https://www.qualityhealth.org/bree/

New **DRAFT**

Bree Opioid Prescribing Guidelines for Older Adults

February 2022

Background

- 2018 – AHRQ highlighted increasing rates of opioid-related hospitalizations in older adults, with the highest reported median rates in Oregon and Washington.
- While opioid prescribing and mortality specific to prescribed opioids have fallen between 2017-2018, the CDC reported that the specific opioid related mortality rate for persons ≥65 years increased by 4.8%.

Wilson N, Kariisa M, Seth P, et al. Drug and opioid-involved overdose deaths, United States, 2017-2018. Morb Mortal Wkly Rep 2020; 69:290–297. URL: http://dx.doi.org/10.15585/mmwr.mm6911a4external icon, Accessed 4/1/2021

Opioid-related harms are increasing among older adults

- Even when using as directed more likely to experience
  - Adverse drug reactions
  - Falls and fractures
  - ED visits, hospitalizations, and death,
- Exacerbate pre-existing conditions
  - Cognitive impairment
  - Compromised respiration
  - Hypogonadism
  - Osteoporosis
  - Frailty (or diminished physical reserve)
  - Other substance (e.g., alcohol) use disorders.

Unrecognized cognitive decline may lead to accidental poisoning or overdose

https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioids-older-adults-techbrief.pdf

Unique Challenges for Assessment and Management

- Age-related changes in pain perception and thresholds
  - Differential aging effects = more or less vulnerability
- Responses to medication
  - higher peak drug levels, delayed clearance, longer duration of action and higher rates of side effects
- Comorbidities (medical and psychological), resulting in polypharmacy
- Psychosocial concerns, and lack of care coordination

Take home message

An integrated, coordinated, and individualized approach may be particularly important in the Medicare population to assure optimal pain management

Focus Areas

1. **Acute prescribing including acute injuries and peri-operative**
   Goal: Prevent transition to chronic prescribing
2. **Co-prescribing with opioids** (e.g., sedative hypnotics, gabapentinoids, z-drugs)
   Goal: Reduce impacts on cognition, falls, delirium
3. **Non-opioid pharmacologic pain management**
   Goal: Evidence base and risk/benefit
4. **Non-pharmacologic pain management**
   Goal: Evidence base and risk/benefit (e.g., CBT, active exercise)
5. **Intermittent (chronic) opioid therapy**
   Goal: Allow very intermittent use for chronic/recurrent pain
6. **Tapering/deprescribing in this population**
   Goal: Differentiators with recent Bree recommendations for legacy patients

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Health Care Site or Delivery System

- **Adopt system-wide policie**s that support safe, person-centered, and evidence-informed opioid prescribing practices supported by clinic workflows, team-based care, and electronic health record (EMR) capability.
- **Establish clear leadership expectations** regarding tapering and support for prescriber accountability regarding tapering
- **Integrate the Prescription Monitoring Program (PMP) into the EHR,** to identify older adults with evidence of co-prescribing of opioids and selected CNS-active drug classes for medication review. Be aware of coordination potential when the co-prescribing is from multiple providers
- **Provide clinical decision support tools** within the electronic health record that consider age, current medications, and co-existing conditions when prescribing medications to older adults to treat pain.
- **Develop multidisciplinary, collaborative teams** to support older adults utilizing care at the site with acute or chronic pain.
  - **Designate a responsible care coordinator** (e.g., health service coordinator, nurse case manager, clinical pharmacist) to facilitate smooth and safe transitions specific to the opioid and pain management plan.
  - **Consider pharmacist to co-manage older adults** on opioids with or without polypharmacy
  - **Integrate pharmacists with tapering plans in primary care** to support complex patients with high-dose opioid regimens or polypharmacy concerns.
- **Perform comprehensive medication review and reconciliation** for all opioid prescribing visits (to ensure the patient is not continuing medication that s/he no longer needs).
- **Evaluate for and ensure there is adequate access to non-pharmacologic strategies** to manage pain, improve patient self-efficacy and address sleep disturbances for older adults.

Health Care Site or Delivery System (cont.)

- **Incorporate topical medications** (e.g., topical lidocaine, topical NSAIDS) into formulary.
- **Educate providers and staff** about older adult patient population including:
  - Age-related changes in pain perception and pain thresholds.
  - That differential aging effects lead to more or less vulnerability resulting in the need for a more individualized approach.
  - Responses to medication.
  - Comorbidities (medical and psychological), resulting in polypharmacy.
  - Psychosocial concerns specific to an older population.
  - Importance of avoiding co-prescribing of CNS-active drugs in older adult patients.
- **Train or provide access to training for** motivational interviewing, shared decision making, and how to discuss health risks of long-term opioid therapy and personal or health reasons to taper.
- **Provide educational materials for older persons and their caregivers** about non-opioid pharmacologic pain management options including associated risks and benefits. This should include education on the potential dangers of polypharmacy and potential benefits of deprescribing.
- **Monitor prescribing practices and patient safety.**
  - Develop metrics sufficient to monitor the process and outcomes of tapering
  - Use transparent benchmark data reporting that leadership can use to talk with prescribers
  - Use evidence-based peer comparison to track and compare tapering care
- **Improve access for patients attempting to begin tapering**, especially for patients unable to taper in primary care due to complex care needs.
  - **Track that the taper** is occurring safely over time
  - **Establish processes to enable warm handoffs** between patients and specialty providers when they are not located in the same system.

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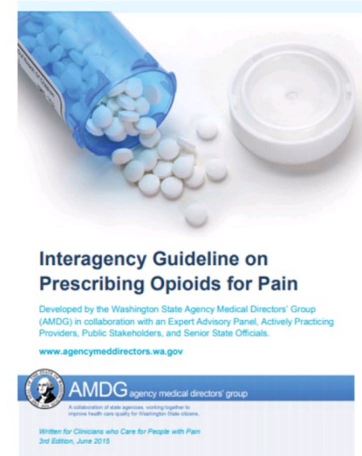
Bree Recommendations

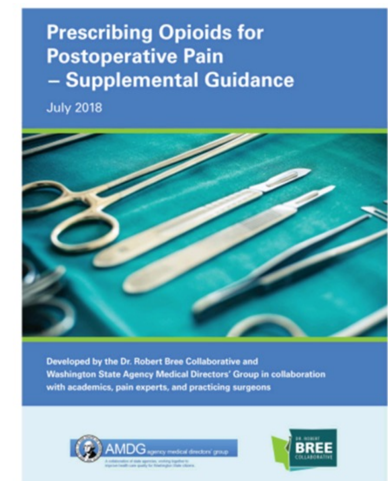
Acute prescribing including acute injuries and peri-operative

Acute prescribing

Prior to procedure and prescribing

- **Perform a risk assessment for severe acute pain and adverse effects** of opioids prior to prescribing (outlined in 2015 Washington State Agency Medical Directors' Group (AMDG) guidelines, 2018 Bree perioperative supplement)
- **Engage in proactive pain management planning, including pharmacologic and nonpharmacologic methods** of pain management. Establish realistic goals and expectations with the patient and family or caregiver (if present) including: control of pain while maximizing function, minimizing adverse events, side effects, and plans to reduce and discontinue opioid therapy to avoid persistent opioid use
- **Designate provider to be responsible for managing ongoing acute or postoperative pain**, including prescribing any opioids, policy on opioid refills, patient reassessment





When considering dosing

- **Start at 25%-50%** of what would be initiated in a younger adult and **extend the dosing intervals**
- **Use lowest dose for shortest duration** possible, prescribing <7 days (ideally ≤3 days) (consistent with CDC guidelines and WA pain rules).
- **Avoid complicated regimens**. Consider the person's other medications (e.g., muscle relaxers, antihistamines, anticholinergics)
- **Use caution with morphine** due to variable renal function and potential accumulation of active metabolites.
- **Avoid using long-acting opioids for acute pain** (methadone, levorphanol, fentanyl patch or opioid delivered by extended-release forms)

During discharge and follow-up

- **Maintain a high vigilance for exaggerated side effects** (e.g., respiratory depression, constipation with need for bowel prophylaxis, delirium, psychomotor effects that may increase risk of falls)
- **Track opioid use and signs of potential misuse** including the emergence of opioid use disorder during acute recovery and related functional status with outcome measures (e.g., mood, mobility, activities of daily living, sleep, appetite, cognitive impairment, weight changes)
- **Be attentive to varying degrees of cognitive impairment** that may impact opioid and other medication safety. Provide clear oral and readable written instructions on:
  - The risks, safe use, and storage of opioids and proper disposal of controlled substances through Safe Medication Return Program.
  - Which provider will be responsible for managing ongoing acute or postoperative pain, including who will be prescribing any opioids, the policy for refills and follow-up evaluations
  - Planned taper of acute opioids, including a timeline for return to preoperative or lower opioid dosing for those on chronic opioids
- **Perform medication review and reconciliation** at follow up visits to ensure the patient is not continuing medication that s/he no longer needs

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Bree Recommendations

Intermittent Opioid Use

Intermittent (Chronic) Opioid Therapy

There is a lack of high quality published evidence on this topic.

or should we say insufficient data?

- Consider prescribing intermittent opioid therapy for chronic conditions with **sporadic pain flares** (e.g., relapsing remitting MS) **only if it improves physical and social function.**
- Use the **lowest dose of immediate release** opioids possible, no more than once per day on average.

  or should we say short acting?
- **Re-evaluate frequently for risk** of falls, sedation, and other opioid-related adverse effects, as risk changes with advancing age and use of other CNS-active medications and alcohol.

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Bree Recommendations

Co-prescribing with opioids

Co-prescribing with opioids

- **Consider non-pharmacologic ~~alternatives~~** for pain management to prevent co-prescribing opioids with CNS-active medications, in particular, benzodiazepines, Z-drugs, skeletal muscle relaxants and gabapentinoids.
- If opioids are determined to be necessary, **perform a targeted medication review …**Identify reason for use and determine whether medication(s) are still needed.
- **Taper other medications, if possible, prior to prescribing opioids** to limit exposure to co-prescribing. If available, use a collaborative team-based approach.
- For patients **continuing to use benzodiazepines, refer them to an integrated behavioral health provider** if this has not already occurred.
- Although a combination of opioids and gabapentinoids is not recommended in older adults, guidelines make **exceptions for co-prescribing when transitioning from opioid therapy to gabapentinoids or when using gabapentinoids to reduce opioid dose**. Carefully monitor patient for potential harmful side effects.
- **Educate patients and caregivers on the risk of opioids in combination** with benzodiazepines, Z-drugs, skeletal muscle relaxants, and gabapentinoids, including instructions to be vigilant for adverse drug effects (e.g. falls, driving impairment, sedation). Use teach-back methods to ask that adverse drug effects be reported to the prescriber.
- **Deprescribe CNS-active drug combinations**, whenever possible.

Patients already using long-term opioids with other CNS-active drugs

- **Re-evaluate chronic pain care plan** with patient and their family, if available, at a routinely **with frequency based on risk assessment** (e.g., at least quarterly for high risk, biannually for moderate and annually for low risk) and look for opportunities to deprescribe targeted CNS-active drug combinations.
- For qualifying Medicare patients, encourage participation in a **Medication Therapy Management program**, thereby ensuring access to annual Comprehensive Medication Review and quarterly Targeted Medication Reviews, as indicated.
- **Monitor for adverse effects** from opioids and other CNS-active medications. When an adverse effect is identified, re-evaluate risks vs potential benefits and the chronic pain care plan.
- **Review non-pharmacologic** alternatives for pain management with the patient, especially prior to deprescribing CNS-active drugs.
- **Educate older patients and caregivers on the risk** of opioids in combination with benzodiazepines, Z-drugs, skeletal muscle relaxants and gabapentinoids. Provider, patient and/or caregiver should participate in shared decision-making to minimize risk of drug-related adverse outcomes.
- **Consult with psychiatric provider(s**) due to often complex psychiatric comorbidities.

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Bree Recommendations

Non-opioid pharmacologic pain management

Non-opioid General Considerations

- **Avoid polypharmacy** whenever possible
- **Give first line consideration to acetaminophen and non-systemic topical medications** such as topical non-steroidal anti-inflammatory drugs (NSAIDs), capsaicin, and topical lidocaine.
- **Educate patient and family/caregivers on the potential harms** of polypharmacy and benefits of deprescribing when considering non-opioid medications for chronic pain.
- **Use shared decision-making** with the patient, and consider existing co-morbidities and current medications when selecting non-opioid medications for pain.
- **Regularly screen for and assess risk** for medication related adverse events (e.g., falls, sedation, changes in cognition).
- **Give particular attention to renal function** (estimated glomerular filtration rate) when prescribing non-opioid medications for pain.

Non-opioid Medication Recommendations

- **Consult professional resources such as the *Beers Criteria*** *for Potentially Inappropriate Medication Use in Older Adults* for guidance in selection and dosing of non-opioid medications for pain.

Initial non-opioid medications

- **Acetaminophen**: Acetaminophen is safe and effective for acute and chronic mild to moderate pain in older adults unless there is a specific contraindication such as liver failure or severe renal impairment.
- **Topical analgesics**: Non-systemic topical medications such as topical NSAIDs, capsaicin, and topical lidocaine may be helpful and are often included in multi-modal pain management approaches. Topical agents are effective locally and are best for pain in the extremities, including elbows, fingers, knees and feet.

Medications to use with caution

- **NSAIDs:** This class of drugs is particularly dangerous in older adults with long term use; however, unless there is a contraindication, NSAIDS may be useful for short-term treatment of acute pain.
- **Serotonin norepinephrine reuptake inhibitors (SNRIs**): Consider an SNRI as adjuvant treatment for neuropathic pain, fibromyalgia, or low back pain with careful consideration and close monitoring for side effects.
- **Gabapentinoids** should be used with extreme caution in older adults, especially those who are frail, and should never be used in combination with opioids and benzodiazepines.

Medications to Avoid

- **Tricyclic antidepressants** (TCAs): TCAs, such as amitriptyline, desipramine, and nortriptyline show good evidence in older studies for reducing the pain of postherpetic neuralgia and painful diabetic peripheral neuropathy in older populations. However, these drugs are highly anticholinergic and increase the risk for syncope, falls, fractures, and bradycardia. Thus, the **Beers Criteria®** has a strong recommendation against use in older adults.
- **Muscle relaxants:** Skeletal muscle relaxants, such as methocarbamol, cyclobenzaprine and carisoprodol are highly anticholinergic and poorly tolerated by older adults. The **Beers Criteria®** recommends avoiding these drugs.

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Bree Recommendations

Non-pharmacologic pain management

Recommend

- **Refer to cognitive-behavioral therapy (CBT)** for pain reduction in multiple chronic pain syndromes.
- **Regular aerobic and strength** training exercise (approximately 150 minutes per week, cumulatively)
- **Regular tai chi practice** (approximately 60 minutes twice weekly) for pain reduction in multiple chronic pain syndromes.
- **Yoga**, either alone or coupled with other pain management strategies such as mindfulness-based stress reduction, for pain reduction in multiple chronic pain syndromes and settings.
- Interventions utilized by **Doctors of Chiropractic**, including spinal manipulation, in-office and home-based therapeutic exercise, for pain reduction in musculoskeletal pain conditions.
- **Nutritional counseling** and **lifestyle education**
- **Heat therapy**, both as adjunctive therapy with other complementary therapies (e.g., massage) and as a self-care measure at home
- **Acupuncture** for pain management either alone or in combination with other
- **Therapeutic massage**, either alone or coupled with multi-modal pain management
- **Mindfulness-Based Stress Reduction (MBSR)** can help patients be aware of behavior patterns related to stressful situations and choose how to respond.
- **Acceptance and Commitment Therapy (ACT)** can help patients with chronic pain improve their functional status despite the experience of pain by moving away from controlling pain.

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Bree Recommendations

Tapering and deprescribing in this population

Recommendations

- **Risks** include: illicit opioid use, opioid overdose, suicide or other mental health crisis.
- Review the **2020 Bree Collaborative Guideline on Long-Term Opioid Therapy that builds on the HHS Guide** that walks thru patient engagement, assessment, and 3 possible treatment pathways:
  - (1) Maintain, (2) Tapering/discontinue, or (3) Transition to medications for opioid use disorder
- Should be **supported, gradual and as patient-centered** as possible.
- **Talk to the patient and their family or caregivers about their experience with long-term opioid** therapy, how this experience has been for them including benefits and whether they have experienced any side effects or harms
- **Ensure tapers are negotiated** with patients, and the **speed of the taper does not exceed guideline-recommended** taper speeds.
- Ensure that all providers offer patients a variety of **nonpharmacologic** pain treatments.
- Ensure that all providers **assess for OUD and offer OUD/MOUD treatment** when indicated.
- Increase use of **motivational interviewing** approaches to draw on intrinsic motivations to taper.
- If possible, connect the patient to others who have successfully tapered for **peer-to-peer support**.
- **Assess each patient for anxiety, depression, suicidality, and insomnia**. Refer to behavioral health, preferably integrated. Use CBT and non-addictive psychotropic medications, when indicated.
- Develop **tapering/deprescribing plans that are collaborative and multidisciplinary**, including in collaboration with pharmacy, behavioral health, and patient voice. **Follow patients closely** during taper process.
- **Consider transition to buprenorphine for patients at high risk** who are unable or unwilling to taper regular opioids.

Summary

- There is little high-grade evidence on opioid prescribing/use specific to advancing age by decade of life
  - ~6% opioid naïve adults ≥ 65 transitioned to chronic opioid use
- Approaches to opioid prescribing and pain management should be focused on function and safety
- Comprehensive medication review and reconciliation should occur at each care transition
- Start low, go slow and "*stop soon*"
- Individual care plans, comprehensive medication review, and care coordination seem critical