In-Person Training on Individualized Pain Management and Non-Opioid Approaches to Managing Pain

August 2019

Qsource

Welcome, Introductions, and Agenda Overview

1. Welcome
2. Housekeeping Items
3. Ice Breaker Question
4. Audience Participation

Welcome!

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Background on Opioid Use in Nursing Homes

1. Proportion of residents with opioid orders
2. Opioid efficacy for chronic non-cancer pain
3. Negative effects of opioids in the elderly
4. Connecting pain management and opioids to quality measures

Proportion of Residents with Opioid Orders

- Approximately 70% of nursing home residents with chronic non-cancer pain receive regularly scheduled opioids.
- Studies and guidelines on medication use in older adults warn that these drugs may have particularly adverse effects—and may even be largely ineffective as pain treatment—in this vulnerable population.

Opioid Efficacy for Chronic Non-Cancer Pain

- Long-term studies on opioid efficacy for chronic non-cancer pain are lacking
- Some studies have shown that opioids may not be associated with effective pain relief, increased function, or greater quality of life

Negative Effects of Opioids in the Elderly

- Anyone who takes opioids is at risk for negative effects
- Factors in elderly people and those with multiple chronic conditions make negative effects more likely
  - Polypharmacy → drug-drug interactions
  - Physiologic changes

Sedation	Constipation	Cognitive impairment
Dry mouth	Increased pain	Nausea and vomiting
Tolerance = need higher doses for the same pain relief		
Dependence = withdrawal symptoms if opioid is stopped suddenly		

Connecting Pain Management and Opioids to Quality Measures

Quality Measure	Connection to Pain Management and Opioids
Falls with major injury	Opioids are associated with increased fall risk
Self-report of moderate to severe pain	Opioids may be ineffective for some pain, lack of targeted pain treatments may be ineffective
Pressure ulcers	Opioids cause sedation which can increase risk of pressure ulcers
Bladder incontinence	Opioids decrease bladder contraction which can cause or worsen overflow incontinence, sedation can cause or worsen functional incontinence
Physical restraints	Ineffectively treated pain can cause or worsen behaviors for which restraints might be used
Increased help with ADLs	Sedation and poorly treated pain may lead to need for increased ADL assistance
Weight loss	Opioids can cause nausea and vomiting
Depression	Ineffectively treated pain many cause or worsen depression

Audience Participation

- Has your facility ever focused on pain management in order to improve quality measures?
- What do you think of this concept?

Applying Opioid Clinical Practice Guidelines to Nursing Home Residents

1. Beers and STOPP/START Criteria
2. CDC Guideline for Prescribing Opioids for Chronic Pain
3. Tennessee Chronic Pain Guidelines

Beers Criteria 2019 and STOPP/START

- Beers
  - Opioids are potentially inappropriate medications to use in people with a history of fall or fractures
    - Avoid opioids for pain management except for severe acute pain
  - Avoid using opioids concurrently with benzodiazepines or gabapentinoids
  - Avoid a total of three or more CNS-active drugs
    - Antidepressants, antipsychotics, antiepileptics, benzodiazepines, opioids, "Z-drugs (e.g. zolpidem, zopiclone)
- STOPP/START
  - Avoid using strong opioids for mild pain

CDC Guideline for Prescribing Opioids for Chronic Pain

- These guidelines do not include people with active cancer, or those receiving palliative care, end of life care, or hospice
- We will focus specifically on applying to Guidelines to long-term care residents
  - Some recommendations apply more than others

CDC Guideline: Recommendation 1

Opioids not first-line or routine therapy for chronic pain

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)

CDC Guideline: Recommendation 2

Establish and measure progress toward goals

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 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)

CDC Guideline: Recommendation 3

Discuss benefits and risks with patients

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)

CDC Guideline: Recommendation 4

Use immediate-release opioids when starting

4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)

Additional cautions for

- *Methadone*
- *Transdermal fentanyl*
- *Immediate-release opioids combined with ER/LA opioids*

CDC Guideline: Recommendation 5

Use caution at any dose and avoid increasing to high dosages

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 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)

CDC Guideline: Recommendation 6

6

Prescribe no more than needed

- 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.
- 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)

CDC Guideline: Recommendation 7

Offer a taper if opioids cause harm or are not helping

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)

CDC Guideline: Recommendation 8

Evaluate and address risks for opioid-related harms

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)

CDC Guideline: Recommendation 11

Avoid concurrent opioid and benzodiazepine prescribing

11

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)

Tennessee Chronic Pain Guidelines

- No specific recommendations for the elderly or nursing home residents
- A patient prescribed opioids by a previous provider is not, in and of itself, a reason to continue opioids
- Reasonable non-opioid treatments should be tried before opioids are initiated
- A specific evaluation and history of the patient's pain condition should be obtained
- The initiation of opioids should be presented to the patient as a therapeutic trial
- Opioids should be used at the lowest effective dose
- A provider should not use more than one short-acting opiate concurrently
- National data suggests risk of overdose death starts at 40 MME in opioid naive patients with the greatest risk in the population is in the first two weeks of treatment. The risk of overdose for all patient populations increases tenfold at 100 MME

Understanding Specific Indications: The Key to Individualized Pain Management

1. What is a specific indication? Why is it so important?
2. Example workflow changes to increase specific indications
3. Results of Qsource's pilot project

Audience Participation

Which of the following represents an appropriate specific indication for opioid use?

a) Chronic pain

b) Acute left knee pain

c) Osteoarthritis

d) Neuropathy in both feet

Understanding Specific Indications

Ensure each resident on opioids has an specific indication for use

These data will guide us on next steps to take reduce opioid use and treat pain effectively

- CDC guidelines: Opioids are not first line or routine therapy for chronic pain

https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Why is it Important to be Specific About Residents' Pain?

- To help determine if medication therapy is indicated.
- To help determine which medication therapy is indicated.
  - Acetaminophen, gabapentin, opioids, etc.

What Specific Information Do We Need About Residents' Pain?

- Location
- Cause

  Other helpful information
- Severity
- Duration
- Type

Opioids In Nursing Homes

AMDA – The Society for Post-Acute and Long-Term Care Medicine has two primary policies related to opioids in nursing homes:

1. Provide access to opioids when indicated to relieve suffering and to improve or maintain function, and

2. Promote opioid tapering, discontinuation and avoidance of opioids when the above goals are not achievable, to prevent adverse events, dependence and diversion.

Specific opioid stewardship strategies in nursing homes include the following:

First, nursing home practitioners who prescribe opioids should do so based on thoughtful inter-professional assessment indicating:

- **A clear indication for opioid use**

Audience Participation

- What processes do you have in place to gather this information?

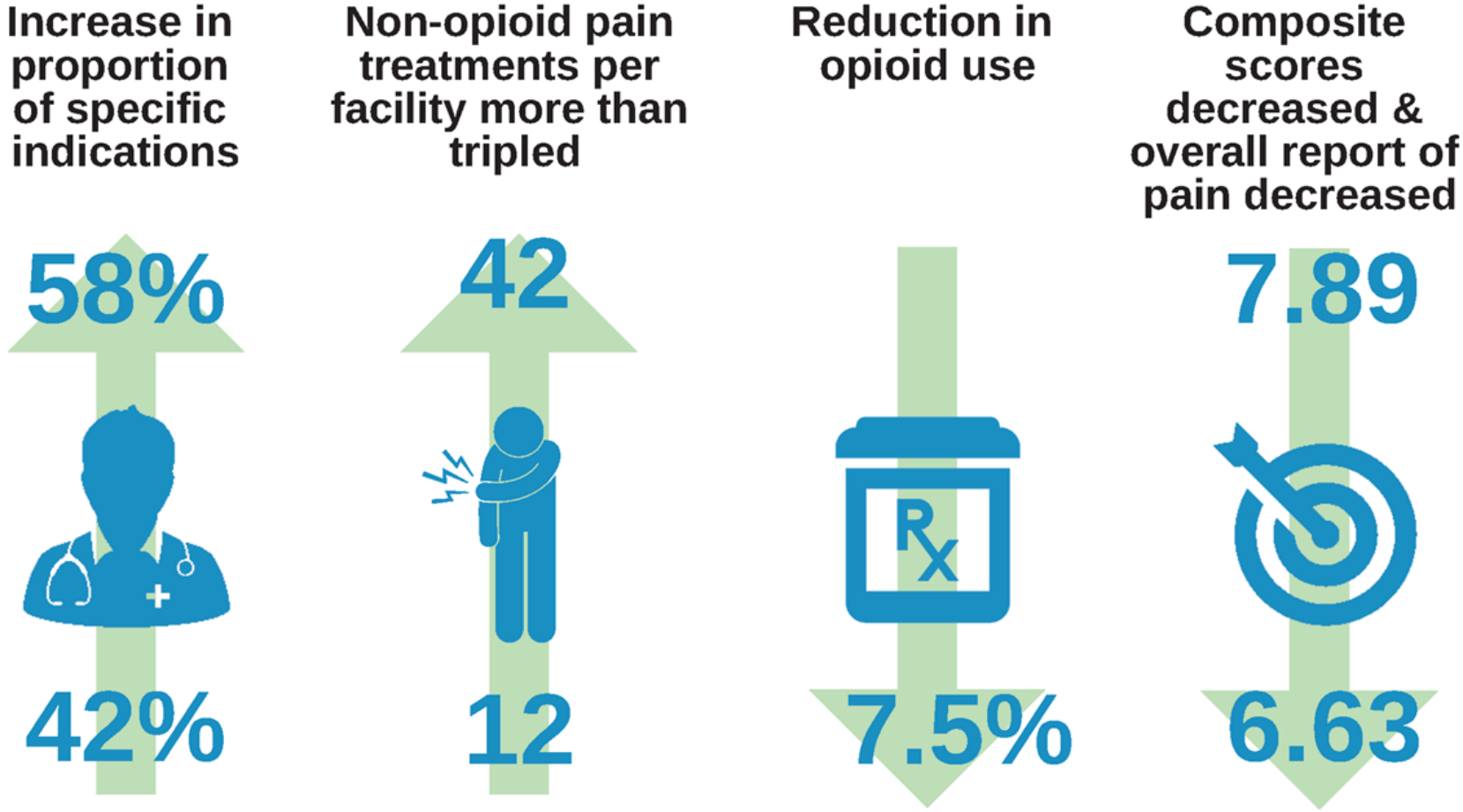
- What challenges do you face?

Example Workflow Changes to Increase Specific Indications

- **Develop a Checklist to utilize at admission**
  - Include items such as:
    - Demographics
    - Medical Information (Diagnoses, allergies, precautions, diet)
    - Physical findings (vital signs, O2, Mental status)
    - Cognition
    - Functional Status (mobility, continence)
    - Immunizations (name, date administered)
    - Medications (Current list, HRMs, specific indication, date/time last administered, pre admission med list, allergies, INR goal)
    - Current pain assessment and treatments
    - Pressure Ulcers/Skin condition
    - Advanced Directives/Power of Attorney

Results of Qsource's Pilot Project

Project Results



How to Use Specific Indications

1. Types of pain and how they respond to different pain management treatments
2. Risks and benefits of pain management treatments

Types of Pain

- Nociceptive pain
  - Caused by damage to body tissue
  - Usually well-localized and sharp, aching or throbbing
  - Examples: fracture, arthritis
- Neuropathic pain
  - Caused by injury or malfunction of the nervous system
  - Often burning, numb or “heavy”
  - Examples: diabetic neuropathy, post-herpetic neuralgia
- Acute or chronic?
  - 3 months is the cutoff

Types of Pain Treatments: Non-Medication

This category has the most options, lowest risk of adverse effects, and can be effective for many types of pain!

- Movement
- Heat
- Cold
- Repositioning
- Massage
- Prayer
- Meditation
- What else?

Types of Pain Treatments: Non-Opioid Medication

Category	Example(s)	Notes
Acetaminophen (APAP)		- 325 mg APAP can be combined with 200 mg ibuprofen for effective pain relief - Generally safer than other oral medications
Oral non-steroidal anti-inflammatory drugs (NSAIDS)	Ibuprofen, naproxen, meloxicam, celecoxib	Can cause GI, cardiac and renal adverse effects
Topical NSAIDS	Diclofenac	Fewer adverse effects compared to oral NSAIDs
Tricyclic antidepressants (TCAs)	Amitriptyline, nortriptyline	Can cause anticholinergic effects and increase fall risk

Types of Pain Treatments: Non-Opioid Medication (continued)

Category	Example(s)	Notes
Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants	Venlafaxine, duloxetine	Generally safer than TCAs
Gabapentinoids	Gabapentin, pregabalin	Can cause edema, caution with heart failure and renal disease
Other topicals	Capsaicin, lidocaine, many others	Can be less expensive
Muscle relaxants	Baclofen, cyclobenzaprine	Cause sedation
Anticonvulsants	Carbamazepine	Can cause drowsiness/ dizziness

Types of Pain Treatments: Opioids

Example(s)	Notes
Buprenorphine patch	May be safer than other opioids
Codeine	Frequent GI upset
Fentanyl patch	- RESIDENT MUST BE OPIOID TOLERANT - 50-100 times stronger than morphine
Hydrocodone	
Hydromorphone	Four times stronger than morphine
Morphine	
Oxycodone	
Tramadol	- Drug interactions with antidepressants - Safer than other opioids?

ALL opioids (1) Cause CNS depression, especially when given with other CNS depressants (2) Increase fall risk (3) Need caution with kidney and liver impairment (4) May be ineffective for some types of pain

Types of Pain and How They Respond to Different Pain Management Treatments

- Osteoarthritis
  - Exercise, patient education
  - Acetaminophen, topical NSAIDs, capsaicin
- Neuropathic pain
  - SNRIs like Cymbalta, lidocaine patches, gabapentin, Lyrica
- Low back pain
  - Exercise, limit bedrest when possible
  - Acetaminophen, SNRIs like Cymbalta

Risks and Benefits of Pain Management Treatments

- All pain management treatments have risks, but these vary for each person
- Benefit can be assessed using validated scales
  - To be discussed later
- Pain treatment benefits should outweigh risks for each resident

Guiding Principles for Use of Pain Treatments

- Non-medication pain treatments should be added first and stopped last
- Non-opioid pain medications should be added second and stopped second to last
- Opioids should be added last and stopped first

Audience Participation

- Has your facility used these guiding principles before?
- What are your greatest challenges in implementing principles like this?

To Be Continued During One-On-One Technical Assistance Sessions

- Defining facility-specific challenges in choosing pain treatments
- More details on options for pain treatment

Tapering Opioids According to Residents' Needs

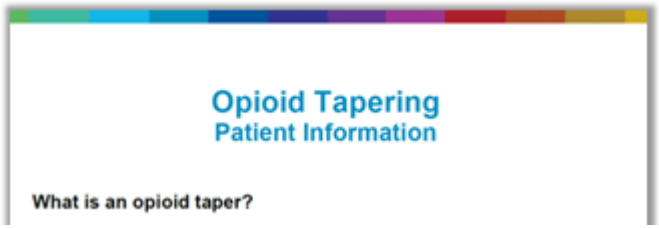
1. When and how to taper
2. Tapering resources available from Qsource

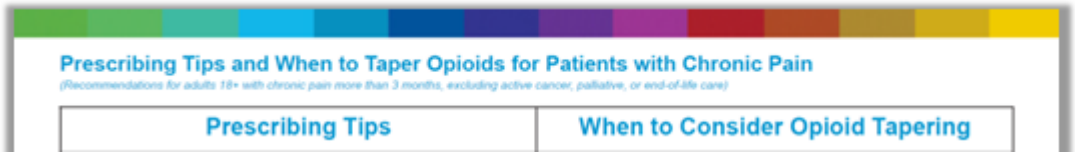
When and How to Taper

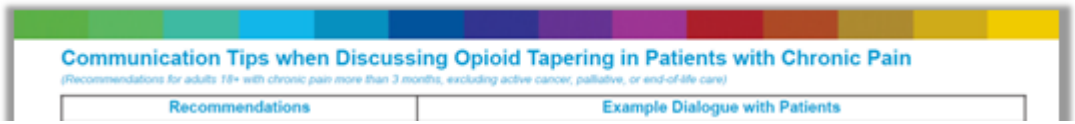
- Should all residents' opioids be tapered? NO!
- When should tapering be considered?
  - If opioids cause harm or are not helping
    - Use the PEG Scale
  - Resolution of condition causing pain
  - Work in collaboration with residents and families
  - Optimize other therapies first and then taper opioids to lower dosages or discontinue opioids
  - 10% per week is a reasonable starting point, but specific residents may need a slower or faster taper
  - Adjust rate and duration of taper based on resident's response

Tapering Resources Available

- Who are atom Alliance and TIMES?







- The Qsource team can help you apply these resources to the nursing home setting

Team for Innovation in MEdication Safety

Communicating with Residents and Families about Opioids

Resources available

Resources Available

CDC Guideline for Prescribing Opioids for Chronic Pain: Effective communication with patients about opioid therapy

- Discuss ways to strengthen the provider-patient relationship to support shared decision-making in the use of opioids for chronic pain
- Identify potentially negative outcomes that may result from a lack of concordance between provider and patient on opioid therapy
- Identify when to coordinate care with mental health providers and other specialists for patients on opioid therapy
- Discuss ways providers can enhance collaboration with patients to optimize the benefits and minimize the harms from long-term opioid therapy

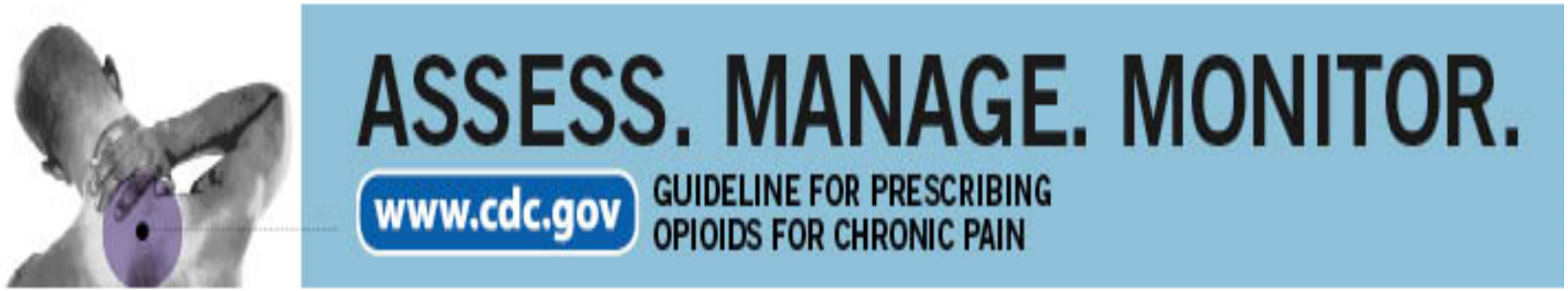
https://emergency.cdc.gov/coca/calls/2016/callinfo_121316.asp

Effective Communication is Critical When…

- Communicating important information (For example, “Taking opioids with alcohol or other drugs can cause you to stop breathing and die.”)
- Motivating behavior change (For example, committing to taper opioids)
- Addressing conflicts (For example, “I don’t think opioids will help your headaches.”)

Two Principles for Effective Communication

- Approach patients with compassion
- Use relationship-building skills, including
  - Reflective listening
  - Empathic statements



Your Multidisciplinary Team

1. Role of the SNF Instructor
2. Others to Include on Your Team
3. TeamSTEPPS

Role of the SNF Instructor

Each facility will have one designated staff member to receive training to become an Instructor.

Responsibilities include:

- Lead the project to facilitate improvement efforts
- Train staff at the facility on new processes for pain management, to include alternative options for pain treatment.
- Collect and report data to Qsource on a monthly basis
- Be the main point of contact for Qsource during this project

Others to Include on Your Team

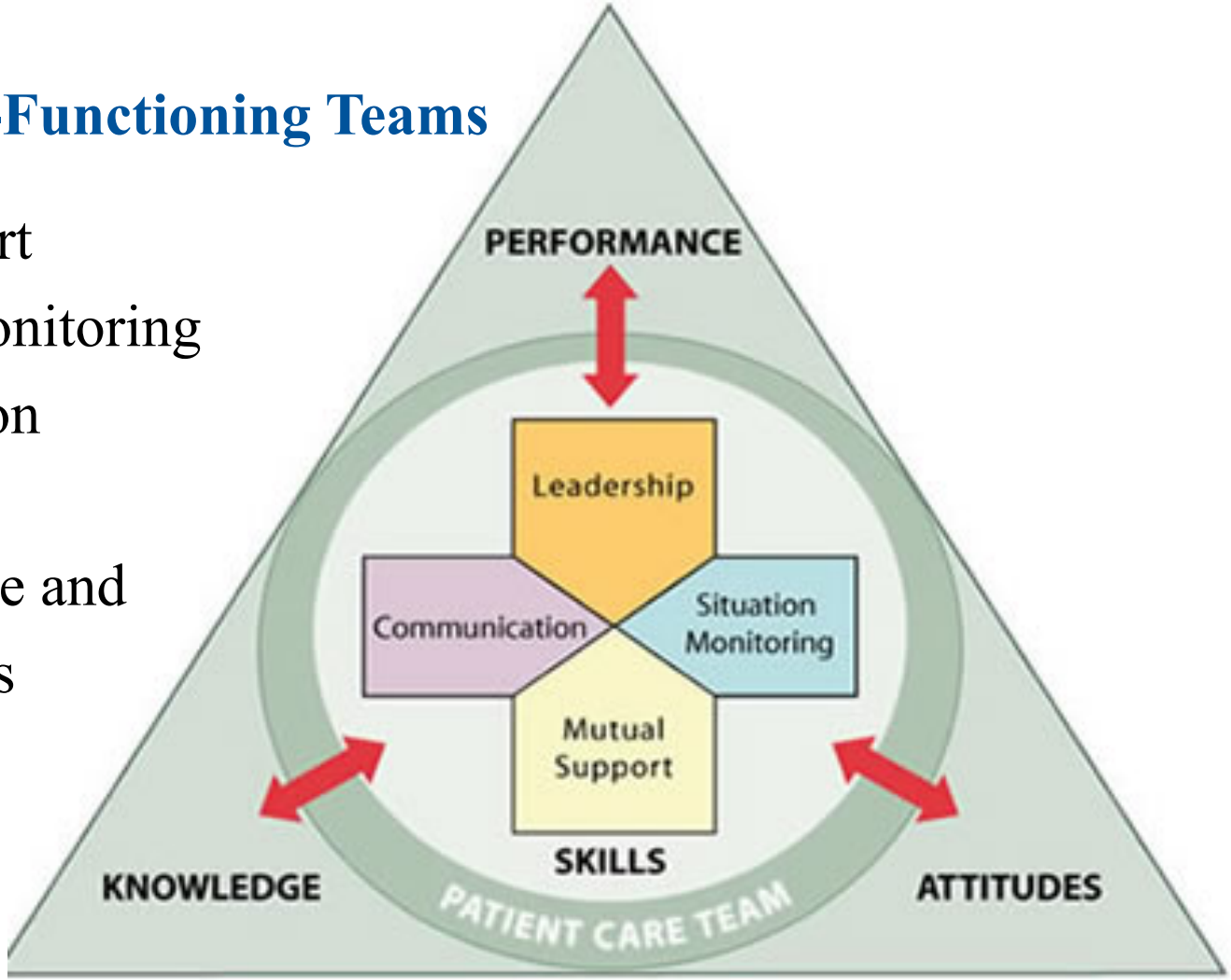
- Front line staff
- Director of nursing
- Administrator
- Pharmacist
- Quality staff
- Medical Director
- Resident/Family members

TeamSTEPPS

Team Strategies and Tools to Enhance Performance and Patient Safety

Developing High-Functioning Teams

- Mutual Support
- Situational Monitoring
- Communication
- Leadership
- Team Structure and Characteristics



What are Comfort Menus?

1. One way to increase access to non-opioid pain management options
2. How to create a comfort menu for your facility

One Way to Increase Access to Non-Opioid Pain Management Options

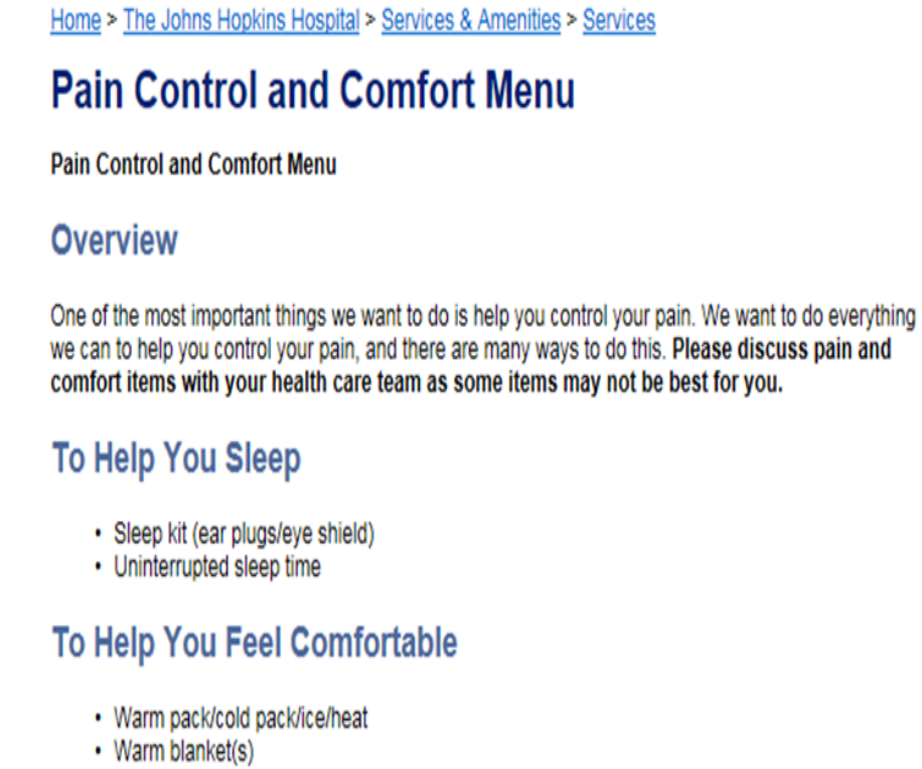
- Comfort Menus for Pain Management

- When residents experience pain, do we always prescribe an opioid?

- What can we do instead?

https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/services_amenities/services/pain-control-comfort-menu.html

JOHNS HOPKINS MEDICINE



Home > The Johns Hopkins Hospital > Services & Amenities > Services

Pain Control and Comfort Menu

Pain Control and Comfort Menu

Overview

One of the most important things we want to do is help you control your pain. We want to do everything we can to help you control your pain, and there are many ways to do this. **Please discuss pain and comfort items with your health care team as some items may not be best for you.**

To Help You Sleep

- Sleep kit (ear plugs/eye shield)
- Uninterrupted sleep time

To Help You Feel Comfortable

- Warm pack/cold pack/ice/heat
- Warm blanket(s)

Comfort Menus for Pain Management

Menu of Comfort Items Available

Sleep
- Warm bath or shower
- Essential oil
- Darkness
- Eye mask
- Night light
- Quiet
- Music
- No interruptions
- Herbal tea
- Snack or sandwich
- Massage
- Television
- Sound machine

Feeling Better
- Shampoo
- Scalp massage
- Toothbrush and floss
- Mouthwash
- Pet visit
- Prayer
- Pastoral care visit
- Meditation
- Deep breathing
- Guided imagery
- Sunshine
- Lollipop
- Chocolate
- Walking in the hallway
- Gental stretching

Comfort
- Warm blanket
- Warm washcloth
- Extra pillows
- Ice pack
- Hand massage
- Hand-held muscle massager
- Neck pillow
- Temperature adjustment
- Location
- Lip balm
- Repositioning
- Straightening bed linens

Relaxation
- Soothing sounds recording
- Snoezelen Room (sensory experience)
- Stress ball

Entertainment
- Adult coloring book
- Book (large print, audio)
- Magazine
- Deck of cards
- Reading visit
- Talking visit
- Hand-held electronic game

Benefits to Nursing Home Setting

- Minimal to no cost items
- Many items you may already be doing (repositioning, ice pack, etc.)
- Post at bedside and/or throughout facility and discuss with each patient
- Add to admission packet (?)
- Helps with consistent messaging across facility

Beyond the 0-10 scale: Monitoring Resident Response to Pain Treatment

1. PEG Scale: pain, enjoyment, general activity
2. For residents with dementia or who are nonverbal: Pain Assessment in Advanced Dementia Scale

PEG Scale

- Brief assessment scale
- Includes measurement of pain-related functioning
- May be more relevant that pain intensity to a resident's quality of life

1. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

http://mytopcare.org/wp-content/uploads/2013/06/PEG-Pain-Screening-Tool1.pdf

Pain in Advanced Dementia Scale

Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf

Pain in Advanced Dementia Scale

- Five-item observational tool
  - Breathing
  - Negative vocalization
  - Facial expression
  - Body language
  - Consolability
- Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items)
- A higher score indicating more severe pain (0="no pain“ to 10="severe pain")

How This Project Can Fulfill Federal Quality Assurance and Performance Improvement (QAPI) Requirements and Align with Survey Requirements

1. QAPI Requirements
2. How this project can fulfill the QAPI requirements for a performance improvement project
3. Pain management in survey requirements

QAPI Requirements

Phase 1: November 28, 2016
Facilities should be able to demonstrate compliance with updated policies, procedures, training needs, staff knowledge, resident information, updates and more.

Phase 2: November 28, 2017
Quality Assurance and Performance Improvement – QAPI Plan

Phase 3: November 28, 2019
Provide proof that facility has performed at least one performance improvement project (PIP) following all the elements of the new and revised regulations.

http://atomalliance.org/download/qapi-written-plan-guide/?wpdmdl=21045

How This Project Can Fulfill the QAPI Requirements for a PIP

- **Data Driven**
  - We will gather baseline data for this project prior to implementing interventions to drive improvement as well as gather monthly data to show trends.
- **Choosing a PIP based on high risk, high volume or problem prone areas**
  - Pain management is a high volume and problem prone area, and opioids are high risk medications.
- **Promote sustained improvement**
  - By implementing new processes, such as the comfort menu

Pain Management in Survey Requirements

- F697 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)
  - §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
  - The resident's needs and goals as well as the etiology, type, and severity of pain are relevant to developing a plan for pain management. It should be noted that **while analgesics can reduce pain and enhance the quality of life, they do not necessarily address the underlying cause of pain**. It is important to consider treating the underlying cause, where possible.

Guidance for §483.25(k)

- Address/treat the **underlying causes of the pain**, to the extent possible
- Develop and implement **both non-pharmacological and pharmacological interventions**/approaches to pain management
- Identify and use specific strategies for **preventing or minimizing different levels or sources of pain** or pain-related symptoms based on the resident-specific assessment, preferences and choices, a pertinent clinical rationale, and the resident's goals and; using pain medications judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences
- It is important that a resident be monitored for the presence of pain and be **evaluated when there is a change in condition and whenever new pain or an exacerbation of pain** is suspected

Post-Test and Session Evaluation

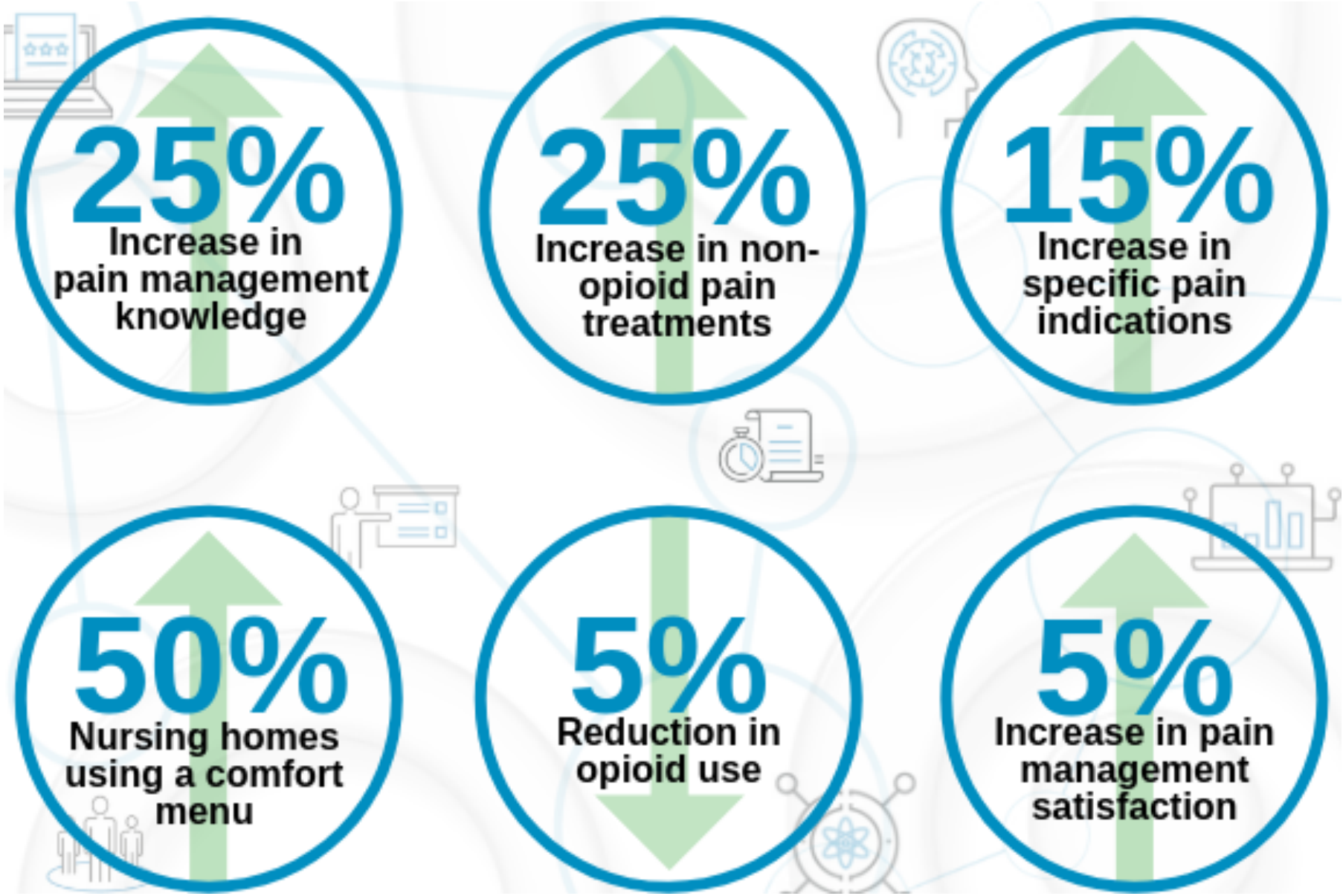
Thank you for attending today's in-person training event!

*Please complete the Post-Test and Session Evaluation and submit to a training facilitator before leaving.

Next Steps

1. Schedule one-on-one technical assistance
2. Share training with staff at your facility
3. Monthly data collection process
4. What to expect from the Qsource team

Goals and Expected Project Successes



Project Timeline

- **September 2019**
  - Attend summary webinar (exact date TBD)
- **Before 10/15/19**
  - Participate in a one-hour one-on-one virtual technical assistance session
  - Additional technical assistance provided as needed
- **10/1/19, 11/1/19, 12/1/19, 1/1/20, 2/1/20, 3/1/20**
  - Monthly data due
- **Early April 2020**
  - Attend outcomes congress webinar (exact date TBD)

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