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From the Front Lines

AlixaRx Clinical Pharmacists Address Everyday Challenges in Long-Term Care

Opioid use in Older Adults

The rapid growth in deaths due to opioid abuse has prompted a renewed look at the use of opioids in managing chronic pain. While the risk of abuse and side effects in older adults is important, so is the effective evaluation and management of chronic pain in a complex and vulnerable population that requires person-centered care.

What's Important to the Patient?
Quality of life and function are two of the most important elements to be aware of in the care of older adults.

The opioid crisis in the United States presents some challenges in relation to the management of pain in older adults. From a bioethical perspective, there is little disagreement as to the focus on pain management of those nearing the end of life. Comfort and quality of life are of paramount importance, and concerns about addiction and side effects are quite different. The question then becomes one of when does the focus change? When does control of pain at all costs supersede the "risks" of such treatment? What are the risks? In someone nearing the end of life and suffering from severe pain or discomfort, does the risk that over-sedation might lead to respiratory failure preclude treatment of pain with opioids? Other factors come into play, particularly a patient's overall quality of life and function. Is the patient severely demented? Is he or she bed-bound?

Assessing Pain in Older Adults
The first step in assessing pain may be getting the patient to acknowledge that he or she is actually having pain. There are many social and cultural reasons a patient might either minimize or deny pain. First is the belief that pain is a normal consequence of aging. There is also the fear of pain being related to other problems that might lead to additional diagnostic evaluation and treatment. If a patient is cognitively impaired, it may prove more challenging, but certainly not impossible, to identify pain. Observation of a patient by caregivers can provide useful signs that indicate he or she is experiencing pain or discomfort.

Assessment of quality of life and function are the defining factors in person-centered care and should also be the key to effective evaluation and management of pain. How is pain impacting the patient's quality of life? Has it caused any limitations to his or her functional abilities? Using a pain scale can be helpful, but what is most important is how the pain impacts the patient. The other piece of important clinical information is determining the source of the pain. Obviously, assessing the nature of the pain, its intensity, and frequency are all important factors in helping to determine the etiology of the pain. The etiology and the impact will determine an effective approach to treatment.

Approach to Pain
In older adults it is particularly important to identify the etiology of pain. If the pain is determined to be musculoskeletal in nature, is it due to an inflammatory process? Is it more structural in nature? Is it neuropathic? Is the pain general? Is it localized? It's important to remember that medications have side effects. While pharmacotherapy has been the mainstay for treating pain since antiquity, it is worth considering other modalities, especially when considering the risk of side effects and adverse events from opioids and anti-inflammatory agents.

Acetaminophen given around the clock is the simplest and safest approach to chronic pain management. Concerns about excess acetaminophen intake due to its availability in a number of over-the-counter products has led to the suggested maximum daily dose being reduced to 3gm per day. The main concern regarding acetaminophen toxicity is in patients with liver disease or a history of excessive alcohol use.

In this issue:

The risks from acetaminophen are significantly lower than the risks from NSAIDs and opioids. The key to the effective use of acetaminophen is that a patient with chronic pain must be instructed to take it around the clock. If taken regularly, it will work 70% of the time. However, many patients do not have continuous, but rather, intermittent pain that can be treated with intermittent, scheduled pain medications.

NSAIDs should be reserved primarily for cases where a clinician believes there is evidence of an inflammatory process. Physical exam findings of warmth, erythema, or swelling are indications for a trial of NSAIDs. If regular dosing of acetaminophen doesn't work, a trial of an NSAID may be warranted, although it's important to recognize the risks of chronic NSAID use in relation to gastrointestinal bleeding and other side effects such as renal dysfunction. If long-term use of NSAIDs is believed to be indicated, consideration should be given to concomitant use of a proton pump inhibitor.

Considering Opioids
In situations where chronic pain is impacting a patient's quality of life or function and non-opioid analgesics or non-pharmacologic therapy have been ineffective, opioids should be considered. Concerns about addiction need to be put in the context of the potential benefit of effective pain management in relation to the risk of side effects. Is the patient's quality of life and/or function improved with the use of an opioid analgesic? The traditional geriatric credo of "start low and go slow" will typically apply. Older adults may be quite sensitive to opioids, especially as they relate to sedation.

The advent of longer-acting opioids has had a positive impact on the effectiveness of opioids in managing chronic pain in older adults. Short-acting opioids, such as morphine, are now primarily used for breakthrough pain.

The following goals are key to the effective use of opioids:

- pain control with limited side effects;
- around-the-clock dosing;
- as needed for breakthrough pain;
- avoidance of polypharmacy;
- recognition of pain triggers, particularly in the cognitively impaired; and
- therapy targeted toward individual pain assessment.

Side Effects of Opioids
Discussion of the use of opioids in older adults would not be complete without a discussion of the common side effects. One of the most common and problematic side effects is constipation. Stool softeners and stimulant laxatives should be started with the initiation of opioid therapy, as there is no tolerance effect. Nausea is a common side effect, as are sedation and cognitive impairment. Respiratory depression is one of the more serious side effects of opioid use and is potentially life threatening. Other side effects include pruritus and urinary retention. In some cases, patients receiving increasing doses of opioids can develop opioid-induced hyperalgesia. Side effects can be managed with dose reduction and symptomatic treatment if opioids are necessary for pain control. Rotating opioids and switching the route of administration are other options. One can augment the use of opioids with adjuvant therapy, or alternatives may be tried in lieu of the use of opioids.

Other Approaches to Pain Management
A variety of other medications may be useful, particularly in the case of neuropathic pain. Serotonin-norepinephrine reuptake inhibitors such as duloxetine (Cymbalta) and anticonvulsants such as gabapentin and pregabalin (Lyrica) can be considered. Topical NSAIDs provide another altrnative for localized musculoskeletal pain, as does topical lidocaine. Corticosteroid injections should be considered for cases of bursitis or tendonitis.

Complementary and alternative medicine approaches to the management of pain may include:

- Physical and occupational therapy
- Exercise itself may have value, and some specific programs such as tai chi or yoga may be beneficial.
- The role of spirituality should not be ignored, particularly from the standpoint of trying to provide a person-centered approach to care.

Risk of Opioid Abuse in Older Adults
We cannot ignore the risk of opioid abuse in older adults. This is becoming a serious issue in the younger population and, regardless of the incidence in older adults, it is important that clinicians recognize any risk as they approach the management of pain in older adults. One way of identifying patients who might be at risk for abuse would be to use an opioid risk tool such as the SOAPP (Screener and Opioid Assessment for Patients with Pain). This tool is available at www.nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf.

Neither fear of abuse nor concern for potential side effects should keep a clinician from ordering opioids when they are deemed potentially beneficial to a patient. Recent studies continue to suggest that we undertreat pain in older adults. Opioids should not be the first line of treatment, and both pharmacologic and non-pharmacologic alternatives should be strongly considered. On the other hand, opioids provide a tried and true approach to pain treatment, especially in cases of moderate to severe pain.

In closing, remember that your AlixaRx clinical pharmacist is an excellent source of information about opioid medication use and alternative medications to treat pain in your patients.

CMS Mega Rule Phase 2 Update - All the News That's Fit to Print

Phase 2 of the CMS Mega Rule was implemented last fall and there are several significant changes that impact pharmacy services in LTPAC facilities including:

- DRR must include a review of the entire medical record, not just the physician orders
- The facility must develop an Infection Prevention and Control Program (IPCP) that includes an Antibiotic Stewardship Program
- Each resident's drug regimen is free from unnecessary medications
- The term 'psychotropic' has been redefined as "any drug that affects brain activities associated with a mental process and behavior." This includes antipsychotics, antidepressants, anxiolytics, and hypnotics.

Antibiotic Stewardship Programs

CMS estimates "that between 25%-75% of antibiotic prescriptions in nursing homes may be inappropriate." CDC guidelines recommend the adoption of:

- Core Elements of Antibiotic Stewardship for Nursing Homes
- Policy and Practice Actions to Improve Antibiotic Use
- Measures of Antibiotic Prescribing, Use and Outcomes
- The Loeb Criteria for Initiation of Antibiotics in Long-Term Care Residents*
- Written facility policies and procedures for infection control and a system of surveillance

*The Loeb Criteria states that the minimum criteria for initiating antibiotics for UTI in LTC residents without an indwelling urinary catheter include:

- Acute dysuria alone; OR
- Fever >37.9°C (100.2F) or 1.5°C increase above baseline temperature, and at least new or worsening, of 1 of the following:
  - Urgency
  - Frequency
  - Suprapubic pain
  - Gross hematuria
  - Costovertebral tenderness
  - Urinary incontinence

Antibiotic orders should include:

- Stop date or duration of therapy
- An appropriate diagnosis, (Note: The use of a symptom (nasal congestion, rhinorrhea, sore throat, cough, etc.) is NOT a diagnosis)
- A culture, when possible/appropriate PRIOR to beginning antibiotics
- Quinolone antibiotics should be avoided in uncomplicated infections
- Culture reports should be reviewed to insure the organism is sensitive to the antibiotic; if resistant, the antibiotic must be discontinued/changed to another agent.

Sample Antibiotic Use Policy and Procedure might include:

- If culture is negative, the antibiotic must be discontinued immediately
- Monthly review of infections and antibiotics used by medical director and consultant pharmacist for appropriate diagnostic testing, antibiotic dose and duration, and whether antibiotic was changed or discontinued based on culture report
- Facility shall obtain an antibiogram (at least annually) and distribute to medical director, physicians, and consultant pharmacist.

Unnecessary Drugs

Each resident's drug regimen should be free from unnecessary medications. An unnecessary medication may include a medication prescribed without an appropriate indication for use*, in excessive doses (including duplicate therapy), without adequate monitoring, in the presence of adverse consequences which indicate the dose be reduced or discontinued. The term 'psychotropic' has been redefined as "any drug that affects brain activities associated with a mental processes and behavior". This includes antipsychotics, antidepressants, anxiolytics, and hypnotics.

*Unacceptable indications for use include:

- Wandering, restlessness, mild anxiety, fidgeting, nervousness, uncooperativeness
- Poor self-care
- Impaired memory
- Insomnia

Examples of drug classes that must be monitored include:

- Narcotics – assess pain, implement bowel program
- Anticoagulants – bleeding/bruising, PT/INRs, interactions
- Diuretics – edema, K+ level, signs of electrolyte imbalance
- Duplicative therapies and effectiveness
- Hypnotics – causes for insomnia, hours of sleep

Expectations

- Physician must provide clinical rationale for continuing a med that may be causing an adverse consequence, including risks vs. benefits
- Pharmacist should identify and report any med irregularities
- Physician or DON must act upon any reported irregularities
- Facility must care plan for interventions for meds that pose a high risk of adverse consequences
- Non-pharmacologic interventions may be used when/if appropriate (invited to activity, physical needs met, etc.)
- Must identify specific mood/disorder for any psychoactive med
- Resident or representative must be provided risks vs. benefits of current medication therapy
- Staff must be able to identify non-pharmacologic interventions
- Staff must know clinical indication for high-risk med
- Staff must know behavior is being monitored for antipsychotics and anxiolytics. – Facility must know last GDR attempt and the results
- Physician must provide risk vs. benefits statement describing the contra-indications if GDR was denied

Medication Regimen Review

Pharmacist review must consider:

- Whether the physician and staff have documented objective findings, diagnoses, symptoms, and/or resident goals and preferences.
- Potential side effects and interactions have been identified and acted upon
- Dose, frequency, route, and duration are consistent with resident's condition and standards of practice
- The physician and staff have documented progress towards, decline from, or maintenance of resident's goals
- A GDR has been attempted or any non-pharmacologic approaches been added
- Medication errors exist or are likely to occur.

Facilities should develop policies and procedures for medication reviews beyond the monthly review. These may include reviews for short-stay residents, acute change of condition, and new admissions. The pharmacist must identify actual or potential adverse consequences which may result from medications.

The surveyor may ask the consultant pharmacist:

- What do you review during your MRR?
- Did you identify and report any irregularities to DON and attending physician?
- What do you think of a specific issue?
- Is this something you should have identified during the monthly MRR?

References:

1. 80 Fed Reg 42168, Proposed Rule, July 16, 2015
2. 81 Fed Reg 68688, Vol. 1, No. 192, Final Rule, October 4, 2016
3. http://www.ltcpharmacynews.com/docs/PDF%20Docs/LTC%20Requirements%20Update.pdf
4. http://www.williamsmullen.com/news/cmsreleases-nursing-facility-mega-rule
5. https://www.cdc.gov/longtermcare/prevention/a ntibiotic-stewardship.html

source: http://www.todaysgeriatricmedicine.com/archive/SO17p18.shtml

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