Opioid Use Disorder Education and Treatment ECHO Series

Session 19 – Opioids and the Older Adult

September 6, 2022

Heather Bell, MD and Kurt DeVine, MD

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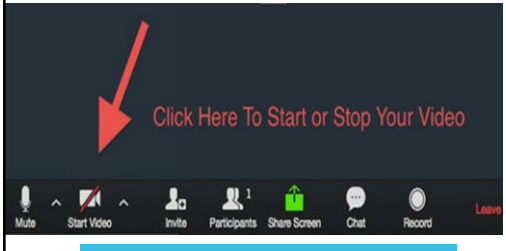
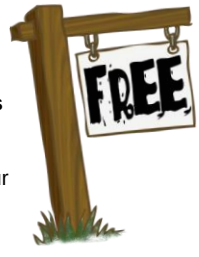


YES, THERE'S *FREE* CME

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Minnesota Medical Association (MMA) through the joint providership of Stratis Health and the Minnesota Academy of Family Physicians. **Stratis Health is accredited by the MMA to provide continuing medical education for physicians.**

Stratis Health designates this educational activity for a maximum of **1 *AMA PRA Category 1 Credits™*.**

Physicians should claim credit commensurate with the extent of their participation in the activity.



Continuing Education Credits and Contact Hours for Other Health Professionals
The OUD Education and Treatment ECHO Series may meet continuing education requirements for your focus. It is the responsibility of the individual to determine if this activity fulfills that requirement.

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Upcoming ECHO Sessions

Tuesday

- **Tuesday, September 20:**
  Wrap Up – The Barriers, including:
  - Administration
  - Time
  - Schedule
  - Stigma
  - More!
  - And some fun review too!

Wednesday

- **Wednesday, Sep. 7, 2022**
  Meth Use Disorder and Buprenorphine Management, Robert Cole Pueringer, MD
- **Wednesday, Sep. 14, 2022**
  Beth Han and Emily Einstein (NIH/NIDA)
- **Wednesday, Sep. 21, 2022**
  988 Suicide Prevention Line, Emily Yang, Minnesota Department of Health
- **Wednesday, Sep. 28, 2022**
  Addiction Legislation Update, Charlie Reznikoff, MD
- **Wednesday, Nov. 2, 2022**
  Sam Quinones, Author, "Dreamland" and "The Least of Us"

TECHNICAL ASSISTANCE

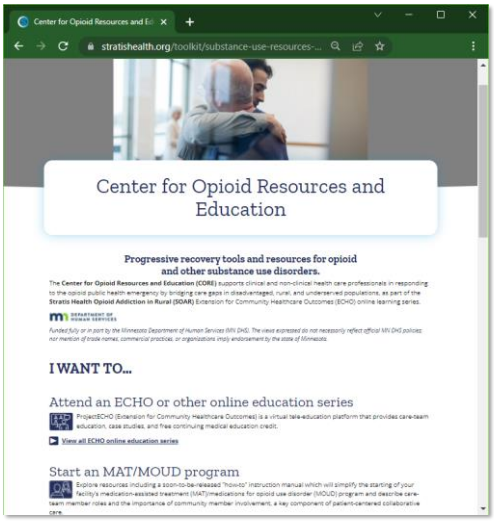
- **We are ALWAYS here for you!**
  - Program implementation
  - Inductions
  - Difficult cases
  - Trouble-shooting
  - Anything!
- **Call us anytime:**
  - Erin Foss, RN, Program Manager/Nurse Specialist efoss@stratishealth.org, Cell: 320-282-6553
  - Heather Bell: 320-630-5607
  - Kurt DeVine: 320-630-2507

NEW! Center for Opioid Resources and Education (CORE)

Online source for progressive recovery tools and resources for opioid and other substance use disorders includes:

- Links to all current OUD ECHOs
- How-tos to simplify starting an MAT/MOUD program
- SUD clinical resources to use in practice
- Info to connect with other MAT/MOUD practitioners
- And more!
- Center for Opioid Resources and Education - Stratis Health

The **Center for Opioid Resources and Education (CORE)** supports clinical and non-clinical health care professionals in responding to the opioid public health emergency by bridging care gaps in disadvantaged, rural, and underserved populations, as part of the **Stratis Health Opioid Addiction in Rural (SOAR)** Extension for Community Healthcare Outcomes (ECHO) online learning series.
https://stratishealth.org/toolkit/substance-use-resources-and-education/



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ECHO model = case-based learning!

1. MAFP website (https://bit.ly/OUDCase)
2. Announcements email!
3. **Center for Opioid Resources and Education - Stratis Health**
   (www.stratishealth.org/toolkit/substance-use-resources-and-education/)

BUT feel free to present in any de-identified format!

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"The Addiction Connection Podcast"

Weekly addiction topics- Tuesday release day!

www.buzzsprout.com/954034
(Or anywhere you get your podcasts!)
Email us questions:
theaddictionconnectionpodcast@gmail.com

Objectives

- Describe opioid prescribing that increases risk of overdose
- Recount aging processes that may increase risk of opioid in this patient group
- Review co-prescribing risks and adverse events

Prescribing Opioids to Older Adults: A Guide to Choosing and Switching Among Them

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Pain Meds in Older Adults

- Analgesic Ladder
  - Non-opioid acetaminophen
  - Weak opioids/NSAIDS (often contraindications)
  - More potent opioids

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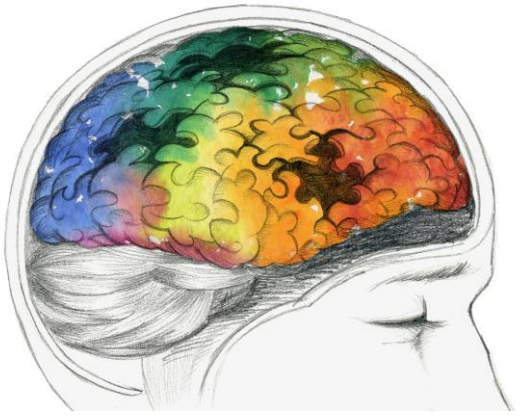
Considerations in Older Adults

- Cognition
- Hearing difficulties
- Visual impairment - difficult to read instructions



As A Result…

- Medication may be taken incorrectly
- May not understand that one opioid was discontinued while another was started (takes both)
- May need assistance setting up medications

Do Formulation and Dose of Long-Term Opioid Therapy Contribute to Risk of Adverse Events Among Older Adults

Chronic Non-Cancer Pain

- Highly prevalent
- Often disabling
- Because of it, 3-4% of adults receive long-term opioid therapy

Chronic Non-Cancer Pain cont.

- Patients taking the highest doses are more likely to have adverse events
  - 3% of older adults received high dose i.e., > 120 MME
  - Dose dependent association to adverse events

Chronic Non-Cancer Pain cont.

- Why do older patients have more risk?
  - Reduced renal, hepatic, and respiratory function
  - This results in altered metabolism which contributes to adverse outcomes

Chronic Non-Cancer Pain cont.

- Does it make a difference if long or short acting opioids?

YES

Chronic Non-Cancer Pain cont.

- Initiation of long-acting opioids are associated with 2x the risk of overdose compared with short-acting
  - What is unclear currently is risk in older adults – no good studies

Monika Salkar et al. Study

- Recent study regarding opioid dose and formulations in older adults (Monika Salkar et al. 2021)
  - Cohort included Medicare patients >65 years old
  - Included patients with CNCP (chronic non-cancer pain)
  - Measured adverse outcomes including
    - Opioid related respiratory depression
    - Opioid OD
    - All cause mortality

Results (Salkar et al.)

- Formulation
  - Use of long-acting was significant risk factor for overdose
  - Long-acting significantly increases risk of overdose, and all cause mortality (when compared to short-acting along)

Dose Relationship to Adverse Effects

20-50 MME

AND ≥ 50 MME

Both risk factors for all cause mortality, opioid induced respiratory depression, overdose as compared to ≤20 MME in older adults

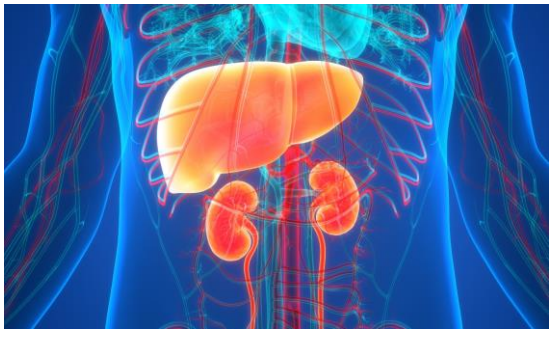
- This is consistent with other recent studies

Dose Relationship to Adverse Effects cont.

- MME ≥ 100 had significantly higher odds of opioid induced respiratory depression than <100 daily MME
- Zedler et al. 2018

Risks cont.

- Cause of increased risk for older adults on long-acting preparations?
  - Decreased renal function
  - Decreased liver function
  - Resultant decreased clearance



Risks cont.

- Renally cleared opioids (Creat Clearance Important)
  - Morphine
  - Hydromorphone
  - Meperidine

Risks cont.

- Not renally cleared as significantly
  - Oxycodone

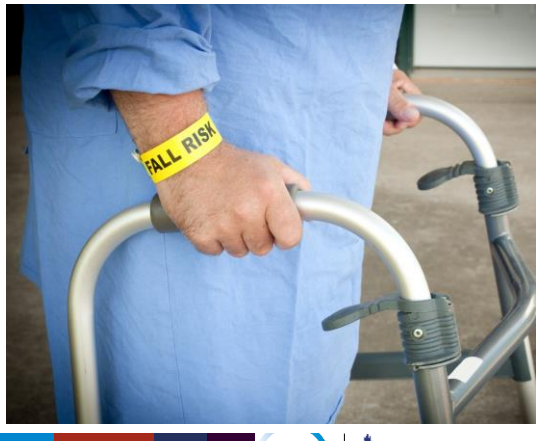
Risks cont.

- In hepatic insufficiency, consider
  - Fentanyl
  - Hydromorphone

Association of Average Daily Morphine Milligram Equivalents and Falls in Older Adult Chronic Opioid Users

Falls

- As an adverse outcome, falls are very significant
  - Leading cause of fatal and nonfatal injuries in older adults
  - 2.8 million ER visits
  - 800,000 hospitalizations
  - 27,000 deaths



Falls cont.

- Fall data from 2018
  - 27.5% of older adults fell at least once
  - 10.2% were injured

Falls cont.

- Prevention of falls - by addressing the modifiable risk factors
  - Medication?
  - And more specifically opioids
  - Is there a dose related effect on falls

Falls cont.

- Does opioid dose predict adverse events
  - Yes, in the case of OD
  - ?? Falls, no studies as to relationship to dosing (MME)

Falls cont.

- Study Design
  - EMR review
  - 10 primary care clinics
  - > 4 prescriptions per year
  - Average daily MME

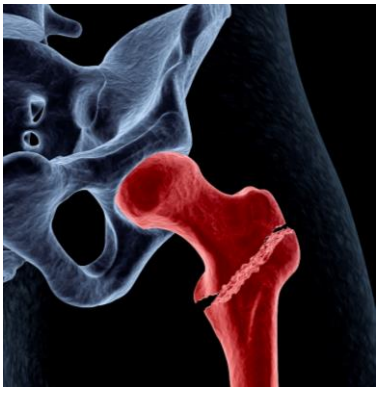
Falls

- Results
  - Older adults taking > 37 MME (for non cancer pain) had a 47% greater risk compared to those taking less than 37 MME

Co-Prescribing and Risk of Falls and Hip Fracture in Older Adults

Co-Prescribing Risk

- Is there an association between co-prescribing benzodiazepines and opioids and hip fractures in those >65 years old
  - 287 patients with hip fracture/ 574 control patients
  - 72.1% female
  - Mean age: 82



Results

- Using opioids and benzodiazepines in the month priors was associated with a greater probability of fall and hip fracture- nearly 4x higher risk

Co-Use of Benzodiazepines and Opioids in Chronic Pain and Older Adults

- **Falls**
- **Fractures**
- **ED**

First Study

- Does overlapping benzodiazepine and opioid prescriptions increase odds of falling or visiting ED (Yarborough et al. 2018)
  - 517 adults
  - Large private health system and VA system

Results

- 25% (127=N) co-prescribed
- Past year benzodiazepines and opioids associated with adverse outcomes

Adverse Outcomes

- 3x greater number of falls
- 1.5x greater number of ER visits

Alcohol Use in Older Age Patients Taking Opioids

Alcohol Use

- Alcohol and opioids are frequently used together
  - Alcohol contributes to many overdose deaths from opioids
  - Both work as CNS depressants resulting in respiratory depression
  - Research on this association is lacking

Alcohol Use cont.

- The majority of patients with OUD also have a chronic diagnosis…and 23.4% also had a diagnosis of alcohol use disorder (Hser et al. 2017)

Alcohol Use cont.

- Kaiser Permanente study of >11,000 patients on opioids showed 12.4% had current alcohol use (Sauders et al. 2012)

Alcohol Use cont.

- In a similar study, 908 patients on chronic opioids were surveyed
  - 36% had at least one drink in the last 30 days
  - 4.4% had 6-10 drinks
  - 5.8% had >10

Alcohol Use cont.

- In patients presenting for AUD treatment 43-73% had history of moderate to severe pain

Alcohol Use cont.

- So, what makes alcohol a bigger issue in older adults?
- Answer: Changing physiology as we age!

Alcohol Use cont.

- Changes cause the following:
  - High BAC with each drink
  - Bigger impairments in balance
  - Slower reaction times
  - Worse driving skills
  - Memory deficits
- All contribute to increase in alcohol related harm

Alcohol Use cont.

- So, in older patients on opioids, how often is alcohol a concern?
  - In developed countries, 90% of patients over 50 years old drink alcohol at some level
  - A United Kingdom study showed 20% of that group consumed at hazardous levels

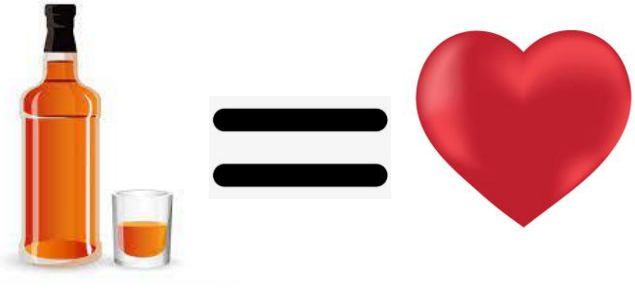
Alcohol Use

- AMA study showed that alcohol consumption in the last 10 years increased the most in patients >65 years old*

  * Up to 65%!!

Alcohol Use

- Older adults are hospitalized as often for alcohol related problems as they are heart disease



Alcohol and Opioids: The Bottom Line

- If a patient needs opioids, ask about alcohol intake
- Counsel patients about risk of co-use
- Screen for OUD if adverse event (fall, OD, and so on)

Why Wait to Improve?

Prescribing Study

- Opioid prescribing decreases after learning of a patient's fatal overdose (Doctor et al. 2018)
  - Study monitored effect of notifying physicians of patient who died of opioid OD if they had prescribed an opioid in the last 12 months
  - Providers received a "warning" from medical examiner to prescribe safely
  - Control group did not receive letters
  - 861 clinicians

Results

- Reduction in high intensity prescribing
- Reduction in opioid naïve patients receiving opioids
- Reduction in cumulative opioid intake

Take Away

- Don’t wait for somebody to die to look closely and thoughtfully at your opioid prescribing

Cases

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Case 1: Family Friend

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Patient #1

- 80-year-old male patient with history of chronic back pain. Takes 4-5/325 hydrocodone daily. Woman calls physicians office and requests stronger pain medications as he is not getting relief from medication. She ends message by saying she is his nurse. Physician receives message and advises visit. At visit patient states that he is taking medication as prescribed.

Patient #1 cont.

- Urine drug screen NEG for hydrocodone
- More information is requested regarding “nurse.” She is a family friend who volunteered to set up patient’s medication. She is also on opioid for chronic pain and has a signed care plan
- What next?

Patient #1 cont.

- Family friend is called in for urine drug screen. She is currently on oxycodone/acetaminophen. Her urine is positive for oxycodone and hydrocodone.
- What next?

Patient #1 cont.

- Social services is called, and vulnerable adult report is made. Nurse admits to taking medication and voluntarily goes to treatment and does well.

Case 2: Cake Lady

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Patient #2

- I walk into my office and find cake and plates. I love cake. I eat cake (at least one piece). My office partner explains that each month his chronic pain patient who is 75 years old (and on Percocet) brings a cake to the office visit. She thinks he is the “best doctor ever.”

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Patient #2 cont.

- One-week later police call regarding a 75-year-old woman who they just bought Percocet from. They have no desire to put her in jail. It is the same lady. The CSCT nurse calls her in initially for urine drug screen and no medication is in her urine. She says lots of times she only takes medication 2 or 3 times per week that's why she has a negative UA.
- What next?

Patient #2 cont.

- Over the next few months, she continues to have negative urine drug screens and the nurse suggests she is using so few (and really had no significant findings on her exam or scans) that non-opioid medication should be considered. Opioids are discontinued. Why not do pill counts?

Patient #2 cont.

- Nurse coordinator has conversation with patient regarding social and financial situation. She has significant problems paying bills. Social worker sees and gets her signed up for programs to help fill the gaps.

Case 3: Chronic Pain

Patient #3

- 67-year-old woman with history of alcohol use disorder and chronic pain. clear indication for pain medication with multiple back surgeries over many years with eventual fusion of thoracic and lumbar spine. She takes >100 MME per day. Presents to ED unconscious brought by ambulance Narcan given without change in status. ED staff removes clothes and pills fall out of bra. Pharmacy identifies as tramadol. Husband is asked about pills and tells staff he is on tramadol. She is intubated and sent by helicopter to a regional hospital. Naloxone infusion is started and eventually she wakes up.

Patient #3 cont.

- Referred for presumed OUD but denies. She has an issue; thought she was referred for pain management on buprenorphine. She clearly has OUD and continues to have tramadol in urine drug screens until husband agrees to lock up tramadol.

Patient #3 cont.

- Buprenorphine adequately controls pain and patient has no further issues after it is increased to 24mg in the first two months. What is the biggest advantage of buprenorphine vs full agonist for this patient?

For questions regarding content:

Heather Bell
heather.bell1012@gmail.com

Kurt Devine
kmdevine.truk@gmail.com

@echocsct

Podcast: The Addiction Connection

Funded fully or in part by the Minnesota Department of Human Services (MN DHS). The views expressed do not necessarily reflect official MN DHS policies; nor mention of trade names, commercial practices, or organizations imply endorsement by the state of Minnesota.

Sources

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