Exploring Options:
Pain Management for Patients with Substance Use Disorder

August 7, 2024

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Today's Event Host

Nikki Harris, MA, CBHC-BS

COE-NF TRAINING AND EDUCATION LEAD

Nikki serves as the training and education lead for the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). 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 Moderator

Tana Whitt, MSN, APRN, PMHNP-BC

CHIEF CLINICAL OFFICER, MINDCARE SOLUTIONS

As the chief clinical officer at MindCare Solutions, Tana Whitt oversees clinical initiatives and operations, emphasizing process optimization and collaboration among clinical teams. She has a proven history of developing evidence-based care strategies and improving patient care outcomes.

Tana's key accomplishments include founding a new psychology department, spearheading value-based care initiatives, reorganizing the operations department for enhanced efficiency, creating a centralized care coordination HUB, redesigning the account manager department to boost collaboration, and implementing a comprehensive nurse practitioner model across multiple healthcare settings.

In addition to her role at MindCare, Tana serves as the vice-chair for The PALTC Behavioral Health Committee and consults with organizations to improve quality care metrics, evidence-based practice, and interdisciplinary care initiatives. She is also an accomplished speaker and advisor in the healthcare industry.

Today's Presenter

Barbara Resnick, PhD, CRNP

PROFESSOR, UNIVERSITY OF MARYLAND SCHOOL OF NURSING

Barbara Resnick, PhD, CRNP obtained her BSN from the University of Connecticut, her MSN from the University of Pennsylvania and her PhD from the University of Maryland. She is currently a professor in the Department of Organizational Systems and Adult Health at the University of Maryland School of Nursing, co-directs the Adult/Gerontological Nurse Practitioner Program and the Biology and Behavior Across the Lifespan Research Center of Excellence, holds the Sonya Ziporkin Gershowitz Chair in Gerontology, and has close to 40 years of clinical experience as a nursing practitioner across all settings of care.

She is the editor of Geriatric Nursing and co-editor of the Journal of the American Medical Directors Association, an associate editor and on editorial board for numerous other journals and has held leadership positions in multiple aging and interdisciplinary organizations including the American Geriatrics Society and the Gerontological Society of America and the American Medical Directors Association. She has also been recognized for numerous national awards including the 2017 David H. Solomon Memorial Public Service Award, the 2018 Johns Hopkins Leader in Aging Award, the 2018 Loretta Ford Award, the 2019 Lawton Powell Award, the 2020 Dodd Award, and the 2022 University of Maryland Distinguished Professor Award and the Elkins Professor.

Today's Presenter

Anthony Nedelman, PhD

DIRECTOR OF PSYCHOLOGY SERVICES, MINDCARE SOLUTIONS

Dr. Anthony Nedelman, an esteemed clinical psychologist based in Ohio and is internationally recognized for his expertise in addressing mental health concerns across the lifespan.

Renowned for his impactful presentations, Dr. Nedelman has shared his insights at conferences nationwide. These include leading workshops on psychiatric illness in long-term care, staff burnout and employee turnover, and models for effective leadership in healthcare.

A leader in his field, he chaired the Ohio Psychological Association's Science and Research Committee and oversees a dedicated team providing counseling and psychological services in long-term care settings.

With a commitment to both leadership and clinical excellence, Dr. Nedelman continues to make significant contributions to the field of psychology.

Today's Presenter

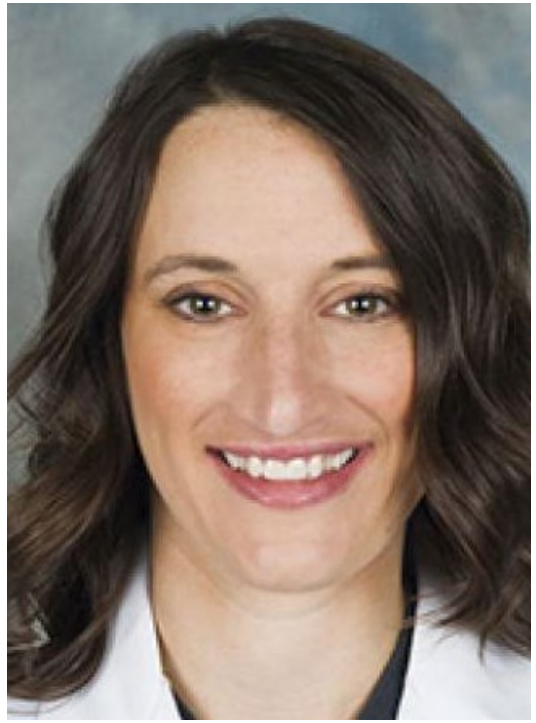
Jenn Azen, MD, MPH

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. Jenn Azen is a board-certified internal medicine and addiction medicine physician. She practices in primary care and post-acute care with UW Medicine. Her primary care practice is focused on medically complex and geriatric patients, including in-home care 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.



Pain Clinical Practice Guideline Overview

Barbara Resnick, PhD, CRNP
Professor
University of Maryland, School of Nursing

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Overall Use and Purpose

- To optimally address pain within your facilities
- To help guide your facility in a quality improvement project or focus on pain management
- To optimize the knowledge and skills of all members of the health care team in assessing, diagnosing and managing pain among residents

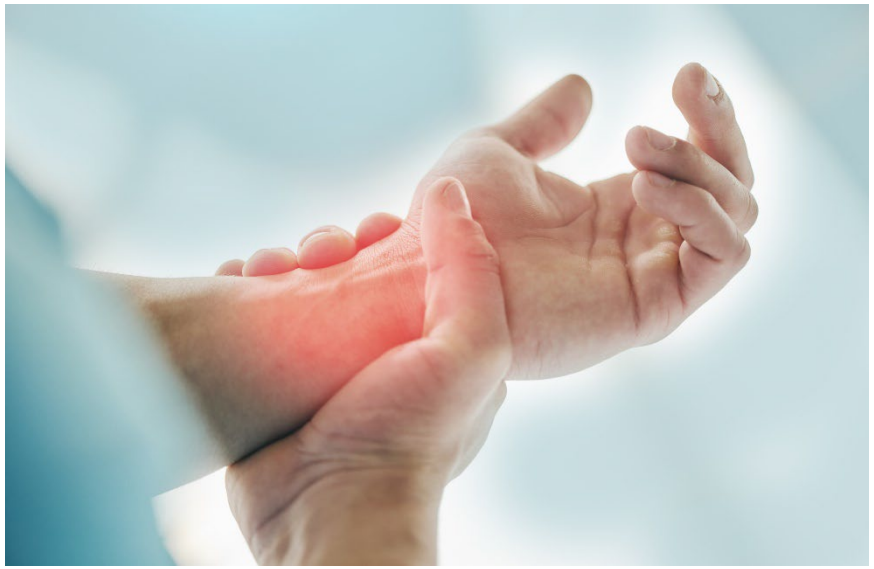
What to Reconsider

- Whether the pain is defined properly (e.g., chronic or acute)
- 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)

Diagnosis of Cause of Pain

Work as a team to diagnose the cause of the pain based on assessment

- Input from nursing
- Input from PCP
- Input from therapy
- Input from activities
- Input from social work
- Others as relevant



Definitions of Pain

- Acute
- Chronic
- Neuropathic pain
- Nociceptive pain

Treatment and Care Plan Development for Person Centered Approach

Make this person centered following a comprehensive assessment and diagnosis which the CPG helps you do.

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Comprehensive Pharm and Non-Pharm Options Provided

Nonopioid Pharm Options – with evidence of support

- NSAIDs
- Acetaminophen
- SSRIs
- Local treatments-lidocaine
- Neuroleptics

Non-Pharmacologic Options – with evidence of support

- Placebo
- Local tx – ice/heat
- Distraction
- Music
- Massage
- Acupuncture
- Physical activity
- Positioning

Guidance on Documentation Needed When Using Opioids

Area of Evaluation
1.Evidence of appropriate opioid use when there is 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.
2.A risk assessment for substance use disorder has been done.
3.Evidence that the simplest analgesic dosage schedules and least-invasive pain management modalities are being used.
4. Evidence that the form of administration that is easiest for the resident is being used.
5. Evidence that the optimal dose of the opioid is the lowest dose that sufficiently and safely relieves the resident's pain and does not cause unacceptable adverse effects or risks, based on established pain relief goals.
6. Evidence that pain has been reassessed periodically for attainment of therapeutic goals, adverse effects, and safe and responsible medication use.
7.Evidence that the frequency of monitoring for beneficial and adverse opioid effects has been done.
8.Evidence that if neither PRN nor standing opioids are substantially effective despite increasing doses or changing medications, the diagnosis and overall treatment approach should be reconsidered instead of adding medications or increasing doses.
9. Evidence that if all other things are equal, less expensive opioids should be used.
10.Evidence that dosing has considered the resident's entire medication regimen as well as factors that influence opioid activity, metabolism, and excretion.

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Once care plans are developed and implemented, the CPG provides guidance on evaluation of outcomes.

- Characteristics (e.g., frequency, intensity, and duration) of pain over time
- Overall effectiveness of current interventions (pharmacological and nonpharmacological) over time, including standing and PRN analgesics
- Impact of pain on function (e.g., interferes with activity)
- Progress toward attaining patient-centered goals
- Analgesic-related side effects and interactions
- Mood indicators (e.g., PHQ-9 from Minimum Data Set)
- Patient, staff, and family observations about function and quality of life
- Extent and ease of activity participation
- Any evidence of substance use disorder or drug diversion

Successful Implementation Tips

- Identify a champion and stakeholder team to implement the CPG.
- Lead and participate in educational sessions.
- Meet monthly to facilitate successful implementation.
- Complete evaluations of residents for pain.
- Use materials provided to optimally identify pain, diagnose underlying causes and best manage the pain.

Findings from Implementation Pilot in 2 Sites

There was evidence that all components could be implemented as intended. A total of 50 residents included. Intervention implemented for six (6) months.

- Stakeholder team meetings all held for to 15-30 minutes
- Education provided –either one time or videoed
- Stakeholder team goals achieved
- Non-significant increase in use of nonpharmacologic interventions – less than a mean of 1 used!!! (.6 to .8)
- Significant improvement in the appropriate use of verbal or observational assessments of pain (dependent on resident cognition)
- Improved documentation of appropriate use of opioids from 40% of residents having documentation to 100 percent
- Increase in the percentage of residents have improvement in a careplan for pain
    - Careplans unfortunately continue to be generic!

Nonpharmacological Interventions

Anthony Nedelman, PhD
Director of Psychology Services
MindCare Solutions

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Gate Control Theory and Mental Health

- Neuronal gates, which either permit or inhibit pain signals, can be affected by one's mental health.
- Depression, anxiety, worry, and stress can "open" these gates, allowing for pain to feel more intense.
- Many ways to improve mental health and "close" these gates

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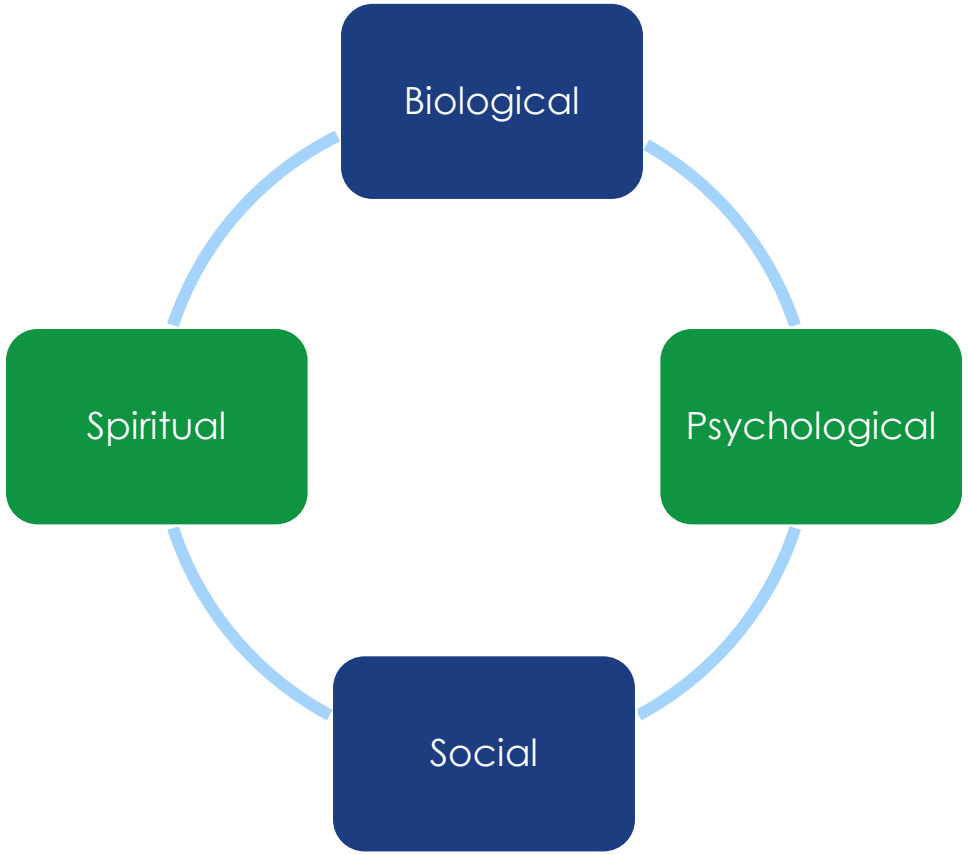
Nonpharmacological Interventions

Bio-Psycho-Social-Spiritual Model



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Nonpharmacological Interventions

Bio-Psycho-Social-Spiritual Model

Biological

- Exercise Exercise Exercise!
  - Moving your body is a natural antidepressant and, in some cases, has been found to have a greater impact on neurotransmitters than medication.
  - Must be done within the confines of ability and the presence or absence of pain.

- Take medications as prescribed.

Nonpharmacological Interventions

*Bio-**Psycho**-Social-Spiritual Model*

Psychological

- Persistent maladaptive thoughts and behaviors that cause distress can signify an underlying mental health disorder.
- Counseling can be extremely useful to learn and implement coping skills to reduce depression, anxiety, worry, stress, etc.
- There is a bidirectional relationship between mental health and physical health.

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Nonpharmacological Interventions

*Bio-Psycho-**Social**-Spiritual Model*

Social

- There is a lot of evidence to suggest how the expression of your genetic expression can be influenced, positively or negatively, by one's environment.
- Changing aspects of one's environment can positively impact mood.
  - Socializing
  - Family Relationships
  - Friendships
- Social support is a significant predictor of mental health outcomes.

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Nonpharmacological Interventions

*Bio-Psycho-Social-**Spiritual** Model*

Spirituality

- Spirituality can refer to well-established organized religious activities and experiences, or more ethereal connections to a higher power.
- Spirituality can help improve self-esteem, confidence, and direct one to purpose, comfort, and hope in difficult times.

Nonpharmacological Interventions

D.I.C.E. Model

D = Describe

I = Investigate

C = Create

E = Evaluate

Managing Pain with Substance Use Disorders, High Risk Patients, and Harm Reduction Strategies: Buprenorphine

Jenn Azen, MD, MPH
Clinical Associate Professor
University of Washington
Internal Medicine, Addiction Medicine

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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

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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Diagnostic Criteria for Substance Use Disorder

Loss of Control	Social Impairments	Health Impairments	Pharmacology*
Use of substance in increased amounts or for longer than intended	Interference of substance 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 substance use	Continued use despite interpersonal or social problems (legal, loss of relationships)	Continued use despite psychologic or physical problems	Withdrawal of substance
Excessive time spent to obtain, use, or recover from substance	Elimination or reduction of important activities due to substance		*Pharmacology is not included for OUD in the criteria for patients on chronic opioids
Strong desire or urge to use substance			
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.

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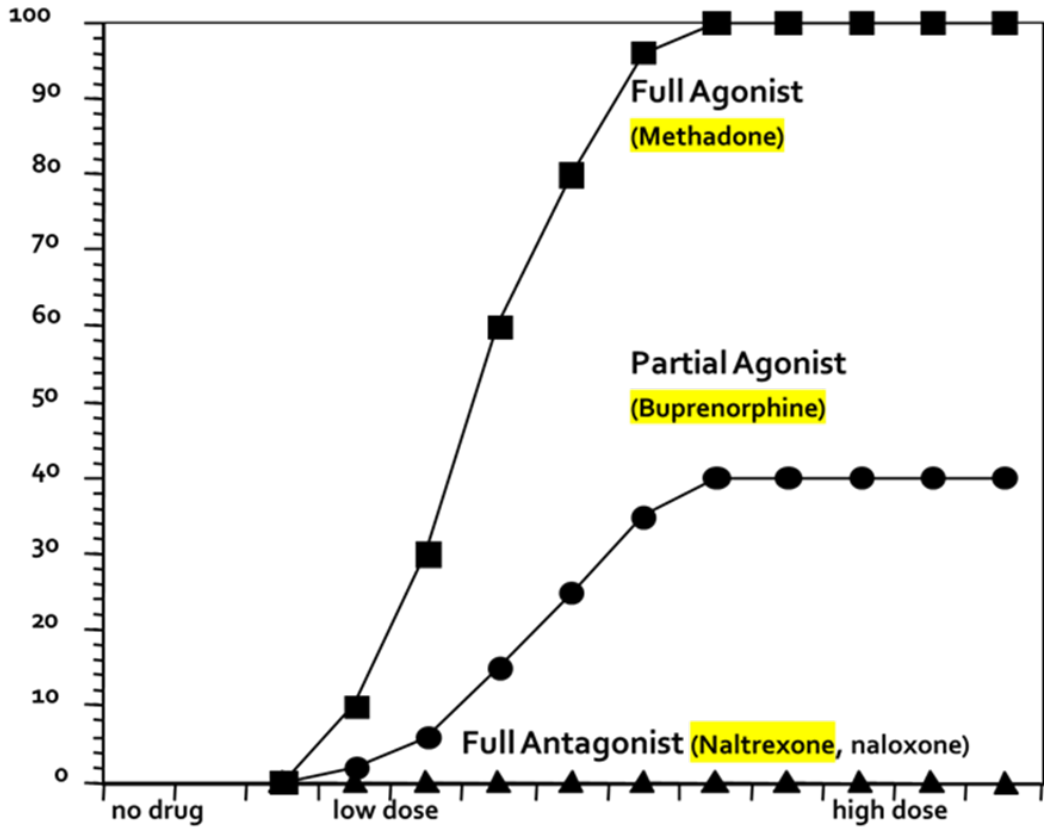
Harm Reduction Strategies for Pain with Buprenorphine

- Co-occurring substance use disorder and chronic pain
  - Alcohol use disorder
  - Stimulant use disorder
  - Substance use disorder in remission
- High-risk medical conditions
  - Pulmonary disease (risk of CO2 retention)
  - Obesity hypoventilation
  - Severe sleep apnea
- Memory concerns
- History of unintentional overdose
- Oversedation with opioids



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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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Transitioning to Buprenorphine

> **Traditional start**

> **Low dose start**

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Traditional Induction (Example)

- ER morphine 45mg bid, 2mg hydromorphone q4h prn pain
- Transition to IR morphine 30mg q8h, continue hydromorphone q2h prn
- After 1 week, hold all meds at midnight, wait 8-12h

- Start 1mg (1/2 of 2mg film buprenorphine/naloxone)
- Repeat every 1-2h until comfortable (improved w/d, pain)
- Once at comfortable dose (typically 1-4mg), can use every 6h prn pain or withdrawal.

Low Dose Induction (Example)

- ER morphine 45mg bid, 2mg hydromorphone q4h prn pain

- Continue current opioids AND
- Start low dose buprenorphine
  - 5mcg Butrans patch,
  - Belbuca 75mcg bid,
  - Suboxone 2mg, ¼ film (0.5mg)

- Reduce total opioids by 10% weekly
- Increase buprenorphine weekly
  - 10mcg Butrans patch
  - 150mcg Belbuca bid
  - Suboxone 2mg, ½ film (1mg)
- Continue to reduce opioids
- Slowly increase buprenorphine
- Stop opioid
- Adjust Dose of buprenorphine as tolerated (Suboxone may need to be tid or qid dosing)

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Questions?

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Thank You!

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