma is and how it can impact the resident and their behavior.
- **Recognize -** Assess for past trauma and remain alert for the effects of past trauma to reemerge.
- **Respond -** Develop a care plan that addresses the trauma, including the effects of the trauma the resident experiences - i.e., how the effects of the event manifest themselves in the resident's behavior.
- **Resist retraumatization -** Ensure the care plan includes the triggers for retraumatization and the interventions to avoid such an experience - i.e., the treatment and staff approaches used to support the resident.

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

5

Who is At Risk?

- Holocaust survivors
- Veterans
- Survivors of large-scale natural and human-caused disasters
- Survivors of crime
- Survivors of all forms of abuse (sexual, physical, and mental)
- Witnesses to horrific events

Other residents with symptoms to suggest past trauma – those with:

- Substance abuse
- Eating disorders
- Depression
- Anxiety

6

Triggers for Retraumatization (and the Associated Loss of Independence) in a Nursing Home:

- Experiencing a lack of privacy or confinement in a crowded or small space
- Being exposed to certain loud noises, or bright/flashing lights
- Having unknown people helping them with ADLs, such as dressing, toileting, or bathing

7

Impact of Cognitive Impairment - i.e., Dementia

May worsen or further complicate a trauma survivor's response to triggers and may also introduce additional language barriers as individuals return to their first (non-English) languages.

8

Specific F-Tags in Appendix PP Where Trauma-Informed Care is Mentioned:

- **F656 Comprehensive care plans -** includes residents who display a history of trauma and/or post-traumatic stress disorder
- **F659 Qualified persons –** services provided are delivered by those with the skills, experience, and knowledge to do a particular task or activity
- **F699 Trauma-informed care –** ensuring residents who are trauma survivors receive culturally competent, trauma-informed care to eliminate or mitigate triggers that may cause retraumatization
- **F741 Behavioral health services –** based on assessment, resident who displays or is diagnosed with a mental disorder, psychosocial adjustment difficulty, or who has a history of trauma receives appropriate treatment and services to achieve highest level of function
- **F949 Behavioral health training –** care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition

9

Professional Support

- Psychologist or psychiatrist
- Licensed social worker
- Licensed counselor or therapist
- Support group facilitated by a mental health professional

10

Resources

- **AAPACN's Certificate Program for Implementing an IDT Approach to Trauma-Informed Care** https://www.aapacn.org/education/trauma-informed-care/
- ***State Operations Manual, Appendix PP (2017)*** www.cms.gov › Manuals › downloads › som107ap_pp_guidelines_ltcf
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** https://www.samhsa.gov/
- **Wisconsin Department of Health Services, Trauma-Informed Care: Resources** https://www.dhs.wisconsin.gov/tic/resources.htm
- **Trauma-Informed Care in Long-term Care, May 16, 2019. Scott A. Webb.** https://www.lsqin.org/wp-content/uploads/Handout_TIC-With-Elders-FINAL-DHS_reviewed-1.pdf
- ***Trauma-Informed Care in Behavioral Health Services: Quick Guide for Clinicians Based on TIP 57.*** https://store.samhsa.gov/product/Trauma-Informed-Care-in-Behavioral-Health-Services-Quick-Guide-for-Clinicians-Based-on-TIP-57/SMA15-4912
- ***1, 2: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*** https://store.samhsa.gov/system/files/sma14-4884.pdf

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 3. Suspected Overdose Response Drill Debrief Form

Facility Name		**Location of Drill**	
Drill Leader		**Drill Date/Time**	
Person Completing this Form		**Title**	
Drill Participants			

Use the following questions to debrief the drill, identify strengths and lessons learned and opportunities for improvement.

	Yes	No	N/A
1. Were the overdose supplies easily located?			
2. Was someone designated to control on-lookers?			
3. Did the person designated to phone 911 know the site address?			
4. Was someone designated to do rescue breathing?			
5. Was the drill debrief conducted with all participants together?			
6. Did staff who participated in the drill have the knowledge/skills to respond to an overdose?			
7. Do staff who did not participate in the drill have the skills/knowledge to respond to an overdose?			

Lessons Learned

What went well?
What would we do differently the next time?
What opportunities for improvement were identified?
What are the next steps? Who is responsible? What are target dates?

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 4. Tips for Overdose Reversal Using Naloxone

RECOGNITION OF OPIOID OVERDOSE	
Signs and Symptoms	**Unresponsiveness, fewer than 10 breaths per minute** **Potential presentation of overdose may include:** • **extreme muscle rigidity, seizures, or other uncontrolled movements** • Slow, shallow breathing • Blue lips/fingernails • Snoring/gurgling sound
RESPONDING TO AN OPIOID OVERDOSE	
Importance of Calling 911	• Medical interventions beyond what you can provide may be needed. • The 9-1-1 operator can help walk through response including chest compressions, if needed.
Clear Airway & Ventilate	• Tilt head, lift chin up, plug nose, and make a seal over the mouth, giving **ONE BREATH EVERY FIVE SECONDS THROUGHOUT THE RESPONSE UNTIL THE PERSON IS BREATHING AGAIN** or until paramedics arrive.
Administer Naloxone	Customize this section to the type of naloxone in your facility, e.g., • Naloxone injection 0.4mg/mL given IM • Naloxone autoinjector 5 mg/0.5mL (brand Zimhi) IM only • Naloxone 4mg nasal spray • Naloxone 8mg nasal spray (Kloxxado®)
Evaluate Effects for 3 Minutes & Administer Naloxone Again if Needed	• **Continue breaths for 2 to 3 minutes** OR until the person is breathing on their own again. • **If no response, after 2 to 3 minutes, administer a 2nd dose of naloxone** • **Continue breaths until the person is breathing normally OR until paramedics arrive.** • **Additional doses may be required.**
Aftercare	• An overdose can be an out of control, frightening experience • Explain to the individual what happened– they may not recall what happened.

Naloxone only works for an opioid overdose (e.g., morphine, fentanyl, oxycontin, dilaudid, combination products with opioids, methadone, heroin) – NOT for non-opioid depressants (e.g., alcohol, benzodiazepines) **AND if you are not sure what a person has taken, naloxone will not harm them. Naloxone is light and heat sensitive. Do not store in vehicle.**

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 5. Opioid Use Disorder Diagnostic Criteria

Opioid Use Disorder: Diagnostic Criteria

Assess for the presence of opioid use disorder (OUD) using the following checklist based on the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) criteria. To confirm a diagnosis of OUD, at least two of the following criteria should be observed within a 12-month period.

Diagnostic Criteria

- ☐ Taking opioids in larger amounts or over a longer period of time than intended
- ☐ Having a persistent desire or unsuccessful attempts to reduce or control opioid use
- ☐ Spending excess time obtaining, using or recovering from opioids
- ☐ 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 in spite of 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

** Tolerance and withdrawal are not considered to be met for those taking opioids solely under appropriate medical supervision*

Severity Level

OUD exists on a continuum of severity. Specify current severity based on the number of diagnostic criteria that have been met.

- ○ Mild: Presence of 2-3 symptoms
- ○ Moderate: Presence of 4-5 symptoms
- ○ Severe: Presence of 6 or more symptoms

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 6. Opioid Risk Tool

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 7. Clinical Opiate Withdrawal Scale

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ___ /___ /___ :_____

Reason for this assessment:_____

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 greater than 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/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/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 opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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 or 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; more than 36 = severe withdrawal

This version may be copied and used clinically.

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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 8. Example of a 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 resident in the Program ("protected information"), it is fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Resident 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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

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	Program Director
XYZ Service Center	[Name of the Program]
[address]	[address]

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 9. Example Release of Information

CONSENT FOR RELEASE OF INFORMATION

Resident 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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

☐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: _____
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 _____ 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 Resident or Personal Representative

_____
Resident Signature (or Personal Representative) Date

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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

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 §§ 2.12l(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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 10. Example: 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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 11. Example: 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

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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

Appendix 12. Example: 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 Do you use your prescription card? YES, NO If YES : specify type:_____		
6. Are there medications that you need that you cannot obtain? YES, NO If YES, ask resident to explain.		

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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*

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

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

**This document is only an example for guidance and does not represent legal advice of the State of Connecticut. Organizations looking to develop similar content should consult with their own legal counsel to ensure that they are following all applicable laws.*