Shifting Focus

From the Opioid Crisis to Quality Pain Management

Older adults are identified as one of the most vulnerable populations in the world needing improved pain control (International Association for the Study of Pain, 2019). With advancing age, individuals become more susceptible to developing persistent pain and other harmful effects of uncontrolled pain or its treatment. Older adults have substantially higher rates of severe and disabling pain than their younger counterparts, which has increased in recent decades (Nahin, Sayer, Stussman, & Feinberg, 2019). As professionals who care for older adults, we have seen how pain erodes the body, mind, spirit, and quality of life of so many and the importance of effective treatment.

In recent years, attention on the opioid crisis has led to practice and policy changes that impact the treatment of all patients with pain, including frail older adults. We present an overview of these actions, the effect on care of vulnerable older adults, and nursing's call for action.

With more than 100 million Americans with chronic pain and 20 million having daily pain severe enough to interfere with daily activities, opioid treatment has been considered a safe and effective treatment for some older adults (American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Persons, 2009). Subsequent public health data raised concerns about the potential misuse and abuse of opioids, resulting in dissemination of the

2016 Centers for Disease Control and Prevention (CDC) opioid prescribing guideline for primary care providers treating individuals with chronic pain who were not being actively treated for cancer or receiving palliative care (Dowell, Haegerich, & Chou, 2016).

Key provisions of the CDC guidelines can be summarized as follows:

- Nondrug and nonopioid medications are preferred pain treatments.
- Before initiating treatment, a comprehensive pain and risk assessment is needed.
- Goals of therapy are established, including pain reduction and functional improvement.
- Vigilant reassessment of treatment safety and effectiveness is performed every few months.
- When a treatment is unsafe, ineffective, or not adhered to, it should be tapered or stopped.
- Avoid drug interactions and monitor opioid-dispensing databases.
- Signs of addiction should be further evaluated and treated.

These are sound general guidelines that should be supported. However, these guidelines also included other specific recommendations related to dose and duration of opioid prescribing for acute and chronic pain that have been adopted as policy mandates

TABLE 1

SELECTED RESOURCES TO SUPPORT QUALITY PAIN MANAGEMENT IN OLDER ADULTS

Source/Description	URL
University of Iowa Csomay Center for Gerontological Excellence • Website with evidence-based tools and resources for providers, patients and caregivers to promote quality pain care (last updated 2019)	https://GeriatricPain.org
International Association for the Study of Pain—Pain in Older Persons • Educational resources and webinars on pain in older adults (last updated 2019)	https://www.iasp-pain.org/GlobalYear/PaininOlderPersons
The Hartford Institute for Geriatric Nursing • Resources and tools to support pain management in older adults (last updated 2012)	https://consultgeri.org/geriatric-topics/pain

by many states, health care organizations, pharmacies, and payers. These recommendations, not based on clinical research, have superseded clinical judgment and patient-centered approaches to treatment planning and can have unintended consequences that are harmful (Inouye, Brown, & Tinetti, 2018).

Many primary care practices, under pressure to implement these guidelines, started discharging patients with chronic pain who were taking opioids (O'Malley et al., 2017). Within 2 years, it was evident that opioid prescriptions were cut by more than one third (Bohnert, Guy, & Losby, 2018); however, opioid overdose deaths reached record high levels (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2018). Further analyses revealed three waves of the opioid crisis, implicating prescription opioids (1999-2010), then heroin (2010-2012), and subsequently illicitly manufactured fentanyl as the primary causes of overdose deaths. The most recent data show 1.5% of overdose deaths involve a person 65 years or older, taking a prescribed opioid (Scholl et al., 2018).

In 2019, Medicare policies added requirements for prior authorizations and dose and duration limits of prescribed opioids. These requirements have resulted in denials, delays in dispensing, fewer pills than ordered being dispensed, and the requirement for repeated trips to prescribers and pharmacies for vulnerable older adults. Within a few months of that policy change, the U.S. Food and Drug Administration (2019) issued a warning against rapid tapers or abrupt cessation of opioids, given mounting evidence that this practice can result in harm or death. Rapid tapering destabilizes patients and precipitates severe withdrawal, pain/suffering, disability, and even death among chronic pain patients. Policies promoting this led to an international outcry that forced tapering is a humanitarian crisis (Darnall et al., 2019).

All this attention on opioids has taken the focus away from potential harm that can occur from nonopioid pain treatments. Estimates show that long-term nonsteroidal anti-inflammatory drug use carries a 5% risk of having major cardiovascular, gastrointestinal, or renal events, with an elevated risk of dying from these complications with each year of therapy (Solomon et al., 2017). Gabapentinoid and antidepressant agents have also been implicated in serious side effects and an increased risk of death (Coupland et al., 2011; Enke et al., 2018; Nelson & Spyker, 2017), with drug interactions a concern, especially for older adults (Cavalcante, Sprung, Schroeder, & Weingarten, 2017). In fact, the American Geriatrics Society Beers Criteria® Update Expert Panel (2019) warns against using any combination of three or more central nervous system depressants (e.g., antidepressants, antipsychotics, nonbenzodiazepine and benzodiazepine receptor agonists, hypnotics, antiepileptics, opioids) in older adults, particularly in those with multimorbidity (Boyd et al., 2019).

Amidst reports that patients with chronic pain are being treated as pariahs and drug seekers in a dismissive or adversarial tone, we need to advocate for patient-focused quality care. In older adults, this focused care requires the development of individualized pain treatment plans with shared goals of improving comfort, functioning, and avoiding treatment-related harm. Of particular concern are older adults with cognitive impairments, who have limited ability to engage in nondrug interventions and are at higher risk of harm from pain and its treatment. Additional barriers faced by older adults may include limited mobility, few socioeconomic resources, comorbidities involving major organ systems, and drug interactions. Nurses have a duty to balance concerns of helping without harming individuals experiencing pain and suffering.

Nurses are in a position to improve access and diminish disparities in care for individuals with pain through

clinical practice, education, advocacy, and research (**Table 1**) (American Nurses Association, 2018). These actions include identifying and addressing patterns of under-prescribing, over-prescribing, or abandonment of patients with pain. Access to nonopioid and nondrug ways of managing pain should be made more accessible, while providing respectful, individualized care to all patients experiencing pain regardless of their personal characteristics, values, or beliefs. However, the science supporting nondrug approaches and resources to implement must also be in place to support evidence-based practice. It is too easy to become morally disengaged by blaming patients or others for the problem. Nurses need to preserve their professional and personal integrity by having the courage and resilience to speak up about the moral distress they feel and bear witness to when patients experience untreated pain. As the largest professional group in health care, nurses can unite to advocate for legislative and payer policies to assure parity in access to individualized treatment that is based on the clinical judgement that comes with knowing the patient.

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