The United States is in the throes of an opioid crisis. Since 1999, deaths from prescription opioids have more than quadrupled. National organizations such as the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) are taking action and partnering with post-acute and long-term care practitioners to address the opioid crisis throughout the care continuum.

Evolution of Opioids in PALTC
Back in the 1990s when pain was christened the “fifth vital sign,” efforts were ramped up to manage pain, and pain management emerged as a popular specialty. Aggressive pain management that often included opioids was the norm, and new opioid formulations followed suit. Despite a commitment by practitioners to “start low and go slow,” many nursing home patients had opioids added to their medication regimens. Also, although nursing home quality measures scrutinize facilities for managing pain to resident satisfaction, they fail to address drug-seeking behavior.

National Action on Opioids
Last year, CMS published the “Roadmap to Address the Opioid Epidemic” (https://go.cms.gov/2SGrnIn) as part of the agency’s efforts to fight the opioid epidemic on a broad scale. CMS used data to identify Medicare physicians who were prescribing higher levels of opioids than their peers and sent over 24,000 letters over a 2-year period to those physicians to promote safer prescribing practices.

CMS also introduced an opioid mapping tool (https://go.cms.gov/2ExwFHk) to provide a portrait of Medicare Part D prescribing rates. It provides an expanded view of prescribing rates over time and across regions, enabling health care systems and other stakeholders to measure trends and make comparisons. As a result, they can identify which facilities and practitioners might need additional training and information regarding opioids.

Earlier this year, CMS announced new strategies to further help Medicare Part D sponsors prevent and combat opioid overuse, including additional safety alerts at the time of dispensing as a proactive step to engage both patients and prescribers in overdose risk management and prevention. CMS’s strategy included new policies on improved safety edits when opioid prescriptions are dispensed at the pharmacy and drug management programs for the patients who are at risk for misuse or abuse of opioids. CMS stresses that their policies are not “one size fits all.” For instance, patients in long-term care communities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt.

Medicare Part D plans may implement a drug management program that limits access by patients considered to be at risk for prescription drug abuse with certain controlled substances that have been determined to be frequently abused drugs. For 2019, CMS has identified opioids and benzodiazepines as frequently abused drugs. The potentially at-risk patients are identified by their opioid use, which involves multiple prescribers and pharmacies. The prescriber limitations require such patients to obtain their prescriptions for frequently abused drugs from certain prescribers.

Elsewhere, the CDC has introduced its “Guideline for Prescribing Opioids for Chronic Pain” (MMWR Recomm Rep 2016;65:1–49; http://bit.ly/2EPgzdS), which provides recommendations for safer and more effective prescribing of opioids for chronic pain in adult out-patient settings outside of active cancer treatment, palliative care, and end-of-life care. The guide involves 11 modules to address issues such as treating chronic pain without opioids, communicating with patients, reducing the risks of opioids, opioid dosing and titration, assessing/addressing opioid use disorder, and determining whether to initiate opioids for chronic pain.

The Society Steps In
AMDA — The Society for Post-Acute and Long-Term Care Medicine is committed to collaboration with national organizations such as CMS and the CDC to address opioid use and misuse. Toward that end, late last year the Society’s Board of Directors approved a policy statement on opioid use in nursing homes. It calls for providing access to opioids when indicated to relieve suffering and to improve or maintain function; and promoting opioid tapering, discontinuation, and avoidance when these goals are not achievable in order to prevent adverse events, dependence, and diversion. “In addition to the important clinical principles outlined in this statement, our public policy priorities regarding opioid use are to reduce the variability in state laws and regulations regarding opioid prescribing, while acknowledging the unique needs of the PALTC patient population,” said the Society’s executive director Christopher Laxton, CAE.

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– David Smith, MD, CMD

Addressing Opioids in the Trenches
More than ever, when it comes to opioids and pain, practitioners “need to be knowledgeable about pain management and empathetic to those with pain,” said David Smith, MD, CMD, president of Geriatric Consultants in Brownwood, TX. “We have a special challenge in long-term care, as we have patients with chronic pain who aren’t really candidates for alternative treatments. On top of that, we are seeing an influx of younger, non-traditional patients who have psychological comorbidities and are in the facility because of consequences of drug abuse.”

Indeed, practitioners and their teams increasingly need to function in two worlds. One involves older patients who have chronic pain and need treatment, for whom opioids often are the best option. The other world requires the team to be vigilant for drug-seeking behaviors and false complaints of pain. “We have to live in both worlds and be advocates for all of our patients,” Dr. Smith said. “We need to be skilled in pain management and also have some knowledge of addiction medicine.”

Dr. Smith noted, “There is no definitive way to determine if someone has actual, nociceptive or neuropathic pain. But one principle of pain management is to believe the patient’s pain complaint.” However, he said, “this doesn’t mean being a pushover. There is objective evidence if a person truly has pain or is being dishonest to get narcotics.” For instance, he suggested, “when you’re doing a history, you can watch the patient for signs of pain when they don’t think you’re looking.” He recalled one patient who pretended to have pain to get medication. “I asked her to flip over so I could examine her back, and she did exactly that. She was so eager to get the drugs, she showed me that she didn’t need them.” Dr. Smith added that he frequently uses a functional pain scale that forces the patient to score his or her pain on the basis of its impact on function, thereby ensuring a more accurate self-assessment without as much psychological embellishment.

Preemptive action can be effective, according to Dr. Smith. “Sometimes, I may go the extra mile and put together a contract that the patient signs saying that he or she won’t get narcotics from anyone else but me and that he or she will keep the medication safe and secure.” Such a contract can also address issues such as the tapering process so the patient has that information in writing.

Role Modeling Prescribing
The medical director should role model prescribing, and he or she should set expectations that attending physicians will conduct proper pain assessments to determine whether the pain is neuropathic, nociceptive, or psychological, or if the pain complaint is dishonest. Then they can treat the pain more appropriately.

One challenge is that many nursing home residents come from the hospital on opioids. These patients should be reassessed after nursing home admission, and it may be worthwhile to request a stop date for opioids when treating short-term pain. If any attending physicians have a high opioid prescribing rate, the medical director should talk to them, practitioner to practitioner. “You can talk to physicians, discuss your concerns, and appeal to their professionalism,” Dr. Smith noted. If the behavior doesn’t change, more serious action may be necessary. A last resort might decline admissions from that prescriber. However, he stressed that it’s important to work with prescribers and to educate them about the use of opioids in this setting.

“It’s a shame that the national conversation about the inappropriate prescribing of opioids in the general public has spilled over into the minds of residents, families, and surveyors,” said Dr. Smith. However, he noted that this presents an opportunity for practitioners to take the lead on educating people about opioids. It also can open the door for conversations about pain management in general and about alternative treatments, including medical cannabis.

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