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MANAGING OPIOIDS IN SENIOR LIVING CALLS FOR EQUAL PARTS SCIENCE AND COMPASSION

In short order, the medical community has succeeded in reversing the narrative that new, powerful narcotic painkillers that flooded the markets in the 1990s are generally safe and non-habit forming.

It could take decades to reverse the damage the drugs have inflicted on people, particularly the most vulnerable ones in assisted and independent living.

Beyond the nightly news, the long-term care industry finds itself wrestling with issues bearing little resemblance to the rapid and chronic addiction and overdose deaths most associate with young adults. In many ways, those issues are far more complex but no less manageable, according to Todd King, Pharm.D., CGP, FASCP, director of clinical services for Omnicare, a CVS Health company.

In some ways, opioid use in non-skilled settings is a far riskier, less manageable problem. Opioid management becomes even more dicey in settings where residents freely shop and return to their apartments with various OTC non-narcotics.

As if prescribing and dosing issues aren't enough, the problem of polypharmacy can compound medication errors tenfold, experts say. And as seniors move from home to hospital to nursing home to other settings such as assisted living, a lot of information can and does fall through the cracks.

All of which can have dire consequences. Lots of times we're not talking about an overdose or something you might see in the news. We're looking more at problematic side effects that can increase the risk for falls and cognitive impairment," King said.

However, with proper consideration of safer analgesic alternatives, understanding the physiology of pain and judicious and cautious use of opioids for managing long-term chronic pain, many problems affecting opioid use in non-skilled settings can be effectively managed and in some cases, avoided, asserts King, who presented on opioid issues in the elderly for a recent *McKnight's*-hosted webinar sponsored by Omnicare.

Although the tragic cycle of experimenting, addiction, overdose and death may come quickly for young people, seniors who jumped on the opioid treadmill in the 1990s have had decades to build up tolerances to painkillers, seriously raising the risk of higher doses in a demographic that is more susceptible to side effects than any other.

Caregivers in non-skilled settings need to understand that because of residents' silence and

A SUPPLEMENT TO McKnight's SENIOR LIVING News, perspective and analysis

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freedoms, pain can have lasting cognitive and emotional effects such as sleeplessness, low energy, trouble concentrating and depression.

"The more times we see these somatic chronic complaints, the more times there's likely a medication involved," King said. "And anytime you add another medication to an already complex medication profile, it does put that resident at risk."

Precautions and side effects

Despite the ubiquitous messaging around opioids these days, consultant pharmacists are passionate about never missing the chance to disseminate factual information as a baseline for best-practice pain management.

The Centers for Disease Control & Prevention's "Guideline on Prescribing Opioids for Chronic Pain" is a good place to start. The operative term is "chronic," because so many primary care providers have prescribed powerful narcotic pain meds immediately after an injury or the onset of some kind of acute pain, King said. The CDC recommends opioids for seniors only if pain persists after six months. Although current medical literature allows for wide interpretation, King urged providers to consider the "overall evidence base" and begin with opioids that are not only appropriate for a specific injury or condition, but also those that pose the lowest possible risk.

One often-missed protocol with opioids is failing to adjust dosage and volume over time. This requires routine reassessments.

"Because of the nature of being comfortable with these opioid products, we often don't go back and re-evaluate those medications," King said. "That is an opportunity for us to reduce or avoid addiction and also some of the side effects."

A thorough look at the CDC's opioid "prescribing and dosing precautions" reveals a fundamental, common sense dictum: Go low and slow.

"The most important word there is 'Go,'" King said. Caregivers sometimes under-treat pain in their effort to avoid medication errors. The best approach is addressing the pain as soon as possible to get and stay ahead of it. The payoff can be significantly less time spent on narcotic therapy while using the safest and most effective therapies to heal the issue that's causing the pain in the first place.

Other precautions include prescribing immediate-release, short-acting opioid formulations to avoid side effects from lingering narcotics, keeping the number of doses, or pills, to a minimum, and following up and re-evaluating the risk of harm so doses can be tapered or discontinued.

> *"There are so many folks over 65 in independent or assisted living facilities who choose to deal with their pain in silence."*

Providers also need to thoroughly understand the plethora of side effects from even short-term opioid use in seniors. These often pose more risk than addiction or overdose, according to King.

The most common adverse effects can produce drastic mood swings and somnolence, which can further cause lethargy and drowsiness, while stimulation of the chemoreceptors in the brain can induce nausea and vomiting. Other frequent effects from opioids include constipation and hives, itching or an asthma exacerbation due to opioid mediated histamine release.

In addition, other major opioid side effects may include respiratory depression (often seen with excessive or too-frequent dosing) and delirium.

King stressed the need for providers to understand the difference between immediate-release and long-acting opioid analgesics such as morphine, oxycodone and fentanyl. Immediate release formulations typically are indicated for acute, or short-term, pain, whereas long-acting forms are designated for chronic pain. Long-acting scripts never should be used as a first-time therapy for any kind of pain and should be re-evaluated at least every two to three days, he added.

One alarming trend in assisted and independent living is the increased use of transdermal fentanyl patches. In most cases,

Photo: John Merkle @ Elmhurst Park Place

WHAT THE DOCTOR ORDERED?

Opiod use in the senior living sector presents unique challenges.

For more information

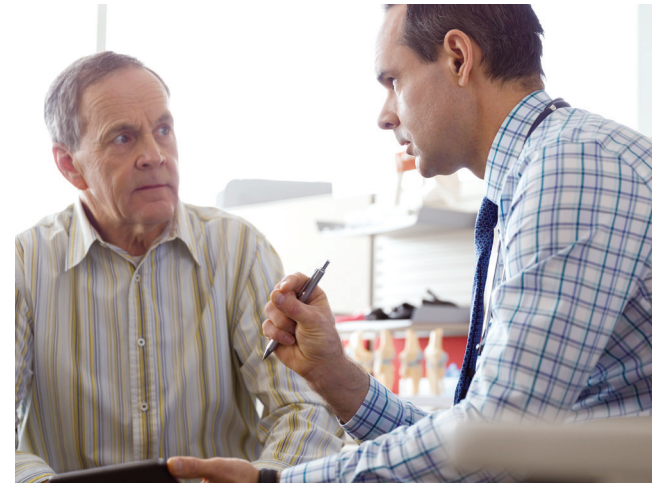
The original webcast is available at www.mcknightsseniorliving.com/December5webinar.

seniors in these settings can well tolerate immediate-release oral fentanyl (transmucosal) and avoid many of the needless and risky instances of long-acting dosing of this extremely potent painkiller, which can lead to a host of adverse consequences if the resident with a patch is not constantly monitored, King said.

Other challenges accompanying the use of fentanyl patches pertain to the fact that most seniors have lean body mass and poor circulation, making it difficult to administer them effectively and safely.

DIFFICULT CONVERSATIONS

Many older residents are reluctant to disclose how much pain they feel.



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Spotting telltale signs early

Ironically, seniors are the least likely to report or complain about pain because so many accept things like early onset arthritis as an inescapable part of getting old.

"There are so many folks over 65 in independent or assisted living facilities who choose to deal with their pain in silence," King said. "Healthcare professionals have a couple of dilemmas – making sure that we appropriately assess and identify pain so it's not undertreated, but also when we do choose to treat pain that we use the safest medication possible at the least effective dose."

Providers need first to understand how pain is defined by the medical community from the American Pain Society and Centers for Medicare and Medicaid Services to the elegantly simple definition made famous by Margo McCaffery, RN, in 1968: "Pain is whatever the patient says it is."

"That is a pretty impactful comment," King said, "because to me that means our patients do have to process their pain. They are the ones who will assess it the best and give us the information on where the pain is occurring, what are the types of things causing it and how it can best be managed appropriately."

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Providers also need to understand the difference between acute and chronic pain, and how managing it can change when one advances to the other. For example, the difference between acute and chronic pain may be behaviors such as constant rubbing and moaning versus depression, and sympathetic hyperactivity such as sweating versus anorexia and severe fatigue.

King focused a key part of his presentation on the critical role that assessments play in managing pain. There are various methods ranging from the common Wong-Baker FACES Pain Rating Scale and Visual Analog Scale to the Numeric Pain Distress Scale. Whatever method is used, an accurate pain assessment ultimately can determine the best course of treatment, including medication.

"The most important thing is choose a scale the patient feels most comfortable with; it can be used to set goals for looking at appropriate pain treatments," he added.

Because of this, providers are urged to first consider non-pharmacologic options including physical and non-physical therapy (such as meditation and relaxation) and non-opioid analgesics such as acetaminophen, oral NSAIDS such as ibuprofen and prescription meloxicam, and even tramadol, a powerful non-opioid pain reliever that King said "is probably used more than any other analgesic in our assisted living and independent living residents."

He stressed, meanwhile, that providers should be mindful that even non-opioid analgesics come with a host of harmful side effects (such as hepatotoxicity and nephrotoxicity) if not managed carefully.

"Physical and non-physical therapy techniques are getting a lot of increased attention out there, especially in assisted living, where these residents are more apt to participate in their care," King said. "I see this as an opportunity for us in the senior living population because of their pain and the situations they have to reduce their medications and therefore reduce some of the adverse events." ■

Editor's note

This McKnight's Senior Living Webinar Plus supplement is based on a similarly named webinar presented on Dec. 5. The event was sponsored by Omnicare. The full presentation is available at www.mcknightsseniorliving.com/December5webinar.