The Opioid Crisis
What does it mean for Long Term Care

Objectives

- Participants will understand the prevalence of risks related to overuse of opioid use in senior settings
- Participants will understand the key principles and care processes for opioid use in long term care settings
- Participants will understand the CDC’s Prescriber’s Guidelines
- Participants will understand potential steps for safe reduction of opioid use in long term care settings
• Prescription pain relievers, heroin, synthetic opioids (Fentanyl)

• What do we know?
  • Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them
  • Between 8 and 12 percent develop an opioid use disorder

• Recent reviews of science found surprisingly little evidence supporting effectiveness of opioids in treatment of chronic pain conditions (pain lasting longer than 3 months)

• In some cases, opioids may even contribute to a worsening of pain (hyperalgesia) leading to a vicious cycle of taking more opioids to treat a condition that the medication itself has made less tractable
• Palliative Care and Pain Management
  • “Legitimized palliative sedation as a recognized medical practice by advancing the court case that recognized that dying patients have a constitutional right to receive as much pain medication as necessary, even if it advances the time of death, in the U.S. Supreme Court decision Vacco v. Quill (1997)
  • “Established the undertreatment of pain as a form of elder abuse and that caregivers must manage patients’ pain in Bergman v. Eden Medical Center (2001)
Key Principles

- Opioids are sometimes useful & are often not indicated or are ineffective
- Even when indicated, opioids may be ineffective or cause significant adverse consequences
- We must manage pain in context of other conditions & symptoms, not as an isolated issue
- We must consider pain medications in light of total medication regimen

Care Process

- Pain is a symptom, not a diagnosis
- Must follow care delivery process steps faithfully
  - If pain is, or might be present, we must look at whole picture, not just manage in isolation
- Adequate assessment & diagnostic efforts are essential
- Entire interprofessional team, not just nurses or medical practitioners, must follow process
- Details are mandatory to understand what we are treating & how to manage it
  - Nature (sharp, stabbing, dull, aching, shooting, etc)
  - Location
  - Intensity
  - Other factors (localized, generalized, what makes it better or worse, etc)
Opioid Risks & Adverse Consequences

- Significant psychiatric and behavioral issues
- Falls
- Dizziness
- Confusion
- Urinary retention
- Abdominal pain
- Disorientation
- Impaired function
- Apathy
- Lethargy
- Anorexia/weight loss
- Death

Centers for Disease Control, March, 2016
Prescribers’ Guidelines

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type: 3).

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (recommendation category: A, evidence type: 3).
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4).

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).
• 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).

• 11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3).
Centers for Disease Control, March, 2016 Prescribers’ Guidelines

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).

Opioid Considerations

- Be explicit and realistic about expected benefits of opioids, explaining that while opioids can reduce pain during short-term use, there is no good evidence that opioids improve pain or function with long-term use, and that complete relief of pain is unlikely (clinical evidence review, KQ1).
- Emphasize improvement in function as a primary goal and that function can improve even when pain is still present.
- Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations.
Opioid Considerations

- Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase hydration and fiber intake and to maintain or increase physical activity. Stool softeners or laxatives are usually needed.

- Discuss effects that opioids might have on ability to safely perform ADLs, particularly when opioids are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently. INCREASES FALL RISKS

- Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often.

Opioid Considerations

- Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opioids.

- Discuss risks to caregivers and other individuals if opioids are intentionally or unintentionally accessible to others for whom they are not prescribed, including the possibility that others might overdose at the same or at lower dosage than prescribed for the patient. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (188).

- Discuss the importance of periodic reassessment to ensure that opioids are helping to meet patient goals and to allow opportunities for opioid discontinuation and consideration of additional nonpharmacologic or nonopioid pharmacologic treatment options if opioids are not effective or are harmful.
Treating Pain Without Pills

- Use opioids safely and appropriately
- Acknowledge and address relevant issues
- Commit to a disciplined, consistent approach to pain management
- Recognize that prescribing any medication(s), including opioid, requires significant knowledge & skill
  - Good intentions are relevant but secondary
- Ensure opioids are prescribed, administered, and monitored safely and effectively

Preventing & Identifying Diversion

- Every facility needs an organized & assertive effort to oversee opioid use & prevent & ID diversion
- Drug diversion is a continuing & growing problem in healthcare facilities including nursing homes, assistive living facilities, and residential care facilities
- Prescribers & staff must be alert to issues of organizational oversight, diversion, & theft of opioids
  - Must take risks of drug diversion seriously & address them vigorously
  - Be alert for, & report, situations & clues that could represent diversion
### Steps to Opioid Reduction

#### Step 1
- Evaluate all current PRN opioids
- Target residents who are receiving 0-1 PRN doses daily
- Discontinue PRN opioid
- If needed, substitute non-opioid medications such as acetaminophen 650mg

#### Step 2: An On-Going Process
- Evaluate all PRN opioid orders on new residents
- Discuss pain assessment with nursing to determine:
  - Why opioid ordered initially
  - How often resident receiving it
  - If it was used prior to hospitalization
- Consider trial DC of all PRN opioids on resident who were not on the medication prior to hospitalization & were not placed on opioids due to fracture, injury or surgery

#### Step 3
- Assess all scheduled opioids after Step 1
- Assess pain source & offer alternative to pain medication (i.e., heat, ice)
- Discuss pain with residents who can verbalize symptoms & explain importance of reducing opioid dose
- Offer alternative non-opioid pain med if desired
- Discuss opioid weaning schedule (reduce dose by 10% every 1-2 weeks)

#### Step 3 (Continued)
- Discuss alternative methods to relieve pain
  - If resident refuses weaning or alternative treatment, document reason & attempt to educate
- Assess all PRN opioid use on residents who cannot verbalize pain
  - Consider weaning trial
  - Monitor results with reduction of dose & frequency
  - Discuss findings with family or DPOA
Steps to Opioid Reduction

Step 4
- Assess all scheduled opioids
- Document why resident is receiving medication
- Consider weaning trial (reduce dose by 10% every 1-2 weeks) on those residents not receiving opioids for cancer diagnosis or end of life
- Implement alternative pain measures during weaning
- If resident fails GDR trial, document why

Step 5
- Provide in-service to nursing, including CDC opioid prescribing guidelines
- Stress adverse affects related to long term opioid use in LTC setting
  - Increased fall risk, respiratory depression, constipation, confusion, urinary retention, delirium
- Stress importance of limiting opioid use to less than 3 months & educating residents
- Alert nursing to educational material to provide residents & family members whose opioids are being weaned
- Explain that residents who receive long term opioids may complain of more pain, not less

Steps to Opioid Reduction

Step 6
- Provide in-service to therapy department
- Explain therapy's role in pain reduction
  - Discuss their role in pain assessment & offering of alternative pain control measures (heat, ice, massage, ROM)
- Stress importance of therapists not asking physician or nursing for pain medication

Step 7
- Attempt to make a goal of limiting all opioid prescriptions to those residents with an appropriate diagnosis (cancer, end of life)
  - Place a time limit on all opioid orders (1-2 weeks)
  - Reassess pain & need of current dose/frequency weekly
  - Make appropriate changes
Resources

- https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- https://www.compassionandchoices.org/who-we-are/
- Fentanyl Fantasies: How Prudent and Problematic Pain Management Efforts Impacting quality Results- Dr. Steve Levenson; Dr. Jean Storm, 2019 AHCA Quality Summit