hello everyone. welcome to the tennessee nursing home pain management and opioid safety collaborative.

This is the first of three training sessions you will be participating in this session we will go over pain and opioid background, as well as clinical practice guidelines for nursing homes.

My name is sarah sutherland and i am a quality improvement advisor at Qsource. I will be facilitating the training sessions along with my colleague, Amanda Ryan, who is our clinical pharmacy specialist here at Qsource.

Please make sure you have completed the pre-test prior to attending this training. Also if you are viewing this training as a group, make sure you have documented your name on a sign-in sheet to ensure we have a list of people in attendance during this session.

We encourage you to pause and take a moment to discuss the content whenever you like. With that i will turn it over to Amanda to begin your training.

Okay thank you sarah and thanks to everyone who's joining us for this training. We are going to set the stage for this pain and opioid safety project by looking at some opioid background and also some clinical practice guidelines that go along with using opioids safely.

So we really want to show you what evidence is so that you can understand where the rationale for this project comes and also just to kind of help you with some background information.

So we're going to go over a couple of things here at the beginning first is talking about how many residents take opioids. We're going to have a look at how efficacious or how effective opioids actually are for chronic non-cancer pain. We're going to look at some of the effects some negative effects of opioids, specifically in the elderly, and then something that you may not have thought of before, looking at pain management and opioids and how we can optimize their use and influence lots of quality measures really that have nothing to do with pain.

So before i begin with a little more background i just wanted to clarify for you what opioids are in case that's something that you're not familiar with. We will go into a lot more detail on this in the second training session, but opioids are pain medications you probably know them by the name oxycodone or hydrocodone brand name oxycontin or lortab and they're used to treat all different types of pain acute, pain chronic pain and they can be very effective tools but they also have some drawbacks.

So the idea with this project is really to strike the balance between using opioids when they're indicated and when they're in the best interest of a resident and then when they're not. On the flip side of that, figuring out what alternatives we may have and really how we can use those to best treat resident pain and impact their quality of life.
So to be very clear, this project is not about eliminating opioid use. It's not about reducing opioid use unless it's appropriate. It's really about finding that balance.

So to give you a little bit more background, we know, and this is not a surprise to anybody listening, that a lot of residents in a long-term care facility take opioid medications.

So we've got one citation here that says if we just look at chronic non-cancer pain, we have about 70 of our residents across the board who take opioids on a scheduled basis for that pain and we also know that in older adults the adverse effects of opioids can be potentially more serious than they are in younger and healthier patients and that's even true of long-term care residents who may be younger.

We're hearing more and more about residents being treated for chronic pain in the nursing facility who are younger, but they typically have a lot more medical conditions and these adverse effects could be dangerous for them as well.

The other thing to know is that, sometimes opioids are not even effective for certain types of pain. Certain types of chronic pain we actually know that opioids can make that pain worse.

So we want to figure out kind of how to put that puzzle together and use them to the best way that we can use them safely.

So we don't have a lot of studies on chronic non-cancer pain we don't really know how well they work. We may not have a lot of effect in using opioids for that type of pain and some studies have shown that opioids don't provide the pain relief that we're looking for, but beyond that, not just looking at the pain level itself, but looking at the quality of life of the person taking the medication and their ability to function, sometimes opioids do provide that to people, but sometimes they don't and when they don't, we need to start looking and thinking about alternatives.

So you see on the right some stats that came from the cdc so between 1999 and 2014 the number of prescribed opioids in the united states quadrupled.

So we had four times the number of prescriptions that we did in 1999, but the amount of pain that people were reporting was unchanged over that period of time.

So you could argue that in the late1990s we were really under treating pain. We were at one side of the pendulum swing if you will, but now in the 19 or the 2014 and beyond we're really swinging to the other side.

So maybe we're treating pain too much sometimes with opioid medications and we need to figure out how to kind of get back in the middle.

So thinking about adverse effects related to opioids, we know that really for any medication at all, but it's also true of opioids, there are risk of negative effects when we take those medications and there are factors that are present in elderly people and people with multiple chronic conditions that make them more susceptible to these adverse effects.

One of those is polypharmacy, which is simply taking a lot of medications we know that every time we add a new medication to a drug regimen, we have a greater chance of adverse effects from drug drug interactions.

We also know that as people get older, they have physiologic changes. So one example is our kidneys tend to be much less efficient when we get older, meaning we don't eliminate drugs as quickly as we did when we were young.

So we often have to a dose adjust so do lower dosages there's lots of other physiologic changes as well that happen that make it very important to manage these drugs carefully. The table at the bottom of the slide shows you lots of different adverse effects that happen with opioids.

I want you to take note. Increased pain is on there. That is definitely possible for some people taking opioids. A couple of things at the bottom that happen to anyone that takes opioids for a period of time. So that could even be as little as a couple of weeks.

The first one of those is tolerance. We know that you need higher doses of opioid medications over time to get the same level of pain relief that you had when you were taking lower dosages.

So with that increased dosage is an increased risk of adverse effects. Second at the bottom, you'll see dependence. All that means is the body gets used to having an opioid around and when you take that away suddenly, then the body has withdrawal symptoms.

So we want to make sure that if we would like to reduce the opioid dose in someone taking that medication, that we do that very carefully and with thought to avoid that withdrawal symptoms.

So now we'll switch gears and take a look at how different quality measures can be connected to managing pain safely and effectively and using opioids safely.

So over on the left you see some different quality measures is for short stay and is for long stay and the first one here we've got is falls. We know we have a lot of evidence in the literature and a lot of experience using opioids and we know that there's increased fall risk in people who take opioid medications.

So if we're able to reduce opioids when it's appropriate and then use them safely when we need to use them then that has the potential to positively increase our risk for fall.
So, decrease the risk of falls in people taking the medication as far as depression, we know that pain and depression are very closely associated with one another.

So if we can treat pain well and if we can be effective and safe when doing so then that can positively influence the management of depression opioids we know cause nausea and vomiting, very well known adverse effects. Those can lead to weight loss. A far as activities of daily living, we know opioids also cause sedation.

So if you've got somebody who's tired or if their pain is not being treated well, that could certainly lead to an increased need for adl assistance.

And then moving on to the next slide, when we're talking about mobility it's very similar to activities of daily living if you're sleepy or if you're in pain you're going to have trouble being mobile on your own.

So there's a definite connection there as far as pressure ulcers. The sedation comes back again if somebody is sedated they're not likely to be able to shift when they need to as easily and that can increase the potential for pressure ulcers. Bladder incontinence is one you may not have thought of before, but there's a couple of ways that opioids can influence that.

The first way is that we know that opioids decrease how well the bladder contracts and when that happens we have too much left over urine in the bladder, which can lead to an overflow incontinence situation. In addition to that, the sedation from opioids can lead to trouble getting to the restroom. So functional incontinence.

And then finally, physical restraints which thankfully we don't use nearly as much as we used to, but if we have someone who has pain that's not being treated as effectively as it could be that can worsen their behaviors and that's a situation where restraints might be used. It's also a situation where if you've got somebody with dementia you may see increased behaviors for pain that's not being treated as well as it could be.

So a couple other considerations related to quality measures. The question comes up what about the pain quality measure. Well that was recently removed by cms and i wanted to go over the verbiage that's the rationale cms gave for removing that specific quality measure.

So they said that the change supports the federal initiative to reduce opioid utilization and they're really seeking to prevent a scenario where a facility might use opioids inappropriately.

So they are afraid that facilities might be over utilizing opioids in order to make sure that they are meeting the requirements of that pain quality measure.

So this project is very much in line with what cms is thinking here. As far as this rationale goes we don't want to use overuse opioids when they're not appropriate.
So it's not going to affect your pain quality measure the way it used to. Since that's not included the way it was previously but it can still affect resident quality of life overall and in many other quality measures that we look at if we use opioids in a safe and effective manner.

The other thing i wanted to point out is on that table we had both short and long stay measures. We often get the question when we're working with nursing homes which population should we focus on? Should we do both? Should we do one? What's the best thing to do there?

And our answer to that is that you get to choose based on the needs of your facility and your resident population. We've had some facilities that we've worked with in the past that wanted to focus on short stay, because they had a lot of residents coming in post hip replacements, knee replacement, that sort of thing and they really wanted to focus on the manage the acute management of the opioids that were coming in that way.

And then we've had other facilities who have a lot of long-stay residents who've been on opioids for quite some time and they wanted to take a look at those residents and their specific needs.

So pick whatever works for you. We just ask that whatever you choose, that you stay with that population through the project, so that we're not bouncing back and forth between the two populations.

So here is an opportunity to take a minute and discuss with your team. So if you've got others with you in the room we encourage you to pause the video and just have a quick chance for discussion. If you're watching this by yourself, we encourage you to have this discussion with your team or just kind of get their thoughts on this sometime after the training is over so.

We're curious if your facility has ever focused on pain management in order to improve quality measures. So have you ever thought of this concept before? What do you think of it do you? Think it would work? Do you have additional questions? And what does this bring up for you?

So we'd be interested in discussing that with you when we get a chance to interact with you again.

Okay moving on to looking at some clinical practice guidelines and really where the evidence comes from for this project. We're going to go through a couple of different guidelines. One is the beers criteria. Then we'll talk about stop start criteria. We'll look at the cdc guideline on opioids that came out in 2016 and then we'll also touch on the tennessee chronic pain guidelines.

Now it's important to note that there are no specific pain clinical practice guidelines that are for long-term care facilities or entirely for the elderly.

So what we're going to be doing here is taking pieces out of these guidelines that are available and applying them to the long-term care setting where it makes sense and which things make the most relevance to managing pain in the long-term care facility.

So you may be familiar with the beers criteria. They were actually updated just last year and they are a list that's been produced for several decades now and it gives us some guidance on different medications that may be inappropriate in certain situations. They're called potentially inappropriate medications or pim for short they do have a little bit on opioids in the beers criteria.

So they specifically point out falls and the risk of adverse effects in resident who had falls so they say to that it may be potentially inappropriate to use opioids in someone who either has a history of falls or in someone who has a fracture and to use not use opioids for pain management except for severe acute pain.

So that's a pretty black and white statement in the beers criteria. I would say you know that that's not always going to be practical for sure, but it's something to think about.

Severe acute pain is one of those scenarios where it's almost always appropriate to use an opioid. You got to look at the individual resident, but that's generally where they're most effective. That's where they have the least risk compared to benefit. So that's why the beers criteria call that out.

They also talk about some drug interactions. Benzodiazepines is one those are drugs,
like ativan and valium, and then they also talk about a lot of sleep meds. So zolpidem or ambien is one example. They talk about antipsychotics which we know we use a lot of in long term care. Antidepressants, any of these drugs used together with opioids, have additive adverse effects. So additive confusion, additive sedation and then also and probably the one that we worry about the most is a decrease in in breathing. So this is generally how opioid overdoses happen in the community.

Someone takes an opioid medication, perhaps in combination with drugs similar to these, and they actually stop breathing. So we want to make sure that we manage these drugs together very carefully. If we decide to use them and if we can avoid them, using them together, that is an even better scenario. The stop start criteria are similar to the beers criteria, but instead of just talking about potentially inappropriate medications,
they also talk about medications that you can add for benefit. They actually have just a very short statement around opioids and they say to avoid using strong opioids for mild pain.

So this kind of gets back to that idea of if we've got severe acute pain that makes sense to use an opioid and the stop start kind of reinforces that. So these are the big ones the cdc guidelines came out in 2016 and it's important to notice what the population is that we apply these guidelines to. They were intended to be used in primary care practices for adult patients. We did consult with the cdc shortly after the guidelines came out to see if it was appropriate to use some elements of the guidelines for long-term care residents and the response from the cdc was as long as you're not looking at active cancer, palliative care end-of-life care or hospice, then there are a lot of pieces of these guidelines that can apply to long-term care.

So i wanted to point out a key point here and that is for this project we will not be focusing on these populations. So when you're looking at reviewing residents information perhaps collecting data for this project, we would like you to exclude those populations and then just make sure you're doing that all throughout the project so that we can make sure that we're applying the evidence appropriately. We will also focus here in the next few slides about applying these guidelines to long-term care residents. Some guidelines apply more than others, so you'll see that the numbers skip around here a little bit in the next couple of slides and that's the reason for that.

Alright, so recommendation one from the cdc is that opioids are not first line or routine therapy for chronic pain. So all that means is that we shouldn't go to opioids for our first choice when we're talking about treating ongoing pain. That doesn't mean we shouldn't use them in some situations, but we need to kind of think a little broader. So non-pharmacologic and non-opioid pharmacologic therapy are preferred.

So if we can use something that's not a medication at all that's great. If we can use another medication that's not an opioid, we got to look at that medication in particular,
especially in long-term care, but there might be some options that are more effective and less risk than opioids for residents.

The other kind of key theme for recommendation one here is that we want to use opioids along with other treatments. So we would want to make sure the opioids are never a standalone therapy for pain even when they're completely appropriate. We want to use other things along with them and that might be a non-medication option.

This project, as we'll be working through it will help you to increase access of these other therapies for your residents and we'll get into the details of that in future training sessions number two is that we want to really look at pain and function when we're talking about using opioids and when we're looking at treatment goals.

The pain scale, a 0 to 10 scale, when we're looking at pain for example is not the only thing we should look at. We also want to see how that pain is affecting the resident,
because that is just as important. We'll be talking about how to do that through the course of this project and then number three is all about benefits versus risk.

So we want to make sure that if we're using any pain treatment, but opioids specifically that our benefits outweigh the risks for a resident and we want to discuss that to the extent that we can with residents and their care partners as well. Number four is about when we're starting a brand new resident on opioids.

We should use an immediate release version of the medications so norco or hydrocodone with acetaminophen is an example of that percocet which is oxycodone with acetaminophen is another example. We do not want to start out with extended release formulations and one special extended release formulation that we use a lot in long-term care are fentanyl patches. They're really attractive because then we don't have to worry about swallowing difficulties. We don't have to worry about dosing multiple times a day, but they can actually cause severe respiratory depression in a person that has not taken opioids before. So that's just kind of a special caution for long-term care facilities to think about, but really we want to stay away from those long-acting opioids when we're just starting someone out on the medications.

Number five is about dosing and essentially all it means is the higher the dose the higher the risk for adverse effects. You'll see at the bottom of the slide where we talk about greater than 50 mmes. mme stands for morphine milligram equivalent and that is just a way to compare one opioid to another and look at dosing apples to apples. So if you're above 50 mme - so taking the equivalent of 50 milligrams of morphine every day - you really need to start looking at risk versus benefit and then above 90 you want to either avoid that or carefully justify.

I want to clarify something here quickly and that is there was some misunderstanding of the guidelines. Especially when they first came out. That anybody that's above these thresholds needs to be brought down to a lower dose immediately and that is not necessarily the case. We need to look at the specific situation of people who are on higher doses and then if we want to bring them to lower doses do that in a

cooperative fashion in a very carefully managed taper. So if we can avoid getting higher than these doses in the first place then that's a great goal but we also should be careful going the other direction as well.

Number six relates to acute pain and the take home message here is only use as many opioids as you need to and as low dose as you need to to treat acute pain. So the guidelines say three to seven days for some sort of acute pain might be enough if that's the case. That's fantastic. We do know on this graph to the left that you can see the longer our initial opioid prescription that's the numbers along the bottom the higher the chance that someone will take opioids either one year or three years from now and this is for people who have never taken opioids before.

So if we can prevent someone who's experiencing acute pain from transitioning to a chronic user, then that is certainly the goal. Especially when we're thinking about different ways to treat their acute pain in an effective way and making sure we just continue to monitor and keep an eye on that as well.

Number seven is about tapering opioids. So i talked about dependence a little while ago. People become dependent on opioids when they take them. So if we want to decrease the dose, we just want to do that very carefully. We want to look at benefits versus harms at the beginning of a taper and throughout the taper and then when someone is taking opioids we just want to make sure to reevaluate them periodically. That's a fairly standard practice, but a good reminder.

So one way to benefit or look at benefits versus harms is by using what's called the peg scale. We're going to come back to that later when we talk about pain assessment, but it is a three item scale that is a very quick way for you to see not only how someone's pain levels are doing but also how their function is doing so looking at risk versus benefit and so that will show you the benefit and then the risk we know based on specific adverse effects that might happen to that specific resident.

There are also some resources available for tapering the department of health and human services came out with a guide. The link is there. We've got some resources here at Qsource and we are always available for technical assistance on that as well. So if that's something you're looking to do and you need some help and we'll be happy to help you during this project.

Number 11 goes back to what we saw in the beers criteria. So we want to avoid prescribing both opioids and benzodiazepines whenever we can. So the reason for that additive adverse effects. So we're going to have more cognitive impairment. We're going to have higher fall risk and we're going to have a higher risk of respiratory depression when we use these medications together.

So if we can only do one that's great. If we can't, we need to be aware of that risk and make sure that we are carefully monitoring that resident for any of these adverse effects that could happen.

Alright, so that is the end of the cdc guidelines that apply to long-term care. Now we're going to touch briefly on the tennessee chronic pain guidelines. Some of your prescribers in your facility may be familiar with these. It is important to know that there's no specific recommendations either for the elderly or for nursing home residents in these guidelines, but there's some things that can apply.

So we'll go over them now. One is that just because someone has been on opioids for a long time that all by itself is not a reason to continue. So if somebody simply says i've just been taking this forever that doesn't mean they necessarily still need to be. That we now know that that can be a very difficult situation some people are used to taking medications they've been on them for years and they want to continue them. So if that's something that you're running into at your facility we can work with you on some communication strategies and also adding other ways to manage pain to help them. So maybe you could reduce the dose. Even if you can't get someone off an opioid, you can maybe get it to a safer level while

still managing their pain. Using non-opioid treatments should be tried first that's what we've talked about already.

And then a history of the pain condition should be obtained so they're saying a nice thorough evaluation and the history of that resonance pain is important to obtain. We're going to talk about that at length in the next session and what we're going to be calling that is specific indications. So we'll get into all the details of that but we wanted to show you how it aligns with the Tennessee chronic pain guidelines.

Here's another potential strategy. When you're starting someone newly on opioids is you can present that to the resident and to their care partners as a therapeutic trial. So the way to potentially communicate that, is you can say you know we have a medication that may help with your pain, but we don't know how well it's going to work or what sort of side effects that you're going to experience. So let's try this for a week or two. We'll reevaluate and see how you're doing.

That way it's not presented from the get-go as something that will stay permanently if it's not working. So that's a strategy to consider doing using the lowest effective dose is mentioned in the guidelines and not using more than one short acting opioid at a time.

So if we can avoid that that will simplify the administration of the medication and reduce risk of drug interactions all right. So i have finished with the training content for session one.

I'm going to turn it back over to Sarah so she can talk about some next steps.

Thanks Amanda. Alright everyone now that you have finished the content for this first training session, here are some next steps. First you're going to complete your post test for training session one. You can complete a printed paper version of the test and provide it to your instructor or access the link to complete online.

Next make sure to complete training sessions 2 and 3 and the post-tests for those sessions. Lastly once all of the training is complete you will need to schedule a follow-up call with Qsource references for this material are available on the last slides of this presentation.

We hope you enjoyed this training and we will see you next time in session two.