LTC PHARMACY

By Robert C. Accetta, RPh, BCGP, FASCP

Pain Management, CDC Guidelines, and CMS Requirements in the Era of the Opioid Crisis

Post-acute and long-term care providers employ many strategies to address the challenge of managing pain, including by treating pain according to current clinical practice guidelines, encouraging safety, and aiming for the best possible outcome for our patients and residents. In addition, providers must remain vigilant by following the regulations in the Requirements of Participation, State Operations Manual (SOM), Appendix PP, and the F tags such as F697 associated with pain management. And, to complicate matters, they must accomplish all this while considering the nuances related to insurance, step therapy, drug formularies, and the multiple Drug Enforcement Administration (DEA) prescribing requirements for providers practicing in facilities. They must also be aware of the Centers for Medicare & Medicaid Services quality measures for pain, crunch the data, and analyze their facility's standing compared with local and national rankings.

While providers have had to do all these things for many years, the last decade — fraught with opioid overdoses and death — has further increased the complicated nature of pain management.

The Continued Opioid Crisis

Sadly, the rate of opioid-related drug overdose deaths has continued to climb. The Centers for Disease Control and Prevention has reported that drug overdoses have increased remarkably since 1999, with a staggering 30% increase from 2019 to 2020; 75% of the deaths in 2020 involved an opioid ("Understanding the Opioid Overdose Epidemic," June 1, 2022, http://bit.ly/3izz9Nx). Provisional 2021 data from the CDC show an additional 15% increase in opioid-related deaths ("U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 — But Are Still Up 15%," May 11, 2022, http://bit.ly/3QEqHcl). However, deaths caused by prescription opioids alone have steadily declined since 2011 (National Institute on Drug Abuse, "Overdose Death Rates," Jan. 20, 2022, http://bit.ly/3QBbXeq).

Although it is common knowledge that younger adults are most affected by the opioid crisis, opioid-related deaths among those aged 55 and up have hovered around 19% since 2012 (KFF, "Opioid Overdose Deaths by Age Group," http://bit.ly/3IQ5f2i).

New Approach for Pain Based on Expert Consensus

Due to the opioid crisis, guidance about pain management continues to change. The updated "2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain" (*MMWR Recomm Rep*. 2022;71[3]:1–95, http://bit.ly/3Wbn4Ml) offers 12 recommendations grouped into four areas of concern. These include steps that are familiar to prescribers of any drug:

1. Determine initially whether opioids are appropriate.
2. Select specific medications and dosages.
3. Decide the duration and follow-up.
4. Conduct risk assessment.

The new guidelines also acknowledge the importance of informed, patient-centered decisions and the collaborative nature of pain management. To this end, they recommend several strategies that include improved communication around risks and benefits, and improved safety and effectiveness of pain medication while also concentrating on quality of life for patients (CDC, "What's New, What's Changed," Nov. 3, 2022, http://bit.ly/3iEV1qT).

Note that the guidelines are not applicable for the treatment or management of pain related to sickle cell disease, cancer, palliative care, or end-of-life care.

The recommendations are intended to advise on strategies for pain management for all age groups; we in PALTC would naturally focus on their application for residents arriving for short-stay rehabilitation services as well as long-term residents. In addition, facilities and providers are being re-educated about resources and pathways to treat residents who have a substance use disorders, including opioid use disorder. The latest revised SOM, Appendix PP (effective on October 24, 2022) emphasizes having assessment and treatment options available for pain management for residents with these conditions, with consequences such as survey citations for not addressing them (CMS, "Nursing Homes," Nov. 11, 2022, http://bit.ly/3k8VDW5).

The CDC guidelines are also prompting clinicians to think twice before selecting an opioid as the first choice for pain management. As in previous and current guidelines as well as surveyor guidance in Appendix PP, providers will face increased scrutiny over whether nonpharmacological and nonopioid therapies are being considered and initiated as treatment options before opioid use. Once again, the patient or resident's specific needs as well as the risks associated with any therapy that includes opioids should be thoroughly weighed in all cases.

Useful Therapies for Treating Pain

- Nonopioid medications such as acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), and selected antidepressants and anticonvulsants.
- Physical treatments (e.g., heat therapy, acupressure, spinal manipulation, remote electrical neuromodulation, massage, exercise therapy, or weight loss).
- Behavioral treatment (e.g., cognitive behavior therapy or mindfulness-based stress reduction).

From CDC, "Guideline at a Glance," Nov. 3, 2022, http://bit.ly/3IU6I7Z.

Types of Pain: Selecting the Duration of Treatment, Re-evaluating Success

The CDC guidelines have a new emphasis on assessment of the type of pain, which addresses the expected duration of pain:

- *Acute pain* (duration < 1 month)
- *Subacute pain* (duration of 1–3 months)
- *Chronic pain* (duration > 3 months)

A new recommendation in the guidelines states that "when opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids." This is a challenge when our facilities accept short-stay residents on opioid regimens and during care transitions when a resident is discharged home. In addition, abrupt discontinuation of opioids may predispose the resident to withdrawal and adverse events.

Simply stated, opioid prescribing requires careful discussion and assessment between the provider and the resident about the benefits and risks of opioids.

Additional Risk Factors and Planning for Overdose

Combination therapy of opioids with benzodiazepines is a known risk factor for adverse outcomes and should be avoided or mitigated as much as possible.

Naloxone, a rescue medication used to reverse opioid overdose, has now been highlighted in the SOM as a necessary emergency medication to have on hand at facilities. Any successfully

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Practical Mentorship: For Discussion Between Medical Director and Staff Providers

- Provide a high-level review of the CDC guidelines and the different categories of pain.
- Identify opportunities to reduce reliance on opioids after acute procedures.
- Review the process used to assess residents' complaints of pain.
- Avoid relying only on reports by the nursing staff placed in a communications book.
- Review the percentage of residents with pain in the facility's quality measures report, and consider using it as a tool for a deeper dive into the subject of pain management.
- Have access to the electronic medication administration record and check for frequent as-needed medication use.
- Avoid high-risk medications and mitigate the chances for hospital readmissions due to drug interactions.
- Include interdisciplinary team members in planning and education, including the activities staff, social workers, and rehabilitation services.
- Educate others: create pain management champions.

Questions to Explore

- How many residents are receiving antidepressants and are not treated for complaints of pain?
- Does the provider have adequate time to assess pain during interim or regulatory visits?
- Could the team consider a pain rounds/huddle when assessing multiple residents on a floor?
- Is the pharmacist consultant a resource to evaluate pain medication selection and offer suggestions to mitigate risks while providing adequate pain relief?

OBRA REGULATIONS AND CLINICAL PRACTICE

By Steven Levenson, MD, CMD

Highlighting Key Principles and Practices of Pain Management

Pain is a vast and complex topic with many detailed aspects. As with so many other conditions and symptoms, pain management remains challenging. There are already many guidelines and articles on the topic. Instead of covering specific clinical aspects of pain management, the goal of this month's column is to highlight some key considerations that I have found particularly useful over time as a medical director, across all patients and settings.

In 2016, the Centers for Disease Control and Prevention issued a report with 12 key recommendations for using opioids more appropriately to manage pain. As a result of this report and the growing problem of substance use disorders in the country, considerable legal and regulatory pressure was asserted to limit opioid prescribing. It became something of an overreaction, but the basic concerns were warranted.

At the time, many post-acute and long-term care (PALTC) practitioners believed that the 2016 recommendations did not apply to patients in PALTC. However, my own assessment of the situation was that at least nine were relevant to PALTC practice.

Then, in 2022, the CDC issued an updated report that recommended liberalizing some of the recommendations about indications, doses, and duration of use for opioids in certain pain situations. However, there were no major changes to the basic principles of prescribing espoused in 2016.

What are we to make of all of this?

There is nothing remarkably new in 2023 to help assess and manage pain. Ultimately, pain management exemplifies the need for clear thinking about a complex topic. Simply stated, the universal and enduring principles and processes — recognition, problem definition, cause identification, interpretation of findings, management, and monitoring — apply to pain management just as they do to any symptom. This includes more careful assessments, searching for specific underlying causes, and adapting generalities to specific patient situations. But, because we as practitioners have limited time to think in fast-paced health care settings, we often need collaboration with the rest of the interdisciplinary team (IDT) to identify and organize complex information.

Assessing the Situation: Gathering Details

Sometimes pain is straightforward, and the answers are relatively apparent. But much of the time, such as when the origins of pain are unclear or simple measures are unsuccessful, more details are essential.

The challenges of getting enough accurate details about patients' pain complaints are well known; this process is hampered, for example, by limited objective findings and patient and staff variability in reporting and describing pain. In a PALTC facility, the rest of the IDT has likely already assessed and documented details about a patient's symptoms. It is not unreasonable for practitioners to rely on others' work, but this information may be inadequate and unreliable.

Unavoidably, facility staff must collaborate with the medical director and medical practitioners to push for sufficient detail. This includes not just the severity (intensity) of pain (e.g., "7-out-of 10"), but also its frequency, precise location, and duration, along with a chronological story and the pain's characteristics (sharp, stabbing, dull, aching, etc.). This information is usually enough to guide appropriate pain management.

A facility that cannot or will not follow this process routinely is likely not managing pain safely and effectively. For example, it is common to see opioids used based on progress notes that describe simply "leg pain" or "arm still hurts." This is not enough information to help choose the most appropriate and lowest risk interventions.

The Impact of Cognitive Bias

Cognitive biases can have a major impact on all clinical practice. Assumptions may be acceptable in simple situations or when the results are satisfactory, but they can otherwise be problematic. Pain management is no exception. For example,

- Grimacing in a nonverbal patient does not necessarily reflect pain.
- New onset pain in someone with cancer could be due to something other than cancer.
- Certain pain descriptions such as burning, stabbing, or shooting cannot automatically be assumed to reflect neuropathic pain or pain that is due to diabetes.
- Minimal effectiveness of opioids is not an automatic indication to give more opioids; conditions such as fibromyalgia or inflammation are not opioid sensitive.

Treatment Challenges

There are many opinions and recommendations about treating pain. Every analgesic has pros and cons. They may work for one type of pain or condition or patient but not for another. When a pain intervention is not as successful as anticipated — especially after repeated adjustments — it is prudent to reconsider the causes and current treatments, rather than just do more of the same. Empirical (trial-and-error) approaches based on evidence are sometimes necessary, but guessing without supporting evidence is much less successful.

To aid in treatment selection, it is useful to try to categorize pain as acute or chronic, and then to subdivide chronic pain further (e.g., chronic widespread or chronic cancer-related). For help with this process, see AMDA – The Society for Post-Acute and Long-Term Care Medicine's "Pain Management in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline," and the Pocket Guide (pp. 22–25, available from https://bit.ly/painCPG). Opioids, for example, are not necessarily appropriate for more severe pain, depending on the situation. And gauging severity alone is less helpful in many cases of chronic pain.

Discussion about treatment with opioids often centers around whether to use or switch to long-acting opioids (LAOs). The advice is often to switch patients to long-acting opioids if they use more than occasional doses of short-acting opioids. LAOs should be given with care and prescribed only by practitioners who are familiar with their appropriate use and appropriate dosing, frequency, selection, and checking for side effects.

When it comes to pain management, too much of a good thing can become a bad thing because of adverse consequences and interactions. It is not uncommon to see medical practitioners keep increasing LAOs despite little or no relief. Although this is sometimes warranted, it is also essential to consider whether opioids were the right choice or even indicated to begin with.

Fentanyl is becoming the latest drug disaster to afflict the United States (U.S.

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designed treatment plan will incorporate mitigation around potential adverse drug events, overuse, overdose, and availability of naloxone.

Tapering and deprescribing must be carefully assessed before implementation, and, if appropriate, must be carried out slowly with the acknowledgment of the patient or resident to reduce the risks associated with opioid dependence. Written opioid overdose policies should be available in facilities that include education of facility staff on how to identify a potential overdose occurrence. Many organizations have created resources that contain their policies and procedures, which can be tailored to the individual needs of the facility or organization.

Legislation Changes the Game in the Efforts for Access to Treatment Medications

Of recent importance is the Consolidated Appropriations Act of 2023, signed into law at the end of 2022, which includes a provision to relax the requirements for obtaining the "X-waiver" to prescribe buprenorphine, one of the US Food and Drug Administration's approved medications to treat opioid use disorder (H.R.2617, https://bit.ly/3XEyskP). For more information, see

- Substance Abuse and Mental Health Services Administration (SAMHSA), "Removal of Data Waiver (X-Waiver) Requirement," Jan. 12, 2023, http://bit.ly/3koOJvU.
- American Society of Addiction Medicine (ASAM), "ASAM Praises Congress for Passing Vital Provisions in End-of-Year Legislation that Will Increase Access to Addiction Care and Save Lives," Dec. 23, 2022, http://bit.ly/3ZGEu6s.

Photo by Towfiqu barbhuiya on Unsplash.

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