Appropriate and Safe Use of Opioids as Part of Effective Pain Management

Dr. Steven A. Levenson, MD, CMD

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Steven Levenson, MD, CMD

Steven Levenson, MD, CMD, has spent 43 years providing and overseeing long-term and post-acute care. He has been a medical director in 22 different nursing homes in Maryland and has reviewed and guided the care of thousands of patients in facilities in 28 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.

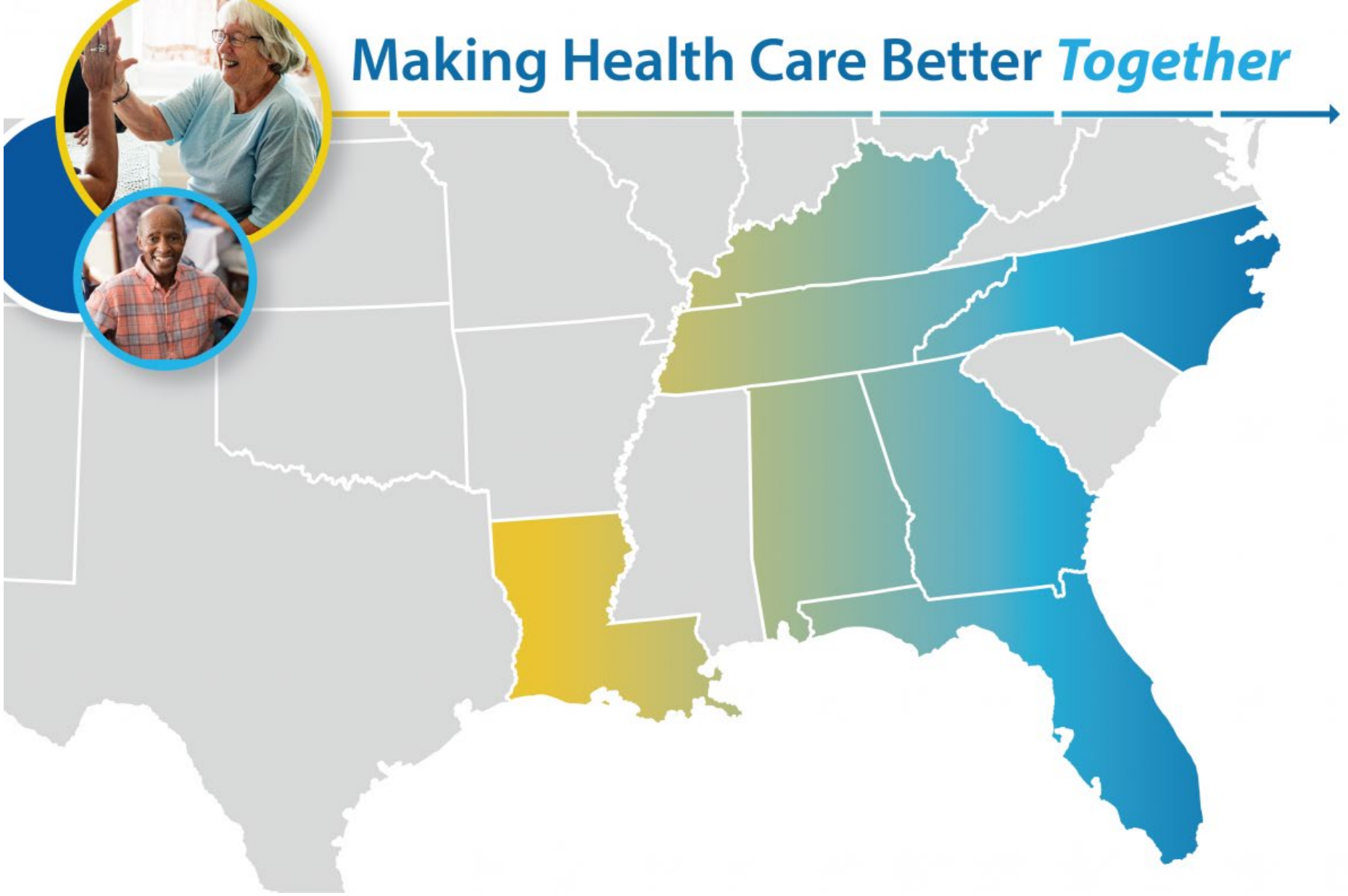
Between 1988 and 2013, he was extensively involved with CMS in developing and refining various aspects of the OBRA process, including surveyor guidance, the MDS, and training materials for surveyors and facilities. This included several updates to the Unnecessary Drugs guidance, including those related to psychopharmacologic medications. He also recently chaired the workgroup that revamped the AMDA Pain CPG.

Tanya Vadala, PharmD

MEDICATION SAFETY PHARMACIST

Tanya is an IPRO pharmacist with 18 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



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Objectives

- Review the situation with pain management and opioids in 2022
- Identify key elements of the pain-related care process
- Identify issues related to opioids in pain management

Elements of High-Quality Care

- According to the Institute of Medicine (IOM), high-quality care is
  - Safe
  - Effective
  - Efficient
  - Patient-centered
  - Timely
  - Equitable

Pain Case #1

- Patient has fentanyl patch q 72h for pain
- Nursing Assistant tells the nurse that the resident is "crabby," and would not go for his walk after dinner
- Nurse checked fentanyl patch
- Nurse updated Nurse Practitioner (NP)
- NP ordered patch to be changed to q 48 h instead of previous q 72 h

A World Awash in Pills

Slogans and Activists

- Slogans are political and metaphorical
  - "Everyone has a right to be free of pain"
  - "Pain is whatever the patient says it is"
  - "Pain is underdiagnosed and undertreated"
- Activism is a sign of failures of process, practice, and accountability
  - Activism can have dire consequences when the means and the ends are not reconciled adequately

The Upshot of Opioids: 2016

http://www.cbsnews.com/news/former-fda-head-doctor-david-kessler-opioid-epidemic-one-of-great-mistakes-of-modern-medicine/

Former FDA head: Opioid epidemic one of "great mistakes of modern medicine"

CBS News May 9, 2016, 7:32 PM

cbsnews.com

Former FDA head: Opioid epidemic one of "great mistakes of modern medicine"

Doctor David Kessler, who ran the FDA from 1990 to 1997, doesn't hold back when talking about the explosion in opioid use in the last two decades.

"This has been one of the great mistakes of modern medicine," said Kessler, who went on to say opioid addiction in the U.S. amounts to an epidemic.

Dr. David Kessler
CBS News

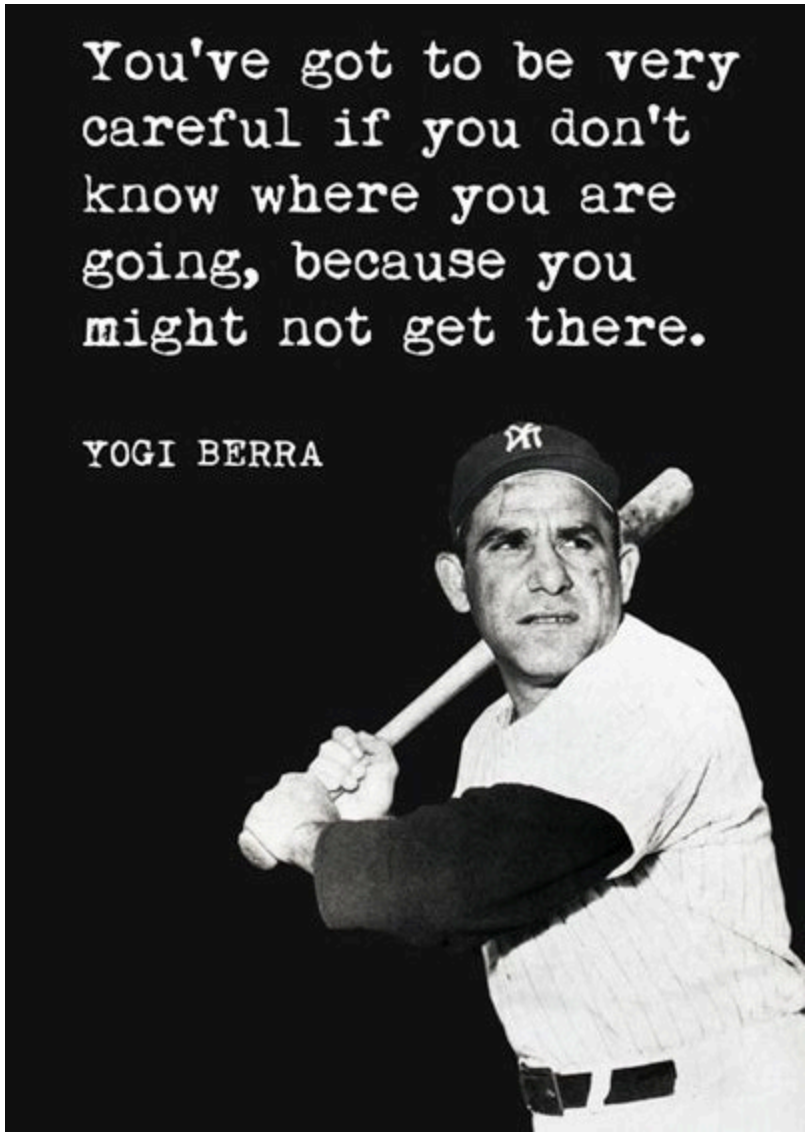
"FDA has responsibility, the pharmaceutical companies have responsibility, physicians have responsibility. We didn't see these drugs for what they truly are," Dr. Kessler said.

Key Principles

- Pain is common
- We must utilize the authoritative information that is available
- 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

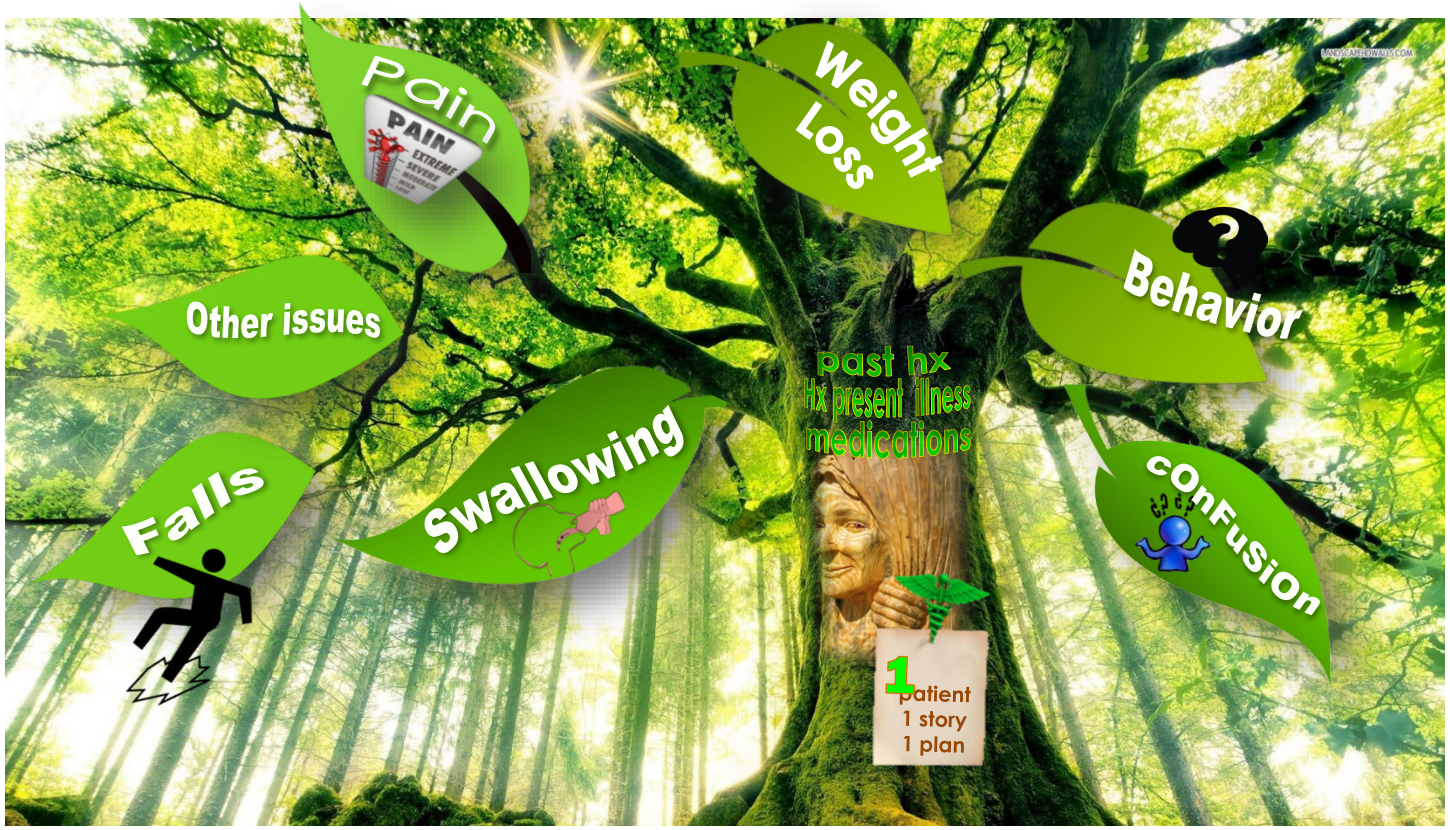
Yogi the Clinician



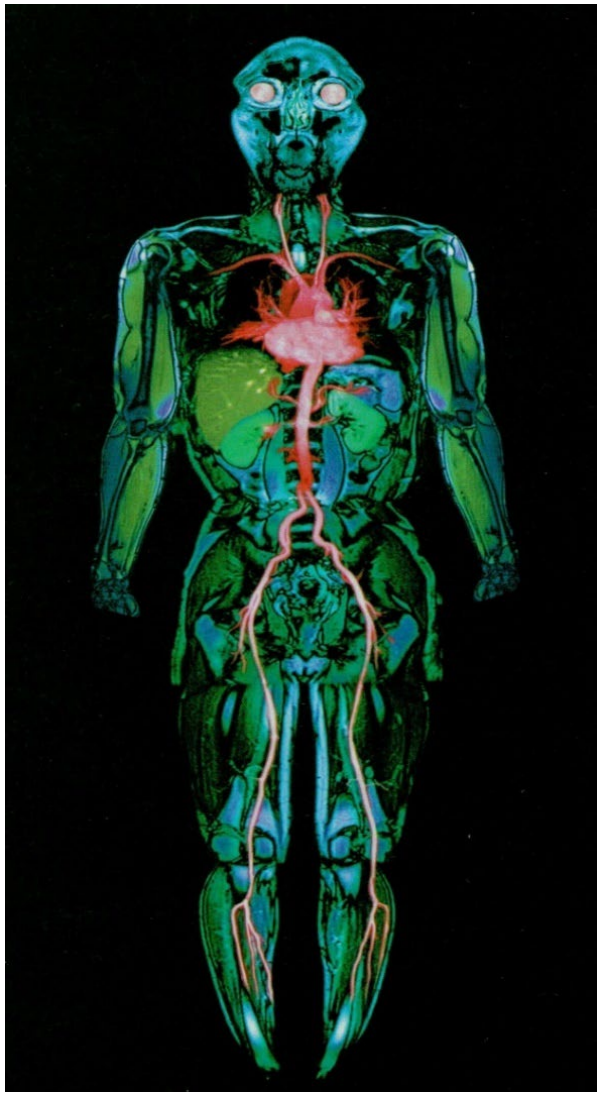
The Perils of Guessing

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
- 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
Falls
Swallowing
cOnFusion
1
patient
1 story
1 plan

The Whole and the Sum of Its Parts



Patient A

- **Cymbalta Capsule Delayed-Release Particles (DULoxetine HCl)** - Give 90 mg by mouth one time a day for depression
- **Flexeril Tablet (Cyclobenzaprine HCl)** - Give 10 mg by mouth every 8 hours as needed for muscle spasms
- **Lyrica Capsule 225 MG (Pregabalin)** - Give 1 capsule by mouth two times a day for neuropathy
- **Percocet Tablet 5-325 MG (Oxycodone - Acetaminophen)** - Give 5 mg by mouth every 4 hours as needed for pain
- **SEROquel Tablet (QUEtiapine Fumarate)** - Give 25 mg by mouth at bedtime for depression
- **TraMADol HCl ER Tablet Extended Release 24 Hour 100 MG** - Give 100 mg by mouth two times a day for pain

Patient B

- **Cymbalta Capsule Delayed-Release Particles (DULoxetine HCl)** - Give 60 mg by mouth one time a day for depression
- **Flexeril Tablet (Cyclobenzaprine HCl)** - Give 10 mg by mouth three times a day for muscle spasms
- **Imitrex Tablet (SUMAtriptan Succinate)** - Give 100 mg by mouth every 4 hours as needed for HA max 2 tabs in 24 hr period
- **OxyCODONE HCl Tablet 15 MG** - Give 15 mg by mouth every 4 hours as needed for pain
- **Promethazine HCl Tablet** - Give 12.5 mg by mouth every 4 hours as needed for N/V
- **Vistaril Capsule (HydrOXYzine Pamoate)** - Give 50 mg by mouth every 6 hours as needed for anxiety

Patient C

- **Flexeril Tablet (Cyclobenzaprine HCl)** - Give 5 mg by mouth one time a day for muscle spasms
- **Lyrica Capsule 150 MG (Pregabalin)** - Give 150 mg by mouth two times a day for neuropathy
- **Norco Tablet 7.5-325 MG (Hydrocodone-Acetaminophen)** - Give 7.5 mg by mouth every 6 hours as needed for PAIN
- **Sertraline HCl Tablet** - Give 50 mg by mouth at bedtime for depression
- **TiZANidine HCl Tablet** - Give 4 mg by mouth three times a day for muscle spasms

Patient D

- **AmLODIPine Besylate Tablet -** Give 5 mg by mouth two times a day for HTN
- **CeleXA Tablet (Citalopram Hydrobromide**) - Give 20 mg by mouth one time a day for depression
- **Lyrica Capsule 75 MG (Pregabalin) -** Give 1 capsule by mouth two times a day for neuropathy
- **Norco Tablet 10-325 MG (Hydrocodone- Acetaminophen) -** Give 10 mg by mouth q6 hours PRN
- **Remeron Tablet (Mirtazapine) -** Give 45 mg by mouth at bedtime for depression
- **Roxicodone Tablet 30 MG (OxyCODONE HCl) -** Give 30 mg by mouth every 6 hours for pain
- **TiZANidine HCl Tablet** - Give 750 mg by mouth two times a day

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.)
- 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

Rationale

- If treatment started elsewhere is ineffective or causing complications, more of the same will not work twice as well
- Must reconsider current pain management when we have little or no guidance from referring sources
- Even when opioids are warranted initially as analgesics, they can often be switched subsequently
- Even if it is not appropriate to change orders immediately upon admission or transfer, it is still appropriate to ask questions and try to validate the current regimen

“Not Causing Harm” as a Key Element of Quality

Case #1: 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 #1: 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 #1: Missing Elements

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

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 requests for medications—especially opioids

Believing and Trusting

- With nonverbal symptoms, we need to consider ("rule out") other explanations for the symptom
- Even when nonverbal expressions strongly suggest pain, opioids are only sometimes appropriate
- We cannot assume that a decrease in nonspecific or nonverbal symptoms with opioids implies successful pain treatment or are indicated indefinitely

TREATMENT

Back Pain: CR Hits the Mark

Back Pain: CR Hits the Mark

- "Relief for aching backs"
  - Consumer Reports, May 2009, p. 12-13
- "Be wary of narcotics to treat back pain"
- CR low-back-pain survey
  - More than 50 percent of those given a prescription drug received an opioid pain reliever
    - Despite little research to support the use of opioids for acute low-back pain

Considering Opioids

- Decisions to add opioids to a regimen or increase current opioid doses require detailed discussion and analysis
- Opioids may not be indicated or effective even for moderate to severe pain
- Key reasons why a patient may not get much relief with opioids
  - Opioids are not indicated or are ineffective for their pain
  - Underlying cause has not been identified or has been misdiagnosed
- To justify giving more of an existing intervention, we need objective evidence of at least partial effectiveness without disproportionate side effects

Considering Opioids

- A lower dose of an opioid analgesic should be at least partially effective to warrant adding more of it
- If an increase in opioid dose by phone or remotely does not materially improve symptoms without causing undue side effects, we need to assess and discuss more before adding drugs or doses
- It is often appropriate to use non-opioid measures, including topical or local treatments, instead of or in addition to opioids
- Medical practitioners should help review things before increasing doses, frequency, or numbers of opioids

Using Opioids PRN

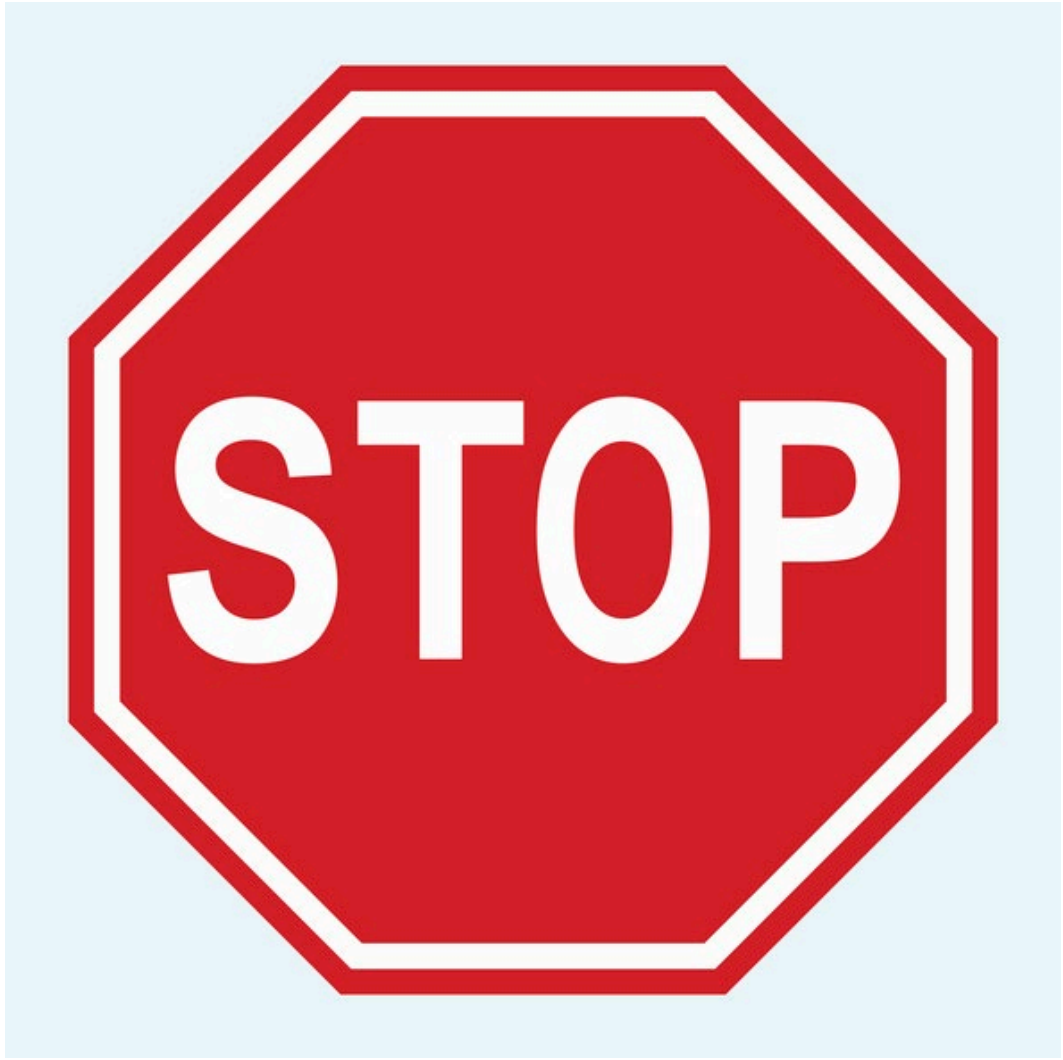
- Order and administer PRN analgesics–including opioids–judiciously and appropriately
  - Based on objective evidence of pertinence, effectiveness, and safety over time
- When multiple PRN options are available, an adequately detailed assessment is essential to determine which PRN medication to give
- There are several reasons why a patient may request PRN analgesics frequently
  - Possibly ineffective, inappropriate, or insufficient standing doses or a regimen that needs to be modified
- Do not switch PRN opioids to a standing dose until thinking through and discussing current PRN use

Requests or Demands For Opioids

- Staff, patients, and families should report pain symptoms objectively and in detail
- Opioids should not be prescribed or dispensed based primarily or solely on patient or family demand
- Patients and/or families may request or demand opioids generally or specific ones
  - Sometimes threatening or intimidating staff and practitioners
- Patients and families do not necessarily understand the care process, the need to seek underlying causes of symptoms, medication indications, risks or adverse consequences

Requests or Demands For Opioids

- Good customer service and patient-centered care does not mean simply giving in to requests or demands
- Staff and practitioners should coordinate responses and actions in response to requests or demands for certain medications, including opioids, or if they refuse to consider alternatives
- Opioids should be carefully prescribed and dispensed on discharge from the facility
  - Limited time
  - Only to those with a clear need
- Studies: Opioids that are prescribed on discharge
  - Often go unused
  - Likely to be stolen


STOP

MONITORING

Monitoring

- Essential questions
  - How is the pain compared to xxx?
  - Severity, location, radiation, relieving and exacerbating factors, nature
  - NOT simply "Are you still having pain?" or "Is the pain better?"

- Assess the progress of managing causes

Progress Assessment

- Some basic examples, found in sound documentation and reporting
  - Less intense
  - Less often radiating
  - Does not last as long
  - Longer duration of relief with intervention
  - Lesser dose of medication needed to obtain comparable relief

Progress Assessment

- Some basic examples:
  - Less frequent use of interim PRN medication
  - Lower standing dose with comparable interval relief
  - Relief obtained with nonpharmacological measures
  - Improved function / improved sleep
  - Able to focus more on things other than pain

Identifying Drug Seeking

- Some patients may seek drugs or may be addicted to or dependent on opioids
- Use available resources to identify whether other providers have prescribed opioids for a patient
- There are valid clues to opioid seeking, dependency and addiction
  - —Staff and practitioners should seek, document, and address clues
- Evidence suggesting possible drug seeking should be taken seri0ously, clarified, and addressed
  - —Set limits for prescribing opioids

Clues to Possible Medication Seeking

- Vague, general, nonspecific symptoms
- No meaningful improvement over time despite multiple medication and dose changes
- Demanding every dose ahead of time
- Demanding on the minute
- Little or no improvement in relief proportionate to increases and total amounts

Clues to Possible Medication Seeking

- Active and happy within minutes of a dose despite complaints of excruciating pain
- Will not try anything other than opioids, even as a baseline
- Pain does not match known anatomy or natural course (location, radiation)
- Intimidating or threatening to staff
- Will not try dose reductions or substitutions

When to Reconsider Current Approaches

- If patient does not seem to get relief but keeps asking for more medication
- When relief is not roughly proportionate to increased dose or frequency
- When pain has diminished or stopped
- When cause(s) of pain are corrected
- When adverse consequences are identified or suspected

Analgesics and Behavior

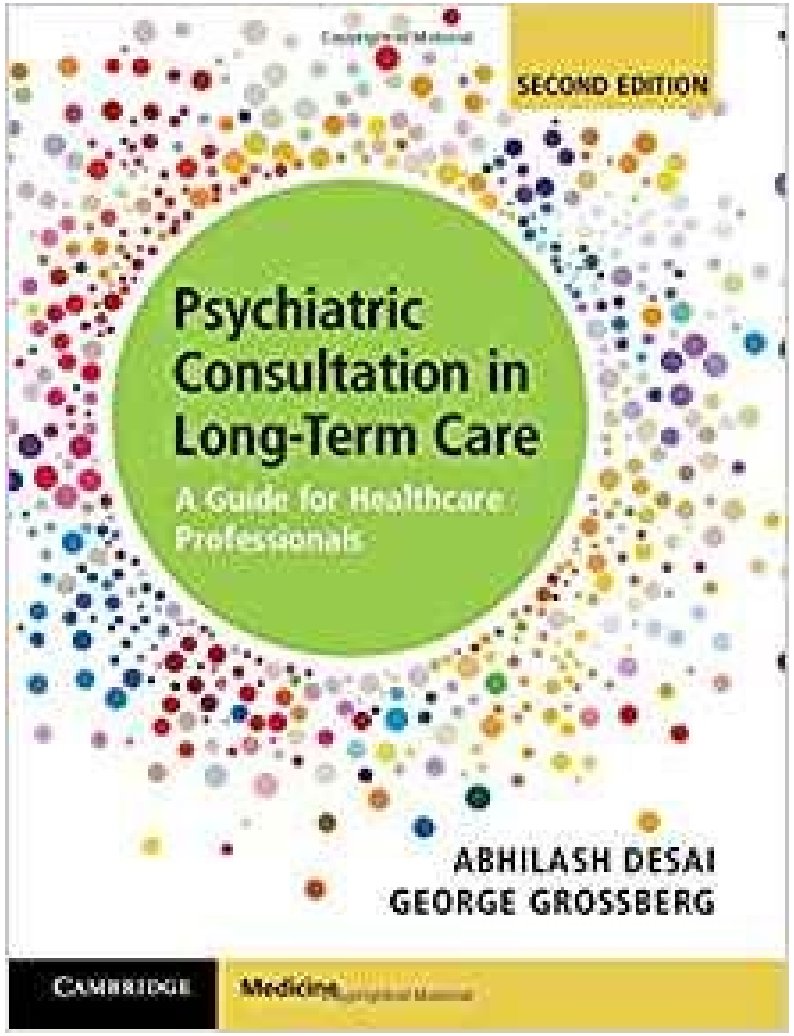


Table 1. Some Drug Classes (continued)

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

Differential Diagnosis of Behavior

- "The **first question** that should always be considered in the differential diagnosis is **whether the presenting symptoms arise from a substance that is exerting a direct effect on the central nervous system (CNS)**. Virtually any presentation encountered in a mental health setting can be caused by substance use. **Missing a substance etiology is probably the single most common diagnostic error made in clinical practice**. This error is particularly unfortunate because making a **correct diagnosis has immediate treatment implications**. "

  – First, MB. DSM Handbook of Differential Diagnosis, p. 2

What to Reconsider

- Whether the problem is defined properly
- Whether underlying diagnosis(es) is (are) accurate and complete
- Whether the intervention is appropriate
- Whether we need:
  - More, less, or same amount of intervention
  - A completely different intervention
  - Additional intervention(s)

Wildly Out of Control

- Multiple prescribers
  - —Including pain clinics that will not coordinate care or that believe whatever the patient tells them
- More than three standing and PRN analgesics with no clear relief despite increasing doses
- Inconsistent symptom and physical findings, vague and inconsistent documentation
- Multiple clinically significant side effects are present
  - —Falls, anorexia, lethargy, behavior or mood issues
- Many PRN doses of multiple medications despite standing doses

Questions?

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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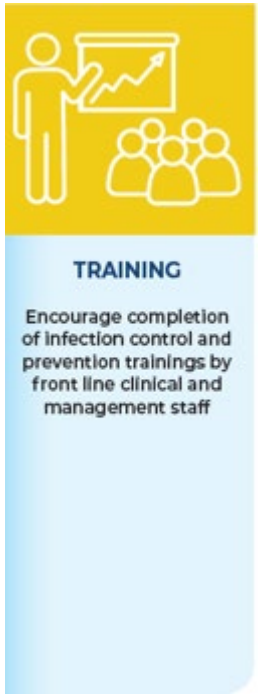
Scan the QR code or Click the Link to Complete the Assessment!

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 is engaging nursing home leadership on each of these key areas to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR code below and complete the assessment.



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment

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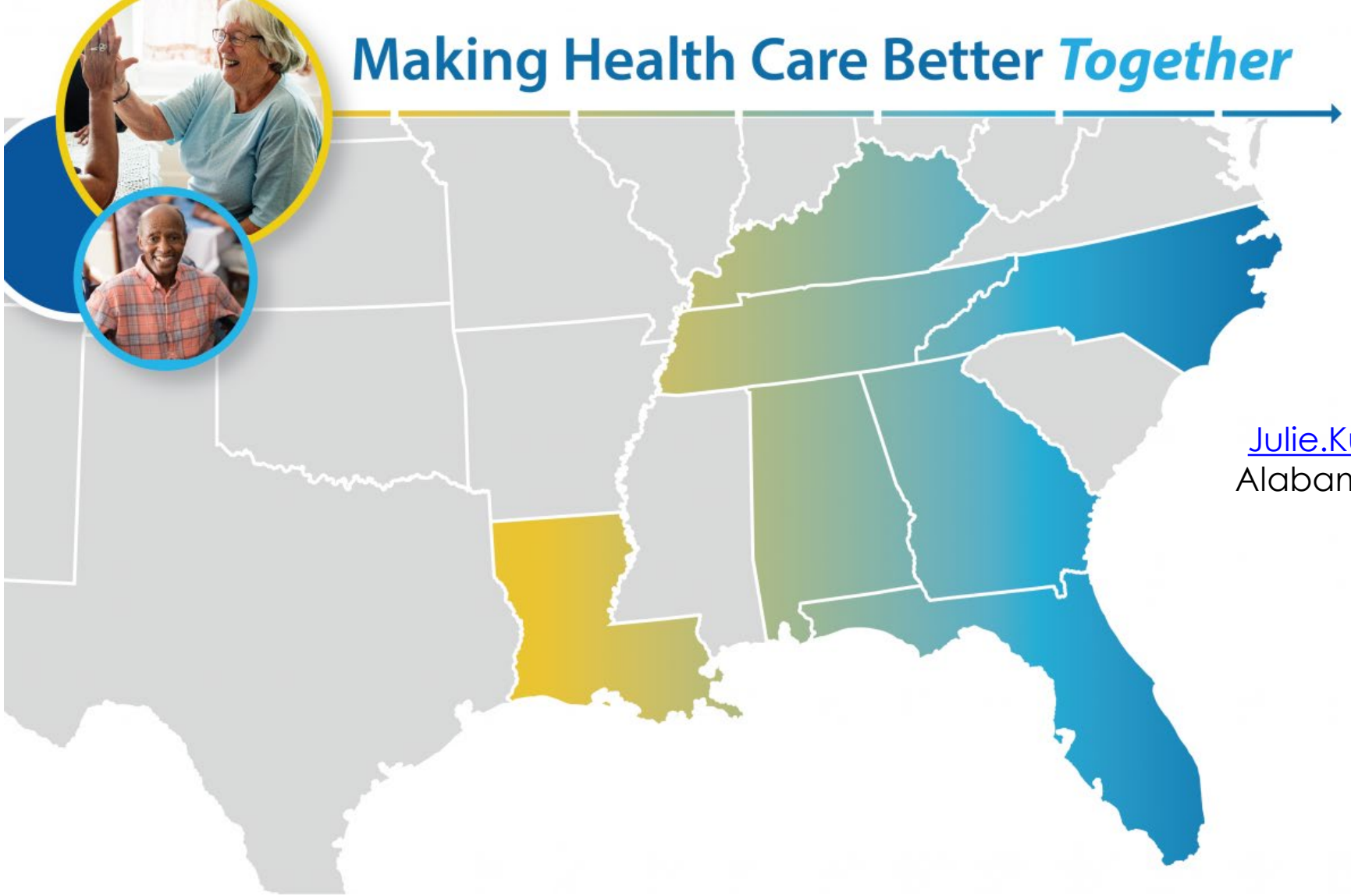

Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

Program Directors

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