Opioid Use & Challenges in Subacute and Long-Term Care

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Fourth Annual Bi-State Conference on Post-Acute & Long Term Care
April 27, 2019

Disclosures

- No financially relevant disclosures.

Objectives

- Identify patients at risk for opioid abuse in the nursing home setting
- Manage patients with acute pain and a history of opiate abuse
- Evaluate patients with chronic pain and a history of substance use

The problem

- 1 in 7 NH residents was prescribed opioids long-term.
- Opiate prescribing twice as high in NH than community dwelling elders
- No studies have determined efficacy of long-term opiates
- NH residents may be more vulnerable to adverse effects of opiates

Prevalence of Long-Term Opioid Use in Long-Stay Nursing Home Residents JN Hunnicutt, SA Chrysanthopoulou, CM Ulbricht, AL Hume, J Tjia, KL Lapane. *JAGS* 66:48–55, 2018.

Illinois

- No restriction on prescribing opiates
- Must check drug monitoring database prior to prescribing
- Initial 7 day opioid limit in clinic patients.
- Unclear if 7 day limit applies to long term care facilities.
- Some insurance carriers are also limiting prescriptions for opioids.

Missouri

- Missouri does not have a standardized opioid reporting program but St Louis does.
- No requirement to check it prior to dispensing.
- NP/PAs cannot prescribe.
- Quantity limit of 7 days first dispense is the standard followed.

Results of inadequate pain control

- Poor quality of life
- Decreased functioning
- Anxiety/depression

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

- Estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription
- Elderly, persons with cognitive impairment, and those with cancer and at the end of life, can be at risk for inadequate pain treatment
- Serious risks, including overdose and opioid use disorder

Determining When to Initiate or Continue Opioids for Chronic Pain

- **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred** for chronic pain. Expected benefits for both pain and function should outweigh risks. Opioids should be combined with nonpharmacologic and nonopioid pharmacologic therapy.
- Before starting opioid therapy, establish **realistic treatment goals for pain and function**, and consider how therapy will be discontinued if benefits do not outweigh risks. Continue only if there is clinically meaningful improvement in pain and function that outweighs risks.

Determining When to Initiate or Continue Opioids for Chronic Pain, cont.

- Before starting and periodically during opioid therapy, discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

- Start with **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.
- Prescribe the **lowest effective dosage**. 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 avoid increasing dosage to =90 MME/day or carefully justify a decision to titrate dosage to =90 MME/day.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation, cont.

- For **acute pain**, prescribe lowest effective dose of immediate-release opioids and no greater quantity than needed for the expected duration of severe pain. Three days or less will often be sufficient; more than seven days will rarely be needed.
- **Evaluate benefits and harms** with patients within 1 to 4 weeks of starting opioid therapy or of dose escalation and every 3 months. If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and taper opioids to lower dosages or to discontinue.

Assessing Risk and Addressing Harms of Opioid Use

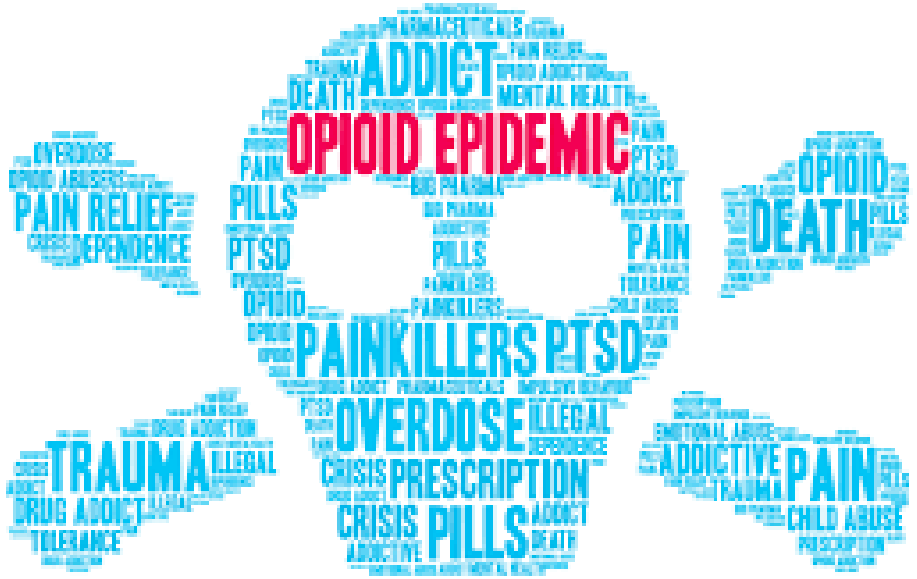
- Before starting and periodically, **evaluate risk factors for opioid-related harms**. Incorporate plan strategies to mitigate risk, consider naloxone if increased risk for opioid overdose, (h/o of overdose, h/o substance use disorder, higher opioid dosages (=50 MME/day), or concurrent benzodiazepine use).
- Review state **prescription drug monitoring program** (PDMP) data when starting opioid therapy and periodically, ranging from every prescription to every 3 months.

Assessing Risk and Addressing Harms of Opioid Use, cont.

- 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.
- **Avoid prescribing opioid pain medication and benzodiazepines** concurrently whenever possible.
- 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**.

Challenges

- NH staffing
- Reimbursement of non-pharmacologic therapies
  - biofeedback, massage, electrical stimulation
- Insurance coverage for non-opiates
  - Lidocaine patch limited to post-herpetic neuralgia and diabetic neuropathy
  - Diclofenac gel
- Pain control is a quality measure
- Transportation for injections, nerve blocks, etc.


OPIOID EPIDEMIC
ADDICT
DEATH
MENTAL HEALTH
PAIN
PTSD
PILLS
ADDICT
PAIN
OPIOID
PAINKILLERS
PTSD
OVERDOSE
ILLEGAL
CRISIS
PRESCRIPTION
CRISIS
PILLS
ADDICT
TRAUMA
DRUG ADDICT
TOLERANCE
ADDICTIVE
PAIN
CHILD ABUSE
OPIOID
DEATH
PAIN RELIEF
DEPENDENCE
OVERDOSE

Initial Checklist

- Objective Pain Assessment
- PHQ9 (in MDS)
- Opioid Risk Tool
- Patient Evaluation for Chronic pain
- Controlled Substances Agreement and Patient Responsibility form
- Chronic Pain Opioid Informed Consent
- Review old records
- Review Prescription Drug Monitoring database

Subsequent Visit Checklist

- Objective Pain Assessment
- PHQ9 (in MDS)

Objective Pain Assessment Tool for Older Adults

- 1. Pain Location:
- 2. Pain Duration:
- 3. Exacerbating Factors:
- 4. Relieving Factors:
- 5. Degree of interference with activities because of pain:
  - Mobility (bed, ambulating), transferring, toileting, bathing, dressing, sleeping, concentration, relationships, activities outside the home (shopping, church, appointments)
- 6. Treatment Goals of Patient:

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Opioid Risk Tool

- Should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management
- Score of 3 or lower indicates **low** risk for future opioid abuse
- Score of 4 to 7 indicates **moderate** risk for opioid abuse
- Score of 8 or higher indicates a **high** risk for opioid abuse

Patient Evaluation for Chronic Pain

- Past medical history
- Family medical history
- Past substance use
- Current substance use
- Previous pain treatments, timeframe, efficacy
  - Injections
  - TENS unit
  - Physical Therapy/Occupational Therapy
  - Chiropractor
  - Acupuncture
  - Surgery

Controlled Substance Agreement & Patient Responsibilities

- Obtain from only one prescriber
- Obtain from only one pharmacy
- No early fills
- No replacement of "lost/stolen" prescriptions
- No use of street drugs

Chronic Pain Opioid Informed Consent

- Goals
- “No Guarantees”
- Side Effects (in detail)
- Patient responsibilities

Prescription Drug Monitoring Program

- Report summarizes the controlled substances a patient has been prescribed, the practitioner who prescribed them and the dispensing pharmacy where the patient obtained them.
- Good idea prior to prescribing opiate for residents receiving rehab and/or planned transition back to community
- Less utility for long-term care residents

Case 1

- 72 y/o retired nurse s/p Rt TKA
- PMH: HTN, h/o morphine addiction
- Allergies: Darvocet
- SH: lives alone 3rd floor condo
- Functional status: independent with ADLs and IADLs, uses a cane
- PE: Rt knee effusion, no warmth, 90 degrees flexion, +5 degrees extension

Case 1, cont.

- Received PRN IV hydromorphone and PO hydrocodone in the hospital
- Discharged with scheduled acetaminophen 1000mg q 8 hrs.
- PT reports patient not able to participate in ROM exercises due to pain
- Orders?

Case 1, cont.

- Start hydrocodone 5/325 q 4 PRN, decrease scheduled acetaminophen to 500mg q6 hours
- Nurses complain patient is asking for hydrocodone every 4 hours and watching the clock
- Orders?
- Schedule hydrocodone 5/325 q4 hours and discontinue acetaminophen
- Duration?

Case 1, cont.

- Patient is discharging home
- ROM is 110 degrees flexion, 0 degrees extension
- Able to climb 3 flights of stairs
- Discharge with pain medications?
- How many?

Case 2

- 80 y/o male with HFpEF, HTN, early DAT, CKD (Cr 1.7)
- Remote h/o heroin use, recent marijuana use
- c/o severe low back pain
- Not progressing in PT due to pain with ambulation
- Goal is to discharge home with wife
- XR shows DDD lumbar spine
- Failed acetaminophen 1000mg q8 hrs.
- Insurance denied diclofenac gel and lidocaine patch

Case 2, cont.

- Orders?
- Is he a surgical candidate?
- What about an epidural?
- Discharge with pain medication (given marijuana use)?
- How many?

Non-Pharmacologic alternatives

- Heat and cold
- Biofeedback
- Massage, stretching
- Nerve block
- Electrical stimulation

Case 3

- 55 y/o female s/p stroke with right hemiparesis, cognitive impairment, seizures, HFrEF
- h/o cocaine use, previous smoker
- Transfers from another facility to be closer to family
- PE: lethargic, only able to answer simple yes/no questions, no apparent pain with position changes or ROM of arms/legs
- Meds: amlodipine, citalopram, atorvastatin, ASA, lisinopril, tiotropium, fentanyl patch

Case 3, cont.

- Concerns?
- What to do about fentanyl patch?

Red Flags

- Finding pills in drawer, purse, room, etc.
- Pocketing pills
- Refusing to take pills while observed
- Asking for specific drug (and/or dose) only
- Watching the clock
- Allergies to multiple pain medications

Utilize The Four A's of pain treatment outcomes

- **A**nalgesia (pain control),
- **A**ctivities of daily living (patient/resident functioning and quality of life),
- **A**dverse events (medication side effects) and
- **A**berrant drug-related behavior (addiction related outcomes).

Passik and Weinreb, 2000

Urine Drug Screens

- May be appropriate for residents who leave the facility
- May be appropriate when the clinical picture doesn't make sense
- Likely not appropriate for residents who are totally incontinent
- Likely not appropriate for residents on hospice or end-of-life care

Setting Boundaries

- Limit who visits the resident
- Visitors limited to common areas where he/she can be directly observed
- Illegal substances vs. controlled substances
- Observe med administration
- Controlling pain ≠prescribing resident's preferred opiate

Discharging Residents Home

- Limit number of tablets
- Consider if resident has a controlled substance contract with another provider
- How soon can resident be scheduled with PCP/ortho/prescriber?
- Consider if resident has other controlled substances at home (taking prior to hospital admission) – obtain via Prescription Drug Monitoring Program report


PAIN


NO OPIATES


GUARANTEES

References

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