Individualized Pain Management and Non-Opioid Approaches to Managing Pain

Training Session 1: Pain and Opioid Background and Clinical Practice Guidelines for Nursing Homes

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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

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Proportion of Residents with Opioid Orders

- Approximately 70 percent 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.

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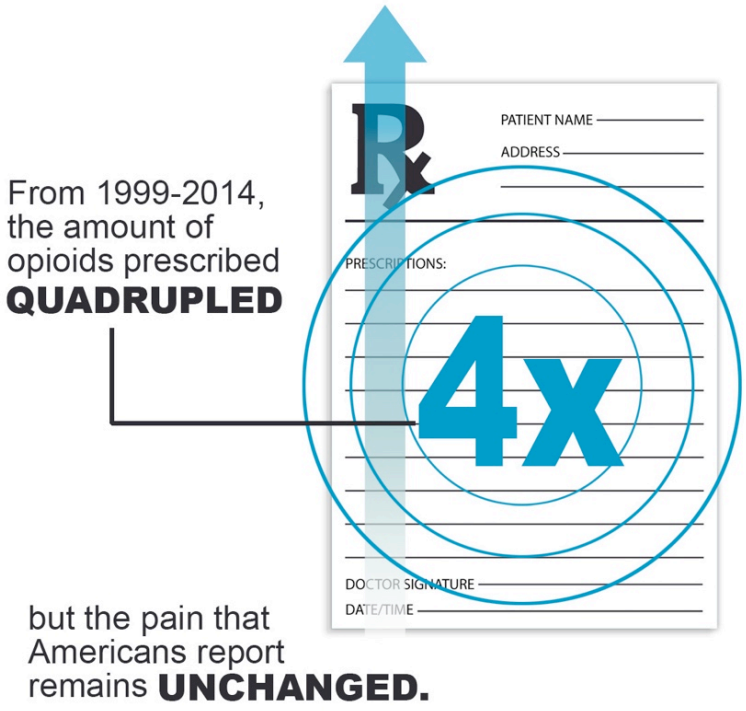
Opioid Efficacy for Chronic Non-Cancer Pain

- 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



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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		

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Connecting Pain Management and Opioids to Quality Measures

Quality Measure	Connection to Pain Management and Opioids
Falls (SS/LS)	Opioids are associated with increased fall risk
Depression (LS)	Ineffectively treated pain many cause or worsen depression
Weight loss (LS)	Opioids can cause nausea and vomiting
Help with ADLs (LS)	Sedation and poorly treated pain may lead to need for increased ADL assistance

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Connecting Pain Management and Opioids to Quality Measures (cont.)

Quality Measure	Connection to Pain Management and Opioids
Improvement in function/ability to move independently (SS/LS)	Sedation and poorly treated pain may lead to difficulties with locomotion, transfer, and walking
Pressure ulcers (SS/LS)	Opioids cause sedation which can increase risk of pressure ulcers
Bladder incontinence (LS)	Opioids decrease bladder contraction which can cause or worsen overflow incontinence, sedation can cause or worsen functional incontinence
Physical restraints (LS)	Ineffectively treated pain can cause or worsen behaviors for which restraints might be used

Quality Measure Considerations

What about the pain quality measure?

- Removed by CMS
- "This change supports the federal initiative to reduce opioid utilization by seeking to prevent a potential scenario where the performance of a facility on the pain quality measures may inappropriately contribute to their decision to seek the administration of an opioid." https://go.cms.gov/2MqTMIf

We talked about short and long stay measures. Which population should we focus on for this project?

- You choose based on the needs of your facility, but stay consistent throughout the project

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Discuss With Your Team

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

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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

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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

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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
  - KEY POINT: These populations are <u>not</u> included in this project
- We will focus specifically on applying the Guideline to long-term care residents
  - Some recommendations apply more than others

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CDC Guideline

Recommendation 1: Opioids not first line or routine therapy for chronic pain

- Non-pharmacologic and non-opioid pharmacologic therapy are preferred for chronic pain
- If opioids are used, they should be combined with non-pharmacologic and non-opioid pharmacologic therapy, **as appropriate**
- This project will help you increase access to these therapies for your residents

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CDC Guideline (cont.)

Recommendation 2: Before starting opioids for chronic pain, clinicians should establish treatment goals, including realistic goals for **pain and function**

Recommendation 3: Consider how therapy will be discontinued if **benefits do not outweigh risks**

- Discuss risks and benefits with residents and their representatives

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CDC Guideline (cont.)

Recommendation 4: When starting opioids, clinicians should prescribe immediate-release (IR) instead of extended-release/long-acting (ER/LA) formulations

- Special caution for fentanyl patches and combining IR and ER/LA opioids

Recommendation 5: Use caution at any dose and avoid increasing to high doses

- ≥ 50 MME: assess benefits vs. risks
- ≥ 90 MME: avoid or carefully justify

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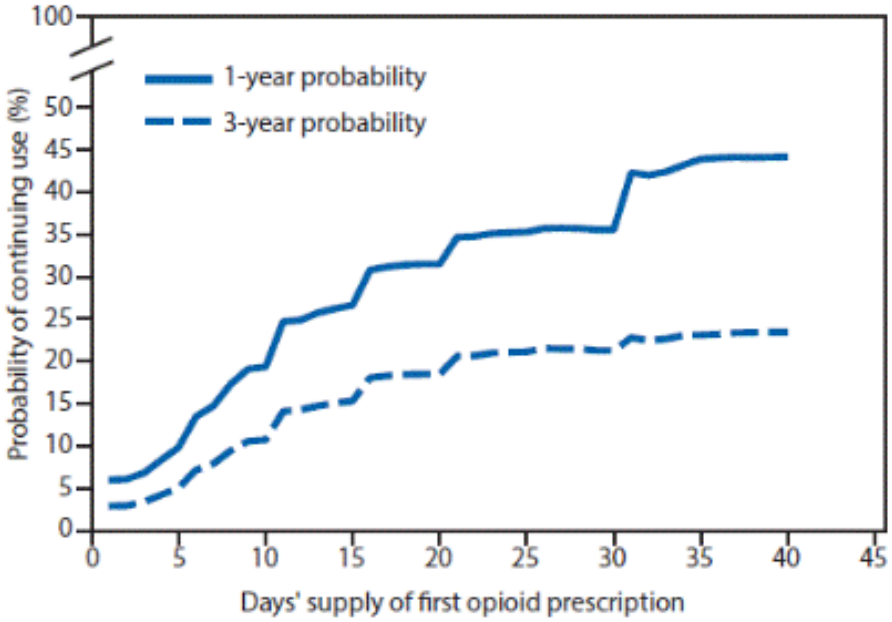
CDC Guideline (cont.)

Recommendation 6:

For acute pain, prescribe no more than needed

- Lowest effective dose, immediate release
- 3-7 days might be enough



https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

Probability of Continued Opioid Use of Opioid Naïve Patients, by Number of Days Supply of the First Prescription

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CDC Guideline

Recommendation 7: Offer a taper if opioids cause harm or are not helping

- Evaluate benefits and harms within 1 to 4 weeks of starting opioids or increasing dose
- Re-evaluate at least every 3 months

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CDC Guideline (cont.)

Recommendation 7

How can you evaluate benefits and harms?

- The PEG Scale: We'll come back to this later

Need help with tapering?

- HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics https://bit.ly/36Zdgx1
- http://resourcehub.exchange/times/
- Qsource is available for assistance

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CDC Guideline

Recommendation 11: Avoid concurrent opioid and benzodiazepine prescribing whenever possible.

Benzodiazepine examples

- Lorazepam (Ativan®)
- Diazepam (Valium®)
- Alprazolam (Xanax®)

Why? Additive adverse effects:

- Cognitive impairment
- Fall risk
- Respiratory depression

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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
- A specific evaluation and history of the patient's pain condition should be obtained
  - *Preview of specific indications, which we'll discuss later*

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Tennessee Chronic Pain Guidelines (cont.)

- 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 opioid concurrently

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Next Steps

1. Complete your Post-Test for Training Session 1
2. View Training Sessions 2 and 3
3. Schedule check-in call with Qsource

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References

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8. Tennessee Chronic Pain Guidelines. Tennessee Department of Health. 2020. https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf

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