Opioid and Pain Management Best Practices

Strategies for Success

September 22, 2021

12pm-1pm

IPRO QIN-QIO

Healthcentric Advisors

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Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

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Agenda

- IPRO QIN-QIO – Who we are and what we do
- Overview of IPRO QIN-QIOs Opioid and Pain Management Best Practice Assessment and Results
- Guest Presentations:
  - A Healthcare System-Level Intervention to Increase Naloxone Availability for Patients With Opioid Prescriptions: Joan Papp, MD and Jonathan Siff, MD, MetroHealth System
  - Overview of Medications for Opioid Use Disorder in Long Term Care: Rob Accetta, RPh, BCGP, President Rivercare Rx Consulting
  - CalvertHealth Medical Center – Opioid Best Practices Progress since February: Kara Harrer, PharmD
- Opioid and Pain Management Resources
- Discussion, Question & Answer
- Wrap-up

The IPRO QIN-QIO: Who We Are

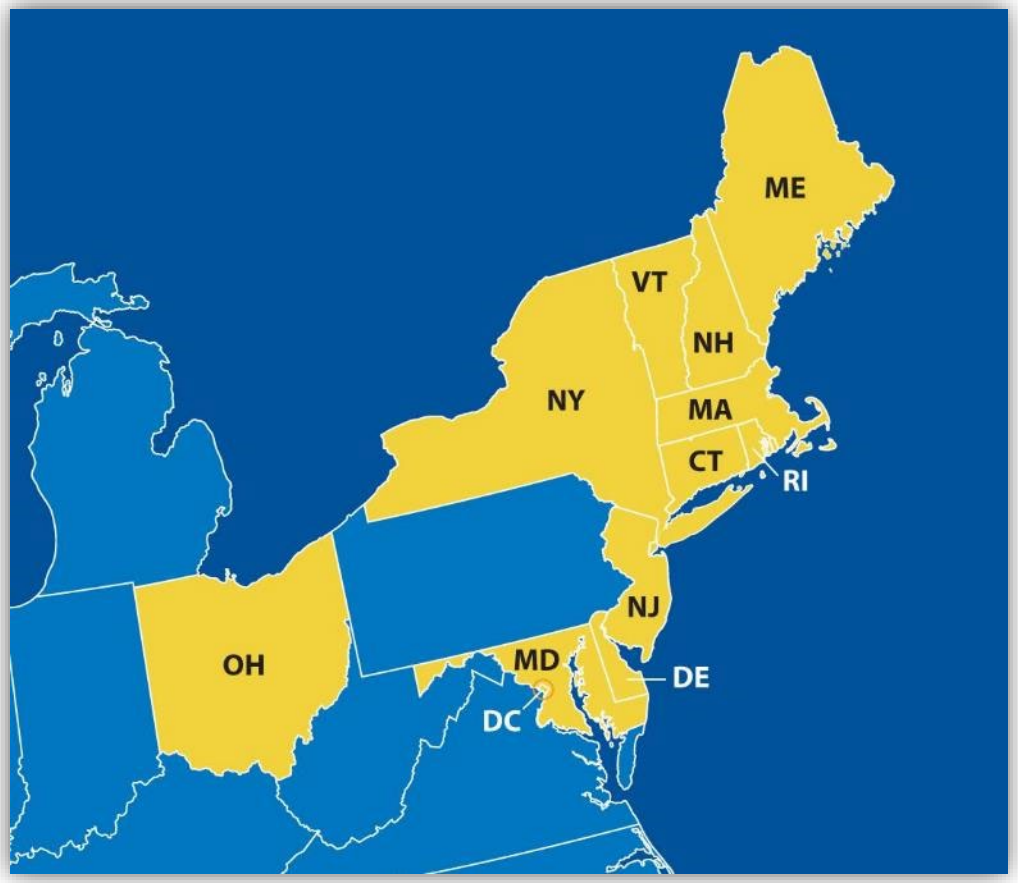
The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network–Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

IPRO:
New York, New Jersey, and Ohio

Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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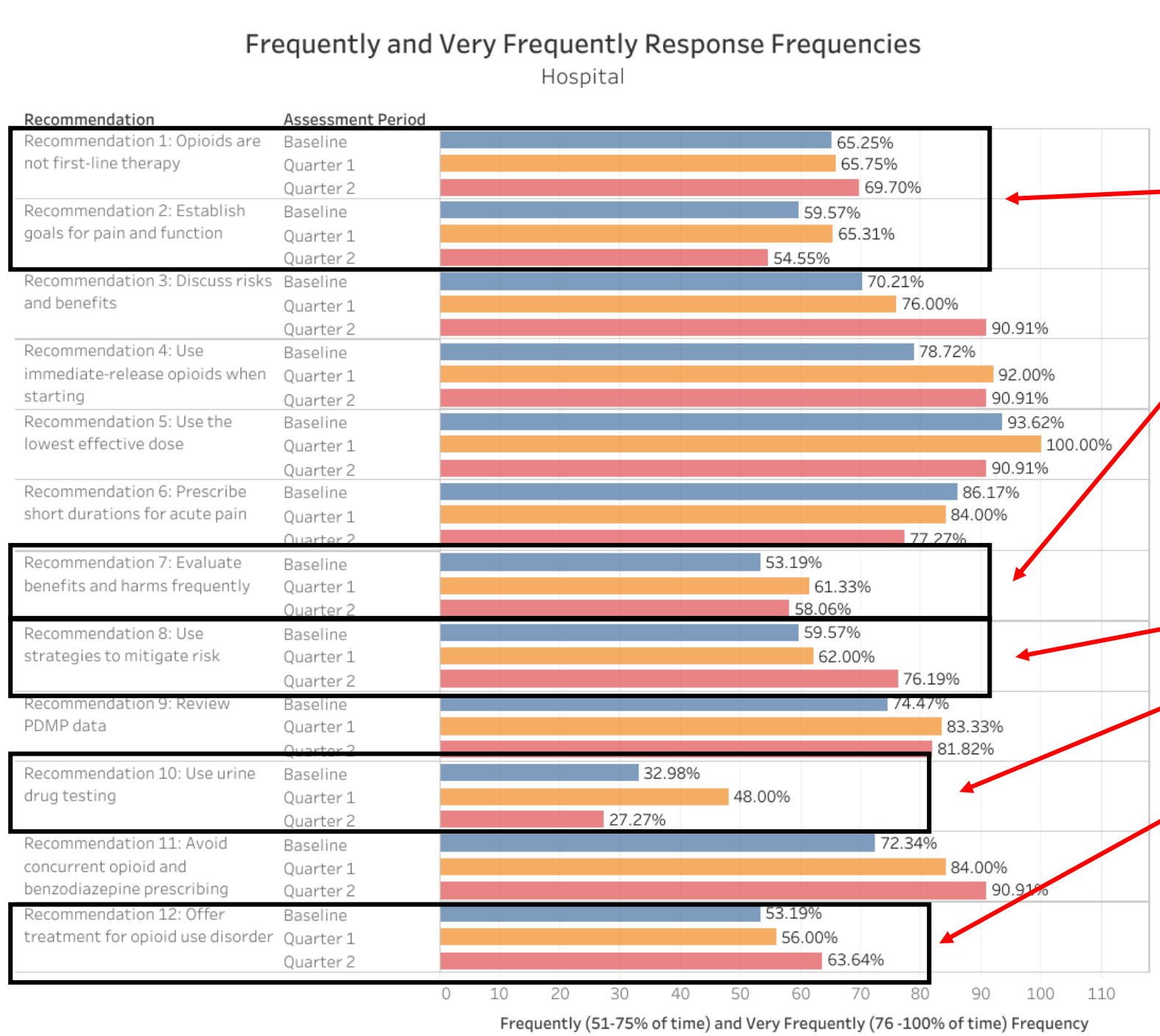
Opioid & Pain Management Best Practices Assessment

- Provider self-assessment of opioid & pain management practices to identify potential areas of improvement.
- *Guideline Purpose:* To encourage careful and selective use of long-term opioid therapy in the context of managing chronic pain through (a) an evidence-based prescribing guideline, (b) quality improvement (QI) measures to advance the integration of the CDC Guideline for Prescribing Opioids for Chronic Pain (CDC Prescribing Guideline) into clinical practice, and (c) practice-level strategies to improve care coordination.
- *Guideline Goal:* To ensure patients have access to safer, more effective chronic pain treatment by improving the way opioids are prescribed through an evidence-based clinical practice guideline, while reducing the number of people who misuse, abuse, or overdose from these drugs.

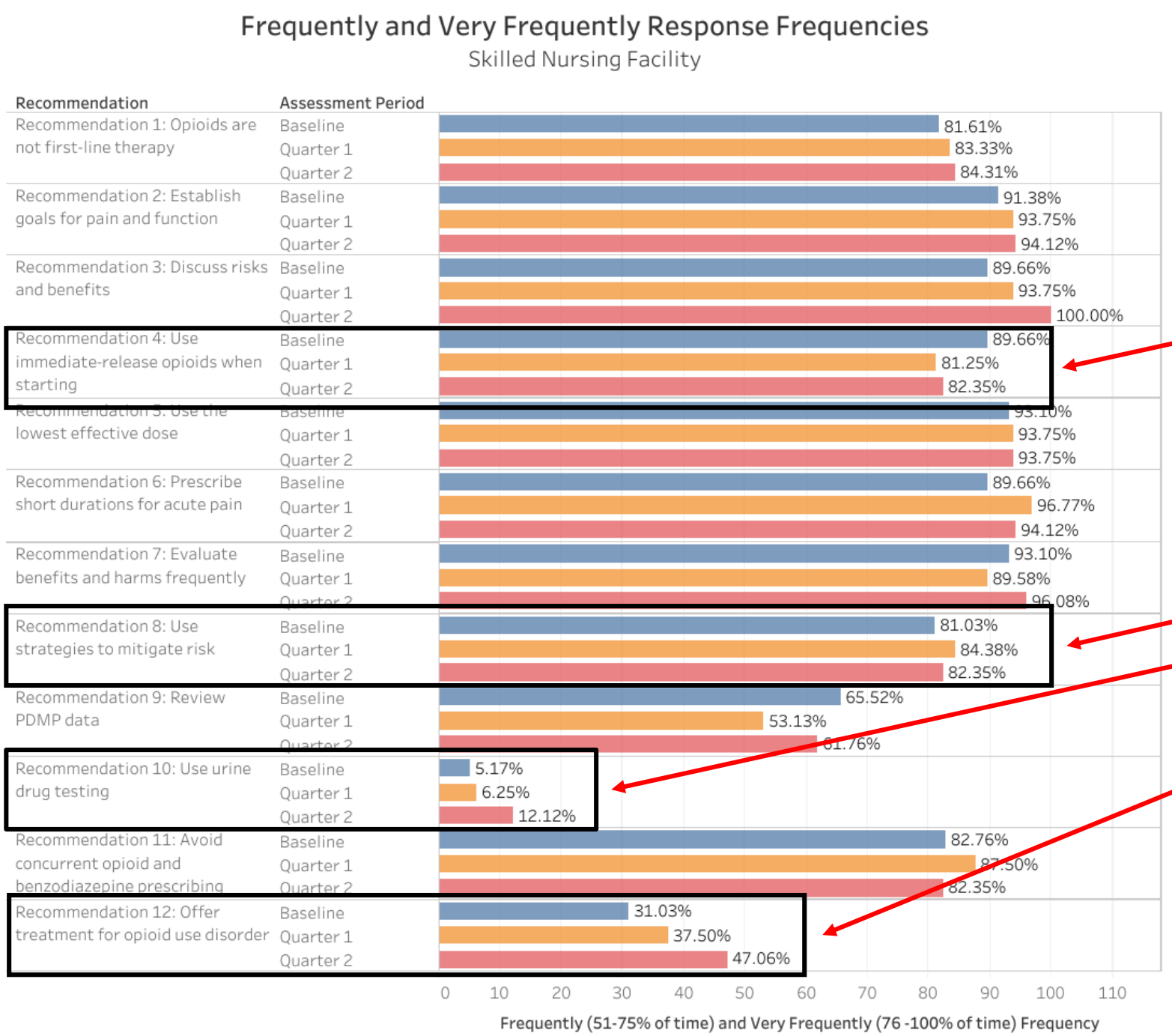
Centers for Disease Control and Prevention. Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA.



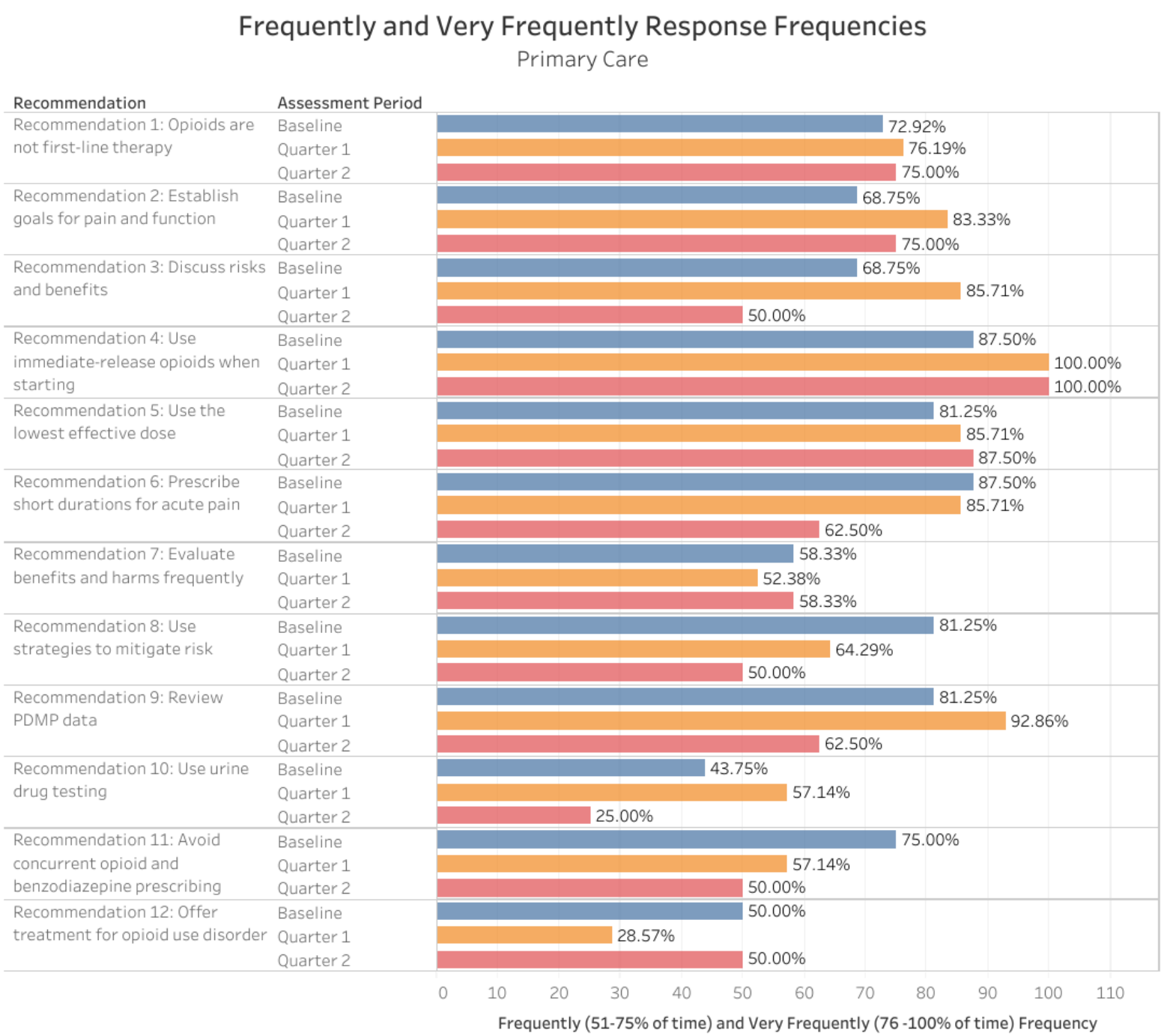
- Discharge communication opportunities with patients and subsequent providers

- Naloxone prescribing
- Urine drug testing – much education needed
- Medications for opioid use disorder and therapy

[Opioid and Pain Management Best Practice Assessment Aggregate Results Public Dashboard]



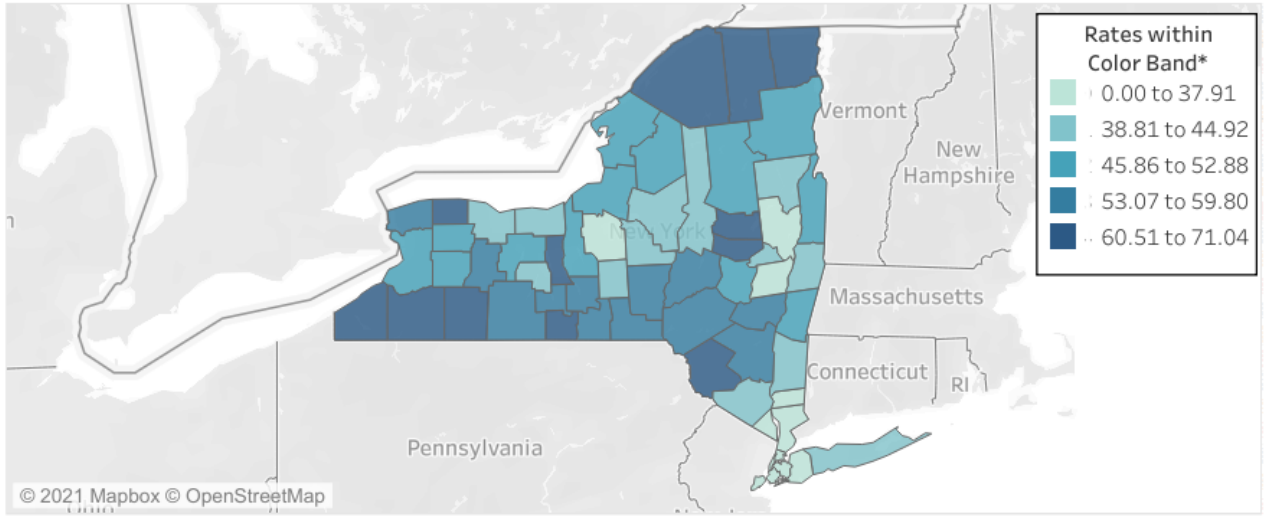
- Should never initiate opioid dosing with long-acting formulations
- Naloxone prescribing
- Urine drug testing – much education needed
- Medications for opioid use disorder and therapy



- <10 respondents
- More data needed, but current results track with known issues:
  - Risk mitigation strategies/ Naloxone prescribing can be improved
  - Offering treatment for OUD can be improved
  - Use of urine drug testing can be optimized – education needed
  - Items that require more conversation/time may happen less frequently

Beneficiaries Utilizing Opioids Per 1,000 Medicare Population

IPRO · QIN-QIO · HQIC



Rates within Color Band*
- 0.00 to 37.91
- 38.81 to 44.92
- 45.86 to 52.88
- 53.07 to 59.80
- 60.51 to 71.04

Select State
NY

Select Time Period
- 1/1/2019 through 6/30/2019 (Interval 1)
- 7/1/2019 through 12/31/2019 (Interval 2)
- 1/1/2020 through 6/30/2020 (Interval 3)
- (●) 7/1/2020 through 12/31/2020 (Interval 4)

Select 90-Day Average MME** Tier
- (●) Any Opioid
- 90 - 119MME
- 120 - 239MME
- 240MME Higher

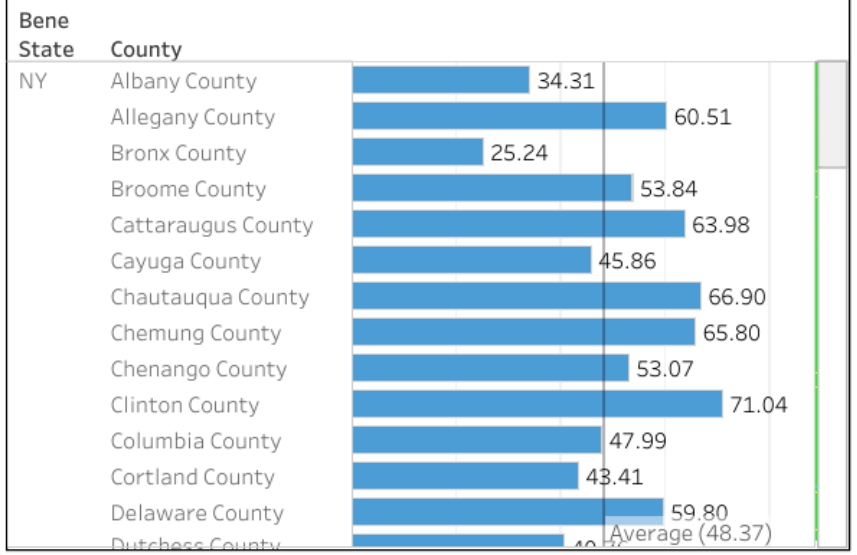
More Information | Go to Opioid Data Table

*Legend presents ranges of rates encountered within each color band. Color bands are tiered by performance percentile (e.g. 5 bands = 20% of counties fall within each color band)

**morphine milligram equivalents

[Opioid Utilization Public Dashboard]

Beneficiaries Utilizing Opioids Per 1,000 by County



Percent Change in Opioid County Rate between Available Time Intervals for Any Opioid

Bene State	County	Interval 2 vs. 1	Interval 3 vs. 2	Interval 4 vs. 3
NY	Albany County	↓-5.98%	↓-1.57%	↓-6.41%
	Allegany County	↓-1.49%	↓-5.33%	↓-0.81%
	Bronx County	↓-8.49%	↓-6.01%	↓-0.99%
	Broome County	↓-6.83%	↓-4.26%	↑ 1.48%
	Cattaraugus County	↓-6.02%	↓-4.61%	↑ 6.88%
	Cayuga County	↓-5.20%	↓-0.10%	↓-0.06%
	Chautauqua County	↓-7.38%	↑ 2.41%	↑ 3.28%
	Chemung County	↓-7.12%	↓-0.02%	↑ 1.73%
	Chenango County	↓-8.50%	↓-5.04%	↑ 0.99%
	Clinton County	↓-4.92%	↑ 1.40%	↓-2.77%
	Columbia County	↓11.04%	↓-8.38%	↑ 4.51%
	Cortland County	↑ 3.72%	↓-1.65%	↓-1.06%
	Delaware County	↑ 2.55%	↓-1.99%	↓-0.40%

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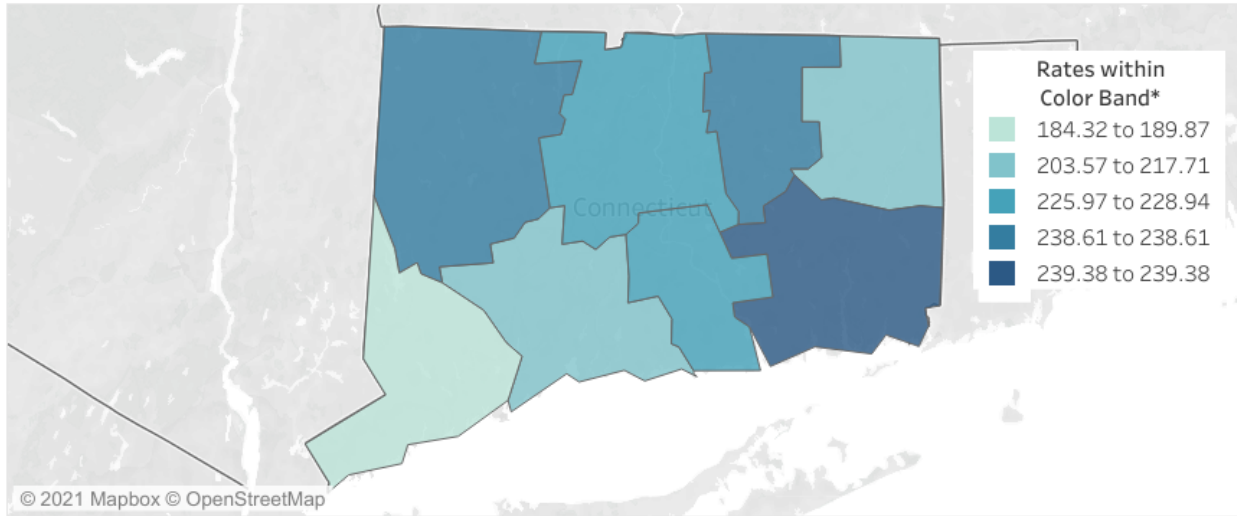
Version 1.0 July 1, 2021

Benzodiazepine Use per 1,000 Beneficiaries Prescribed Opioids



Select State
CT

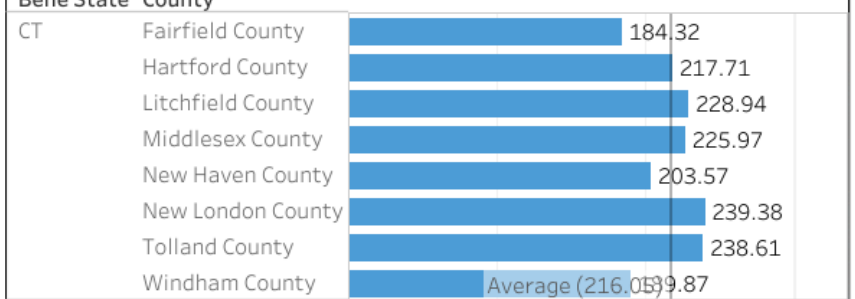
Select Time Period
- (●) 1/1/2019 through 6/30/2019 (Interval 1)
- ( ) 7/1/2019 through 12/31/2019 (Interval 2)
- ( ) 1/1/2020 through 6/30/2020 (Interval 3)
- ( ) 7/1/2020 through 12/31/2020 (Interval 4)

More Information

Go to Dangerous Combinations with Opioids Data Table

*Legend presents ranges of rates encountered within each color band. Color bands are tiered by performance percentile (e.g. 5 ba..

Benzodiazepine Use per 1,000 Beneficiaries Prescribed Opioids by County



Percent Change in Benzodiazepine-Opioid Utilization Rates Between Available Time Intervals

Bene State	County	Interval 2 vs. 1	Interval 3 vs. 2	Interval 4 vs. 3
CT	Fairfield County	↑ 0.00	↓ -0.06	↓ -0.08
	Hartford County	↓ -0.08	↓ -0.14	↓ -0.05
	Litchfield County	↓ -0.10	↓ -0.06	↓ -0.07
	Middlesex County	↓ -0.02	↓ -0.10	↓ 0.00
	New Haven County	↓ -0.05	↓ -0.12	↓ -0.06
	New London County	↓ -0.09	↓ -0.07	↓ -0.09
	Tolland County	↓ -0.08	↓ -0.05	↓ -0.20
	Windham County	↑ 0.01	↓ -0.05	↓ -0.09

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Version 1.0 July 1, 2021

A Healthcare System-Level Intervention to Increase Naloxone Availability for Patients with Opioid Prescriptions

Joan Papp, MD, FACEP
Associate Professor in Department of Emergency Medicine at MetroHealth Medical Center, Cleveland, Ohio

MetroHealth

Jonathan Siff, MD, MBA, FACEP, FAMIA
Associate Chief Medical Informatics Officer and Emergency Medicine Physician at The MetroHealth System, Cleveland, Ohio

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METROHEALTH
NALOXONE CO-PRESCRIBING INITIATIVES

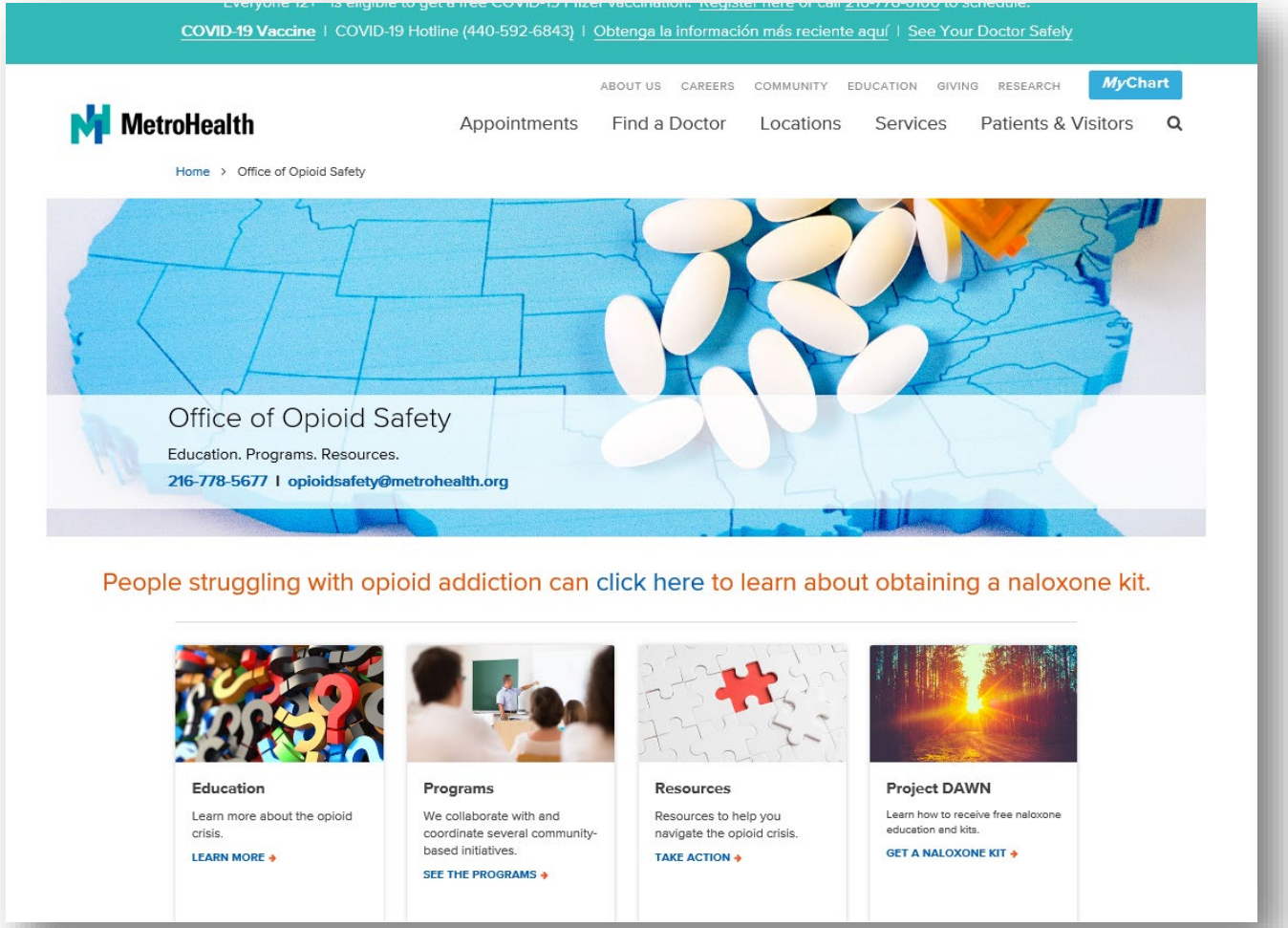
Dr. Jon Siff MD, MBA, FACEP, FAMIA
Associate Chief Informatics Officer

Dr. Joan Papp MD, FACEP
Medical Director, Office of Opioid Safety

September 22, 2021

MetroHealth

MetroHealth Office of Opioid Safety



https://www.metrohealth.org/office-of-opioid-safety

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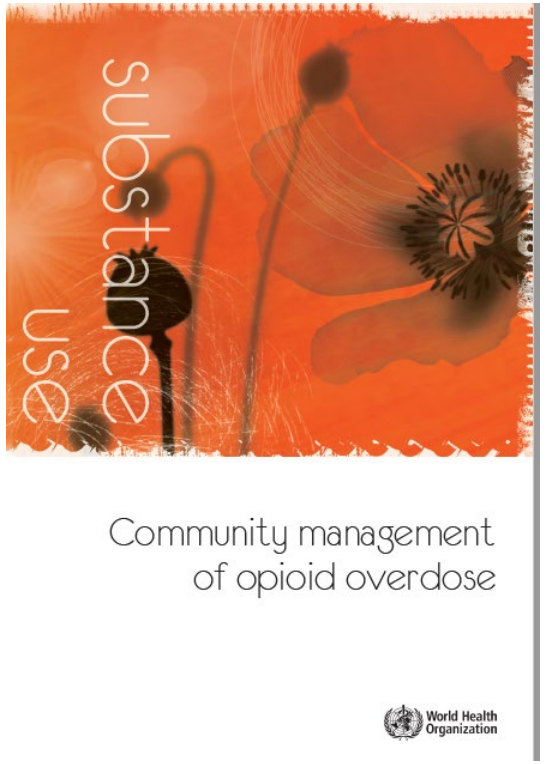
Increasing naloxone is BEST PRACTICE

CDC Guidelines for prescribing opioids for chronic pain



World Health Organization

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1external icon.

Community management of opioid overdose.
1.Opioid-Related Disorders – prevention and control. 2.Drug Overdose – prevention and control. 3.Naloxone – therapeutic use. 4.Community Health Services. 5.Guideline. I.World Health Organization.
ISBN 978 92 4 154881 6 (NLM classification: WM 284)

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Increasing Naloxone Access is a Best Practice Focused on High Risk Populations

- Community access for people who use illicit opioids

- Co- prescribing for high risk patients on prescribed opioids

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Educational Efforts Aimed at Improving Naloxone Access at MetroHealth

- Community education
- Peer review
- Opioid Town Halls
- Opioid Safety Grand Rounds
- Lunch and Learn Sessions
- Safer prescribing education modules
- Academic Detailing

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Community Access Naloxone Efforts at MetroHealth

- Walk-in Sites
- Community distribution sites
- Service entities
- Jail distribution
- Nalox- Box – public access

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Example Intervention: Naloxone Co-Prescribing

- Co-prescribing naloxone with opioids is a best practice
- Availability of naloxone in the community can save lives
- Implemented decision support tool to encourage naloxone co-prescribing

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Decision support for naloxone prescribing

- Respects the 5 “rights” of decision support
- Only shown to prescribing providers
- Triggers
  - Sign order of an ambulatory opioid medication
    - Includes at hospital discharge
    - Excludes cough preparations
  - Sign benzodiazepine order with opioids
    - High risk behavior which is discouraged by an additional alert
  - Trigger fires BEFORE completion of the order
  - Does NOT fire if patient has an active naloxone prescription

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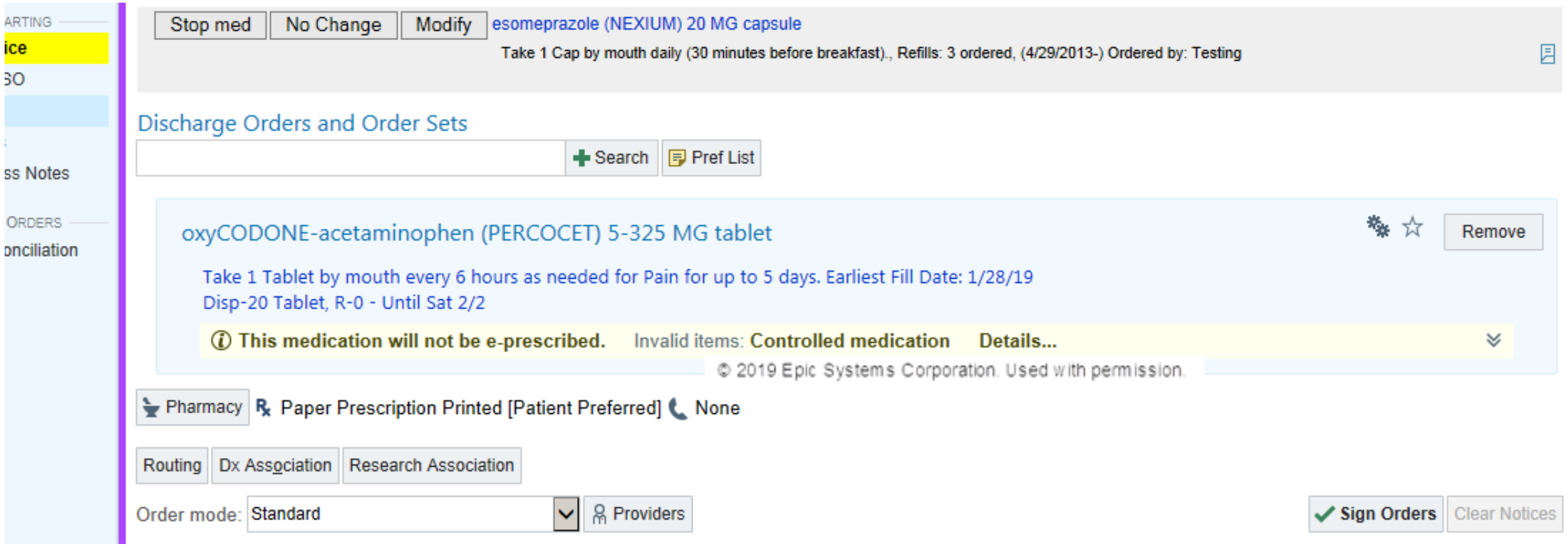

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BestPractice Advisory - SLDuke, Wowie

Consider prescribing naloxone along with this order. Remember to verify and document OARRS.

Why is this showing up?

This patient meets CDC criteria to receive naloxone with their opioid prescription. Possible reasons include a total MEDD > 50, concurrent use of benzodiazepines and opioids or a history or prior overdose. Please discuss naloxone with your patient and prescribe as appropriate.

Order | Do Not Order | **naloxone nasal liquid**

Consider taking these recommended actions after addressing this advisory:

Consider removing: oxyCODONE-acetaminophen (PERCOCET) 5-325 mg per tablet
Take 2 Tablets by mouth every 4 hours as needed for Pain for up to 3 days. Disp-12 Tablet, R-0 - Starting today, Until Sat 6/20, Maximum MEDD: 90 mg MEDD for this order

Acknowledge Reason

Not clinically indicated | For procedure | Patient Declined | Already prescribed | See comments

Accept | Cancel

CDU ADMIT ORDERS

Order Reconciliation

oxyCODONE-acetaminophen (PERCOCET) 5-325 MG tablet

Take 1 Tablet by mouth every 6 hours as needed for Pain for up to 5 days. Earliest Fill Date: 4/19/19
Disp-20 Tablet, R-0 - Until Wed 4/24

This medication will not be e-prescribed. Invalid items: **Controlled medication** **Details...**

Pharmacy | METROHEALTH BROADWAY PHARMACY - CLEVELAND, OH [Patient Preferred]

Routing | Dx Association

Order mode: Standard | Providers

Sign Orders

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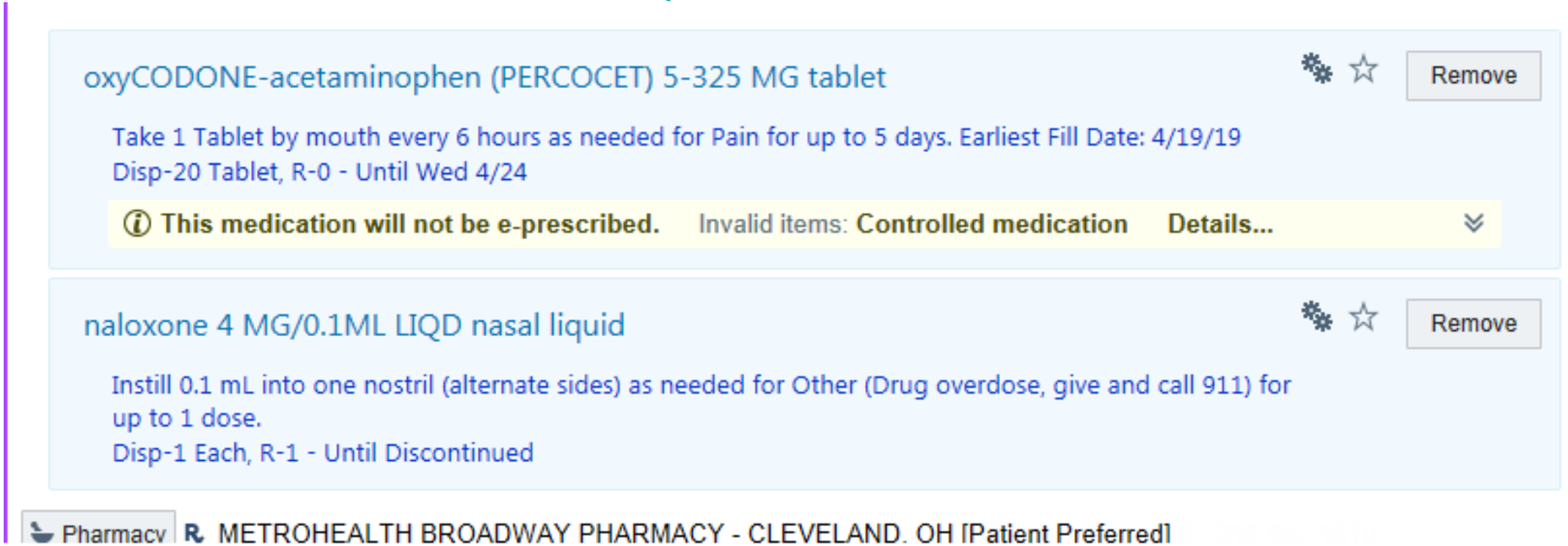
Accepting the alert automatically queues up the naloxone order for the provider



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Did the alert work?

	Pre Naloxone Alert	After Naloxone Alert
# naloxone Rx	322	8136
% high MEDD Rx with Naloxone	17%	71%
Unique prescribers	25	824

But does anyone actually fill these?

- Looked at all naloxone prescribed in the pre and post implementation timeframes
- YES!

	Pre Naloxone alert	Post Naloxone alert
Fill rate	42%	42%
Number filled	322 x 0.42 = **135**	8136 x 0.42 = **3417**

- Fill rate lowest in ED 33% vs 47% in General Medicine
- An opportunity to encourage higher fill rates

What's even more exciting?

- We got to share this process!

- I have had discussions with teams from numerous hospitals on how to implement something similar in their organizations

- We also published this process:
  - Siff, J.E., Margolius, D., Papp, J., Boulanger, B. and Watts, B. (2021), A Healthcare System-Level Intervention to Increase Naloxone Availability for Patients With Opioid Prescriptions. Am J Addict, 30: 179-182. https://doi.org/10.1111/ajad.13136

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Challenges and Opportunities

- Early challenges to the intervention
  - "One more alert"
  - Provider concern no one would fill the prescriptions
  - Legal implications
  - Providers not understanding importance / prioritization

- Future opportunities
  - Continue to share successes
  - Promote importance with patients to increase fill rates

Medications for Opioid Use Disorder in Long Term Care

Robert C. Accetta, RPh, BCGP, C-MTM, FASCP
President
Rivercare Rx Consulting
Greater NY Area

Medication Assisted Treatment , Medications and Opioid Use Disorder in LTC Settings: A Work in Progress

Robert C. Accetta, RPh, BCGP, C-MTM, FASCP

President, RivercareRx Consulting

Greater NY Area

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Overview of Medications and Opioid Use Disorder in Long Term Care

Web-based resources for this presentation include:

- https://www.samhsa.gov/medication-assisted-treatment Accessed 09172021
- https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program Accessed 09172021
- https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021
- https://www.hivguidelines.org/substance-use/oud/#tab_0 Accessed 09172021, New York State of substance abuse guidelines

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Patient Admission Criteria for Opioid Treatment Programs (OTP): Federal Regulations

PATIENT ADMISSION CRITERIA

SAMHSA
Substance Abuse and Mental Health Services Administration

42 CFR 8.12(e) *Patient admission criteria*. (1) Maintenance treatment. An OTP shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), that the person is currently addicted to an opioid drug, and that the person became addicted at least 1 year before admission for treatment. In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment.

https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program Accessed 09172021

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OTP and Scope of Required Services

OTPs must provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. Any assessments or treatments not directly provided at the facility must be assured via a formal documented agreement with the appropriate community providers. Adequacy of services is manifest by a plan to manage and follow up each problem identified in the patient's history, physical exam, psychiatric evaluation, health risk assessments, and social support evaluations within 30 days of admission. An OTP should have appropriate information sharing agreements with other providers, in accordance with federal regulations, in order for these services to be considered fully available to patients.

https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program Accessed 09172021

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OTP: Drug Abuse and Testing Requirements

Clinical drug testing is used for the purposes of diagnosis, monitoring, and evaluating progress in treatment and the promotion of long-term recovery. Through drug testing, patients' use of specific drugs as well as the absence of prescribed medications, which may be an indication of diversion, can be identified. Although testing panels typically include opioids (including prescription opioid analgesic compounds), benzodiazepines, barbiturates, cocaine, marijuana, methadone (and its metabolites), buprenorphine, amphetamines, and alcohol, they are not limited to these substances.

https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program Accessed 09172021

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Medication Assisted Treatment (MAT): Goals and Guidance

Effective medication-assisted treatment has the following desired outcomes:

- Prevention of the onset of subjective and/or objective signs of opioid abstinence syndrome for at least 24 hours (opioid agonists).
- Reduction or elimination of drug craving routinely experienced by the patient (opioid agonists or antagonists).
- Blockage of the euphoric effects of any illicitly acquired, self-administered drug without the patient experiencing or observers noticing undesirable effects (opioid agonists or antagonists).

https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program Accessed 09172021

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SAMHSA- Medication Assisted Treatment

SAMHSA
Substance Abuse and Mental Health Services Administration

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Medication-Assisted Treatment

- MAT Medications, Counseling, and Related Conditions
- Find Medication-Assisted Treatment
- Become a Buprenorphine Waivered Practitioner
- Find Buprenorphine Waiver Training
- Buprenorphine Practitioner Resources and Information

Medication-Assisted Treatment (MAT)

Learn how medication-assisted treatment (MAT) is used to treat substance use disorders as well as sustain re
prevent overdose.

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behaviora
to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MA
approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to

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https://www.samhsa.gov/medication-assisted-treatment Accessed 09172021

Medication Assisted Treatment- OUD

SAMHSA
Substance Abuse and Mental Health Services Administration

MAT Effectiveness

In 2018, an estimated 2 million people had an opioid use disorder which includes prescription pain medication containing opiates and heroin.

MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy that address the needs of most patients.

The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse. Learn more about substance misuse and how it relates to HIV, AIDS, and Viral Hepatitis.

https://www.samhsa.gov/medication-assisted-treatment Accessed 09/17/2021

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Approach to Treatment

Medication-Assisted Treatment

MAT Medications, Counseling, and Related Conditions

Buprenorphine
Methadone
Naltrexone
Naloxone
Opioid Overdose
Co-Occurring Disorders

Find Medication-Assisted Treatment

Become a Buprenorphine Waivered Practitioner

Find Buprenorphine Waiver Training

MAT Medications, Counseling, and Related Conditions

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. It is also important to address other health conditions during treatment.

MAT Medications

The Food and Drug Administration (FDA) has approved several different medications to treat alcohol and opioid use disorders MAT medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used for MAT are evidence-based treatment options and do not just substitute one drug for another.

Methadone used to treat those with a confirmed diagnosis of Opioid Use Disorder can only be dispensed through a SAMHSA certified OTP. Some of the medications used in MAT are controlled substances due to their potential for misuse. Drugs, substances, and certain chemicals used to make drugs are classified by the Drug Enforcement Administration (DEA) into five distinct categories, or schedules, depending upon a drug's acceptable medical use and potential for misuse. Learn more about DEA drug schedules.

Contact Us

For information on buprenorphin waiver processing, contact the SAMHSA Center for Substance Abuse Treatment (CSAT) at 866-

https://www.samhsa.gov/medication-assisted-treatment Accessed 09/17/2021

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Program Medications and Rescue Treatment

Opioid Dependency Medications - Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MAT medications are safe to use for months, years, or even a lifetime. As with any medication, consult your doctor before discontinuing use.

- **Buprenorphine** - suppresses and reduces cravings for opioids. Learn more about buprenorphine.
- **Methadone** - reduces opioid cravings and withdrawal and blunts or blocks the effects of opioids. Learn more about methadone.
- **Naltrexone** - blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria. Learn more about naltrexone.

Learn more about MAT for opioid use disorders or download TIP 63: Medications for Opioid Use Disorder – Introduction to Medications for Opioid Use Disorder Treatment (Part 1 of 5) – 2020.

Opioid Overdose Prevention Medication – Naloxone saves lives by reversing the toxic effects of overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system.

- **Naloxone** – used to prevent opioid overdose, naloxone reverses the toxic effects of the overdose. Learn more about Naloxone.

https://www.samhsa.gov/medication-assisted-treatment Accessed 09/17/2021

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Rescue Medication: Naloxone

Medication-Assisted Treatment

MAT Medications, Counseling, and Related Conditions

Buprenorphine
Methadone
Naltrexone
Naloxone
Opioid Overdose
Co-Occurring Disorders

Find Medication-Assisted Treatment

Naloxone

Naloxone is an opioid antagonist medication that is used to reverse an opioid overdose.

What Is Naloxone?

Naloxone is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids, such as such as heroin, morphine, and oxycodone. Administered when a patient is showing signs of opioid overdose, naloxone is a temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical intervention as soon as possible after administering/receiving naloxone.

https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone Accessed 09172021

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Transitions: Admissions to LTC (STR)

Medication for Opioid Use Disorder in Long-Term Care Program

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

TIP 6: Transitions of Care

DESCRIPTION

Care transitions are described as when a patient/resident moves from one health care provider or setting to another.[163, 164] In order to have a safe and successful transition of care, sufficient and timely communication of clinical information between providers must occur, so that the downstream clinicians can assume responsibility for resident care. By fostering an atmosphere of clear communication between health care providers or settings, improvement can be seen in resident outcomes, resident satisfaction, and decreased cost.[165] This communication can be particularly important for those residents who are on medication for opioid use disorder (MOUD) for maintenance or new inductions. Coordinated care for complex chronic conditions has repeatedly shown positive influence on disease progress; treatment of opioid use disorder (OUD) is no different.[166] This section will discuss the steps needed to facilitate a successful transition of care for resident on MOUD and the key documentation needed between health care provider and setting.

https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021

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Process for Transition of Care

PROCESS

Process for transitions of care from hospital to LTCF

- Resident is on methadone maintenance (*only for residents on methadone maintenance*)
- Resident is newly inducted on methadone (*only for residents newly inducted on methadone*)
  - Note: Residents newly inducted on methadone will require more coordinated efforts between LTCFs and the OTP. Be sure to reach out to your community OTP regarding their admission process. Patients must be transported to the OTP the morning after they've been discharged from the hospital.
- Resident is on buprenorphine (*only for residents on buprenorphine or Vivitrol, newly inducted or maintenance*)

Key steps in the transition process

Developing Qualified Service Organization Agreement (QSOA)

What is a QSOA? It is a two-way agreement between a substance use disorder program (OTP or OBOT) and an entity that provides services to the patient/resident (LTCF). It authorizes communication between the parties and restricts what information may be disclosed and/or re-disclosed. The QSOA is used only by substance use disorder programs that are subject to Federal Regulation 42 CFR Part 2. [167]

- **QSOAs should be completed prior to admission to LTCF**
- QSOAs should include types of services QSO provides, medical services (example counseling services, on-site call coverage, treatment plan, etc.)
- Discussions between LTCF and OTP or OBOT administrators should occur prior to admission of residents on MOUD.

https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021

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How is Methadone Supplied to LTCF ?

Arranging transportation of methadone to LTCF

(note: only applies to those residents on methadone with take-home waiver) *Opioid Treatment Exception Request- Eligible residents may receive take-home medication from OTP, must submit for this at discharge from hospital or admission to LTCF.

- Process should be started at the time of admission
- Diversion trained RN/LPN picks up the methadone with a locked container(s)
- Coordinate with OTP for the best time, typically at the end of dispensing at the OTP, after the first pick-up, LPN/RN- bring back empties. (look at synchronizing pick up times- if multiple residents have pick-ups)
- Once LTCF nurse arrives at the OTP, OTP nurse will verify with LTCF nurse the contents prior to locking and confirm on chain of custody form
- Once LTCF nurse is back at the facility, document and confirm with residents that meds are in the box
- Chain of custody form should stay with medicine and have initials that LTCF/OTP confirmed that the count of meds is in the box; chain of custody should also go back with empty boxes
- Communication - OTP/LTCF to communicate best time to pick-up medication; chain of custody form needs to be signed by LTCF RN/LPN, OTP RN/LPN, and resident

Notes:

https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021

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Storage and Accountability in LTCF

Managing pre-poured methadone

- LTCF to create an area to manage methadone within a double locked area, potentially locked in medication room; cabinet within the med room locked; resident locked box inside (The management of pre-poured methadone at the LTCF needs to meet DEA criteria in that it must be stored under a double lock (e.g., door and safe), and separately from all other medications (on a separate shelf))
- Set-time for staff to give meds; locked box taken out of the med room brought to the resident room; resident unlocks and self-administers and relocks box; nurse to take lock box back to med room, relock in the med cabinet
- Communication – between Nurse and Resident; resident signs MOUD administration affidavit sheet
- Notes:
  - SNF may want to look into buying a lock box and training staff on what to look for regarding diversion
  - Our recommendation would be that 2 nurses every shift would need to have the authority to open lock box
  - Follow facility's recommendations on including in narc book.
  - If resident leaves against medical advice, alert OTP and destroy medications as mandated by federal regulations.*
  - **Naloxone: LTCFs must have a supply of naloxone on hand; know the signs of an overdose and how to administer, see TIP 1 for directions.**

https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021

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Overdose-Rescue Medication-Naloxone

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

Signs of an overdose

- Blue lips and fingertips
- Limp and pale
- Small pupils
- Breathing slow, irregular, or has stopped
- Pulse slow, erratic, or absent
- Nonresponsive to voice or sternal rub

If you suspect a resident has overdosed, follow the guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention Toolkit.[32]

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 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 if there is no response in 3 minutes, administer 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.

https://www.mass.gov/info-details/medication-for-opioid-use-disorder-in-long-term-care-moud-in-ltc-toolkit#moud-in-ltc-toolkit-full-document- Accessed 09172021

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New York State Guidance: OASAS

NEW YORK STATE | Office of Addiction Services and Supports

ANDREW M. CUOMO
Governor

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner

February 24, 2021

Best Practices for Long-Term Maintenance with Medications for Patients with Opioid Use Disorder (OUD)

New York State Office of Addiction Services and Supports (OASAS) Medical Advisory Panel (MAP)

In the United States, unintentional overdose deaths, mostly involving opioids, now eclipse all other causes of death for individuals under 50 years of age[1]. Additionally, approximately 2.4-5 million individuals nationwide have an addiction to heroin or other opioids, including painkillers as well as high-potency synthetic opioids like fentanyl and its analogues[2]. Medications for OUD (MOUD) are widely recognized as the standard of care for OUD. Approved MOUD include buprenorphine, methadone, and long-acting injectable naltrexone (XR-naltrexone). In addition to many other demonstrated benefits, MOUD can reduce overdose death risk by 66-80% while patients are receiving treatment[3] but remains greatly underutilized[4]. While all three available MOUD confer benefits, it should be noted that buprenorphine and methadone currently have more robust evidence bases for treating OUD than XR-naltrexone, especially for preventing overdose death. Early dropout remains a major challenge in treating OUD. For instance, more than a quarter of patients receiving methadone do not complete their first year in treatment, roughly half of patients on buprenorphine leave treatment within 3-6 months, and many patients receiving XR-naltrexone only receive one or two monthly injections before stopping the medication[5]. Following MOUD discontinuation, the great majority of patients eventually experience a recurrence of regular opioid use and face the risk of overdose and death.

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New York State: MOUD and Non-Exclusion from Residential Settings

Patients receiving MOUD cannot be excluded from any OASAS licensed residential or outpatient program and should not be excluded from other settings (e.g., skilled nursing facilities, long term care facilities), simply because of their MOUD use.

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New York State: Clinical Guidance

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE HIV • HCV • STIs • SUBSTANCE USE • LGBT HEALTH HIVQUAL • CEI TRAINING

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HOME > SUBSTANCE USE >

Treatment of Opioid Use Disorder

CONTENTS >

Purpose and Development of This Guideline

Purpose and Development of This Guideline

PDF

https://www.hivguidelines.org/substance-use/oud/#tab_3 Accessed 09172021

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New York State: Program Guidance

HOME > SUBSTANCE USE >

Treatment of Opioid Use Disorder

CONTENTS >

- Purpose and Development of This Guideline
- Definition of Terms
- Protections from Discrimination for Individuals with OUD
- Goals of Treatment
- Pharmacologic Treatment

All Recommendations

Download guideline PDF

Lead author: Chinazo O. Cunningham, MD, MS, with the Substance Use Guidelines Committee, updated January 2021

ALL RECOMMENDATIONS: TREATMENT OF OPIOID USE DISORDER

Pharmacologic Treatment of Opioid Use Disorder

- Clinicians should offer pharmacologic treatment to all patients with opioid use disorder. (A1)
- Clinicians should *not* exclude patients from pharmacologic treatment due to lack of

https://www.hivguidelines.org/substance-use/oud/#tab_7 Accessed 09172021

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Resources : Caring for Older Adults

- SAMHSA
Substance Abuse and Mental Health Services Administration

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Search SAMHSA.gov Search

Find Treatment | Practitioner Training | Public Messages | Grants | Data | Programs | Newsroom | About Us | Publications

Resources for Older Adults

SAMHSA has a number of products for serving older adults with mental and substance use disorders that can be useful to clinicians, other service providers, older adults, and caregivers.

New Items from SAMHSA for Professionals Serving Older Adults

Treatment Improvement Protocol (TIP) 26: Treating Substance Use Disorder in Older Adults

https://www.samhsa.gov/resources-serving-older-adults Accessed 09172021

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CalvertHealth Medical Center- Best Practices Follow Up

Kara Harrer, PharmD
Director of Pharmacy
CalvertHealth Medical Center

Current Priorities–Follow Up

- Inpatient Medication Assisted Therapy (MAT) order sets developed and initiation of MAT before discharge
- Training for providers and ancillary staff on inpatient protocol
- Peer Recovery Specialist back in hospital to provide counseling
- Incorporate Opioid Stewardship best practices in conjunction with mobile health unit and outreach

Opioid & Pain Management Resources

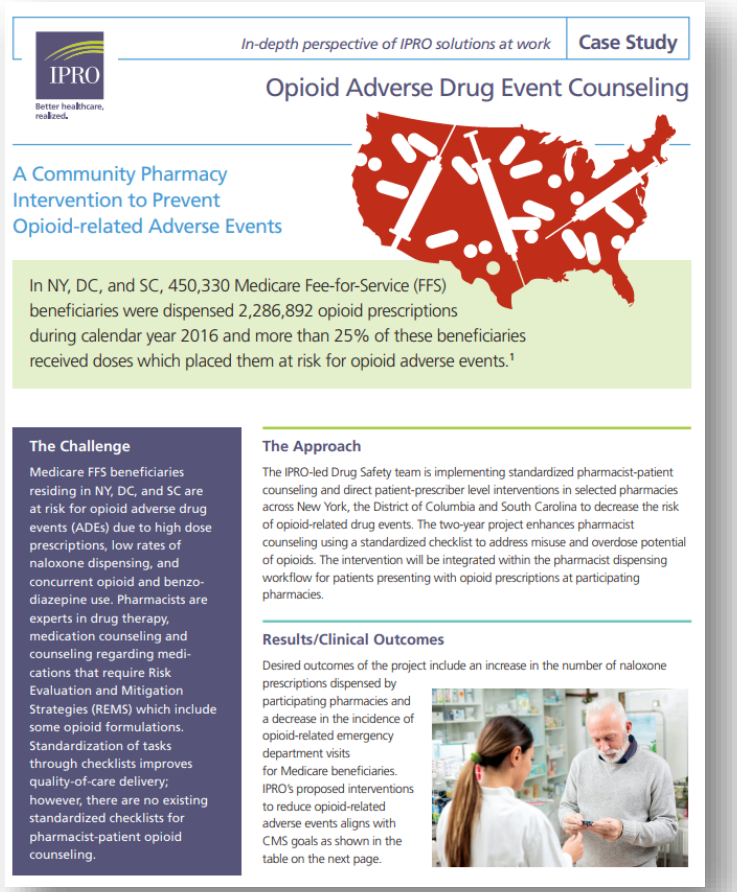
[ASCP Opioid Stewardship Toolkit]

[Pathways to Safer Opioid Use]

[Pain Management in the Post-Acute and Long-Term Care Setting]

IPRO QIN-QIO | Healthcentric Advisors | Qlarant
QIN–QIO Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Opioid & Pain Management Resources



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In-depth perspective of IPRO solutions at work | **Case Study**

Opioid Adverse Drug Event Counseling

A Community Pharmacy Intervention to Prevent Opioid-related Adverse Events

In NY, DC, and SC, 450,330 Medicare Fee-for-Service (FFS) beneficiaries were dispensed 2,286,892 opioid prescriptions during calendar year 2016 and more than 25% of these beneficiaries received doses which placed them at risk for opioid adverse events.[1]

The Challenge

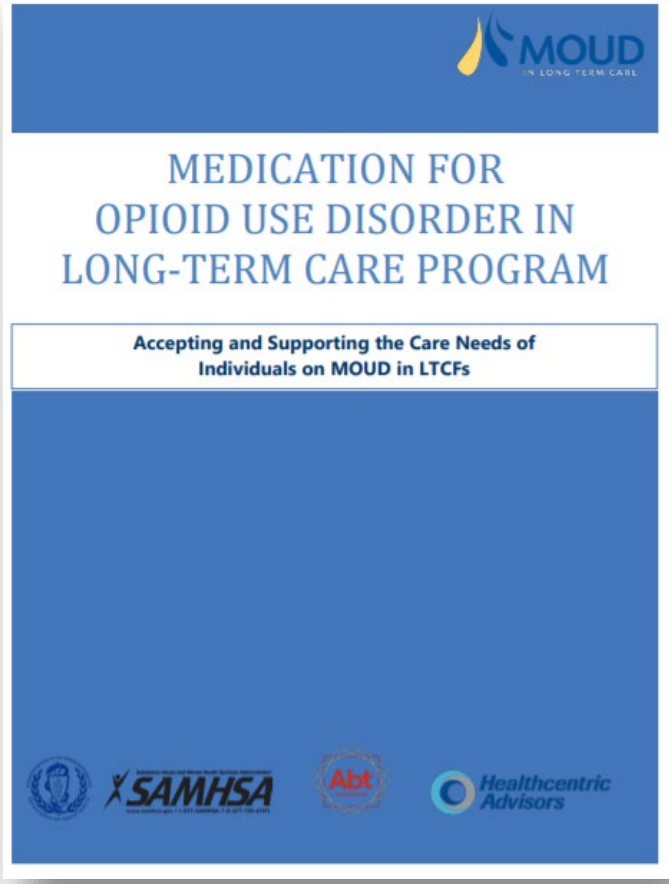
Medicare FFS beneficiaries residing in NY, DC, and SC are at risk for opioid adverse drug events (ADEs) due to high dose prescriptions, low rates of naloxone dispensing, and concurrent opioid and benzodiazepine use. Pharmacists are experts in drug therapy, medication counseling and counseling regarding medications that require Risk Evaluation and Mitigation Strategies (REMS) which include some opioid formulations. Standardization of tasks through checklists improves quality-of-care delivery; however, there are no existing standardized checklists for pharmacist-patient opioid counseling.

The Approach

The IPRO-led Drug Safety team is implementing standardized pharmacist-patient counseling and direct patient-prescriber level interventions in selected pharmacies across New York, the District of Columbia and South Carolina to decrease the risk of opioid-related drug events. The two-year project enhances pharmacist counseling using a standardized checklist to address misuse and overdose potential of opioids. The intervention will be integrated within the pharmacist dispensing workflow for patients presenting with opioid prescriptions at participating pharmacies.

Results/Clinical Outcomes

Desired outcomes of the project include an increase in the number of naloxone prescriptions dispensed by participating pharmacies and a decrease in the incidence of opioid-related emergency department visits for Medicare beneficiaries. IPRO's proposed interventions to reduce opioid-related adverse events aligns with CMS goals as shown in the table on the next page.

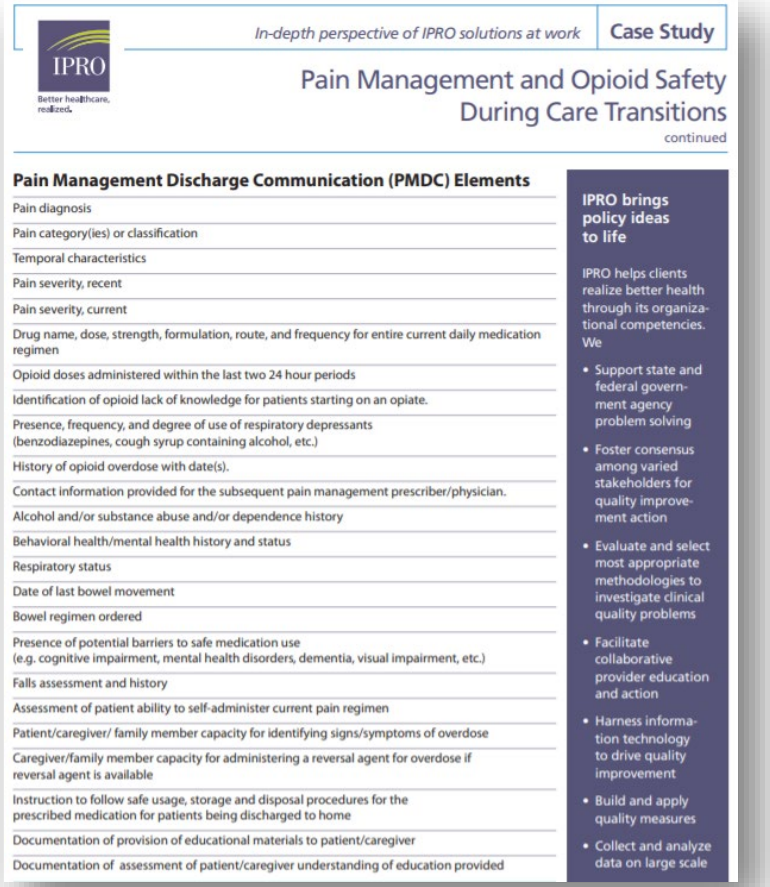


MOUD IN LONG TERM CARE

MEDICATION FOR OPIOID USE DISORDER IN LONG-TERM CARE PROGRAM

Accepting and Supporting the Care Needs of Individuals on MOUD in LTCFs

SAMHSA · Abt · Healthcentric Advisors



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In-depth perspective of IPRO solutions at work | **Case Study**

Pain Management and Opioid Safety During Care Transitions

continued

Pain Management Discharge Communication (PMDC) Elements

- Pain diagnosis
- Pain category(ies) or classification
- Temporal characteristics
- Pain severity, recent
- Pain severity, current
- Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen
- Opioid doses administered within the last two 24 hour periods
- Identification of opioid lack of knowledge for patients starting on an opiate.
- Presence, frequency, and degree of use of respiratory depressants (benzodiazepines, cough syrup containing alcohol, etc.)
- History of opioid overdose with date(s).
- Contact information provided for the subsequent pain management prescriber/physician.
- Alcohol and/or substance abuse and/or dependence history
- Behavioral health/mental health history and status
- Respiratory status
- Date of last bowel movement
- Bowel regimen ordered
- Presence of potential barriers to safe medication use (e.g. cognitive impairment, mental health disorders, dementia, visual impairment, etc.)
- Falls assessment and history
- Assessment of patient ability to self-administer current pain regimen
- Patient/caregiver/ family member capacity for identifying signs/symptoms of overdose
- Caregiver/family member capacity for administering a reversal agent for overdose if reversal agent is available
- Instruction to follow safe usage, storage and disposal procedures for the prescribed medication for patients being discharged to home
- Documentation of provision of educational materials to patient/caregiver
- Documentation of assessment of patient/caregiver understanding of education provided

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Discussion

We welcome your questions and comments!

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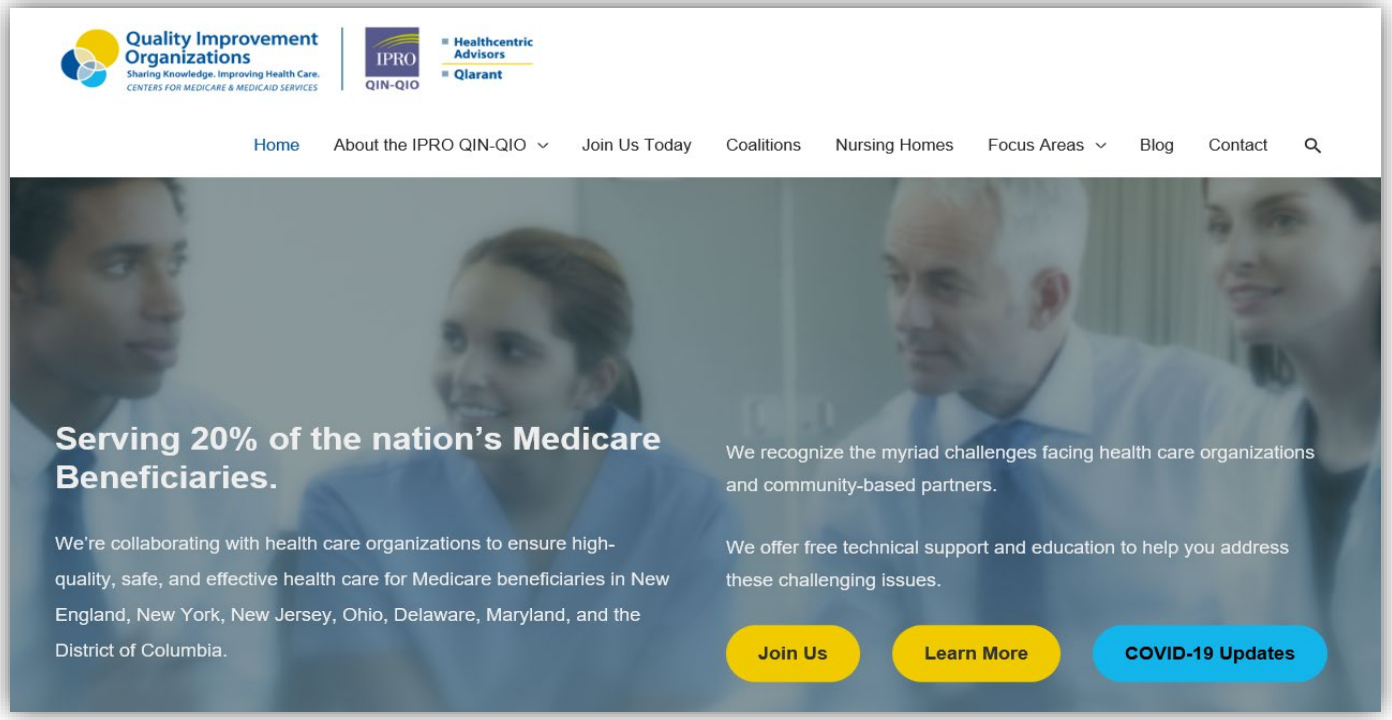

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