Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

Management of Patients on MOUD During the Nursing Home Stay Part 2

Friday, March 8, 2024

In partnership with all Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs)

QIN-QIO Partnership to Address the Opioid Epidemic

This series is a collaboration of all QIN-QIOs. National experts across the healthcare continuum provide robust educational content to address the opioid epidemic.

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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Learning Objectives

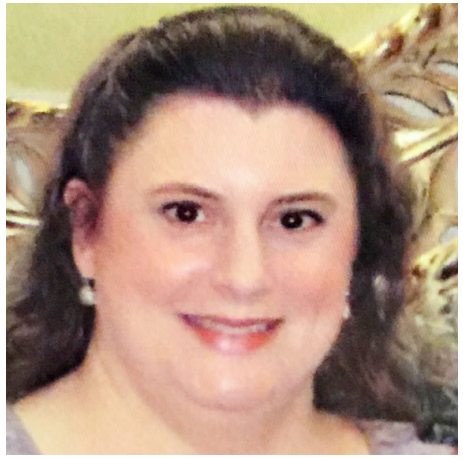
- Describe how to include OUD screening in your admission assessment.
- Review the steps to ensure continuity and/or provide access to treatment for patients with OUD.
- Discuss how to recognize and manage a patient who is overdosing.

Hosts

Jennifer Peerbolte, MPA, RN

Program Specialist

Telligen QI Connect



Debra Wright, RN, BSN, RAC-CT

Quality Improvement Specialist

Quality Insights

Guest Panelists

Jean Storm, DO, CMD, CHCQM

Medical director

Quality Insights

Jacki Ulishney, PharmD, MHSA, BCPS

Case Management Pharmacist

Mountain Pacific

Amy Lund Stone, BSN, RN

Project Manager

CA Bridge

Could you tell us more about your role related to opioid safety in the nursing home setting?

Key Takeaways From the Part 1 Session: February 2024

Speakers

- Jean Storm, DO, CMD, CHCQM

Key Points

- Challenges to make care better for patients with MOUD in long-term facilities.
- Stigma: OUD is a medical condition, not a morale failure.
- More and more Medicare beneficiaries with OUD need care in nursing homes.
- Importance of screening patients for OUD risk.
- Importance of maintaining MOUD during the transition of care (warm hand-off).
- Strengthen staff OUD education (treatment, stigma, recognizing overdose).
- Get the resident perspectives in the care they receive.

Key Takeaways From the Part 1 Session: February 2024 (Cont.)

Speakers

- Rob Accetta, RPh, BCGP, FASCP

Key Points

- Facilities and clinicians might be unfamiliar with MOUD or counseling therapy.
- Ensuring pain management despite OUD.
- Knowing about the resources in your community, need to have relationships with opioid treatment programs (OTP).
- Supporting persons with behavioral health strategies and interventions.
- Opportunities to adopt telemedicine for assessment.
- Importance of having readily available naloxone, recognizing signs of overdose.
- Managing medications including obtaining, storing, administering, and disposing MOUD and addressing illicit substances.

Polling Question:
What are the most effective strategies to manage patients on MOUD during the nursing home stay?

- Staff OUD education (treatment, stigma, recognizing overdose)
- Screening patients for OUD risk
- Warm hand-off during the transition of care
- Get the resident perspectives
- Ensuring pain management for people with OUD
- Having relations with OTPs
- Supporting persons with behavioral health strategies and interventions

- Other: *Please write your comments in the chat box*

What are the most effective strategies to manage patients on MOUD during the nursing home stay?

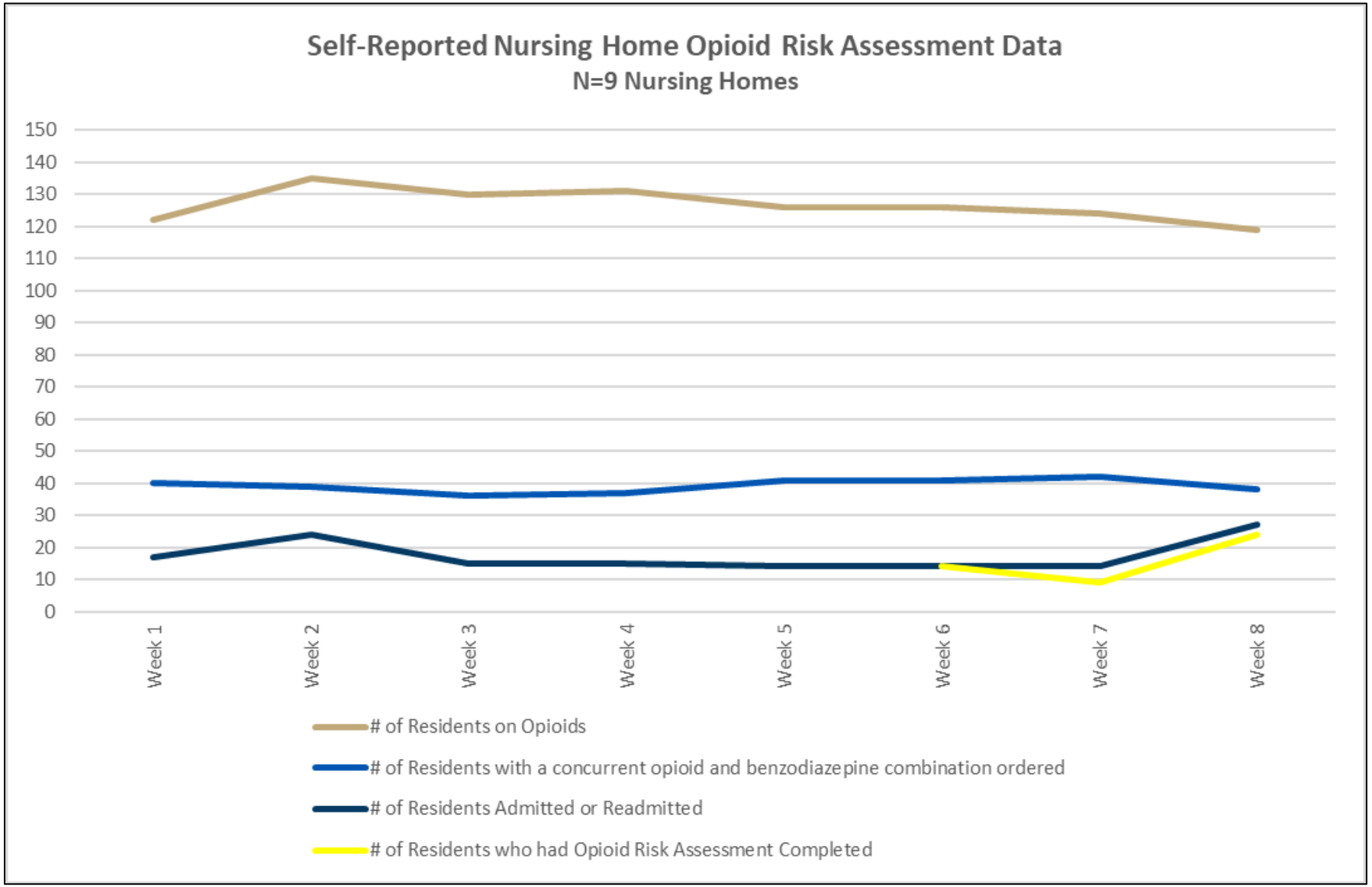
Could you share one success story?
Could you share one resource and/or tool?

Nursing Home Opioid Strategy

Quality Insights designed a 4-hour, continuing education (CE)-eligible program to educate and guide long-term care facilities in effectively managing opioid use within their settings. It comprises four educational modules, each dedicated to a distinct aspect of nursing home opioid use.

- A participating facility reduced percentage of residents receiving opioids from 36.6% to 24.7% in 8 weeks.
- A participating facility reduced percentage of residents receiving concomitant benzodiazepines and opioids from 8% to 3.4% in 8 weeks.
- Several facilities implemented the opioid risk assessment tool into their admission and readmission process.

Opioid Risk Assessment Data



Opioid Risk Assessment Tool

"The education and support provided by Quality Insights has been invaluable in implementing the Opioid Reduction Project at our Centers. Thank you both for being a part of our mission to provide the highest quality of care and compassion to our residents in WV!"

– Opioid Workgroup Participant

https://www.qualityinsights.org/qin/resources#opioid-risk-assessment-tool-fillable

Opioid Risk Assessment Tool

Resident Name: _____ **Admit Date:** _____

This tool should be administered to patients upon admission and readmission. Score each box as appropriate, or enter "0" if not applicable.

Family History of Substance Abuse	Female	Male	Score
Alcohol	1	3	
Illegal Drugs	2	3	
Prescription Medication	4	4	

Personal History of Substance Abuse	Female	Male	Score
Alcohol	3	3	
Illegal Drugs	4	4	
Prescription Medication	5	5	

Psychological Disease	Female	Male	Score
Attention deficit disorder (ADD), obsessive-compulsive disorder (OCD), bipolar, schizophrenia	2	2	
Depression	1	1	

Other Factors	Female	Male	Score
Currently age 16-45	1	1	
History of preadolescent sexual abuse	3	0	

Total Score	

Current Opioid Orders per Plan of Care:

Total Score Key
≤ 3 = **Low risk** for opioid abuse
4 – 7 = **Moderate risk** for opioid abuse
≥ 8 = **High risk** for opioid abuse

Nurse Completing Risk Assessment: _____ **Date:** _____

Physician Review: _____ **Date:** _____

****Any changes to current plan of care to be addressed in New Orders****

SOURCE: Webster, L.R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain medicine (Malden, Mass.), 6(6), 432–442. https://doi.org/10.1111/j.1526-4637.2005.00072.x. PMID: 16336480.

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Buprenorphine for Opioid Use Disorder Provider Factsheet IB 10-1498 (va.gov)

U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Services

CLINICIAN GUIDE

Buprenorphine for Opioid Use Disorder

Quick facts about buprenorphine for treatment of opioid use disorder (OUD)

- Medications, like buprenorphine, are the gold-standard treatment for patients with OUD. Buprenorphine saves lives, reduces illicit opioid use and opioid cravings, and improves retention in treatment and well-being.[1-5]
- OUD is a chronic, relapsing disease. While the optimal treatment duration for OUD has not been defined, medications are often continued indefinitely. Discontinuation should be based on collaborative discussion and the patient's ability to maintain recovery without medication. Medication should NOT be discontinued upon return to non-prescribed opioid use.[1,6]

For questions about buprenorphine or assistance evaluating for OUD, contact your local pain and/or addiction specialists, your Stepped Care for OUD Train the Trainer (SCOUTT) Team: **https://dvagov.sharepoint.com/sites/VHASUD/SCOUTT**, or send an email to the Ask the Expert-SUD email service: AskTheExpert-SubstanceUseDisorder@va.gov (no PHI).

Buprenorphine formulations FDA approved for treatment of OUD[1,2,6,7;a]

Generic name (Brand name)	Buprenorphine and naloxone (Suboxone®)[1,9,b]		Buprenorphine (Subutex®)[10]	Buprenorphine (Sublocade®)[11]
Dosage form and strengths	Sublingual (SL) tablet: 2/0.5 mg, 8/2 mg	SL film: 2/0.5 mg, 4/1 mg, 8/2 mg, 12/3 mg	SL tablet: 2 mg, 8 mg	Extended release subcutaneous (SC) injection: 100 mg, 300 mg
PADR	Not required	Required	Not required	Required
REMS registration*	Not required[b]		Not required	Required
When to use	• Preferred for initiation and maintenance in most patients • Reduced risk of misuse and diversion versus Subutex®	Adverse effects, intolerance, absorption issues with SL tablets (e.g., swallowing or spitting out tablets)	• Not recommended first line in most cases; naloxone combination is preferred • May be used in pregnant women	• After use of SL buprenorphine 8-24 mg/day for ≥7 days • If daily dosing is difficult or risky (e.g., homeless, unstable housing, living with children), or concern for diversion, misuse, or insufficient response with SL
Frequency of use	• Daily for OUD • When used to treat OUD and pain, or off-label for a primary pain indication, consider adjusting the dosage interval to twice or three times daily to provide adequate analgesia			• Monthly (≥26 days between doses) • Administer a missed dose as soon as possible, with the following dose given no less than 26 days later • Occasional delays in dosing <2 weeks should not have significant impact

PADR, prior authorization drug request. *REMS (risk evaluation and mitigation strategies) for all formulations: www.accessdata.fda.gov/scripts/cder/rems/index.cfm.

[a] Buprenorphine perioperative guidance: https://dvagov.sharepoint.com/sites/VHAPBM/Formulary/Clinical%20Guidance/Forms/AllItems.aspx.

[b] REMS registration is required for injectable buprenorphine. For transmucosal buprenorphine, follow the checklist provided by the FDA: Buprenorphine Transmucosal Products for Opioid Dependence (BTOD) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=9)

Clinical pearls	• **Initiate when in sufficient withdrawal** (e.g., Clinical Opiate Withdrawal Scale [COWS] score ≥8) to avoid precipitated withdrawal.[c] • **SL tablet:** Place under the tongue until dissolved. For doses requiring >1 tablet, place 2 tablets under the tongue at a time until fully dissolved and repeat with remaining tablets. • **SL film:** Place 1 film under the tongue close to the base on the left or right side and allow to completely dissolve. If a second film is needed, place on the opposite side of the mouth. If a third film is needed, wait for the first two to dissolve, the place inside the right or left cheek. Do not cut or chew. • Avoid swallowing due to reduced bioavailability. • Avoid abrupt discontinuation and gradually reduce dose to taper off.	• Injection site pruritus and pain are common; apply a topical anesthetic (e.g., lidocaine 5% ointment) 10-30 minutes prior to injection; may dispense to patient to apply prior to appointment. • Peak effect occurs ~24 hours after injection, and 4-6 months needed to achieve steady-state. • After achieving steady-state, plasma levels remain detectable for ≥12 months after discontinuation and will decrease gradually over subsequent months.

[Buprenorphine for Opioid Use Disorder Provider Factsheet IB 10-1498. (va.gov)]

Medication Guide | SUBOXONE® (Buprenorphine and Naloxone) Sublingual Film (CIII)

MEDICATION GUIDE
SUBOXONE (Sub-OX-own) (buprenorphine and naloxone) Sublingual Film, CIII

IMPORTANT: Keep SUBOXONE sublingual film in a secure place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes SUBOXONE sublingual film, get emergency help or call 911 right away. Tell your healthcare provider if you are living in a household where there are small children.

What is the most important information I should know about SUBOXONE sublingual film?

- SUBOXONE contains a medicine called buprenorphine. Buprenorphine is an opioid that can cause serious and life-threatening breathing problems, especially if you take or use certain other medicines or drugs.
- Talk to your healthcare provider about naloxone. Naloxone is a medicine that is available to patients for the emergency treatment of an opioid overdose, including accidental use of SUBOXONE sublingual film by a child. If naloxone is given, you must call 911 or get emergency medical help right away to treat an overdose or accidental use of an opioid.
- SUBOXONE may cause serious and life-threatening breathing problems. Get emergency help right away if you:
  - feel faint
  - feel dizzy
  - are confused
  - feel sleepy or uncoordinated
  - have blurred vision
  - have slurred speech
  - are breathing slower than normal
  - cannot think well or clearly
- **Do not take SUBOXONE with certain medicines. Taking SUBOXONE with other opioid medicines, benzodiazepines, alcohol, or other central nervous system depressants (including street drugs) can cause severe drowsiness, decreased awareness, breathing problems, coma, and death.**
- **Do not inject ("shoot-up") SUBOXONE**. Injecting SUBOXONE may cause life-threatening infections and other serious health problems, Injecting SUBOXONE may cause sudden serious withdrawal symptoms such as pain, cramps, vomiting, diarrhea, anxiety, sleep problems, and cravings.
- **Do not switch from SUBOXONE sublingual film to other medicines that contain buprenorphine** without talking with your healthcare provider. The amount of buprenorphine in a dose of SUBOXONE sublingual film is not the same as in other medicines that contain buprenorphine. Your healthcare provider will prescribe a starting dose of SUBOXONE sublingual film that may be different than other buprenorphine containing medicines you may have been taking.
- Do not stop taking SUBOXONE suddenly. You could become sick and have withdrawal symptoms because your body has become used to the medicine (physical dependence). Physical dependence is not the same as drug addiction.
- In an emergency, have family members tell emergency department staff that you are physically dependent on an opioid and are being treated with SUBOXONE sublingual film.
- Never give anyone else your SUBOXONE sublingual film. They could die from taking it. Selling or giving away SUBOXONE sublingual film is against the law.
- Store SUBOXONE sublingual film securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home.

What is SUBOXONE sublingual film?

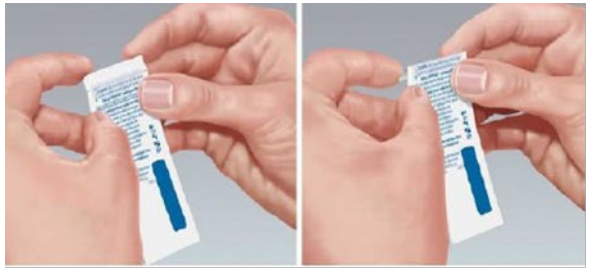
- SUBOXONE sublingual film is a prescription medicine used to treat opioid addiction in adults and is part of a complete treatment program that also includes counseling and behavioral therapy.

Who should not take SUBOXONE sublingual film?

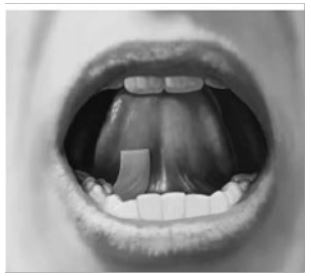
Do not take SUBOXONE sublingual film if you are allergic to buprenorphine or naloxone.

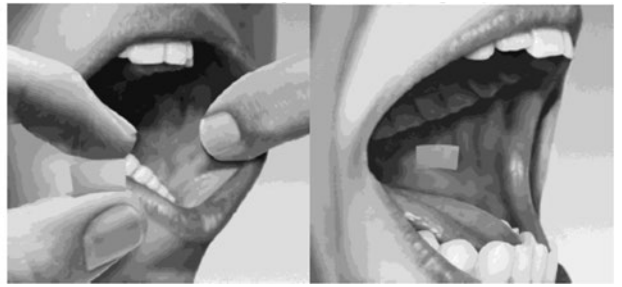
Before taking SUBOXONE, tell your healthcare provider about all your medical conditions, including if you have:

Preparing to take Suboxone



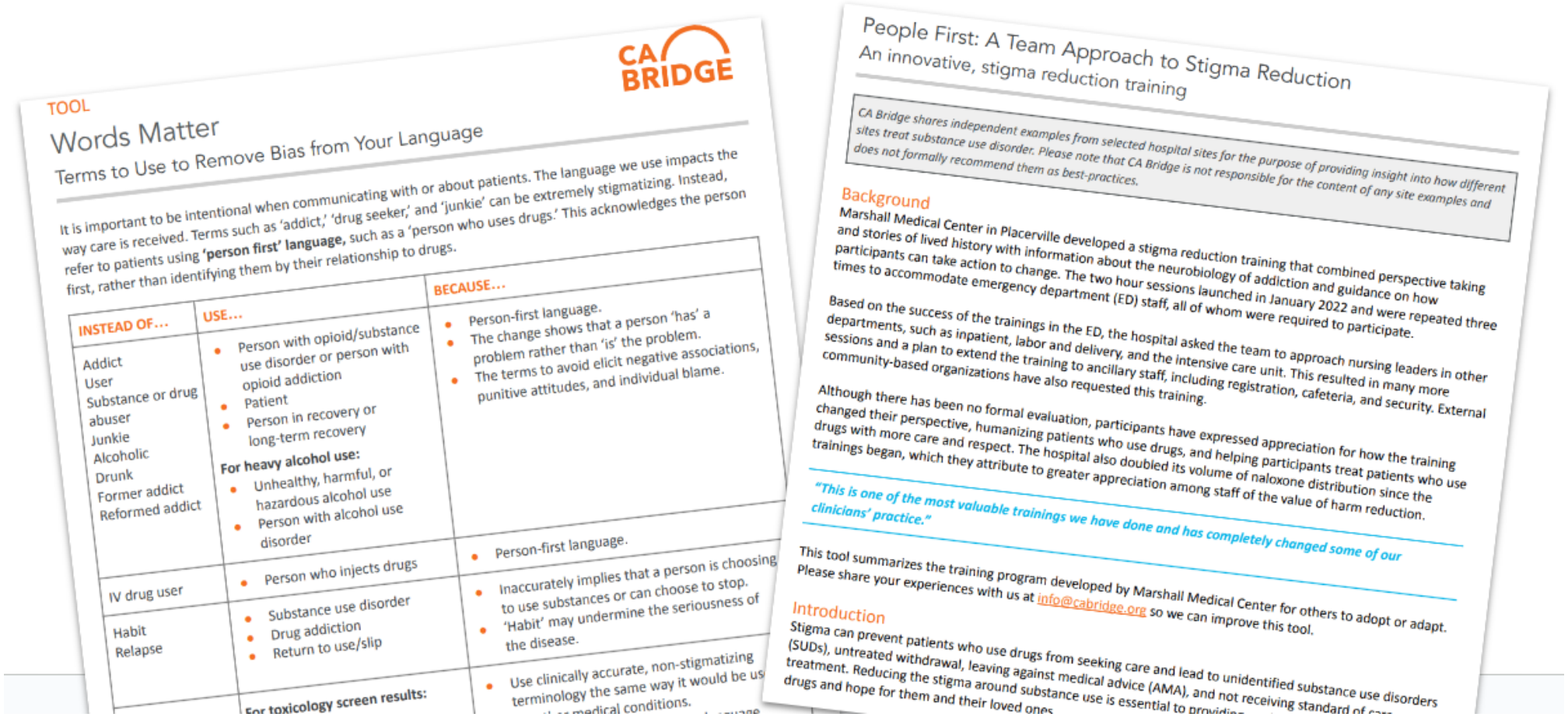
Taking Suboxone





[Medication Guide | SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII)]

Stigma Reduction Education



TOOL

Words Matter

Terms to Use to Remove Bias from Your Language

It is important to be intentional when communicating with or about patients. The language we use impacts the way care is received. Terms such as 'addict,' 'drug seeker,' and 'junkie' can be extremely stigmatizing. Instead, refer to patients using **'person first' language,** such as a 'person who uses drugs.' This acknowledges the person first, rather than identifying them by their relationship to drugs.

INSTEAD OF…	USE…	BECAUSE…
Addict User Substance or drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	• Person with opioid/substance use disorder or person with opioid addiction • Patient • Person in recovery or long-term recovery **For heavy alcohol use:** • Unhealthy, harmful, or hazardous alcohol use • Person with alcohol use disorder	• Person-first language. • The change shows that a person 'has' a problem rather than 'is' the problem. • The terms to avoid elicit negative associations, punitive attitudes, and individual blame.
IV drug user	• Person who injects drugs	• Person-first language.
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• Inaccurately implies that a person is choosing to use substances or can choose to stop. • 'Habit' may undermine the seriousness of the disease.
	For toxicology screen results:	• Use clinically accurate, non-stigmatizing terminology the same way it would be us… medical conditions.

People First: A Team Approach to Stigma Reduction

An innovative, stigma reduction training

CA Bridge shares independent examples from selected hospital sites for the purpose of providing insight into how different sites treat substance use disorder. Please note that CA Bridge is not responsible for the content of any site examples and does not formally recommend them as best-practices.

Background

Marshall Medical Center in Placerville developed a stigma reduction training that combined perspective taking and stories of lived history with information about the neurobiology of addiction and guidance on how participants can take action to change. The two hour sessions launched in January 2022 and were repeated three times to accommodate emergency department (ED) staff, all of whom were required to participate.

Based on the success of the trainings in the ED, the hospital asked the team to approach nursing leaders in other departments, such as inpatient, labor and delivery, and the intensive care unit. This resulted in many more sessions and a plan to extend the training to ancillary staff, including registration, cafeteria, and security. External community-based organizations have also requested this training.

Although there has been no formal evaluation, participants have expressed appreciation for how the training changed their perspective, humanizing patients who use drugs, and helping participants treat patients who use drugs with more care and respect. The hospital also doubled its volume of naloxone distribution since the trainings began, which they attribute to greater appreciation among staff of the value of harm reduction.

"This is one of the most valuable trainings we have done and has completely changed some of our clinicians' practice."

This tool summarizes the training program developed by Marshall Medical Center for others to adopt or adapt. Please share your experiences with us at info@cabridge.org so we can improve this tool.

Introduction

Stigma can prevent patients who use drugs from seeking care and lead to unidentified substance use disorders (SUDs), untreated withdrawal, leaving against medical advice (AMA), and not receiving standard of… treatment. Reducing the stigma around substance use is essential to providing… drugs and hope for them and their loved ones.

[Words Matter]

[People First: A Team Approach to Stigma Reduction]

[Stigma Assessment Survey]

Questions?

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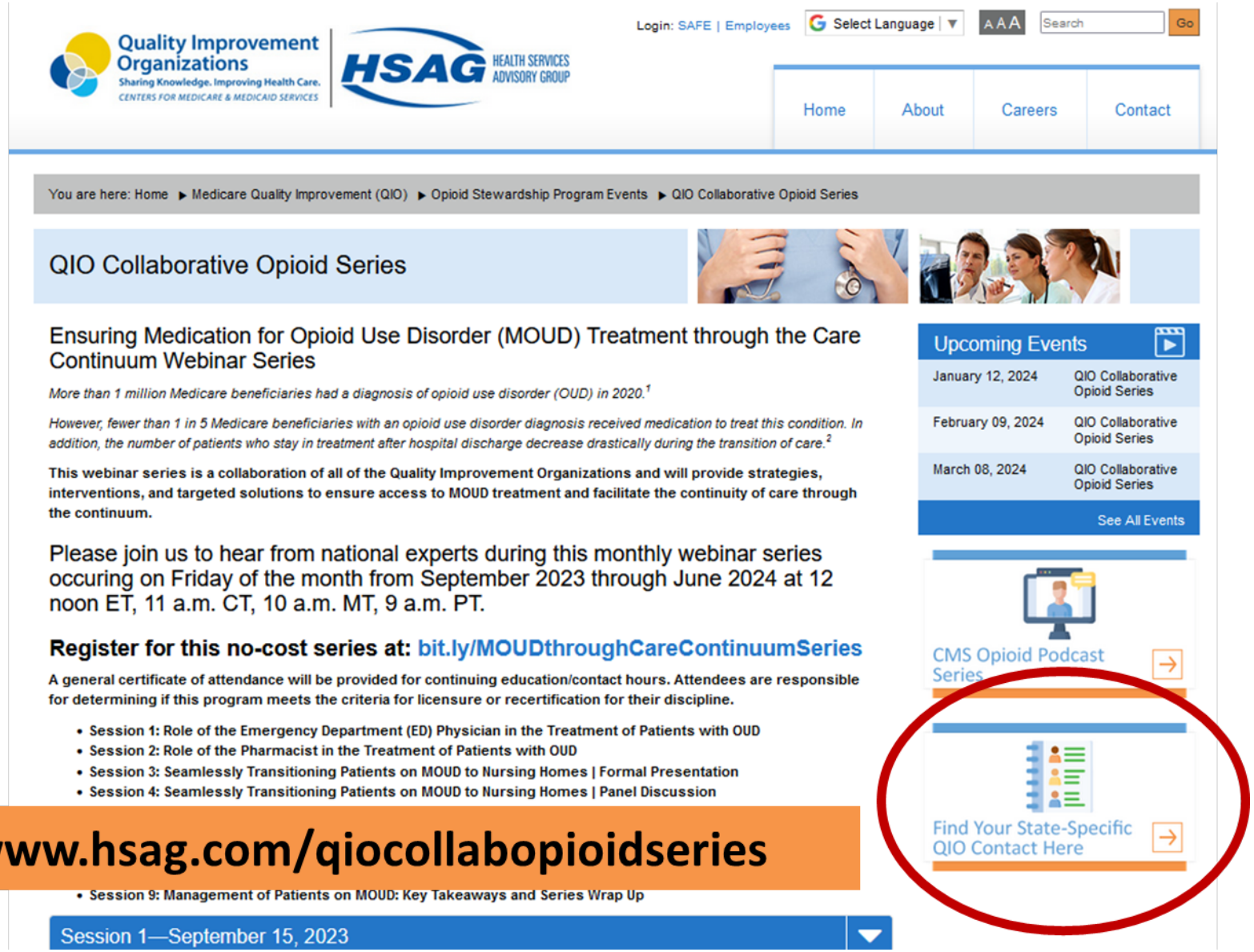
We Want to Hear From You!

Our common goal:

Improving the management of patients with OUD through the care continuum.

- What have you learned through this series?
- What actions have you taken since September 2023?
- What would you like to hear about during our upcoming webinars?

Your State-Specific QIO Point of Contact



What's Next

Join us for the next session on April 12, 2024:

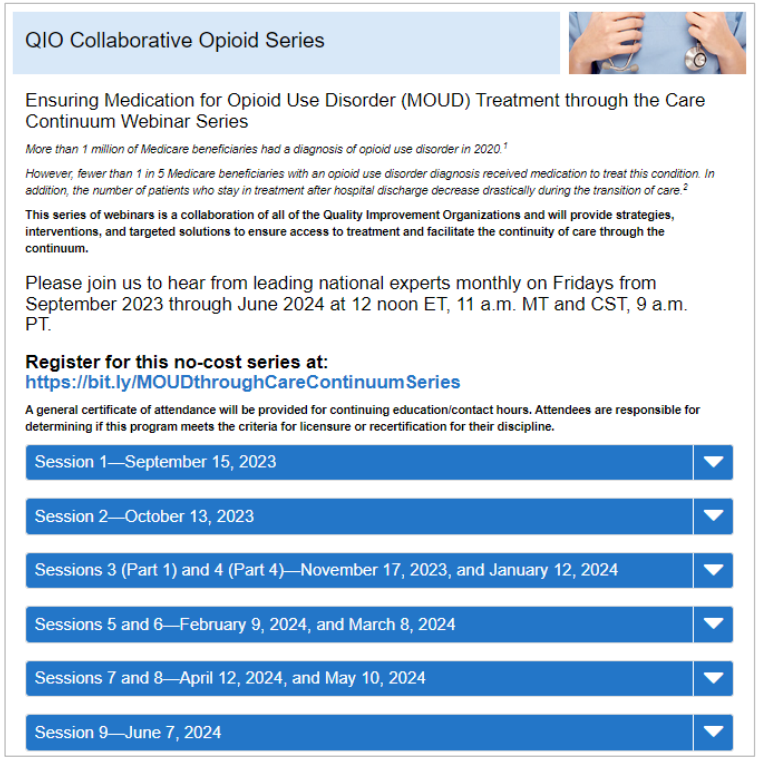
Sustaining Recovery for Patients on MOUD

Part 1

bit.ly/MOUDthroughCareContinuumSeries

Recordings, slides, and resource links are posted for on-demand access 72 hours after every session.

https://www.hsag.com/qiocollabopioidseries


QIO Collaborative Opioid Series

Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

More than 1 million of Medicare beneficiaries had a diagnosis of opioid use disorder in 2020.[1]

However, fewer than 1 in 5 Medicare beneficiaries with an opioid use disorder diagnosis received medication to treat this condition. In addition, the number of patients who stay in treatment after hospital discharge decrease drastically during the transition of care.[2]

This series of webinars is a collaboration of all of the Quality Improvement Organizations and will provide strategies, interventions, and targeted solutions to ensure access to treatment and facilitate the continuity of care through the continuum.

Please join us to hear from leading national experts monthly on Fridays from September 2023 through June 2024 at 12 noon ET, 11 a.m. MT and CST, 9 a.m. PT.

Register for this no-cost series at:
https://bit.ly/MOUDthroughCareContinuumSeries

A general certificate of attendance will be provided for continuing education/contact hours. Attendees are responsible for determining if this program meets the criteria for licensure or recertification for their discipline.

Session 1—September 15, 2023

Session 2—October 13, 2023

Sessions 3 (Part 1) and 4 (Part 4)—November 17, 2023, and January 12, 2024

Sessions 5 and 6—February 9, 2024, and March 8, 2024

Sessions 7 and 8—April 12, 2024, and May 10, 2024

Session 9—June 7, 2024

Certificate of Attendance

CE Credits and Contact Hours for Health Professionals

- This series may meet CE requirements for your discipline. You may use this certificate as proof of attendance. It is your responsibility to determine if the series fulfills that requirement.
- The link to request a certificate of attendance is below and will be included in the follow-up email sent directly to you by Webex.
  - New User Registration Link:
    - https://lmc.hshapps.com/register/default.aspx?ID=73210da7-a0b8-4cb7-b1b8-4733cf8e8a39
  - Existing User Link:
    - https://lmc.hshapps.com/test/adduser.aspx?ID=73210da7-a0b8-4cb7-b1b8-4733cf8e8a39

Thank You

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