Opioids and Older Adults

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What do we know about the role of evidence-based programs in reducing opioid use?

Very Little

BTW: this is true with most health conditions
Is your agency currently serving people taking opioids?

1 = yes

2 = no
Is your agency currently serving people taking opioids?

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>NO</td>
<td>____%</td>
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<tr>
<td>Yes</td>
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The Answer: Almost all of you serve people currently taking opioids.
Beth Darnall, PhD

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Outline

- Introduction
- What is an opioid?
- Medical vs. illicit use
- Common prescription opioids
- What leads to an opioid prescription?
- Terminology (tolerance and dependence; addiction)
- Pros and cons of opioids
- Data on seniors
- Current issues and how you can help
- Resources
Addressing the dual crises of pain and opioids — a case for patient-centeredness

BY BETH DARNALL, OPINION CONTRIBUTOR — 10/31/18 06:00 PM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

[Image of pills]

HEALTHCARE

National Council on Aging
2011 IOM Report: *Relieving Pain in America*

- 100 million Americans have ongoing pain
- $635 billion annually
- Erodes quality of life, confers suffering
5.4% of the U.S. population

17.8 million

Mojtabai R 2017
2016: AARP Medicare Supplement Insureds

- 32% filled at least one opioid prescription
- Of these, 47% were filling a first-time prescription for their current condition
What is an opioid?

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, and many others.

- National Institutes of Health

Opioids are controlled medications.
Medical vs Illicit Use
Medical vs Illicit Use

Medical use ➔

Illicit use ➔
Medical vs Illicit Use

Illicit use →

• Taking someone else’s pills
• Buying medication off the street
• Taking medication to get high

Medical use →

Illicit use ↔
# Common Prescription Opioids

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
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<tbody>
<tr>
<td>hydrocodone</td>
<td>Norco</td>
</tr>
<tr>
<td></td>
<td>Vicodin</td>
</tr>
<tr>
<td></td>
<td>Hysingla (ER)</td>
</tr>
<tr>
<td>oxycodone</td>
<td>Oxycontin</td>
</tr>
<tr>
<td></td>
<td>Percoset</td>
</tr>
<tr>
<td></td>
<td>Roxycodone</td>
</tr>
<tr>
<td>hydromorphone</td>
<td>Dilaudid</td>
</tr>
<tr>
<td>fentanyl</td>
<td>Duragesic (ER)</td>
</tr>
</tbody>
</table>
What leads to an opioid prescription?

PAIN!

- Injury
- Surgery
- Various painful medical conditions
- Pain for unknown reasons
50.5 million older adults
≥65 years
2015-2016

STATISTICAL BRIEF #515  Any Use and Frequent Use of Opioids among Elderly Adults in 2015-2016, by Socioeconomic Characteristics

Asako S. Moriya, PhD and G. Edward Miller, PhD.
Published online: September 2018.
Poor and Low Income

STATISTICAL BRIEF #515  Any Use and Frequent Use of Opioids among Elderly Adults in 2015-2016, by Socioeconomic Characteristics

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Published online: September 2018.
Other Predictors for Long-term Prescription Opioids

≥65 years of age
Study of N=180,000
6% transitioned to long-term opioid use

- Low income
- Older
- Females
- Poor health
- New/chronic back pain
- Mental health issues

Musich et al. Geriatr Nur 2018
THE BIOPSYCHOSOCIAL MODEL OF PAIN

with Dr. Lorimer Moseley
What leads to long-term opioid prescriptions?

- Lack of alternatives
- Lack of effective alternatives
- Opioids may help some people
- Lack of benefit or reduced benefit over time often leads to dose escalation
What leads to **long-term** opioid prescriptions?

- Lack of alternatives
- Lack of *effective* alternatives
- Opioids may help some people
- Lack of *benefit* or reduced *benefit over time* often leads to dose escalation

*Why do some people take higher and higher doses of opioids over time? Are they addicted?*
DAILY Use of Opioids Often Leads to:

• Tolerance - Humans adapt to opioids
• Dependence
• Withdrawal symptoms
DAILY Use of Opioids Often Leads to:

- Tolerance - Humans adapt to opioids
- Dependence
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This alone is NOT ADDICTION
Potential Pros and Cons of Prescription Opioids

PROs

• Pain reduction for some people
• They can be an essential part of a comprehensive pain care plan
• For some patients, opioids may support increased function. This is individual and should be monitored.
Potential Pros and Cons of Prescription Opioids

CONs in Older Adults

- Memory and cognitive effects
- Increased falls and fractures
- Respiratory depression
- Accidental overdose
- For a *fraction* of patients, opioids can be highly rewarding – this can cultivate passivity, depressed mood, and addiction
- Higher doses increase all health risks
Figure 2.1  How opioids can lead to more pain and more medications

Remember....

The most important question is:
How do we best treat pain?
How do we help older adults?

*Integrate conservative approaches*

- Opioids should not be a first-line treatment for chronic pain
- Encourage self-management / behavioral approaches
- Help patients understand what they can do to keep their pain low to spare medication use
- Opioids may be an important part of some patients’ pain care plan – they just shouldn’t be the whole story
Points to Consider

• Stigma
• Opioid “guidelines” and policies
• Forced opioid tapering
• Patient fear
• **You play a vital role in providing non-judgmental support and pain education**
• **Your programs offer important treatment regardless of whether opioids are taken or not!**
• Patient-centeredness is key
• Disparities exist
Resources for Learning More

LESS PAIN
Fewer Pills
Avert the Dangers of Prescription Opioids and Gain Control over Chronic Pain

THE OPIOID-FREE PAIN RELIEF KIT
10 Simple Steps to Ease Your Pain

EBLC
www.eblcprograms.org

NCOA
National Council on Aging

SMRC
Self-Management Resource Center
The Place for Evidenced Programs

- As an adjunct to medical opioid treatment
- Provide a critical solution to non-opioid pain management
- Prepare people for pain management following surgery
- Reduce falls
- Reduce depression that leads to opioid use and also may be a result of opioid use
Pain and Depression Co-occur and May Maintain Opioid Use

Older adults have many painful conditions, among these are arthritis and other musculoskeletal conditions.
Evidence-Based Programs that Reduce Pain and/or Depression

There is evidence that evidence-based programs reduce pain.

- Chronic Pain Self-Management Program  Pain and Depression
- Chronic Disease Self-Management Program  Pain and Depression
- Enhanced Fitness  Pain
- Enhanced Wellness  Pain
- Pearls  Depression
As and Adjunct to Medical Opioid Treatment (prescription opioids and de-prescribing)

- None of the evidence-based programs have been evaluated as an adjunct to medical treatment for opioid use.
- A major barrier to opioid reduction is fear of pain
- **The Chronic Pain Self-Management Program** was trialed in two groups of people taking prescription opioids. They:
  - Had a high completion rate 19/22 (they were paid to attend)
  - Found it helpful to for better eating and exercising
  - Thought others should take it.
  - The CPSMP is currently being evaluated as an adjunct to prescription opioid tapering in a large PCORI trial.
• There is some evidence that exercise or pain management programs before hip or knee surgery reduces time in hospital without increases in complication or rehospitalization.

• None of the evidence-based programs have been evaluated with this specific population.
Falling is one of the biggest problems for those taking opioids. None of the evidence-based programs have been evaluated in this specific population.

The following programs have evidence of reduced falls or reduced fear of falling:

- Enhanced Wellness
- Matter of Balance
There is a HUGE difference between addiction and prescription. The role of evidence-based programs is probably with those taking prescription opioids, though our programs may be useful and should be offered to everyone who wishes to participate.
• You are already serving this population. You just do not know it.

• You may want to contact health plans in your area to let them know how you can serve those that are being de-prescribed opioids. Work with them on how best to serve their population.

• If you hold programs where all the people are taking opioids, you may need incentives to keep them in the program.
Some Thoughts About using Evidence-Based Programs for Those Taking Opioids

• Leaders in CPSMP should be willing to self-disclose their opioid use, if any. If they have not taken opioids then they should be clearly non-judgmental.

• Remember that those taking opioids feel both threatened and angry that they are being forced off these drugs. Stay neutral on this topic or you will push away potential participants.
Opioid use is very complex. Evidence-based programs are NOT the answer.

They may well be part of the answer.
Thank You!

Please write any questions in the Chat Box