# Approaches to Opioid Reduction in LTC

Steven Levenson, MD, CMD

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Quality Innovation Network - Quality Improvement Organizations
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# Steven Levenson, MD, CMD

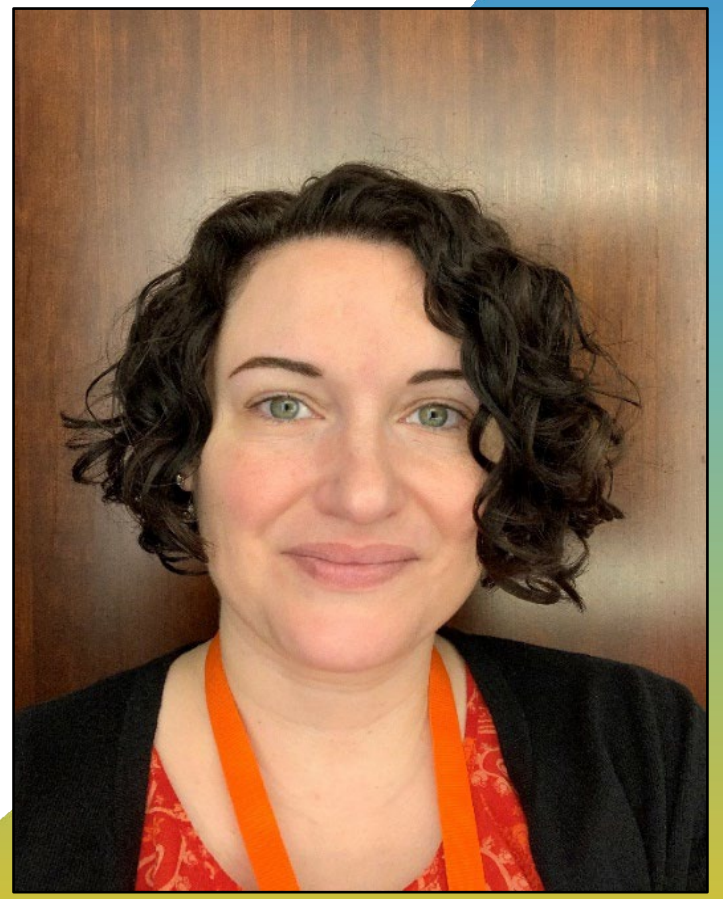
Steven Levenson, MD, CMD, has spent 43 years providing and overseeing long-term and post-acute care. He has been a medical director in 22 different nursing homes in Maryland and has reviewed and guided the care of thousands of patients in facilities in 28 states. He has authored or co-authored more than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

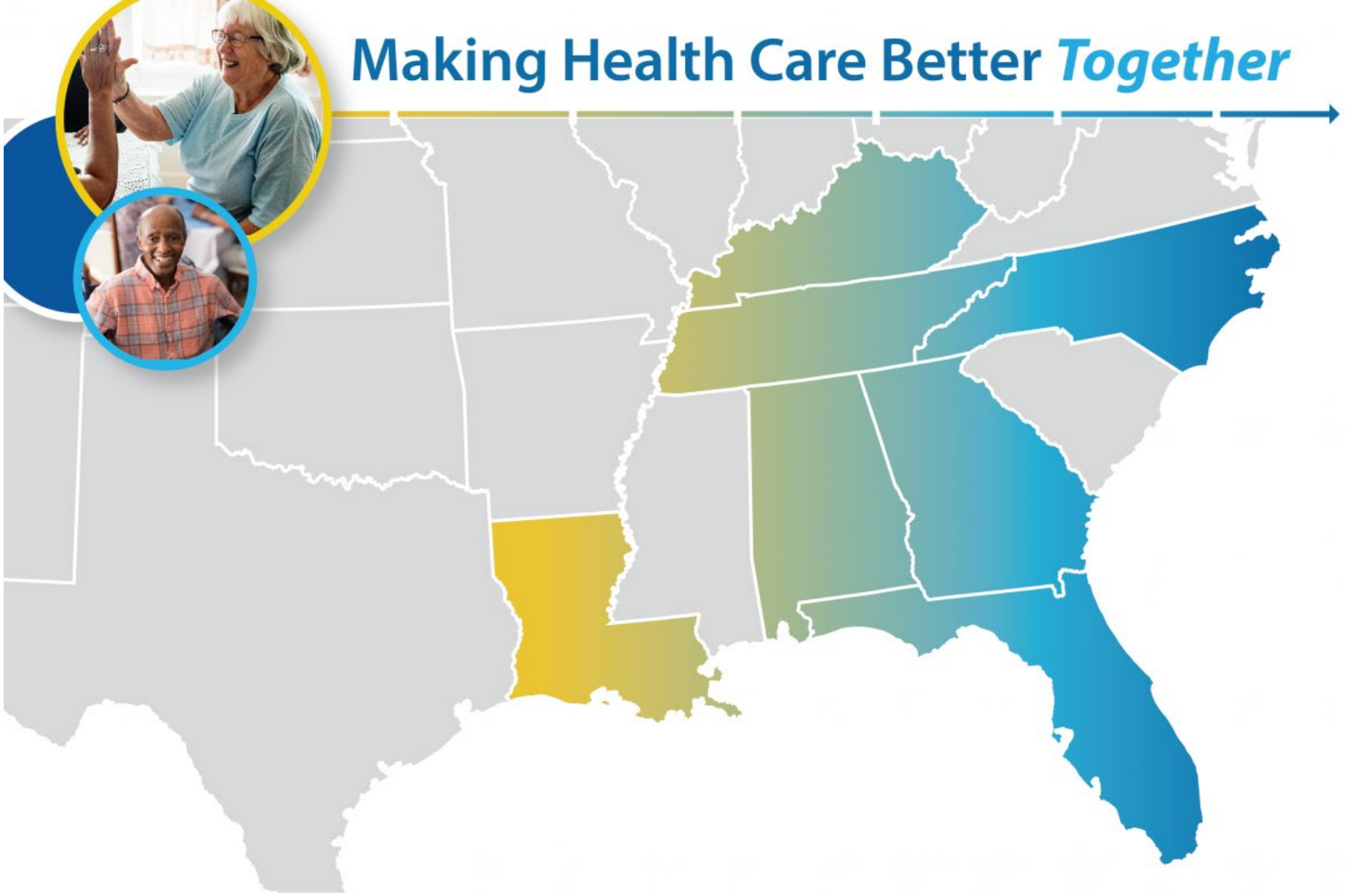
# Tanya Vadala, PharmD

## 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




# About Alliant Health Solutions

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# Objectives

By the end of the session, participants will be able to:

- Recognize why opioid reduction is important in long-term care.
- Identify the benefits of weaning opioid pain medication in short-stay residents.
- Identify how to reduce opioids safely and effectively.

# CDC Guidelines on Opioid Prescribing March 2016

- Opioids are not first-line or routine therapy for chronic pain.
- Realistic goals should be discussed before initiating therapy.
- Nonpharmacologic therapy and nonopioid pharmacologic are preferred, if possible, for chronic pain.
- Risks to patient safety need to be considered before prescribing opioid therapy.

# Why Is a Reduction Strategy Necessary in the SNF?

- Long-term opioid use has well-documented adverse effects in the geriatric population (falls, confusion, constipation, urinary retention).
- Opioids are not first-line therapy for chronic pain.
- Individuals taking opioids long-term often complain of more pain, not less.
- Focus on short-stay residents who are rehab to home to prevent opioid tolerance.

# Why Is a Plan Necessary?

- Standardize opioid reduction across one facility and multiple facilities.
- Provide a framework for staff to follow with progress.
- Provide a tool that can be used by all physicians taking care of LTC residents.

# Patient Populations of Concern Opioid Use in LTC

1. Skilled patients who were not taking opioids before hospitalization and arrived with opioid orders.
2. Skilled patients who were taking opioids long term prior and 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 before 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 ceftriaxone. 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 demanding to go to the ER as the resident states that his Norco "is not working."
- Of note, he was started on Keflex for incision infection three days before the above incident and nursing reports that the incision is "not red at all."
- On evaluation, resident in bed watching TV in NAD.
- Plan to start weaning.

# Patient Population #2

- Residents who are taking opioids long-term and arrive on a dose greater than what they have 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: Gabapentin 100mg tid, oxycodone ER 20 mg po q12, oxycodone IR 5 mg po q4 PRN.
- She states that she was taking Percocet 10/325 mg 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 the 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.

# OPIOID WEANING STRATEGY

# Step 1

- Evaluate all current PRN opioids
- Target residents who are receiving 0 or 1 PRN doses of opioids daily
- Discontinue the PRN opioid
- If needed, substitute non-opioid medication

# Step 2
# An Ongoing Process

- Evaluate all PRN opioid orders on new skilled residents.
- Discuss pain assessment with nursing to determine:
  - Why opioid was ordered initially
  - How often the resident receives it
  - Determine if it was used prior to hospitalization

# Step 2
# Continued

- Consider a trial of discontinuation of all PRN opioids on skilled residents who were not on the medication before hospitalization and were not placed on opioids due to fracture, injury, or surgery.

# Step 3

- Assess all chronic opioids after 1st sweep (step 1) on skilled residents. Determine why the opioids are being used.
- Assess the pain source and offer an alternative to pain medication (i.e., heat, ice).
- Discuss pain with residents who can verbalize symptoms and explain the importance of reducing the opioid dose.
- Ask if the resident has a prescription or supply at home.
- Research pharmacy database as needed.

# Step 3
# Continued

- Offer alternative non-opioid pain medication if desired.
- Discuss opioid weaning schedule (reduce dose by 10% every one to two weeks).
  - Discuss alternative methods to relieve pain.
  - If a resident refuses weaning or alternative treatment, document the reason and attempt to educate.

# Step 4

- Assess all PRN opioid use on long-term residents who cannot verbalize pain.
  - Consider weaning trial
  - Monitor behaviors with a reduction of dose and frequency
  - Discuss findings with family or MPOA

# Step 5

- Assess all scheduled opioids on long-term residents.
  - Document diagnosis of why the resident is receiving the medication.
  - Consider a weaning trial (reduce dose by 10% every one to two weeks) on those residents not receiving opioids for cancer diagnosis or end of life.
  - Implement alternative pain measures during weaning.

# Step 6

- If the resident fails, the opioid GDR trial:
  - Document why GDR failed.
  - Discuss GDR failures in the nursing forum to determine better options for certain residents.

# Step 7

- Inform nursing of supporting information, including CDC general opioid prescribing guidelines.
- Stress adverse effects of long-term opioid use in the LTC setting (increased risk of falls, respiratory depression, constipation, confusion, urinary retention, delirium).
- Stress the importance of limiting opioid use to < 3 months.
- Offer educational material for residents and families whose opioids are being weaned.
    - Identify how residents who receive long-term opioids may complain of more pain, not less.

# Step 8

- Advise and guide the therapy department.
  - — Their role in pain assessment and offering of alternative pain control measures (e.g., heat, ice, massage, ROM).
  - — Stress the importance of PT/OT NOT asking physician or nursing for pain medication.

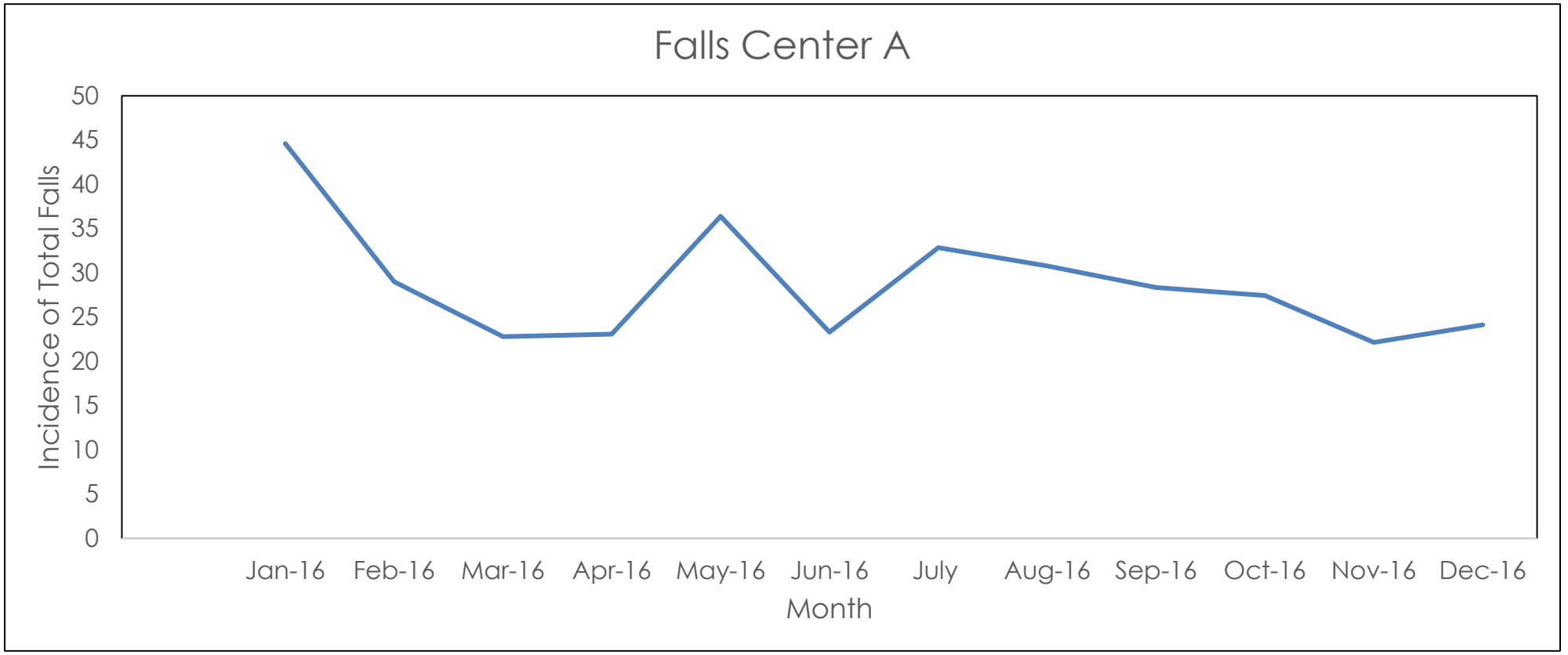
# Step 9

- Attempt to make a goal of limiting all opioid prescriptions to those residents with an appropriate diagnosis (cancer with cancer-related pain, end of life with discomfort).
- Place a time limit on opioid orders (one-two weeks).
- Reassess pain and need for current dose/frequency weekly.
- Make appropriate changes.

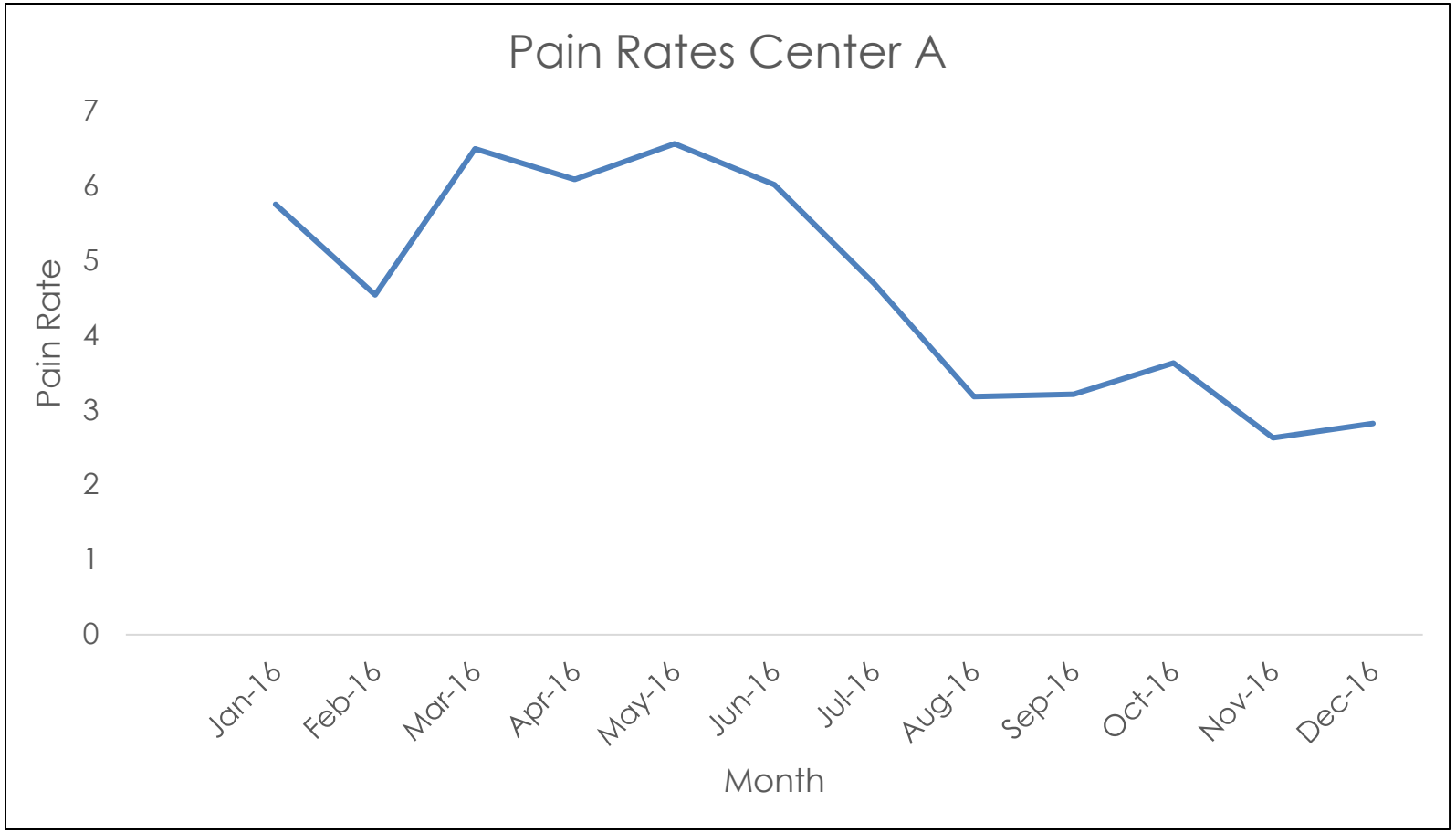
# Challenges

- Many residents are fearful of change. They have been taking/prescribed opioid pain medication for a long time.
- MPOAs do not want their loved ones to be in any pain.
- Nursing staff does not want residents to be in any pain.
- Long-standing culture of responding "knee jerk" to every complaint of pain in the same way.
- Inadequate pain assessments.

# Falls Over Time: Fewer Opioids Used



# Short Stay Pain Rates Over Time: Fewer Opioids Used



# Summary

- Pain management in LTC must be assessed objectively using uniform, specific criteria.
- Objective pain assessments are essential to support subjective statements of pain that can lead to overprescribing pain medications.
- Opioids are not indicated for many types of pain.
  - We cannot assume that stronger opioids are better for pain control.
- Short-stay residents often have fewer pain complaints with reduced opioid medication.
- Practitioners should focus on ensuring these medications are not continued long-term if possible.

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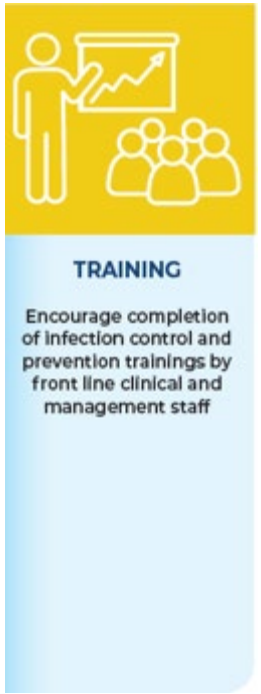
# Scan the QR code or Click the Link to Complete the Assessment!

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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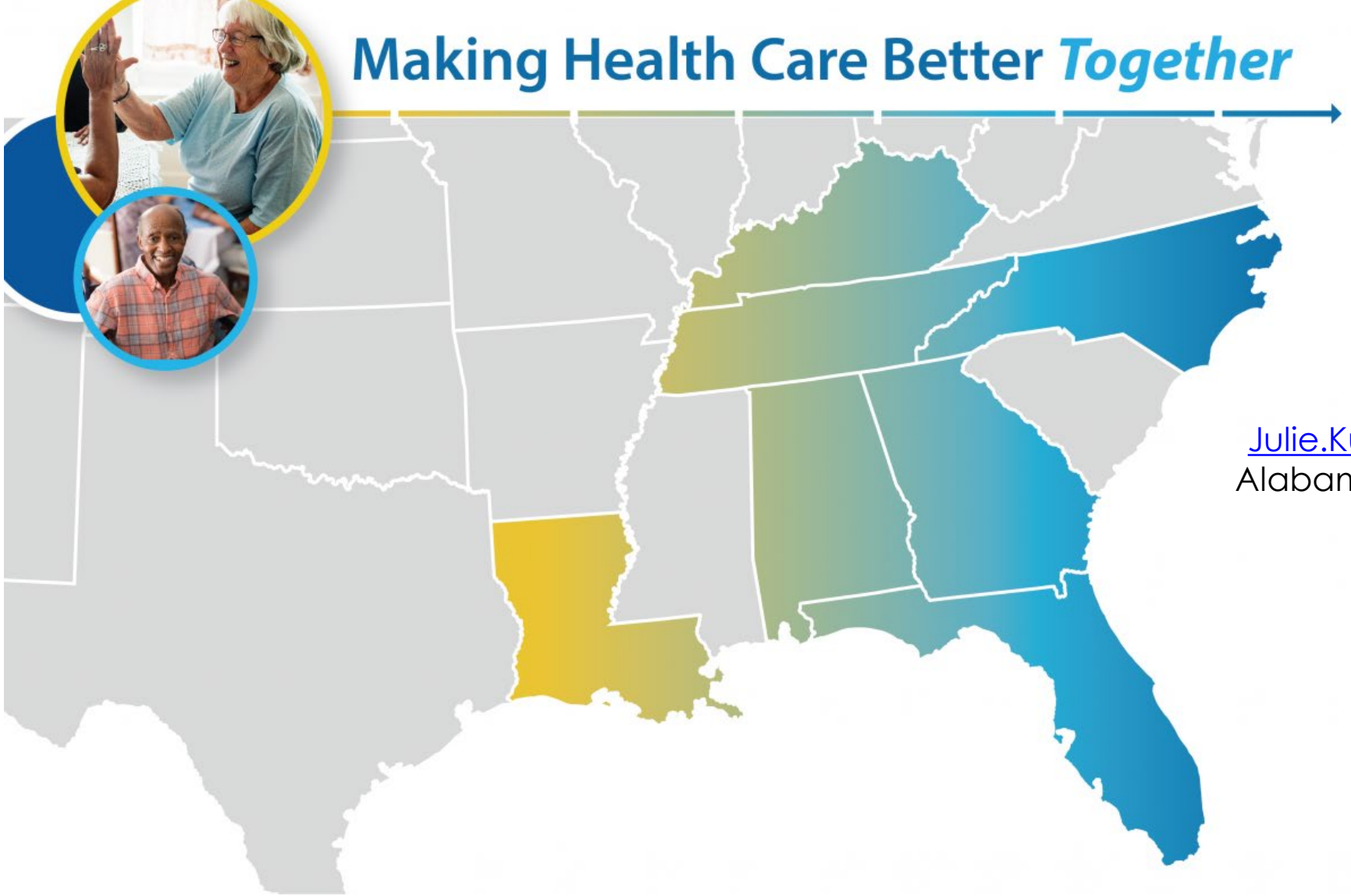


Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

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

# Program Directors

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