# Pain in Transition: Appropriate and Effective Pain Management With Opioids

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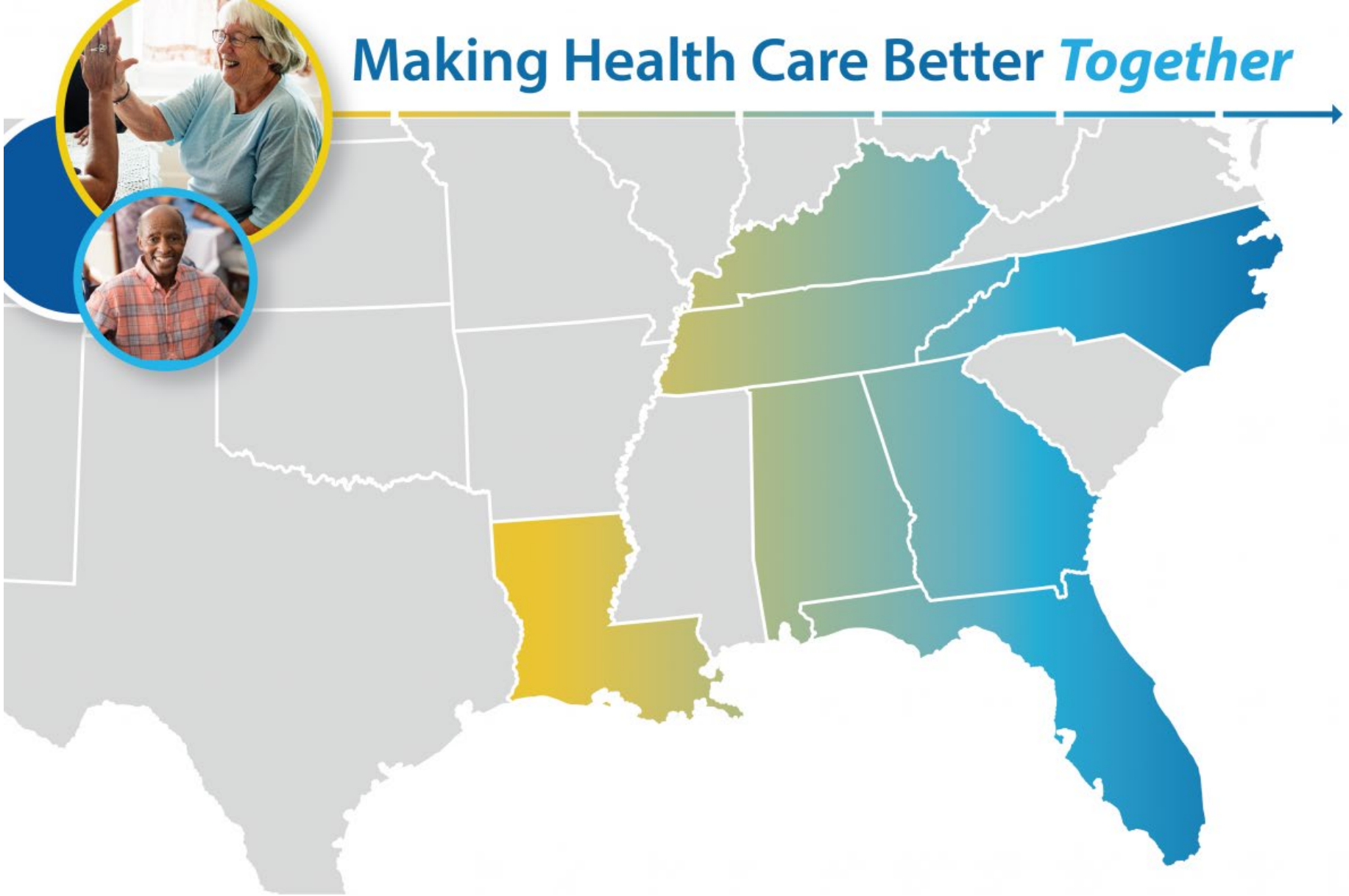


# About Alliant Health Solutions

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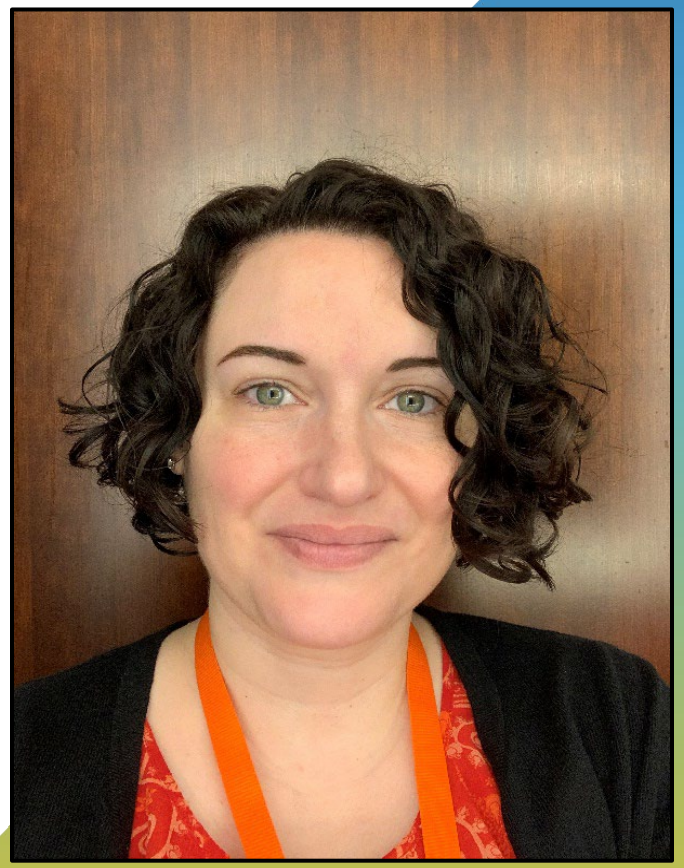
# Tanya Vadala, Pharm.D.

## MEDICATION SAFETY PHARMACIST

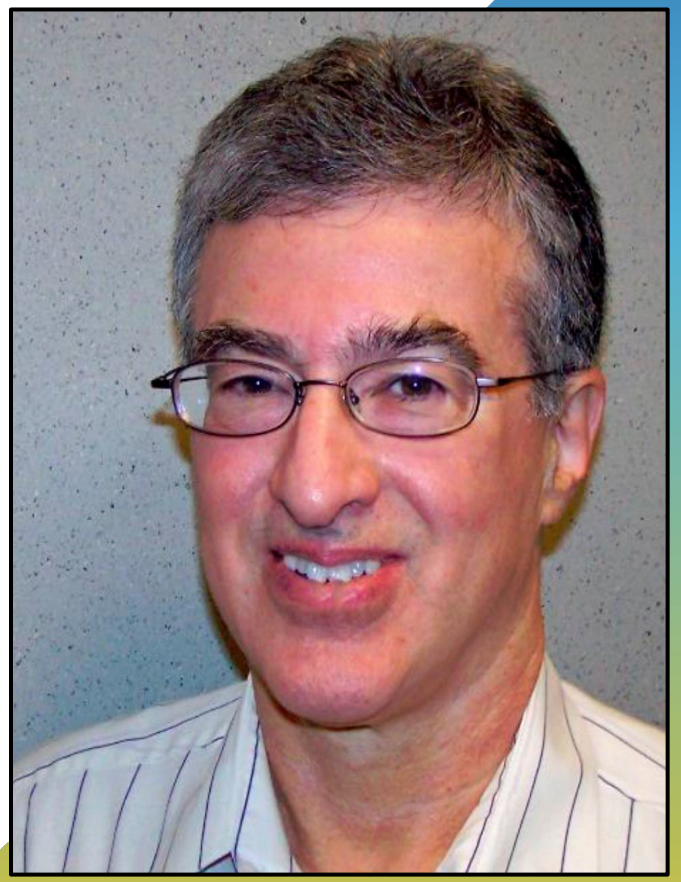
Tanya is an IPRO pharmacist with 19 years of clinical pharmacy, community pharmacy, academia, quality improvement and medication safety experience. Prior to joining IPRO, she worked at various community pharmacies and taught at the Albany College of Pharmacy and Health Sciences in Albany, N.Y. She specializes in Medication Therapy Management (MTM), medication reconciliation, opioids, immunizations and patient self-care. Her formal teaching experience includes courses in pharmacy practice and clinical experiential teaching.



**Contact:** TVadala@ipro.org

# Steven Levenson, MD, CMD

Steven Levenson, MD, CMD has spent 43 years providing and overseeing long-term and post-acute care. He has been medical director in 22 different nursing homes in Maryland, and has also reviewed and guided care of thousands of patients in facilities in 28 different states. He has authored or co-authored more than 80 articles and four books on medical direction, subacute care, quality improvement, and many other topics. Between 1988 and 2013, he was extensively involved with CMS in developing and refining various aspects of the OBRA process including surveyor guidance, the MDS, and training materials for surveyors and facilities. This included several updates to the Unnecessary Drugs guidance. including those related to psychopharmacologic medications. He also recently chaired the workgroup that revamped the AMDA Pain CPG.



# Elements of High-Quality Care

According to the Institute of Medicine (IOM), high-quality care is:

- Safe
- Effective
- Efficient
- Patient-centered
- Timely
- Equitable

# Patient Populations of Concern
# Opioid Use in LTC

1. Skilled patients who were not taking opioids prior to hospitalization arrived with opioid orders.
2. Skilled patients who were taking opioids long-term prior arrived with opioid orders at a higher dose than long-term use.
3. Skilled patients with an opioid use disorder diagnosis who were not taking (prescribed) opioids prior to hospitalization and arrived with opioid orders.
4. Long-term residents taking opioids long-term.
5. Long-term residents with a diagnosis of opioid use disorder and not taking opioids.

# Case #1

76 y/o male sustained a femoral neck fx and underwent hemiarthroplasty. He was treated for PNA during his stay with Rocephin. He presented to the facility for rehab 12 days later.

Med Hx: ESRD, anemia, HTN, a-fib
Meds: clonidine 0.1mg bid, Coumadin, norco 5/325mg q6 prn, coreg 6.25mg po bid
VS: BP 140/74 T 97.7 P 66 R 20

# Case #1

24 days after he is admitted to the facility, the MD is in the facility seeing new admissions and is asked to evaluate the resident due to his demand to go to the ER. The resident states that his Norco “is not working.”

Of note, he was started on Keflex for incision infection three days prior to the above incident and nursing reports that the incision is “not red at all.” On evaluation, the resident is lying in bed watching TV in NAD.

# Hospital Opioid Prescribing

Now, a handful of doctors and hospital administrators are asking if an opioid addiction starts with a prescription after surgery or some other hospital-based care, should the hospital be penalized?

As in: Is addiction a medical error along the lines of some hospital-acquired infections?

"It arises during a hospitalization, is a high-cost and high-volume condition and could reasonably have been prevented through the application of evidence-based guidelines," write Drs. Michael Schlosser, Ravi Chari and Jonathan Perlin.

# How Long Should Residents Receive Opioids Post-Op?

**Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures**

Rebecca E. Scully, MD[1]; Andrew J. Schoenfeld, MD, MSc[1]; Wei Jiang, MS[1]; et al Stuart Lipsitz, ScD[1]; Muhammad Ali Chaudhary, MBBS[1]; Peter A. Learn, MD[2]; Tracey Koehlmoos, PhD, MHA[3]; Adil H. Haider, MD, MPH[1,4]; Louis L. Nguyen, MD, MBA, MPH[1]

JAMA Surg. 2018;153(1):37-43. doi:10.1001/jamasurg.2017.3132

# How Long?

"Ideally, opioid prescriptions after surgery should balance adequate pain management against the duration of treatment. In practice, the optimal length of opioid prescriptions lies between the observed median prescription length and the early nadir, or **4 to 9 days for general surgery procedures, 4 to 13 days for women's health procedures, and 6 to 15 days for musculoskeletal procedures.**"

# Patient Population #2

Residents who are taking opioids long-term and arrive on a dose greater than what they had been taking at home.

Challenges:

1. Tolerance
2. Home supply (send home with a script?)
3. Is screening for opioid use disorder needed?
4. What is the appropriate weaning schedule? Wean to chronic dose?

# Case #2

51 y/o female who was hospitalized due to LLE pain. She was found to have an ABI of 0.41 and underwent L BKA (she had a previous R BKA due to a similar presentation).

Pertinent meds on arrival: Neurontin 100mg tid, oxycodone ER 20mg po q12, oxycodone IR 5mg po q4 PRN.

She states that she was taking Percocet 10/325mg po tid at home prior to hospitalization due to her “foot issues.” Her PCP had been prescribing, and she admits to a home supply but does not know how many. She admits to a several-month use.

# Case #2

Plan:

1. On admission, begin a weaning schedule of oxycodone IR.
2. Once IR is weaned, begin weaning of oxycodone ER.
3. Monitor for symptoms of withdrawal and treat if needed.
4. If the resident is discharged prior to wean being complete, advise to follow-up with PCP regarding pain control since she was admitted to home supply.

# Patient Population #3

These are skilled residents with a documented diagnosis of opioid use disorder who arrive at the facility with orders for opioids due to recent surgery or fracture.

# Case #3

50 y/o male who presented to the ER with acute L limb ischemia. He was admitted and underwent embolectomy and fasciotomy. He was also found to have an LV thrombus on echo. He has a documented diagnosis of an opioid use disorder, and when pain management is discussed at the bedside, he admits to having “past problems with pills.”

Meds: morphine 15mg po bid, oxycocodone 5mg po q6 prn

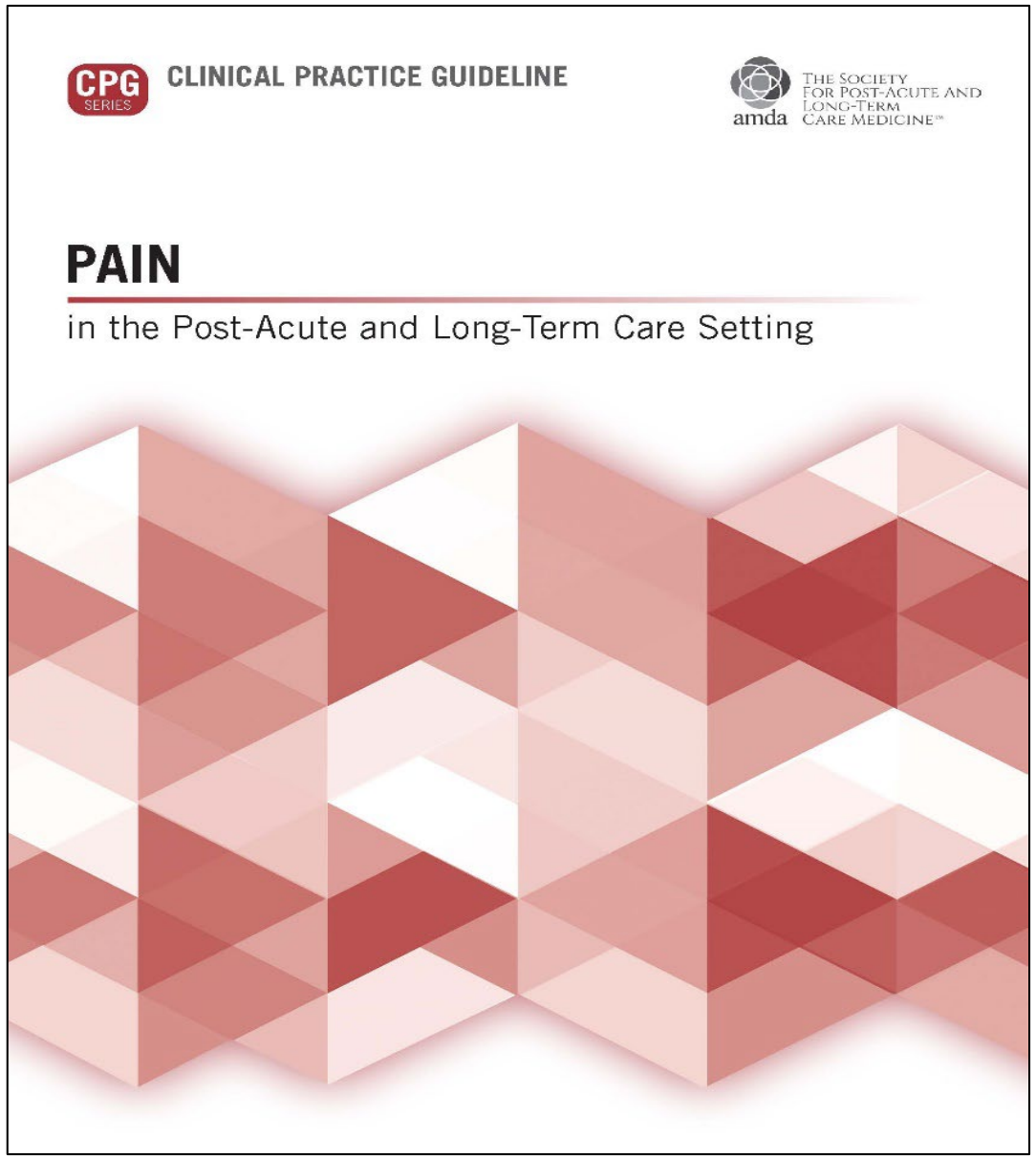
He is initially agreeable to opioid wean, and it is ordered upon admission. Soon after admission, he complains of pain on a daily basis. Opioid alternatives are initiated, and opioids are completely weaned off. Eventually, the resident develops gangrenous toes and is readmitted to the hospital for amputation. He returns with orders for Norco 5/325mg po q6, and weaning orders are written.

# Case #3

The resident transitions to LTC and continually complains of pain but appears in NAD. He ambulates around the facility and states that he cannot be discharged because he is homeless. He becomes friendly with nursing and staff.

Approximately two months after his Norco is completely weaned off, the resident breaks into a med cart with a butter knife and snorts 22 Xanax and 12 norco. He is sent to the hospital and returns to the center the next day and is told he will be discharged in 30 days. The resident walks out of the facility.

# Pain CPG 2021 Update

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# Secrets to Pain Management


- Frequency
- Intensity
- Duration
- Characteristics
- Chronological story

**TABLE 1** Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

| Category | Criteria |
|---|---|
| Impaired control | • Opioids used in larger amounts or for longer than intended<br>• Unsuccessful efforts or desire to cut back or control opioid use<br>• Excessive amount of time spent obtaining, using, or recovering from opioids<br>• Craving to use opioids |
| Social impairment | • Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use<br>• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems<br>• Reduced or given up important social, occupational, or recreational activities because of opioid use |
| Risky use | • Opioid use in physically hazardous situations<br>• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use |
| Pharmacological properties | • Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount<br>• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal |

**TABLE 2** Comparison of FDA-approved medications for the treatment of opioid use disorders

| Medication | Mechanism of action at μ-opioid receptor | Phase of treatment | Formulations | Dosages commonly used | Adverse effects | Regulations/ availability |
|---|---|---|---|---|---|---|
| Methadone | Agonist | Detoxification, maintenance | Oral | Detoxification: 20 - 40 mg/d, maintenance: 80 - 120 mg/d | Respiratory suppression, sedation, prolonged QTc, constipation, hyperhidrosis, sexual dysfunctions | Only available at designated federally regulated opioid treatment sites |
| Buprenorphine | Partial agonist | Detoxification, maintenance | Sublingual, buccal | 2 - 32 mg/d | Constipation, nausea, precipitated withdrawal | Requires DATA 2000 waiver + DEA X-number, available for office-based treatment |
| Naltrexone | Antagonist | Relapse prevention, maintenance | Oral, intramuscular | 25 - 100 mg/d PO, 380 mg/mo IM | Nausea, anxiety, insomnia, precipitated withdrawal | None, office-based treatment |

Data 2000, Drug Addiction Treatment Act of 2000; DEA, Drug Enforcement Administration.

# Case #4

58 y/o male long-term resident of the facility for two years.
The resident had been on multiple opioid medications over the last two years, and his initial presentation to the ER was due to “running out of pain meds.” He was initially prescribed opioids after AKA.

Pertinent meds: morphine sulfate ER 30mg po q12, Neurontin 600mg po q8

# Case #4

Weaning off morphine was discussed with the resident, who was initially resistant, but after much discussion, he became agreeable. Slow wean was started over two months. He became belligerent several times and asked for morphine back. Low-dose benzodiazepine was prescribed for seven days at one point.

The resident is eventually weaned completely off morphine. Nursing encourages the resident to spend more time with family. The resident goes fishing with his son, which he has not done in over two years. He tells nursing that he “feels great” and discharges home one month after morphine is weaned off.

# Case #5

48 y/o LTR of a facility was admitted after hospitalization for a motorcycle accident. He rarely gets out of bed and has a diagnosis of functional quadriplegia.

Pertinent meds: oxycontin 40mg po q12 and oxycodone 30mg po q4 prn

The patient admitted that the regimen “wasn’t working” for his “spine pain.” Opioid weaning was discussed, and he was agreeable. Orders were written to change his PRN dosing from q4 to q6 prn for seven days then his PRN dose was reduced by 10mg every 10 days.

Once the PRN dose reached 10mg, the resident told nursing he was “withdrawing.” He described nausea, anxiety, and insomnia.

# Case #5

The resident denied any pain symptoms to the MD.

The resident then called a complaint to the Health Department and the ombudsman (the complaint was not substantiated).

The weaning schedule stopped. He remained on oxycontin 40mg q12 and oxycodone 10mg po q6.

He told the ombudsman that he wanted more oxycodone, not given.

Sent out to the ER three weeks later due to small bowel obstruction.

# Opioids Cause Psychiatric Issues

**Table 1. Some Drug Classes** (continued)

| Drug | Reactions | Comments |
|---|---|---|
| Monoamine oxidase (MAO) inhibitors | Mania or hypomania, suicidality | |
| Nonsteroidal anti-inflammatory drugs (NSAIDs) | Depression, paranoia, psychosis, confusion, anxiety | Probably more common with indomethacin[6]; one case of exacerbation of psychosis in known schizophrenia with ibuprofen[7] |
| Opioids | Nightmares, anxiety, agitation, euphoria, dysphoria, depression, paranoia, psychosis, hallucinations, dementia | Usually with high doses; also occurs with intrathecal morphine, especially in elderly |
| Procaine derivatives (procainamide, procaine penicillin G) | Fear of imminent death, hallucinations, illusions, delusions, agitation, mania, depersonalization, psychosis | Probably due to procaine |
| Salicylates | Agitation, confusion, hallucinations, paranoia | Chronic intoxication |
| Selective serotonin reuptake inhibitors (SSRIs) | Mania, hypomania, hallucinations, suicidality | Anxiety, irritability, aggression or impulsivity on withdrawal |
| Sulfonamides | Confusion, disorientation, depression, euphoria, hallucinations | Several reports |

# Pain Case #6

Patient has fentanyl patch q 72h for pain.

The nursing assistant tells the nurse that the resident is “crabby” and would not go for his walk after dinner.

The nurse checked the fentanyl patch.

Nurse updated nurse practitioner (NP).

NP ordered the patch to be changed to q 48 h instead of the previous q 72 h.

# Pain Case #7

61 y/o patient with fibromyalgia.

Referred for apathy and behavior issues.

Medications: fentanyl patch 50 mc qday, Morphine ER 30 mg bid

Subsequently had chest pain, so added Dilaudid 4 mg q6h PRN.
Staff, DON and NPs did not like any of the questions or discussion of indications.

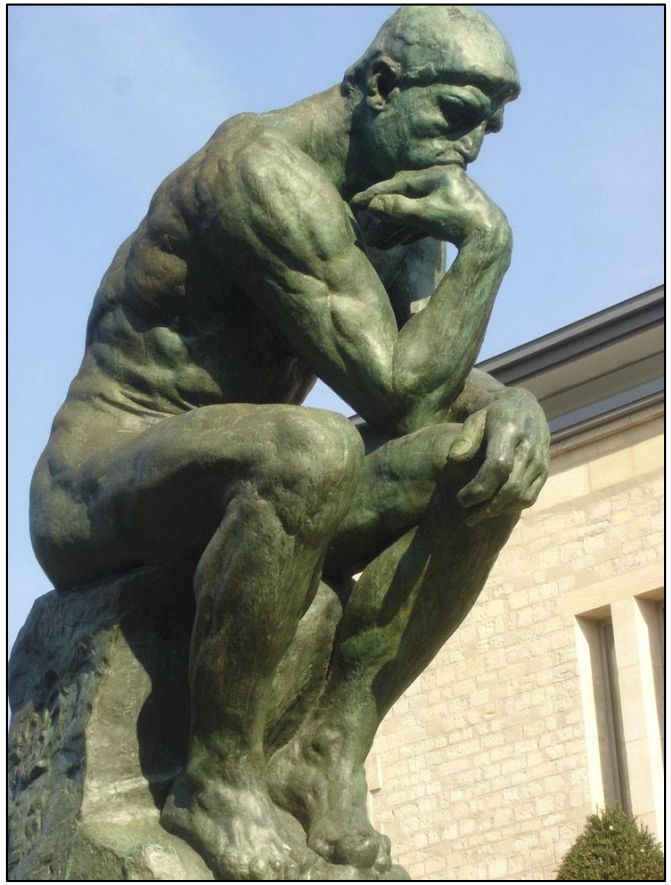
# A World Awash in Pills

# Key Principles

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

# PAIN AND THE CARE DELIVERY PROCESS

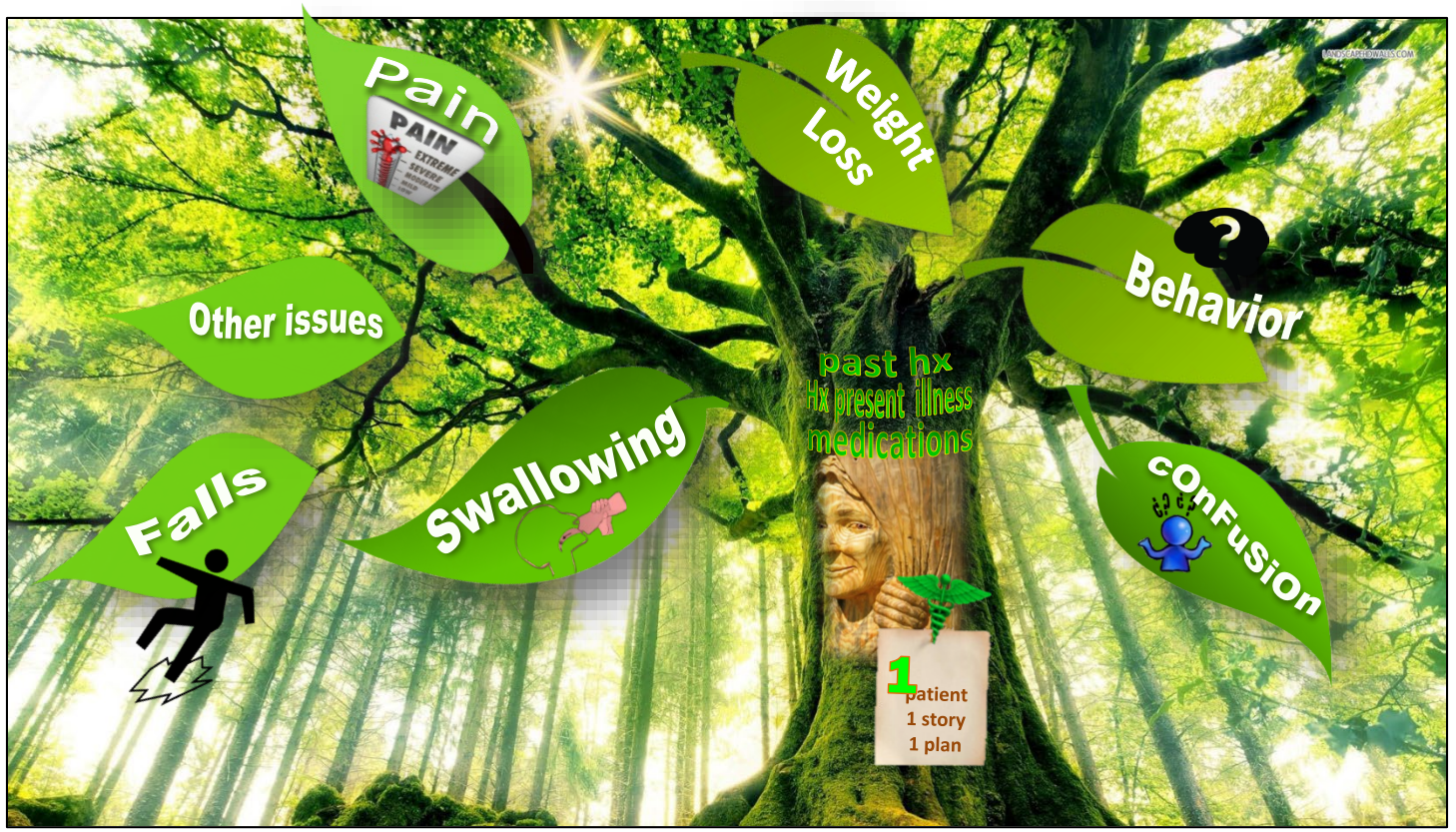
# Clear Thinking and Excellent Detective Work Is Needed



# The Perils of Guessing

# Care Process

- Pain is a symptom, not a diagnosis.
- Must follow the care delivery process steps faithfully.
  - If pain is or might be present, we must look at the whole picture, not just manage in isolation.
- Adequate assessment and diagnostic efforts are essential.
- The entire interprofessional team—not just nurses or medical practitioners—must follow the process.


Pain
PAIN
Weight Loss
Behavior
Other issues
past hx
Hx present illness
medications
Swallowing
Falls
cOnFusion
1
patient
1 story
1 plan

# Care Process

- Details are mandatory.
  - Including nature (sharp, stabbing, dull, aching, shooting, etc.), location, intensity and other factors (localized, generalized, things that make it better or worse, etc.)
- An adequately detailed assessment is needed to determine if opioids are indicated or likely to be effective.
- Vague documentation, description and reporting of pain symptoms are highly problematic.
  - For example, “hurts all over,” “complains of leg pain,” “abdominal pain is a 7 out of 10,” etc.
- Details are needed to help distinguish causes.

# Assessment and Cause Identification

- All symptoms–including pain–are subjective to some extent and need details and verification.
- The need for objective validation of symptoms is a basic principle of all clinical practice.
- The “conventional wisdom” about pain (for example, that it is subjective, so we should simply believe whatever the patient tells us) is misleading.
- People have different ways of experiencing and describing pain.

# Can We Assume a Valid Rationale?

- Usually, we should not assume anything about why opioids were started or whether they are still needed.
- We often do not know who made prior treatment decisions or why or how they made them.
- Upon admission, we often need more information.
- We must consider whether and why opioids are still indicated, first in the short term and then over time.

# Getting Symptom Details

- Not all patients are equally reliable historians.
- Sometimes, the source and nature of pain are apparent.
  - However, we cannot always take the patient's description and requests at face value.
  - There is no shame in asking lots of questions.
- Additional evaluation is often needed when it is unclear whether a patient is having pain or when the nature and severity of pain are unclear.
- We should always hear what the patient has to say.
  - However, we must validate patient and family medication requests, especially opioids.

# All Too Often

# Case #6: Missing Elements

- No evidence of adequate assessment, including physical assessment and symptom details, by nurse or physician.
- No apparent attempt to differentiate the cause of symptoms.
- No validation that pain was the cause of the behavior.
- Superficial report to the nurse.

# Case #6: Missing Elements

- Lack of any meaningful nurse assessment
  - No important details about the symptom
- Superficial report to practitioner
- Inadequate dialogue between staff and practitioner
- Medication adjustment based on inadequate information and isolated incident
- Inappropriate modification of the current analgesic regimen
- Missing evidence about indications for current treatment

# Case #6: Missing Elements

- No evidence of nonpharmacological measures tried.
- No evidence of alternative medication regimens.
- No evidence of effectiveness of current treatment.

# Nursing Home and Partnership for Community Health:
## CMS 12th SOW GOALS

### OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

### PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

### CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

### CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

### COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

### IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

### TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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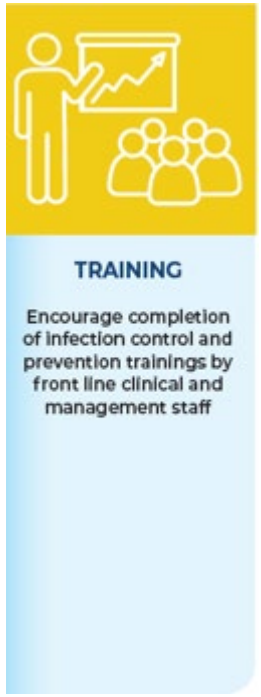
# Scan the QR Codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions will be engaging nursing home leadership on each of these key areas to ensure plans are in place to achieve and maintain health quality and equity. Be on the look out for communications from Alliant Health Solutions!


**Nursing Home Emergency Preparedness Program (NH EPP) Self-Assessment**


**Scan the QR codes or CLICK the links to complete the assessments.**

**Nursing Home Infection Prevention (NHIP) Initiative Training Assessment**




https://bit.ly/AHS_NHEPPAssessment

https://bit.ly/NHIPAssessment

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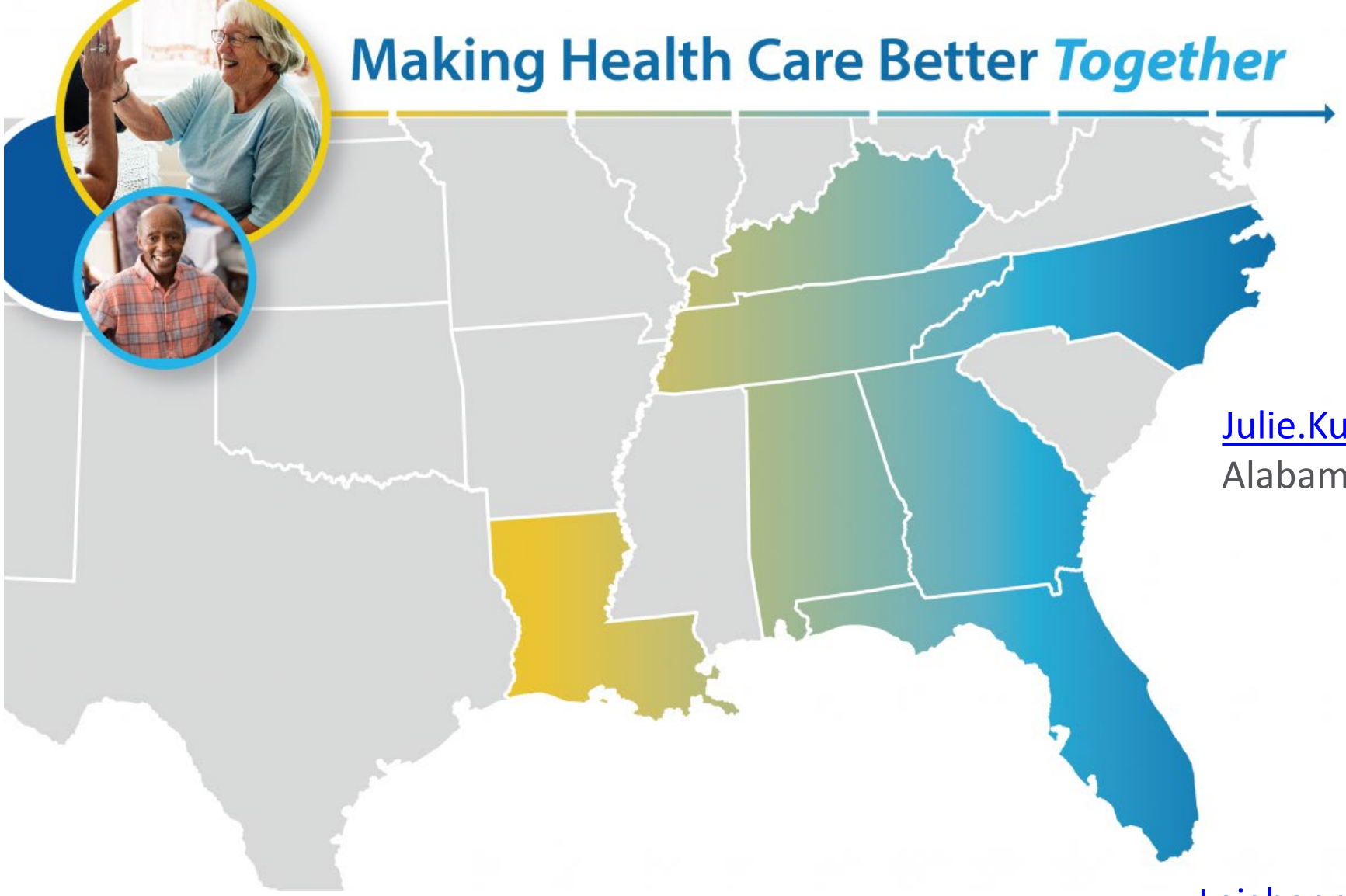
# Questions?

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