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# MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

## 1.14 Recommendations for Older Patients & Patients with Disabilities on Opioid Agonist Therapy

## GENERAL CONSIDERATIONS

Many providers of opioid agonist therapy (OAT) are treating an increasing number of older patients, some of whom may have medical co-morbidities or may develop other disabilities. The number of patients on OAT who are age 65 or older is rising, and this is related to:

- OAT being an effective long-term treatment option that has been available for over 40 years, and many patients have been aging while in treatment.
- A growing number of patients accessing OAT at an older age for treatment of an opioid use disorder (OUD) that developed from taking prescribed opioids for chronic pain, often for a prolonged period prior to seeking addiction treatment.

OAT providers must be mindful of extra safety considerations when treating the aging patient. Likewise, adult patients of any age with physical, mental, cognitive, learning, or sensory disabilities will access treatment for OUD, and may require adaptations to the treatment approach and plan for safe and effective OAT care.

This chapter will highlight key considerations for safety and support while engaging older patients and patients with disabilities in care. The care of other specialty populations is addressed elsewhere in this manual. Specifically, recommendations for patients with Acute, Chronic, & Perioperative Pain, HIV & Hepatitis C, Pregnancy, and Psychiatric Disorders can be found in those respective chapters.

# SPECIFIC RECOMMENDATIONS

There are several important issues to consider when caring for older patients and patients with disabilities on OAT, as outlined below.

### *Co-Occurring Conditions & Medication Interactions*

Older patients are more likely to have co-occurring physical and/or mental health issues (e.g., cardiovascular issues, COPD, osteoarthritis, renal disease, dementia, depression).

Pharmacotherapy for these conditions may interact with OAT medications and altered age-related metabolism must be considered. Careful assessment of comorbidities and thoughtful medication planning is key to optimizing quality of life and avoiding polypharmacy, and the associated harms.

Similarly, pharmacotherapy for management of some disabilities may also interact with OAT medications. Careful medication planning is also key for these patients to optimize quality of life and manage polypharmacy.

The chapters on Managing Polypharmacy and Co-Occurring Psychiatric Disorders in patients with OUD provide detailed recommendations for overall medication management and considerations specific to mental health issues.

#### STRONG RECOMMENDATION: REMINDER TO DISPENSE WITH OAT

**Typically, all psychoactive/sedating medications should be dispensed with OAT**, i.e., on the same schedule as OAT. Communicating with the patient's pharmacy about the plan for managing these medications is essential. Controlled dispensing instructions, such as "dispense as per OAT schedule", must be written on all relevant prescriptions. Please see the Managing Polypharmacy in OAT chapter for further medication safety recommendations.

### *Caution with Induction & Titration*

Generally, older age is associated with increased blood concentrations of drugs and altered metabolism, reduced effectiveness, and increased risk of adverse reactions for many medications, including OAT. Therefore, lower induction doses, slower titration, and more frequent reassessment are important for safety when titrating OAT in older patients.

Similar caution should also be exercised for any patients with co-occurring diagnoses or disorders that would impact metabolic, cardiovascular, or central nervous system function, to prevent overdose during induction and titration of OAT.

### *Small Dose Reductions with Age*

In patients who have been on OAT for many years or even decades, it is important to consider a small OAT dose reduction periodically as the patient ages.

This consideration also applies to other medications that contribute to cognitive impairment and/or sedation. Benzodiazepines/Z-drugs are particularly problematic in older adults, and renewed efforts should be made to taper and/or discontinue these medications as patients age. See Managing Polypharmacy in OAT, specifically MANAGING PRESCRIBED AND ILLICIT BENZODIAZEPINES & Z-DRUG USE for further guidance.

### *Accommodating Patient Needs*

Older patients and patients with disabilities may have mobility, cognitive, or sensory limitations that can impact their ability to attend traditional/in-person clinic appointments. Similarly, attending the pharmacy regularly for witnessed dosing may be problematic.

In establishing the medication management plan, a thoroughly documented risk-benefit analysis is important to support a witnessed versus take-home (carry) dosing schedule that takes into consideration the patient's physical, geographical, and transport challenges, while balancing safety and treatment retention. The patient's overall clinical stability, living situation, and public safety issues must be considered and documented in these situations, particularly when clinical discretion is used to grant take-home doses outside of the typical recommendations for awarding carries. Please see the respective chapters on take-home dosing for Buprenorphine/naloxone and Methadone for further guidance.

Effective communication is vital to assessment, treatment, and therapeutic alliance with any patient. It is important to ask patients about disabilities upon intake and after a new diagnosis, especially since some disabilities are not obvious or visible to treatment providers. Some cognitive, learning, and sensory disabilities will require the OAT treatment team, including pharmacy staff, to adapt their practice to decrease barriers to communication. Given the opportunity to provide honest feedback about their care, patients can often identify helpful adjustments to the treatment approach. A blended model of in-person and virtual care, the use of an appropriate interpreter, and printed materials in large font are just a few examples of how providers can address access barriers. The treatment team must also remain flexible in navigating the role of substitute decision makers, caregivers, supports, and/or aides that are critical to the patient's health and wellness.

### *Take-Home Dosing & Cognitive Impairment*

Cognitive impairment, more common with advancing age, can impact the risk/benefit analysis of having carry doses at home. This concern also extends to other sedating and/or psychoactive medications dispensed along with OAT.

Occasionally, home care support (where available) or other designated personnel/family members may need to be involved in the safe storage of medication and the supervision of self-administration in the home.

### *Continuity of Care for Hospital & Personal Care Homes*

With multiple comorbidities there exists an increased likelihood of hospitalizations. Coordination of care between hospital staff and the community prescriber/clinic staff and pharmacy is essential. The In-Hospital Care chapter provides detailed recommendations for continuity of care.

Elderly patients on OAT may also be transferred to Personal Care Homes (PCH). The PCH attending physician can continue an existing OAT prescription at the same (stable) dose or a reduced dose, if needed, without an OAT prescribing approval. However, consultation with an approved OAT prescriber (ideally the primary OAT prescriber) is required if a dose increase is considered necessary, or to initiate or restart OAT.

If a patient has an existing relationship with an OAT prescriber when they enter PCH, it is recommended that a care plan be established between the OAT provider and the PCH prescriber and/or medical staff. This will ensure that the OAT dose is regularly reviewed, at least quarterly, or at any point of significant change in the patient's health status or medications, or at the request of the patient or their family/caregivers.

## IN SUMMARY

OAT providers are encouraged to be watchful for changes in cognitive, mental, sensory, and physical abilities in their patients, especially as they age. Adapting practice to support patients with disabilities to effectively engage in OAT care is important for safety and equity.

Providers with experience in caring for older patients or patients with disabilities on OAT can be a valuable resource when questions or concerns arise. Importantly, the patients themselves and/or caregivers are the experts in navigating their needs, barriers, and problem solving what works best for them; ask questions and collaborate with patients for effective care and treatment retention.