Treating Opioid Use Disorder in Nursing Facilities

November 30, 2023

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Continuing Education Information

Learning Outcome:

Following this activity, learners will be able to use tools to identify and mitigate the impact of implicit bias around mental health and substance use disorders.

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Disclosure of Relevant Relationships

The planners and faculty for this activity have no relevant relationships. Any relevant relationships are mitigated prior to the start of the activity according to the Standards for Integrity and Independence in Accredited Education.

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Today's Event Host

Nikki Harris, MA, CBHC-BS

COE-NF TRAINING AND EDUCATION LEAD

- For the past 20 years, Nikki has provided program implementation, development, management, external and internal trainings, policy development, quality assurance, and managed training coordination and technical support throughout the southeast region.

- Previously, she served as the program manager for the Division of Behavioral Health and Substance Use Services within the South Carolina Department of Corrections.

- She has a B.A. in psychology from the University of South Carolina, a M.A. in counseling from Webster University and is a certified behavioral specialist.

Today's Presenter

Dr. Swati Gaur, MD, MBA, CMD, AGSF

MEDICAL DIRECTOR, POST ACUTE CARE – NORTHEAST GEORGIA HEALTH SYSTEM

Dr. Gaur is the medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. She is also the CEO of Care Advances Through Technology, a technology innovation company. In addition, she is on the EMR transition and implementation team for the health system, providing direction to EMR entity adaption to the LTC environment.

She has also consulted with post-acute long-term care companies on optimizing medical services into PALTC facilities, integrating medical directors and clinicians into the QAPI framework, and creating frameworks of interdisciplinary work in the organization.

Today's Presenter

Dr. Jenn Azen, MD, MPH

CLINICAL ASSOCIATE PROFESSOR, UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE, DEPARTMENT OF MEDICINE, DIVISION OF GENERAL INTERNAL MEDICINE
ATTENDING PHYSICIAN, UW MEDICINE POST-ACUTE CARE SERVICE
MEDICAL DIRECTOR, UW MEDICAL CENTER ADDICTION MEDICINE CONSULT SERVICE
PRIMARY CARE PHYSICIAN AND PHYSICIAN EDUCATOR, UW MEDICINE PRIMARY CARE CLINICS

Dr. Azen is a general internist who has practiced in the primary care and post-acute care setting. Her primary care practice is focused on medically complex and geriatric patients. She provides in-home visits to medically fragile patients in private homes, adult family homes, and assisted living.

She currently works in post-acute care with Harborview Medical Center's Bed Readiness Program where she cares for patients with social complexity including substance use disorder. The Bed Readiness Program is designed to improve bed capacity within the hospital by partnering with local skilled nursing facilities.

She previously managed the UW Medical Center Post-Acute Care Consult Service and is now the Medical Director of the UW Medical Center Addiction Medicine Consult Service.

During her career, she has focused on removing the silos within our healthcare system and better integrating care so patients can gain access to the care that best meets their needs. She believes post-acute and long-term care is vital to our health care system and believes innovation will improve patient and staff experience.

Description and Learning Objectives:

Description:

This training is designed to equip nursing facility staff with the knowledge, skills, and tools necessary to provide effective and compassion care to residents diagnosed with an opioid use disorder.

Learning Objectives:

- Discuss assessment of residents before starting opioid analgesic treatment for pain.
- Create evidence-based strategies for practicing opioid stewardship.
- Evaluate residents for opioid use disorder in nursing facilities.
- Discuss safe taper of opioids and alternative therapies for pain.

Financial Disclosures

Dr. Azen:

- **CVS stockholder:**

My husband is a home infusion pharmacist with CVS and participates in the employee stock plan.

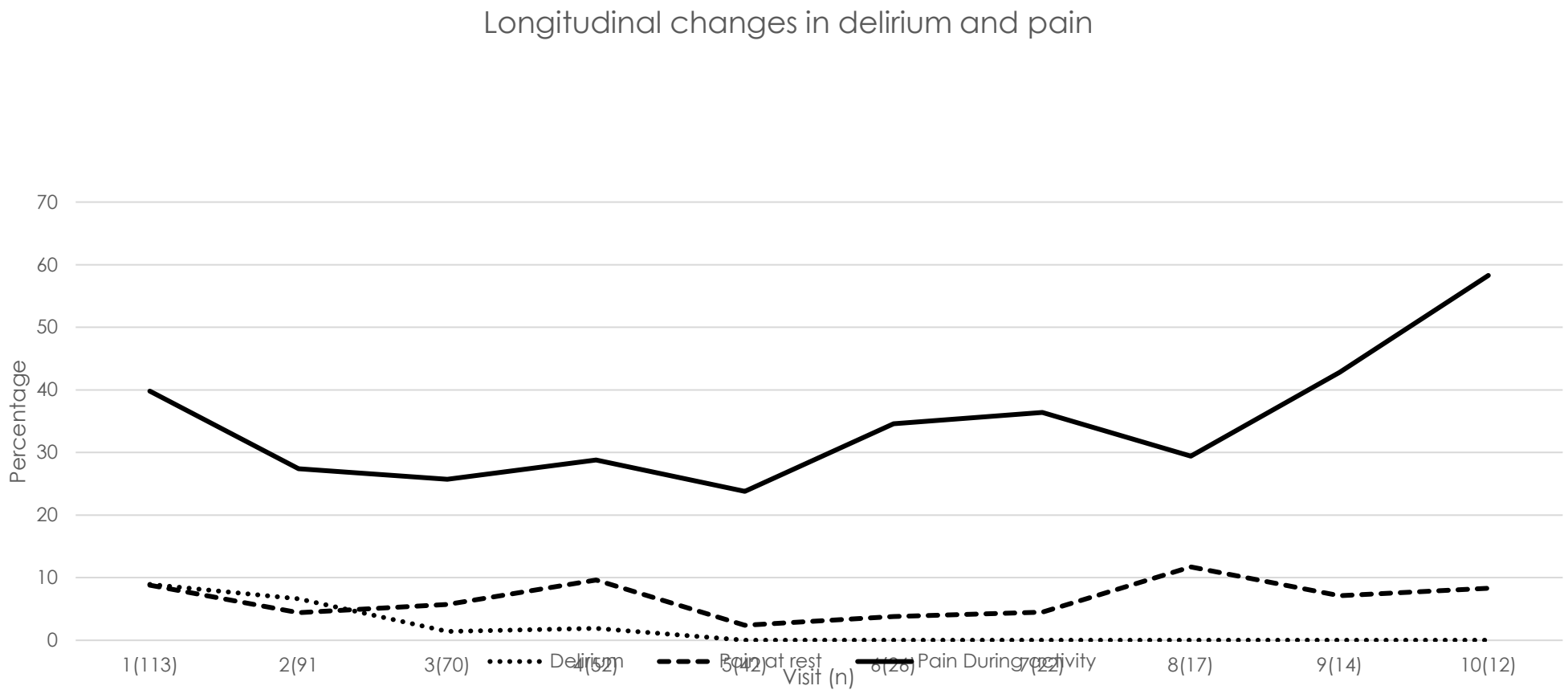
Dr. Gaur:

- Has no disclosures

SCENARIO

A 96-year-old woman has a fall in the nursing home while transferring from a chair to the bed and hits her left shoulder. The X-ray does not show a fracture. Three (3) days later the staff reports that she has stopped getting out of bed and her appetite has steadily gone down to where she's only eating 25% of her meals. A meeting is held with her son who is appraised of the situation, and he decides not to transfer mom to the hospital.

Is there association between pain and delirium?



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6201828/

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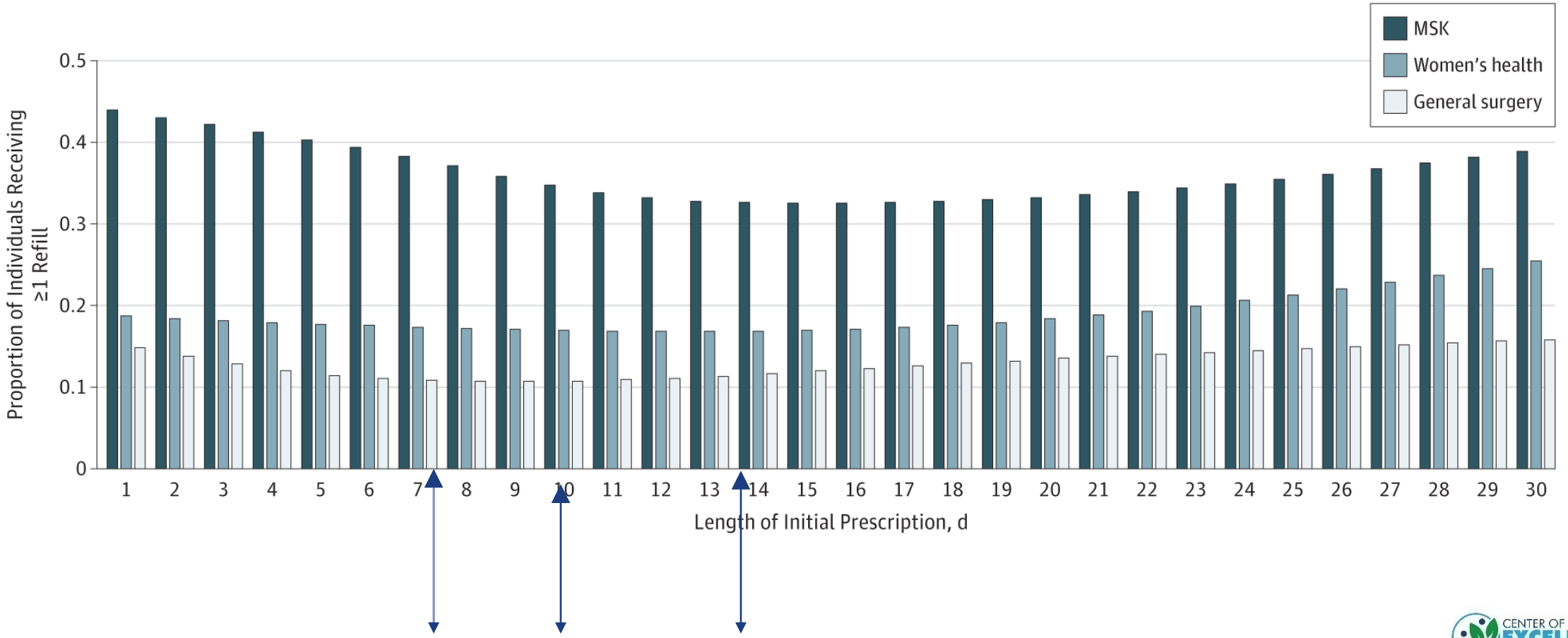
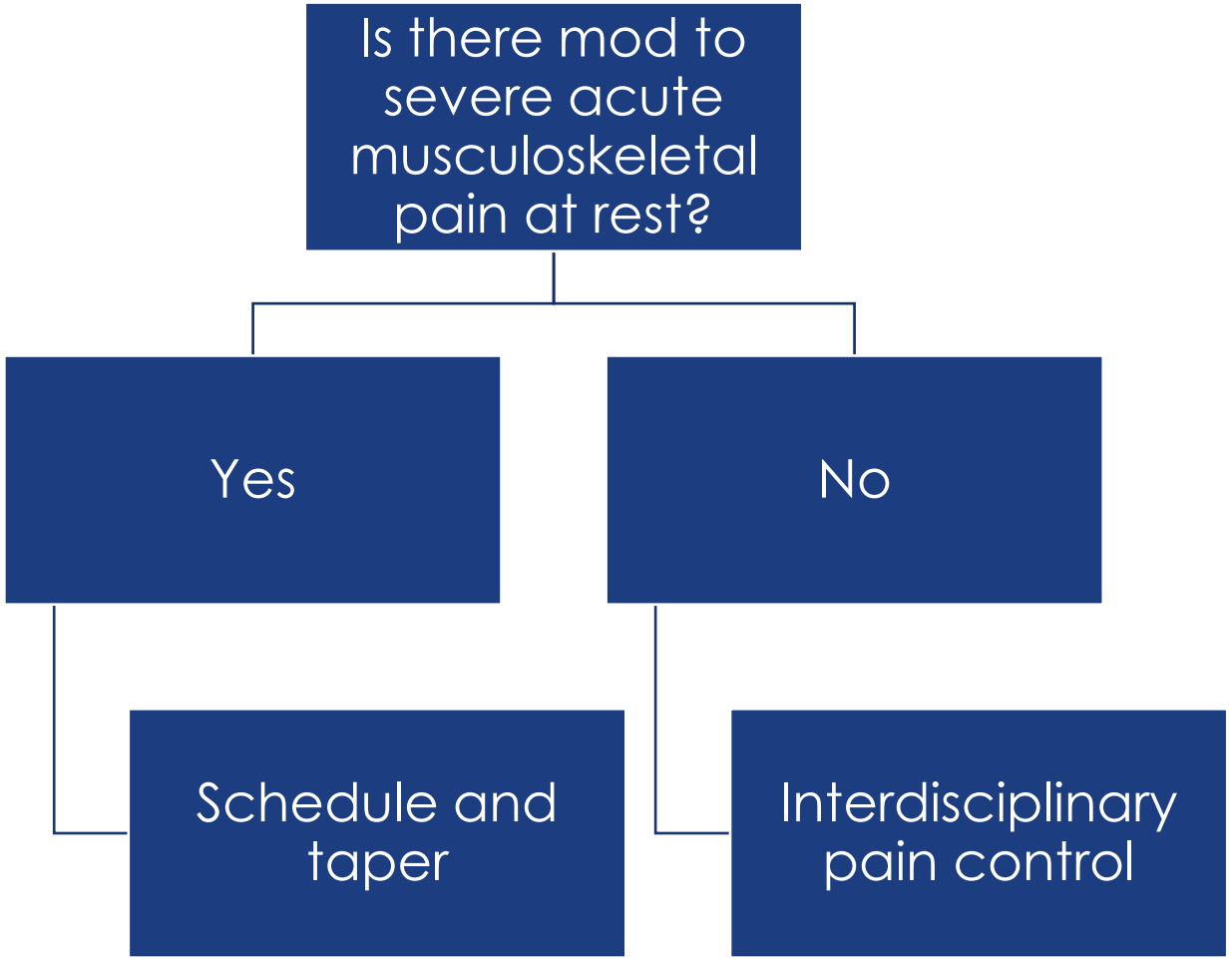
Optimal Length of Opioid Pain Prescription After Common Surgical Procedures



Optimal length of treatment

Procedure	Optimal length in days
General surgical	7
Women's health	10
Musculoskeletal	14

Approach to acute pain in LTC



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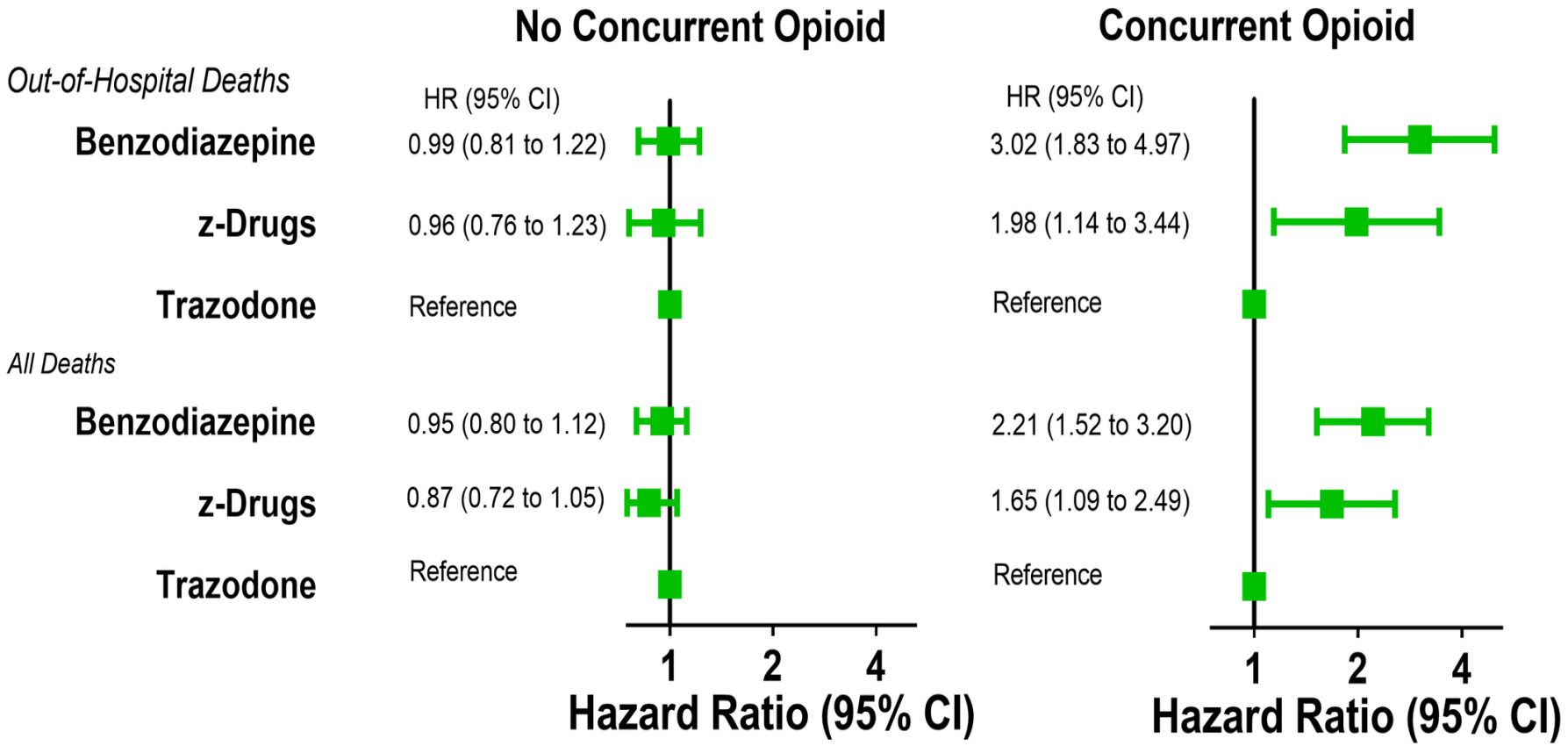
Assessing pain and need for opioid in long term care resident

- A 78-year-old male admitted recently with MS Contin 40mg BID and Dilaudid 2 mg every 4 hours as needed. Staff reports that he's irritable and is demanding no change in medication.
- He's also on Xanax 1 mg BID and Neurontin 800mg Q12H.
- On further history, he has lost his spouse and lives alone and has been approached about cutting down his meds many times recently, has short term memory loss.
- He also has a history of overdose.

Mortality and concurrent use of opioids and hypnotics in older patients: A retrospective cohort study (Wayne A. Ray et al)

July 15, 2021

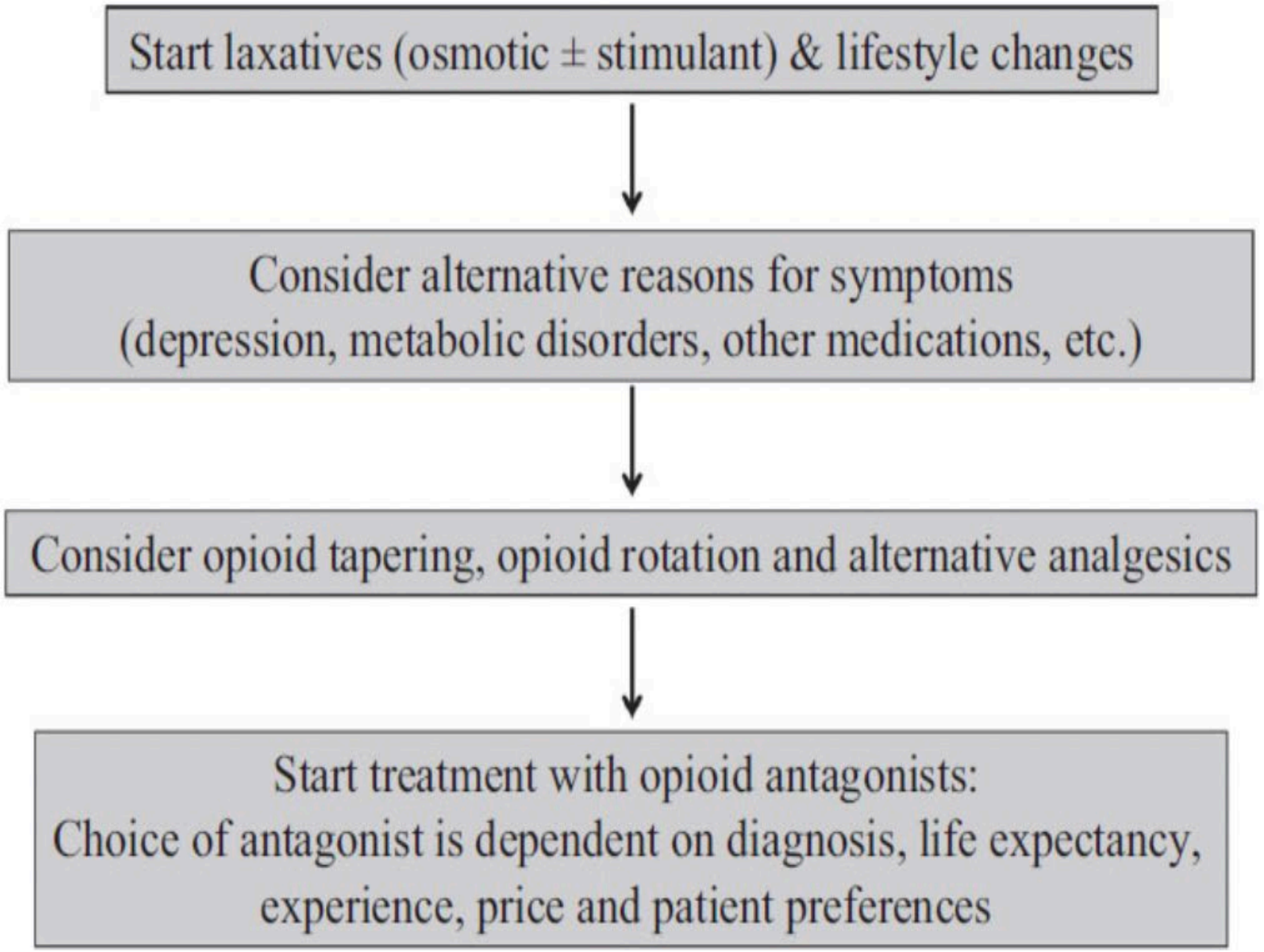


https://doi.org/10.1371/journal.pmed.1003709

Managing opioid related side effects

- **Opioid induced constipation (OIC) Opioid induced bowel dysfunction (OIBD)**
- 4-6/10 will have it
- Slow peristalsis- increase in fluid absorption – hard stool and constipation
- Start laxative proactively
- Never use psyllium

Meds	Typical cost
Senna	$10/100 pills
Polyethylene glycol	$10/100 gm of powder
Relistor	$430/15 pills
Amitiza	$470/60 pills



https://www.degruyter.com/document/doi/10.1016/j.sjpain.2015.12.005/html

Multi Modal Analgesia: Use of Gabapentin

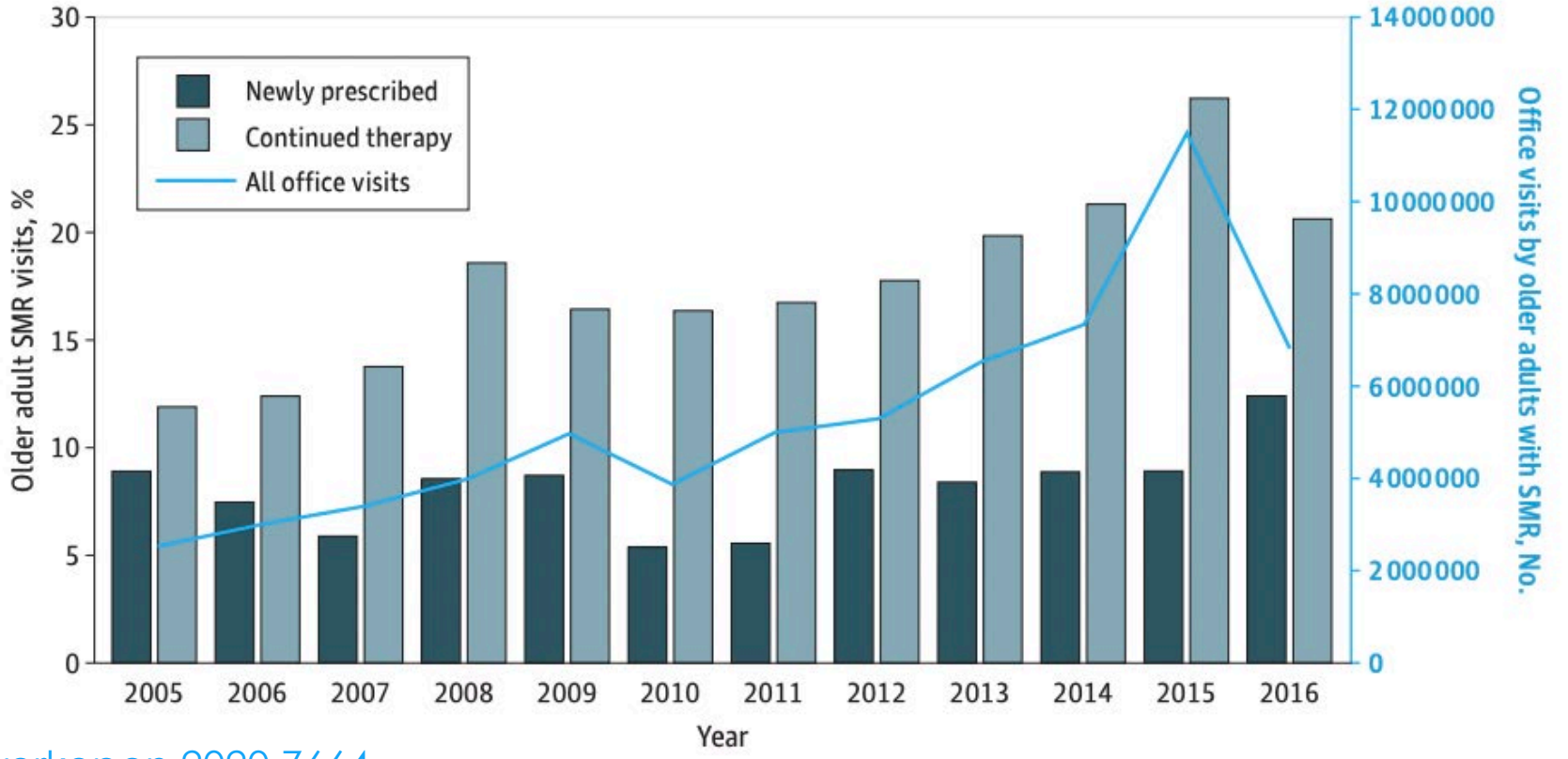
- Park CM, Inouye SK, Marcantonio ER, et al. Perioperative Gabapentin Use and In-Hospital Adverse Clinical Events Among Older Adults After Major Surgery. *JAMA Intern Med.* 2022;182(11):1117–1127. doi:10.1001/jamainternmed.2022.3680

- ~ 970000 patients >65 Y

Outcome	Gabapentin user %	Nonuser %	RR
Delirium	3.4	2.6	1.28
New antipsychotic use	.8	.7	1.17
Pneumonia	1.3	1.2	1.11

Assessment of physician prescribing of Skeletal Muscle Relaxants: Soprano et al

Figure 2. National SMR Utilization Rates Among Adults Aged 65 Years or Older, Stratified by New vs Continued Use, 2005-2016



10.1001/jamanetworkopen.2020.7664

Adjuvant Therapies

Gabapentin

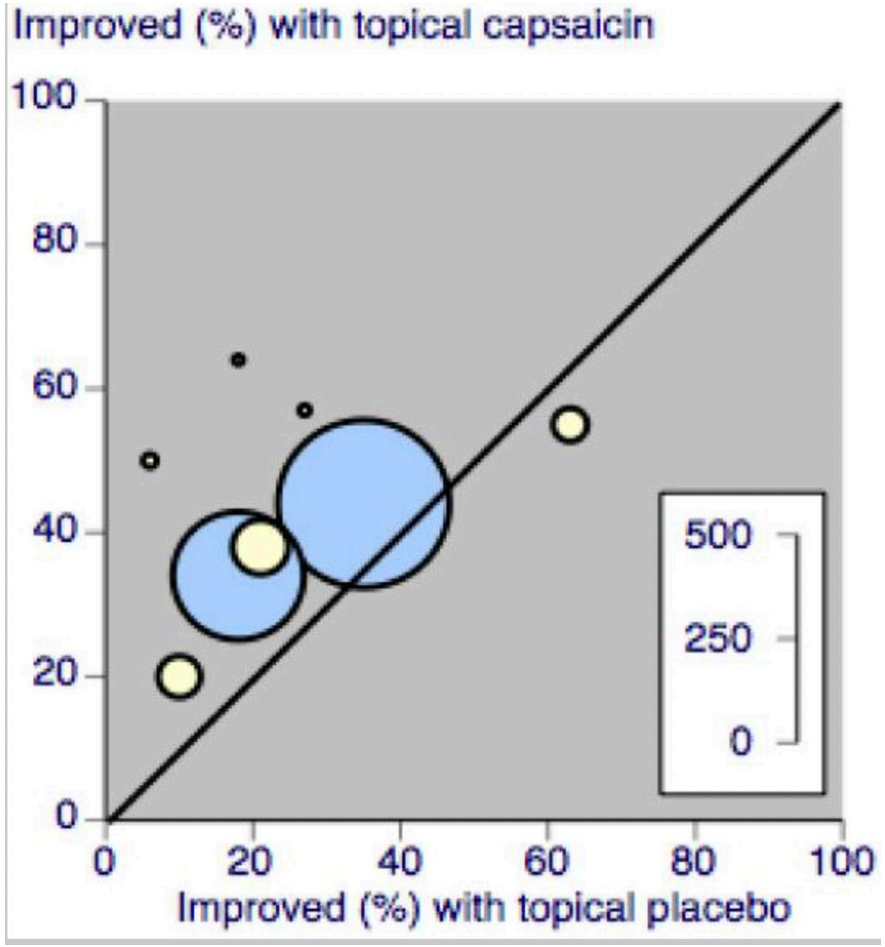
- Used for opioid sparing effects postoperatively (new)
- Most effective in neuropathic pain
- Needs adjusted for CrCl
- Can cause Hypotension, sedation

Muscle relaxant:

- Used as a part of multimodal pain management perioperatively
- Continued use can cause falls, delirium
- Increase use with concurrent use of opioids

Examining alternate modalities for pain control

- Local pain control
- Capsaicin



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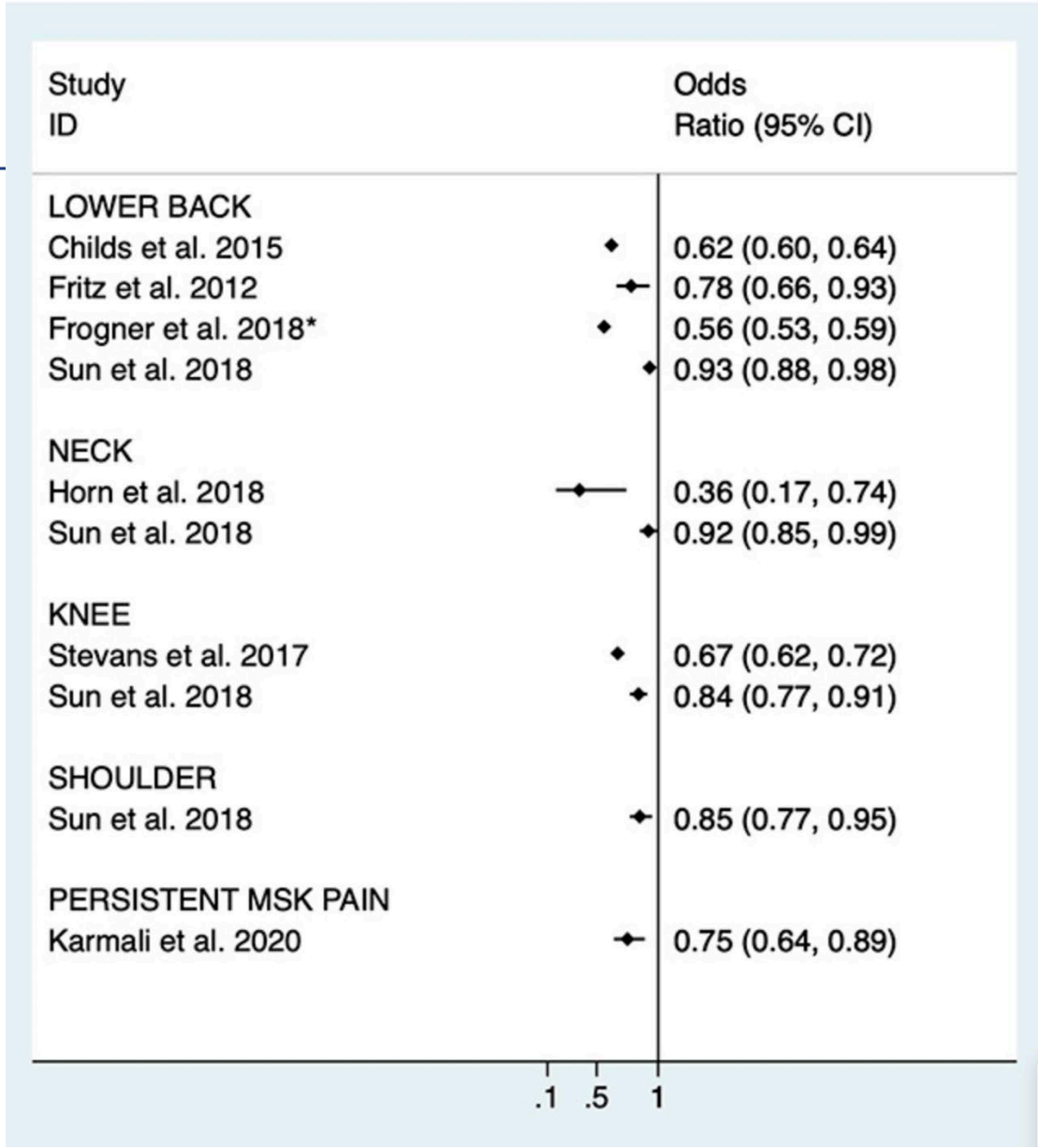


Use of physical therapy and subsequent use of opioids

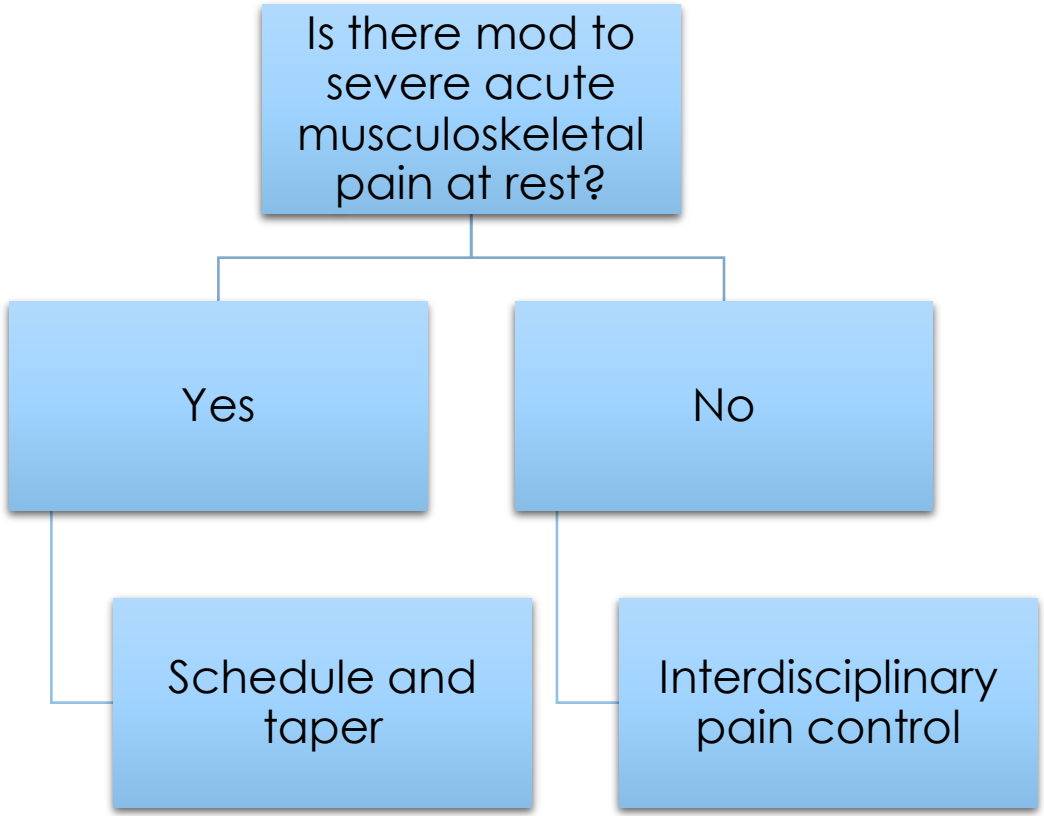
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7808685/

Approach to acute pain in LTC

TABLE 26

Examples of Situations in Which Opioids May Be Beneficial

- High-intensity acute pain
- Initial and short-term treatment of postoperative pain
- High-intensity cancer-related pain
- Daily or almost daily frequent or continuous severe pain related to serious underlying conditions
- High-intensity neuropathic pain due to partially or totally uncorrectable underlying causes (e.g., spinal nerve-root compression).



Pain Management in post- acute and long-term care setting Clinical practice guideline series: The Society for Post Acute Long Term Care Medicine

Choosing wisely: From the Society for Post Acute Long Term Care Medicine

15. Don't provide long-term opioid therapy for chronic non-cancer pain in the absence of clear and documented benefits to functional status and quality of life.

Risks of Chronic Opioid Use

- After 30 days of continuous use, increased risk of lifelong use

- Hyperalgesia
  - Uptitration of pain receptors leading to increased pain
  - Hypersensitivity in all tissues
  - Increased doses do not relieve pain
  - Patient continues to report high pain levels

- Increased risk of unintentional overdose
  - Overdose risk increases at 50 MED (morphine equivalency dose)
  - Significant risk over 100 MED

2022 CDC Clinical Practice Guideline for Prescribing Opioids

Risks of Chronic Opioids

- Increased risk of opioid use disorder
- All-cause death
- Fractures and falls
- Myocardial infarction
- GI symptoms (constipation)
- Chronic withdrawal (resulting in pseudoaddiction)

2022 CDC Clinical Practice Guideline for Prescribing Opioids


CAUTION
BLIND CORNER
PROCEED
WITH CAUTION

Opioid Tapering and Discontinuation

- Reduction or discontinuation of prescribed opioids can actually INCREASE risk of overdose, overdose deaths, all-cause mortality, and suicide

- AMA, CDC, and FDA have issued warnings about tapering practices that expose patients to iatrogenic risks

Darnall & Fields, Pain, May 2022, volume 163, number 5

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Opioid Tapering and Discontinuation

"Opioids do not function solely as painkillers in the human brain but as general stress modulators…

Continuous exposure to exogenous opioid medications alters responsivity to social rewards. Tapering these exogenous opioids may unsettle this system."

Sullivan, Pain, May 2022, volume 163, number 5

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Strategies for Tapering

- **Resident buy-in!**
  - Educate regarding the benefits of tapering
  - Review their goals (many don't want long-term opioids)
  - Explore the risks of discharge on opioids
- **Reduce by 10%**
  - Every 2-3 days if less than 30 days
  - Every week if greater than 30 days
- **Review benefits of tapering regularly**
- **Evaluate for Opioid Use disorder**
  - Consider before tapering
  - Re-evaluate if resident unable/unwilling to taper

Opioid Use/Dependence vs Opioid Use Disorder

- Not all opioid use leads to disordered use, even if there is dependence.
- DSM has diagnostic criteria for Opioid Use Disorder

Loss of Control	Social Impairments	Health Impairments	Pharmacology*
Use of opioid in increased amounts or for longer than intended	Interference of opioid use with social obligations	Continued use in physically hazardous situations (driving)	Need to increase use to achieve same effect (tolerance)
Persistent wish or unsuccessful attempt to cut down or control opioid use	Continued use despite interpersonal or social problems (legal, loss of relationships)	Continued use despite psychologic or physical problems	Withdrawal of opioids
Excessive time spent to obtain, use, or recover from opioids	Elimination or reduction of important activities due to opioids		*Pharmacology is not included in the criteria for patients on chronic opioids
Strong desire or urge to use opioids			
SEVERITY	**MILD:** 2-3 components	**MODERATE:** 4-5 components	**SEVERE:** 6+ components

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Correct Diagnosis → Correct Treatment

- **Opioid Use Disorder**
  - Transition to OUD treatment (methadone, buprenorphine, naltrexone)
  - Buprenorphine best option in skilled nursing environment
- **Opioid Dependence**
  - Slow taper with support
  - Buprenorphine if resident preference
- **Chronic Pain Syndrome**
  - Review safety of continuing
  - Return to chronic dose
  - Explore tapering to a goal of <50 MED (with resident agreement)
- **Opioid Use Without Dependence**
  - If taking opioids but no dependence or use disorder
  - Plan resident-centered taper plan.

Buprenorphine

- Partial Opioid Agonist used in opioid use disorder AND chronic pain.
- Lower risk of respiratory suppression = lower risk of overdose
- Longer acting medication, well tolerated
- Lower sedation
  - Great for respiratory residents
  - Safer for co-occurring SUD

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Conclusions

- Opioid stewardship is important for overall health of residents and their long-term success at discharge.
- Opioids have significant risks and these risks should be reviewed with residents
- Resident-centered taper plans are best tolerated when residents have a sense of control.
- Identify residents with opioid use disorder and consider transitioning to buprenorphine

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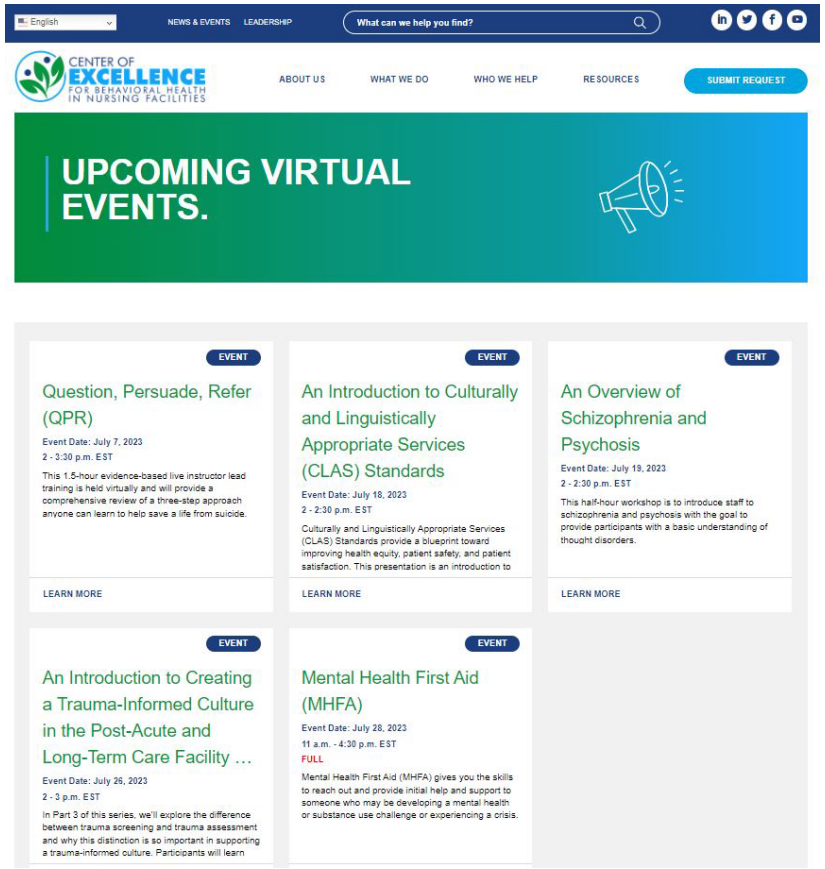
https://nursinghomebehavioralhealth.org/upcoming-events/



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