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## Too Old to Jump Through Hoops: How the Opioid Epidemic Has Impacted Elderly Persons Living in Nursing Homes

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## NOTE

### **Too Old to Jump Through Hoops: How the Opioid Epidemic Has Impacted Elderly Persons Living in Nursing Homes**

Autumn Seib\*

#### INTRODUCTION

Donna's father screamed in pain and agony the day Donna visited him at the nursing home.<sup>1</sup> The nursing staff attempted to change many of her father's medications, but it was not until he received the opiate Vicodin that his agitation ended.<sup>2</sup> Her father's physician determined that the pain was likely arthritis.<sup>3</sup> Unconvinced, Donna expressed her concerns regarding her father's pain, and she requested the physician do an evaluation.<sup>4</sup> The physician, however, scoffed at her concerns and responded that because her father suffered from dementia, an evaluation would not be beneficial.<sup>5</sup> Donna knew about the undertreatment of pain in dementia patients and quickly suggested options for evaluating her father's pain.<sup>6</sup> Unfortunately, not every nursing home resident has an advocate like Donna to encourage treatment.<sup>7</sup> Instead, they must continually complete precursory treatments before receiving opiates to treat severe pain.<sup>8</sup>

Opioids are the most powerful pain relievers available.<sup>9</sup> However, they are not taken without risk. In addition to being highly effective pain relievers, opioids can be highly addictive.<sup>10</sup> If taken in excess, opioids can lead to over-sedation,

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\* Indiana University Maurer School of Law, J.D. 2020; Notes Editor, *Indiana Journal of Law & Social Equality*, Volume 8.

<sup>1</sup> Donna Schempp, *Dementia and Pain Management: A Personal Story*, FAM. CAREGIVER ALL., <https://www.caregiver.org/dementia-and-pain-management-personal-story> (last visited Nov. 4, 2018).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> See Jacob N. Hunnicutt, Christine M. Ulbricht, Jennifer Tjia & Kate L. Lapane, *Pain and Pharmacologic Pain Management in Long-Stay Nursing Home Residents*, 158 PAIN 1091, 1097 (2017) (“[M]any residents in persistent pain may still be undertreated, as the use of scheduled analgesics was low despite guideline recommendations for their use.”).

<sup>8</sup> See *infra* Section I.A.

<sup>9</sup> *Pain Relievers*, MEDLINE PLUS.GOV, <https://medlineplus.gov/painrelievers.html> (last updated Jan. 6, 2020).

<sup>10</sup> Howard L. Fields, *The Doctor's Dilemma: Opiate Analgesics and Chronic Pain*, 69 NEURON 591, 591 (2011).

associated fatal respiratory depression, and potentially death.<sup>11</sup> Other potential medical risks of long-term opiate use include “serious fractures, breathing problems during sleep, hyperalgesia, immunosuppression, chronic constipation, bowel obstruction, myocardial infarction, and tooth decay secondary to xerostomia.”<sup>12</sup>

Despite these risks, many elderly persons in nursing homes rely on opioids for chronic pain relief. Nursing homes are for “people who don’t need to be in a hospital but cannot be cared for at home.”<sup>13</sup> In contrast to assisted or independent living facilities, in nursing homes, nursing aides and skilled nurses provide care twenty-four hours a day.<sup>14</sup> Within nursing homes, as many as 45% to 80% of residents endure persistent pain.<sup>15</sup> According to the American Geriatric Society’s current guidelines, opioid therapy should be given to patients who are experiencing moderate to severe persistent pain.<sup>16</sup> However, in a recent study of nearly 1.4 million nursing home residents in the United States, 6.4% of residents with persistent pain received no pharmacologic pain management, “and over 30% received no scheduled analgesics.”<sup>17</sup> Alarming, severely cognitively impaired residents were more likely to have untreated or undertreated chronic pain.<sup>18</sup> Cognitive impairment can deprive individuals of the ability to communicate their pain and its intensity.<sup>19</sup> Because self-report remains the mainstay to assess pain, many cognitively impaired elders are left underassessed and undertreated.<sup>20</sup>

Treating elderly persons in nursing homes with chronic pain has become increasingly complicated because they are caught up in a regulatory scheme designed to combat the United States’ opioid epidemic. In the mid-90s, the American Pain Society advocated that pain be recognized as the “fifth vital sign” in

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<sup>11</sup> Mark R. Jones, Omar Viswanath, Jacquelin Peck, Alan D. Kaye, Jatinder S. Gill & Thomas T. Simopoulos, *A Brief History of the Opioid Epidemic and Strategies for Pain Medicine*, 7 PAIN & THERAPY 13, 16 (2018).

<sup>12</sup> Michael Von Korff, Andrew Kolodny, Richard A. Deyo & Roger Chou, *Long-Term Opioid Therapy Reconsidered*, 155 ANNALS INTERNAL MED. 325, 326 (2011).

<sup>13</sup> *Nursing Homes*, MEDLINEPLUS.GOV, <https://medlineplus.gov/nursinghomes.html> (last updated Dec. 20, 2019).

<sup>14</sup> *Id.*; *Assisted Living vs Nursing Home*, SENIORLIVING.ORG, <https://www.seniorliving.org/compare/assisted-living-vs-nursing-home/> (last visited Dec. 14, 2018).

<sup>15</sup> Mauro Zanolchi, Barbara Maero, Elena Nicola, Elisa Martinelli, Angela Luppino, Mafalda Gonella, Federico Gariglio, Laura Fissore, Benedetta Bardelli, Rossella Obialero & Mario Molaschi, *Chronic Pain in a Sample of Nursing Home Residents: Prevalence, Characteristics, Influence on Quality of Life (QoL)*, 47 ARCHIVES GERONTOLOGY & GERIATRICS 121, 122 (2008).

<sup>16</sup> Fabio Guerriero, *Guidance on Opioids Prescribing for the Management of Persistent Non-Cancer Pain in Older Adults*, 5 WORLD J. CLINICAL CASES 73, 75 (2017).

<sup>17</sup> Hunnicutt et al., *supra* note 7, at 1091, 1095.

<sup>18</sup> *Id.* at 1091.

<sup>19</sup> Małgorzata Dziechciaż, Luiza Balicka-Adamik & Rafal Filip, *The Problem of Pain in Old Age*, 20 ANNALS AGRIC. & ENVTL. MED. 35, 37 (2013).

<sup>20</sup> Jiwen Li, A. Lynn Snow, Nancy Wilson, Melinda A. Stanley, Robert O. Morgan, Shubhada Sansgiry & Mark E. Kunik, *The Quality of Pain Treatment in Community-Dwelling Persons with Dementia*, 5 DEMENTIA & GERIATRIC COGNITIVE DISORDERS 470, 471 (2015).

an attempt to encourage healthcare providers to prescribe opioids to treat underassessed and undertreated chronic pain.<sup>21</sup> As a result, liberal prescribing practices became standard,<sup>22</sup> and many pharmaceutical companies acted in bad faith to market their pain relievers.<sup>23</sup> While many benefited from the availability of these drugs,<sup>24</sup> liberal prescribing practices also led to increased opioid access for drug dealers, addicts, and teenagers.<sup>25</sup> By 2016, the number of overdose fatalities involving prescription opioids was five-times greater than in 1999.<sup>26</sup> In 2017, President Donald Trump declared the opioid epidemic to be a health emergency.<sup>27</sup>

In response to the opioid epidemic, the Centers for Disease Control and Prevention (CDC) released new guidelines for prescribing opiates for chronic pain.<sup>28</sup> Many states followed suit and enacted legislation to limit opioid prescriptions.<sup>29</sup> While these prescribing practices have been successful in decreasing the number of opioids prescribed annually,<sup>30</sup> these restrictions create burdensome obstacles for elderly persons in nursing homes suffering from chronic pain, like requiring non-opiate therapy first,<sup>31</sup> mandating decreased dosages,<sup>32</sup> and forcing frequent return

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<sup>21</sup> DAVID W. BAKER, *THE JOINT COMMISSION'S PAIN STANDARDS: ORIGINS AND EVOLUTIONS* 3, 5 (2017).

<sup>22</sup> See Alex Berezow, *A Brief History of the Opioid Epidemic*, AM. COUNCIL ON SCI. & HEALTH (Aug. 22, 2018), <https://www.acsh.org/news/2018/08/22/brief-history-opioid-epidemic-13346>.

<sup>23</sup> Jones et al., *supra* note 11, at 16. See generally Berezow, *supra* note 22.

<sup>24</sup> See *Pain Relievers*, *supra* note 9.

<sup>25</sup> Berezow, *supra* note 22.

<sup>26</sup> Puja Seth, Rose A. Rudd, Rita K. Noonan & Tamara M. Haegerich, *Quantifying the Epidemic of Prescription Opioid Overdose Deaths*, 108 AM. J. PUB. HEALTH 500, 501 (2018); *Opioid Overdose*, CTRS. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/prescribing.html> (last visited Aug. 13, 2019).

<sup>27</sup> Julie Hirschfield Davis, *Trump Declares Opioid Crisis a 'Health Emergency' but Requests No Funds*, N.Y. TIMES (Oct. 16, 2017), <https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html>.

<sup>28</sup> See Deborah Dowell, Tamara M. Haegerich & Roger Chou, *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*, 65 MORBIDITY & MORTALITY WKLY REP.: RECOMMENDATIONS & REPS., no. 1, Mar. 18, 2016, <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.

<sup>29</sup> *Prescribing Policies: States Confront Opioid Overdose Epidemic*, NAT'L CONF. ST. LEGISLATURES (June 30, 2019), <http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx>.

<sup>30</sup> *Study Finds 22 Percent Decrease in Opioid Prescriptions*, AM. ACAD. FAM. PHYSICIANS (Apr. 25, 2018, 12:15 PM), <https://www.aafp.org/news/health-of-the-public/20180425opioidstudy.html> (“A 22 percent decrease in opioid prescriptions nationally between 2013 and 2017 reflects the fact that physicians and other health care professionals are increasingly judicious when prescribing opioids.”).

<sup>31</sup> *Checklist for Prescribing Opioids for Chronic Pain*, CTRS. DISEASE CONTROL & PREVENTION, [https://www.cdc.gov/drugoverdose/pdf/PDO\\_Checklist-a.pdf](https://www.cdc.gov/drugoverdose/pdf/PDO_Checklist-a.pdf) (last visited Nov. 6, 2018).

<sup>32</sup> *CDC Guideline for Prescribing Opioids for Chronic Pain*, CTRS. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/prescribing/guideline.html> (last visited Nov. 6, 2018).

assessments.<sup>33</sup> Many states also limit initial opioid prescriptions with exceptions for chronic pain.<sup>34</sup> The enactment of new prescribing practices also brought increased monitoring of the opioid prescribing rates of individual physicians.<sup>35</sup> Consequently, physicians are prescribing opioids less frequently out of fear of being sanctioned.<sup>36</sup>

Elderly persons in nursing homes are suffering as a result of the CDC's new prescribing practices. As nursing home populations continue to increase, this is a dilemma that will not disappear. In 2007, 25% of deaths in the United States occurred in nursing homes; by 2020, an estimated 40% of all deaths will occur in nursing homes.<sup>37</sup> Once admitted to full-time care, the majority of nursing home residents have short stays, as 50% pass away within six months of admission.<sup>38</sup> Even so, laws regulating opioid prescription hinder the quality of life of many residents who are forced to endure unnecessary pain.<sup>39</sup> Legislators attempted to put an end to the opioid epidemic but instead created a new problem. While the CDC recognizes exceptions for pain during cancer treatments, palliative care, and end-of-life care,<sup>40</sup> there are non-cancer suffering elderly persons who endure severe pain without being considered in need of palliative or end-of-life care. It is these elderly people who truly need opioid prescriptions to live as pain-free as possible as they near the end of their lives that are caught up in the new prescribing scheme.<sup>41</sup> Elderly persons in nursing homes represent a vulnerable population whose untreated and undertreated pain creates personal and community issues.<sup>42</sup>

Relief for elderly persons in nursing homes should not be delayed.<sup>43</sup> Part I will provide a brief summary of new prescribing practices resulting from the nation's opioid epidemic. Part II will detail how these practices do not relieve pain

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<sup>33</sup> Dowell et al., *supra* note 28, at 16.

<sup>34</sup> *Prescribing Policies*, *supra* note 29.

<sup>35</sup> See generally Yuhua Bao, Yijun Pan, Aryn Taylor, Sharmini Radakrishnan, Feijun Luo, Alan Pincus & Bruce R. Schackman, *Prescription Drug Monitoring Programs Are Associated with Sustained Reductions in Opioid Prescribing by Physicians*, 35 HEALTH AFF. 1045 (2016).

<sup>36</sup> *Id.* at 1046; Y. Tony Yang, Marc R. Larochelle & Rebecca L. Haffajee, *Managing Increasing Liability Risks Related to Opioid Prescribing*, 130 AM. J. MED. 249, 249 (2017) ("The increase in prescription opioid-related overdose deaths has increasingly led to liability and sanctions for physicians."); Jay Greene, *Opioid Laws Hit Physicians, Patients in Unintended Ways*, MOD. HEALTHCARE (July 30, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180730/NEWS/180739995>.

<sup>37</sup> Andrea Gruneir, Vincent Mor, Sherry Weitzen, Rachael Truchil, Joan Teno & Jason Roy, *Where People Die: A Multilevel Approach to Understanding Influences on Site of Death in America*, 64 MED. CARE RES. & REV. 351, 355 (2007).

<sup>38</sup> Anne Kelly, Jessamyn Conell-Price, Kenneth Covinsky, Irena Stijacic Cenzer, Anna Chang, W. John Boscardin & Alexander K. Smith, *Length of Stay for Older Adults Residing in Nursing Homes at the End of Life*, 58 J. AM. GERIATRICS SOC'Y 1701, 1702 (2010).

<sup>39</sup> See Zanolchi et al., *supra* note 15, at 127.

<sup>40</sup> Dowell et al., *supra* note 28, at 3.

<sup>41</sup> See *infra* Part I.

<sup>42</sup> See *infra* Part II.

<sup>43</sup> See *infra* Conclusion.

or decrease addiction and misuse. Finally, Part III will discuss how untreated pain hinders residents' quality of life and also negatively impacts the community dwelling.

## I. OPIOID PRESCRIBING AMIDST AN EPIDEMIC

The CDC's opioid prescribing recommendations are instrumental in current prescribing practices.<sup>44</sup> Amidst the epidemic, just under half the states chose to enact legislation that closely tracked the CDC's recommendations.<sup>45</sup> Insurance companies and Medicare also looked to the CDC in making their decisions as to which opioid prescriptions they will cover.<sup>46</sup> The CDC claims that their new guidelines ensure that "patients have access to safer, more effective chronic pain treatment, while reducing the number of people who misuse opioids, develop opioid use disorder, or overdose."<sup>47</sup>

### A. The 2016 CDC Opiate Prescribing Guidelines

In response to rapid misuse of opioid prescriptions during the 2000s and early 2010s, the CDC released new prescribing guidelines.<sup>48</sup> The CDC guidelines contain twelve recommendations that are based on patient selection, treatments, follow-up, and risk mitigation.<sup>49</sup> The recommendations for optimizing non-opiate treatments, dosage maximums, and reassessments present the greatest obstacles to elderly persons living in nursing homes.

The CDC gives the following advice to physicians wishing to begin prescribing or continue prescribing opioids for chronic pain:

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.<sup>50</sup>

In its checklist to prescribing opioids, the CDC further notes that one must "check that non-opioid therapies [are] tried and optimized."<sup>51</sup> Its suggestions for non-opioid

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<sup>44</sup> See *infra* Section I.A.

<sup>45</sup> Marilyn Serafini, *The Physicians; Quandary with Opioids: Pain Versus Addiction*, NEJM CATALYST (Apr. 26, 2018), <https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/>.

<sup>46</sup> See *infra* Section I.A.

<sup>47</sup> Seth et al., *supra* note 26.

<sup>48</sup> See Amy S.B. Bohnert, Gery P. Guy Jr., & Jan L. Losby, *Opioid Prescribing in the United States Before and After the Centers for Disease Control and Prevention's 2016 Opioid Guideline*, 169 ANNALS INTERNAL MED. 367, 367 (2018).

<sup>49</sup> *Id.* at 368.

<sup>50</sup> Dowell et al., *supra* note 28, at 16.

<sup>51</sup> *Checklist for Prescribing Opioids for Chronic Pain*, *supra* note 31.

therapies include: (1) non-opiate medications (for example, acetaminophen, NSAIDs [nonsteroidal anti-inflammatory drugs], TCAs [tricyclic antidepressants], SNRIs [serotonin–norepinephrine reuptake inhibitors], or anticonvulsants); (2) physical treatments (for example, exercise therapy, weight loss); (3) behavioral treatments (for example, cognitive behavioral therapy); and (4) other procedures such as intra-articular corticosteroids (for example, injections).<sup>52</sup> The CDC provides the clinical reminder that “opioids are not first-line or routine therapy for chronic pain.”<sup>53</sup> The CDC also provides dosage recommendations:

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day.<sup>54</sup>

If greater than or equal to 90 MME/day is necessary, the CDC also recommends that the physician consider referring the patient to a specialist and “carefully justify” their reasoning for the dosage.<sup>55</sup> The CDC advises that physicians, when making any recommendation, “start low and go slow.”<sup>56</sup>

Once a physician prescribes opiate therapy, the CDC recommends the following reassessment procedures:

Clinicians should evaluate benefits and harms with patients *within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation*. Clinicians should evaluate benefits and harms of continued therapy with patients *every 3 months or more frequently*. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.<sup>57</sup>

In order to assess medication effectiveness, the CDC recommends the PEG Scale (“Pain, Enjoyment of Life, and General Activity”).<sup>58</sup> First, the patient rates their

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<sup>52</sup> *Id.*

<sup>53</sup> *Guideline for Prescribing Opioids for Chronic Pain*, CTRS. DISEASE PREVENTION & CONTROL 1, [https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines\\_Factsheet-a.pdf](https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf) (last visited Feb. 5, 2020); see generally Dowell et al., *supra* note 28, at 16–17.

<sup>54</sup> Dowell et al., *supra* note 28, at 16.

<sup>55</sup> *Guideline for Prescribing Opioids for Chronic Pain*, *supra* note 53, at 2.

<sup>56</sup> *Id.*

<sup>57</sup> Dowell et al., *supra* note 28, at 16 (emphasis added).

<sup>58</sup> *Checklist for Prescribing Opioids for Chronic Pain*, *supra* note 31. See generally Erin E. Krebs, Karl A. Lorenz, Matthew J. Bair, Teresa M. Damush, Jingwei Wu, Jason M. Sutherland, Steven M. Asch & Kurt Kroenke, *Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference*, 24 J. GEN. INTERNAL MED. 733 (2009).

pain from zero to ten with ten being the worst pain the patient could imagine.<sup>59</sup> Next, the patient provides a rating from zero (not at all) to ten (complete interference) as to how their pain has interfered with their ability to enjoy their life in the last week.<sup>60</sup> Lastly, the patient uses the same scale to rate how their pain has interfered with their general activity in the last week.<sup>61</sup>

### *B. State Action Related to the Opioid Epidemic*

As of April 2018, twenty-eight states had enacted legislation designed to limit opioid prescriptions.<sup>62</sup> Just under half of the states enacted laws that closely track the CDC recommendations.<sup>63</sup> The majority of states, like the CDC, limit initial opioid prescriptions to seven days.<sup>64</sup> However, limits range from three to fourteen days.<sup>65</sup> Some states have made exceptions for chronic pain.<sup>66</sup> Arizona, Florida, Indiana, Maine, Nebraska, Nevada, New Jersey, and West Virginia do not have chronic pain exceptions.<sup>67</sup> The majority of states, however, have not followed the CDC in enacting the statutory limit of 90 MME/day.<sup>68</sup> In the few states that do have statutory limits, several have chosen dosages other than 90 MME/day; other states do not specify a daily MME limit.<sup>69</sup> Only two states, Arizona and Nevada, mirror the CDC's recommendation and limit opioid dosages to 90 MME/day.<sup>70</sup> Maine is slightly more generous with a limit of 100 MME/day.<sup>71</sup> In contrast, Rhode Island has greatly deviated from the CDC's recommendations and limits dosages to 30 MME/day.<sup>72</sup>

Per CDC recommendation,<sup>73</sup> many states track physician prescribing practices on prescription drug monitoring programs (PDMPs),<sup>74</sup> “state-based databases that collect information on controlled prescription drugs dispensed by pharmacies in most states and, in select states, by dispensing physicians as well.”<sup>75</sup>

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<sup>59</sup> Krebs et al., *supra* note 58.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Serafini, *supra* note 45.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*; *Prescribing Policies*, *supra* note 29 (diagramming that of the twenty-three states that have enacted statutory limits for initial opioid prescriptions, fifteen states have set their limit at seven days).

<sup>65</sup> *See id.*; *Prescribing Policies*, *supra* note 29.

<sup>66</sup> Serafini, *supra* note 45.

<sup>67</sup> *See Prescribing Policies*, *supra* note 29.

<sup>68</sup> *See id.*

<sup>69</sup> *See id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> Dowell et al., *supra* note 28, at 29.

<sup>74</sup> *See* Bao et al., *supra* note 35.

<sup>75</sup> Dowell et al., *supra* note 28, at 29.

As of June 2016, nearly all states either had operational PDMPs or were in the process of establishing functional PDMPs.<sup>76</sup> PDMPs can be valuable tools to physicians who prescribe opioids. For example, a physician can look up a particular patient to determine whether the patient is already receiving opioid dosages or taking any other medications that may produce a dangerous combination if taken with opioids.<sup>77</sup>

However, PDMPs can also be used to punish physicians for their prescribing practices.

PDMPs are used to identify over-prescribing practices.<sup>78</sup> If physicians improperly prescribe opioids, they can be liable civilly, criminally, and professionally.<sup>79</sup> Civil liability comes in the form of medical malpractice lawsuits for injuries resulting from negligently prescribed opioids.<sup>80</sup> If physicians “knowingly and intentionally prescribe drugs outside of the usual course of medical practice or for non-legitimate medical purposes,” then they can be held criminally liable under the federal Controlled Substances Act.<sup>81</sup> Regardless of legal charges, state medical boards may still discipline physicians when they believe improper prescribing has taken place<sup>82</sup> by suspending or revoking a physician’s license.<sup>83</sup>

### C. Medicare, Insurance Companies, and Pharmacies

As a result of the opioid epidemic, pharmacists are often put in difficult situations where they face conflicts between the prescribing physician’s orders and what a patient’s health insurance or Medicare plan will cover.

In April 2018, the Centers for Medicare & Medicaid Services (CMS) announced changes to the 2019 Medicare Advantage and Part D programs.<sup>84</sup> Medicare Part D coverage helps cover the cost for prescription drugs.<sup>85</sup> Medicare Advantage plans typically include Part D plans.<sup>86</sup> In this announcement, CMS proposed the following dosage limits for opiates:

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<sup>76</sup> Serafini, *supra* note 45; Yang et al., *supra* note 36, at 250 (stating that PDMPs are now available in forty-nine states).

<sup>77</sup> Dowell et al., *supra* note 28, at 29.

<sup>78</sup> Yang et al., *supra* note 36, at 250.

<sup>79</sup> *Id.* at 249–50.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* at 249.

<sup>82</sup> *Id.* at 250.

<sup>83</sup> *See id.*

<sup>84</sup> *2019 Medicare Advantage and Part D Rate Announcement and Call Letter*, CTRS. MEDICARE & MEDICAID SERVS. (Apr. 2, 2018), <https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter>.

<sup>85</sup> *How Do Medicare Coverage Plans Work?*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work>. (last visited Nov. 26, 2018).

<sup>86</sup> *See 2019 Medicare Advantage and Part D Rate Announcement and Call Letter*, *supra* note 84.

*We expect all sponsors to implement an opioid care coordination edit at 90 morphine milligram equivalent (MME) per day. This formulary-level safety edit would trigger when a beneficiary's cumulative MME per day across their opioid prescriptions reaches or exceeds 90 MME. In implementing this edit, sponsors should instruct the pharmacist to consult with the prescriber, document the discussion, and if the prescriber confirms intent, use an override code that specifically states that the prescriber has been consulted. Sponsors will have the flexibility to include a prescriber and/or pharmacy count in the opioid care coordination edit. Sponsors will also have the flexibility to implement hard safety edits (which can only be overridden by the sponsor) and set the threshold at 200 MME or more and may include prescriber/pharmacy counts.<sup>87</sup>*

As evidenced in this announcement, the CMS proposed “soft edits” for prescriptions where the patient receives 90 MME/day and potential “hard edits” for prescriptions at 200 MME/day or more.<sup>88</sup> Pharmacies can override a soft edit, whereas a pharmacy cannot override a hard edit.<sup>89</sup> Therefore, under the CMS’s 2019 policies, a pharmacist can override a 90 MME/day prescription edit and choose to fill it after consulting the prescribing physician.<sup>90</sup> However, some sponsoring organizations will be able to set a hard edit at 200 MME/day and refuse to pay for these prescriptions.<sup>91</sup>

Many insurance companies have also elected to set limits on which opioid prescriptions will be covered and on the total number of opioid prescriptions they will fill.<sup>92</sup> For example, Cigna announced that they would no longer cover most OxyContin prescriptions. Anthem is two years ahead of schedule in reducing opioid prescriptions by 30%.<sup>93</sup> Many insurance companies also choose to decrease the supply of opioids that physicians prescribe. One anonymous patient wrote online that his insurance company refused to fill his full prescription of twenty-eight Norcos, but they were willing to fill a prescription of twenty Norcos.<sup>94</sup>

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<sup>87</sup> *Id.* (emphasis added).

<sup>88</sup> See *Blue Rx Clinical Pharmacy Programs: Employer Guide*, BLUECROSS BLUESHIELD N.M. 3, [https://www.bcbsnm.com/pdf/rx/nm\\_rx\\_employer\\_guide.pdf](https://www.bcbsnm.com/pdf/rx/nm_rx_employer_guide.pdf). (last visited Nov. 11, 2018) (defining hard and soft edits).

<sup>89</sup> *Id.*

<sup>90</sup> See *2019 Medicare Advantage and Part D Rate Announcement and Call Letter*, *supra* note 84; *Blue Rx Clinical Pharmacy Programs: Employer Guide*, *supra* note 88.

<sup>91</sup> See *2019 Medicare Advantage and Part D Rate Announcement and Call Letter*, *supra* note 84; *Blue Rx Clinical Pharmacy Programs: Employer Guide*, *supra* note 88.

<sup>92</sup> Terri D’Arrigo, *In a Sea of Change, Pharmacists Navigate Opioid Prescribing and Dispensing*, 2017 PHARMACY TODAY 40, 40.

<sup>93</sup> Serafini, *supra* note 45.

<sup>94</sup> Greene, *supra* note 36.

## II. ADDRESSING PAIN, ADDICTION, AND MISUSE

These new prescribing practices require the elderly in nursing homes to “jump through more hoops” in order to receive prescription opioids for chronic pain without fulfilling the CDC objectives of ensuring pain relief and decreasing addiction and/or misuse. New prescribing practices do not promote efficient pain relief for elderly persons in nursing homes and do not address how the risks of opioid dependency and abuse function differently in nursing home contexts.

### A. *New Burdens for Treating Pain as a Result of New Prescribing Practices*

There are several new burdens for treating the pain of elderly persons in nursing homes including non-opioid therapy optimization, maximum dosage limits, and frequent reassessments.

#### i. Non-Opioid Therapy Optimization

Requiring elderly persons in nursing homes to exhaust non-opiate therapies is burdensome because it can be a time-consuming process. For nursing home residents, time truly is of the essence. As will be discussed in Part III, half of new admits die within six months, and their quality of life plummets as death nears. Therefore, the focus should be on ensuring remaining lifetimes are pleasurable, which would require prompt pain relief. However, the CDC and states following CDC guidelines do not make an exception for these elderly persons.

Cognitive behavioral therapy (CBT) and physical therapy are both alternatives to opioid prescriptions<sup>95</sup> that may require long treatment periods to produce results in elderly nursing home patients. In addition to meta-analyses that have revealed CBT has only small to medium effects on decreasing pain in older adults,<sup>96</sup> many CBT patients do not report improvement until after completion of ten to twenty sessions.<sup>97</sup> Similarly, the benefits of exercise therapy in nursing home residents may take several weeks before a substantial decrease in pain is documented.<sup>98</sup> A recent article noted that “physical activity treatments . . . are most

<sup>95</sup> *Checklist for Prescribing Opioids for Chronic Pain*, *supra* note 31.

<sup>96</sup> F.J. Keefe, L. Porter, T. Somers, R. Shelby & V. Wren, *Psychosocial Interventions for Managing Pain in Older Adults: Outcomes and Clinical Implications*, 111 BRIT. J. ANESTHESIA 89, 91 (2013); *see also* Dawn M. Ehde, Tiara M. Dillworth & Judith Turner, *Cognitive-Behavioral Therapy for Individuals With Chronic Pain*, 69 AM. PSYCHOL. ASS'N 153, 154 (“A recent Cochrane review concluded that CBT, compared with treatment-as-usual or wait-list control conditions, had statistically significant but small effects on pain and disability . . .”).

<sup>97</sup> Aaron T. Beck & Judith S. Beck, *Determining Treatment Length in CBT*, BECK INST. COGNITIVE BEHAV. THERAPY (Feb. 19, 2014), <https://beckinstitute.org/determining-treatment-length-in-cbt/>.

<sup>98</sup> *See* Mimi M. Y. Tse, Shuk Kwan Tang, Vanessa T. C. Wan & Sinfia K. S. Vong, *The Effectiveness of Physical Exercise Training in Pain Mobility and Psychological Well-Being of Older Persons Living in Nursing Homes*, 15 PAIN MGMT. NURSING 778, 778 (2014) (showing that elderly person in nursing felt pain intensity reduction after completing eight-week physical therapy program); Cristina Piedras-Jorge, Juan Carlos Melendez-Moral & Jose Manuel Tomas-Miguel, *Beneficios del ejercicio físico en población mayor institucionalizada*, 45 REVISTA ESPAÑOLA DE GERIATRÍA Y

successful when tailored individually, **progressed slowly[,]** and account for physical limitations, psychosocial needs[,] and available resources.”<sup>99</sup> Further, physical therapy may also be a time-intensive task due to physical and psychological barriers. Chronic pain sufferers report contemporaneous pain, comorbidities, lack of motivation, kinesiophobia, anticipatory pain, and lack of perceived benefits as reasons to avoid exercise.<sup>100</sup>

Optimizing non-opiate medications can also prolong pain relief because optimization requires that they be tried prior to being prescribed opioids,<sup>101</sup> but taking these medications might also lead to dangerous side effects. The CDC noted that in older patients, “acetaminophen can be hepatotoxic at dosages of >3–4 grams/day”<sup>102</sup> and that “NSAIDs use has been associated with gastritis, peptic ulcer disease, cardiovascular events, and fluid retention, and most NSAIDs (choline magnesium trisilicate and selective COX-2 inhibitors are exceptions) interfere with platelet aggregation.”<sup>103</sup> Thus, the practical use of acetaminophen or NSAIDs for chronic pain treatment quickly deteriorates, especially if prior to admission the resident has already exhausted these medications.

Other non-opiate medications suggested by the CDC may not address all types of chronic pain. CDC explanations to pain relief from anticonvulsants, SNRIs, and TCAs, only discuss neuropathic pain and fibromyalgia,<sup>104</sup> though there are several other types of chronic pain, including chronic headaches, orofacial pain, irritable bowel, visceral pain, musculoskeletal, and back pain that is neither identified as musculoskeletal or neuropathic pain.<sup>105</sup>

Thus, choosing the correct medication for an elderly person’s chronic pain is complicated. First, prescribers must attempt to avoid the negative side effects of acetaminophen and NSAIDs. However, they must also prescribe medication that addresses the type of chronic pain a resident is experiencing. Therefore, if an elderly

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GERONTOLGÍA , 45 SPANISH J. GERIATRICS & GERONTOLOGY 131, 131 (2010) (reporting that light physical exercise significantly reduced pain perception after eight weeks).

<sup>99</sup> Kristen R. Ambrose & Yvonne M. Golightly, *Physical Exercise as Non-Pharmacological Treatment of Chronic Pain: Why and When*, 29 BEST PRACTICE & RES. CLINICAL RHEUMATOLOGY 120, 120 (2015) (emphasis added).

<sup>100</sup> Laura Boutevillian, Arnaud Dupeyron, Caroline Rouch, Emillie Richard & Emmanuel Coudeyre, *Facilitators and Barriers to Physical Activity in People with Chronic Low Back Pain: A Qualitative Study*, 12 PLOS ONE 1, 6–7 (2017).

<sup>101</sup> *Checklist for Prescribing Opioids for Chronic Pain*, *supra* note 31.

<sup>102</sup> Dowell et al., *supra* note 28, at 18 (citing *American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Person*, 57 J. AM. GERIATRICS SOC’Y 1331–46 (2009)).

<sup>103</sup> *Id.* (citations omitted).

<sup>104</sup> *See id.* at 17–18.

<sup>105</sup> Rolf-Detlef Treede, Winfried Rief, Antonia Barke, Qasim Aziz, Michael L. Bennett, Rafael Benoliel, Milton Cohen, Stefan Evers, Nanna B. Finnerup, Michael B. First, Maria Adele Giamberardino, Stein Kaasa, Eva Kosek, Patricia Lavand’homme, Michael Nicholas, Serge Perrot, Joachim Scholz, Stephan Schug, Blair H. Smith, Peter Svensson, Johan W.S. Vlaeyen & Shuu-Jiun Wang, *A Classification of Chronic Pain for ICD-11*, 156 PAIN 1003, 1004–05 (2015).

person is suffering from any type of chronic pain other than neuropathic pain or fibromyalgia, opioids may be the most appropriate medication.

A recent meta-analysis found that nonanalgesic pain treatments were not as effective as analgesic treatments on nursing home residents and that “analgesic therapies should be considered as first-line treatments for managing pain in the population of older adults living in nursing homes.”<sup>106</sup> While not every analgesic study in the meta-analysis included opioid therapy, it stands that, under the CDC, nonpharmaceutical interventions often present a barrier to pain relief for the elderly in nursing homes. Despite current research that concluded that there is no significant difference between opioid and non-opioid medications,<sup>107</sup> this issue has not been addressed in a nursing home context.

The CDC states that “patients should [not] be required to sequentially ‘fail’ nonpharmacological and nonopioid pharmacologic therapy before proceeding to opioid therapy” and that “expected benefits specific to the clinical context should be weighed against risks before initiating therapy.”<sup>108</sup> While the CDC gives physicians this option, it is not realistic. As will be described in the remaining sections of Section II.A, it is difficult for physicians to forego trying all non-opioid therapies due to pressures exerted from state legislatures, pharmacies, and healthcare providers.

## ii. Maximum Dosage Limits

When the CDC created their new prescribing guidelines, it did not consider individuals who need more than 90 MME/day for chronic pain. After many state legislatures changed their prescribing practices, news stories across the nation brought attention to individuals who exceeded the new maximum dosage limits. For example, Gary Snook, a Montana man suffering from Arachnoiditis, took six times more MME than what the CDC recommends.<sup>109</sup> In response to the new limits, he told reporters that the new limits “would leave [him] no option but suicide or becoming a felon.”<sup>110</sup> Similarly, Moriah White, called herself “an ‘opioid war casualty.’”<sup>111</sup> Another chronic pain sufferer, Shannan Hubbard described to an

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<sup>106</sup> Jennifer A. Knopp-Sihota, Pooja Patel & Carole A. Estabrooks, *Interventions for the Treatment of Pain in Nursing Home Residents: A Systematic Review and Meta-Analysis*, 17 J. AM. MED. DIRS. ASS’N 1163, 1163 (2016).

<sup>107</sup> E.E. Krebs, Amy Gravely, Sean Nugent, Agnes C. Jensen, Beth DeRonne, Elizabeth S. Goldsmith, Kurt Kroenke, Matthew J. Blair & Siamak Noorbaloochi, *Effect of Opioid v. Non-Opioid Medications on Pain-Related Function in Patients with Chronic Back Pain or Hip or Knee Osteoarthritis Pain*, 319 J. AM. MED. ASS’N 872, 872 (2018).

<sup>108</sup> See Dowell et al., *supra* note 28, at 19.

<sup>109</sup> Pat Anson, *High Dose Patients Worried by CDC Opioid Guidelines*, PAIN NEWS NETWORK (Sept. 28, 2015), <https://www.painnewsnetwork.org/stories/2015/9/28/high-dose-patients-worried-by-cdc-opioid-guidelines>.

<sup>110</sup> *Id.*

<sup>111</sup> Jayne O’Donnell & Josephine Chu, *Chronic Pain Patients, Overlooked in Opioid Crisis, Getting New Attention from Top at FDA* (July 2, 2018), <https://www.usatoday.com/story/news/politics/2018/07/02/chronic-pain-patients-needs-ignored-opioid-epidemic/727015002/>.

interviewer her debilitation following even a slight decrease from 100 MME/day to 90 MME/day.<sup>112</sup>

Like the aforementioned individuals, opioid-induced tolerance will be a battle for elderly persons living in nursing homes as they seek pain relief. One in seven nursing homes residents are prescribed opioids for long-term chronic pain.<sup>113</sup> As residents take opioids, they will continually need higher dosages to obtain pain relief.<sup>114</sup> For some this may mean eventually taking up to ten times the original dose with daily doses up to 800 MME/day.<sup>115</sup> This will become an issue once residents surpass the hard limits several states have set at 30-100 MME/day without chronic pain exceptions,<sup>116</sup> and it will also be an issue in states without hard limits. In an interview with a registered nurse in the Midwest, she explained that it can be difficult to convince physicians to order opioids to begin with, let alone at such high dosages: “Some doctors are so reluctant to prescribe opioid medications whether a patient has or has not been previously prescribed them. It often takes me painting a very vivid picture of their pain before physicians realize the necessity of the medication.”<sup>117</sup>

If residents are not plainly denied prescriptions greater than the maximum dosage determined by their physician or state law, Medicaid will present another obstacle. Sixty-five percent of nursing home residents are primarily supported by Medicaid,<sup>118</sup> and thus many residents may not survive the proposed “soft” edit at 90 MME/day if the pharmacist chooses not to override the order.<sup>119</sup> Even if a resident has outside insurance, there is also no guarantee that their private insurer will fill the entire prescription either.<sup>120</sup> Therefore, the maximum dosage will become inadequate for many residents, and they will be left to endure untreated pain as they near the end of their lives. As described in the previous section, while other

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<sup>112</sup> Will Stone, *Patients with Chronic Pain Feel Caught in an Opioid-Prescribing Debate*, WASH. POST (Aug. 1, 2018), [https://www.washingtonpost.com/national/health-science/patients-with-chronic-pain-feel-caught-in-an-opioid-prescribing-debate/2018/08/01/d0b72598-9571-11e8-818b-e9b7348cd87d\\_story.html?utm\\_term=.554c4599fb67](https://www.washingtonpost.com/national/health-science/patients-with-chronic-pain-feel-caught-in-an-opioid-prescribing-debate/2018/08/01/d0b72598-9571-11e8-818b-e9b7348cd87d_story.html?utm_term=.554c4599fb67).

<sup>113</sup> Jacob N. Hunnicutt, Stavroula A. Chrysanthopoulou, Christine M. Ulbricht, Anne L. Hume, Jennifer Tjia & Kate L. Lapane, *Prevalence of Long-Term Opioid Use in Long-Stay Nursing Home Residents*, 66 J. AM. GERIATRICS SOC'Y 48, 48 (2017).

<sup>114</sup> Shands at the Univ. of Fla., *Opioid Prescribing in “Naïve” or “Tolerant” Patients*, DRUGS & THERAPY BULL., March 2012, at 1, <https://professionals.ufhealth.org/files/2011/11/0312-drugs-therapy-bulletin.pdf>.

<sup>115</sup> Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain Misconceptions and Mitigation Strategies*, 374 NEW ENG. J. MED. 1253, 1255–56 (2016) (citing H. Eder, *Comparative Study of the Effectiveness of Slow-Release Morphine and Methadone for Opioid Maintenance Therapy*, 100 ADDICTION 1101 (2005)).

<sup>116</sup> See *Prescribing Policies*, *supra* note 29.

<sup>117</sup> Interview with Marni Smith, Registered Nurse, Midwest (Dec. 10, 2018).

<sup>118</sup> Ari Houser, *Nursing Homes*, AARP PUB. POL'Y INST. (Oct. 2007), [https://assets.aarp.org/rgcenter/il/fs10r\\_homes.pdf](https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf).

<sup>119</sup> See *2019 Medicare Advantage and Part D Rate Announcement and Call Letter*, *supra* note 84.

<sup>120</sup> See *supra* Section I(C).

therapies exist, opioids remain the most reliable analgesic agent,<sup>121</sup> and it is questionable if other methods can provide the same relief.

For residents taking dosages already exceeding the CDC recommendation, tapering is a time-consuming and potentially dangerous alternative. Unfortunately, many residents, especially long-term opioid users, may not have enough life left to benefit from a slow taper.<sup>122</sup> Rather, a forced taper may make the remaining months a grueling experience.<sup>123</sup> The CDC advises that tapering should be a slow process with a decrease of 10% per week.<sup>124</sup> However, it also notes that if patients have been taking opioids long-term, slower tapers of 10% per month may be an easier transition for the patient.<sup>125</sup> During the tapering process, opioid withdrawal symptoms can begin within twelve to twenty-four hours after an interruption in one's medicine regimen.<sup>126</sup> Withdrawal "[s]igns and symptoms include dysphoria, insomnia, pupillary dilation, piloerection, yawning, muscle aches, lacrimation, rhinorrhea, nausea, fever, sweating, vomiting and diarrhea."<sup>127</sup> Persistent vomiting and diarrhea can eventually lead to dehydration, hypernatraemia, heart failure, and death.<sup>128</sup> Nursing home residents are not immune to these side effects. In one study, researchers found that nursing home residents who experienced opioid reductions reported higher pain scores during follow-up periods.<sup>129</sup>

### iii. More Frequent Reassessment

While the CDC's recommendations of requiring an initial prescription limits assessment within one to four weeks after a dose escalation and a periodic reassessment every three months may appear reasonable at first glance, the reality of the opioid epidemic makes the need for reassessment much more frequent. The CDC's recommendations are being interpreted as "mandates" rather than

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<sup>121</sup> Fields, *supra* note 10, at 591 (citing G.W. PASTERNAK, *THE OPIATE RECEPTORS* (Humana Press 2011)).

<sup>122</sup> See Kelly et al., *supra* note 38 (stating that 50% of nursing home residents die within six months of admission).

<sup>123</sup> See Shane Drake, Sarah Larney, & Michael Farrell, *Yes, People Can Die from Opioid Withdrawal*, 112 *ADDICTION* 199, 199 (2016) (discussing opioid withdrawal symptoms).

<sup>124</sup> *Pocket Guide: Tapering Opioids for Chronic Pain*, CTRS. DISEASE CONTROL & PREVENTION, [https://www.cdc.gov/drugoverdose/pdf/clinical\\_pocket\\_guide\\_tapering-a.pdf](https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf). (last visited Dec. 9, 2018).

<sup>125</sup> *Id.*

<sup>126</sup> Sarah E. Redding, Sophia Liu, William W. Hung & Kenneth S. Boockvar, *Opioid Interruptions, Pain, and Withdrawal Symptoms in Nursing Home Residents*, 36 *CLINICAL THERAPEUTICS* 1555, 1556 (2014) (citing J.H. Jaffee, *Misinformation: Euphoria and Addiction*, 11 *ADVANCES PAIN RES. & THERAPY* 163 (1989)).

<sup>127</sup> Drake et. al, *supra* note 123.

<sup>128</sup> *Id.*

<sup>129</sup> Redding et al., *supra* note 126.

“guidelines.”<sup>130</sup> To ensure physician license safety, if they are prescribing opioids at all, they are prescribing less, which in turn requires more frequent reassessment.<sup>131</sup> Physicians feel pressure from state lawmakers, medical boards, insurance companies, and hospital executives to prescribe few, if any, opioids for acute or chronic pain.<sup>132</sup> Out of fear, some physicians avoid writing prescriptions for more than three days.<sup>133</sup> In North Carolina, of 2,661 physicians, 58% stated that the opioid epidemic impacted their prescribing practices, and of that 58%, 43% admitted they ceased prescribing opioids altogether.<sup>134</sup> PDMPs that track physicians and prescribing rates are increasingly being used to identify and sanction over-prescribing,<sup>135</sup> so deviating from the CDC’s recommendations could be readily detected.

Skilled nursing homes can vary in size from a few residents to hundreds of residents.<sup>136</sup> Upon entering a nursing home, many residents switch doctors if their personal physician does not make nursing home service part of their ongoing practice.<sup>137</sup> As a result, many patients elect to switch to one of the nursing home’s attending physicians. Therefore, depending on the number of physicians employed by the facility, an attending nursing home physician could have a couple patients or a hundred patients. With each patient, a physician assumes the duty to “[p]hysically attend to each resident in a timely manner consistent with state and federal guidelines (visit every 30 days for the first 90 days following admission, and at least every 60 days thereafter),” respond to changes in function or condition, and develop comprehensive medical care plans.<sup>138</sup>

In nursing homes, shorter prescriptions may create an undue burden on nursing home physicians. If a nursing home physician has more than a handful of patients, frequent reassessments for opioids medications could begin to occupy a significant portion of their schedule. Registered Nurse Marni explained that in the nursing home where she was employed the physicians had anywhere from ten to

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<sup>130</sup> Peter Grinspoon, *The Orphaned Patient: Treating Chronic Pain with Opioids*, HARV. MED. SCH. CME ONLINE: LEAN FORWARD (Feb. 1, 2018), <https://leanforward.hms.harvard.edu/2018/02/01/the-orphaned-patient-treating-chronic-pain-with-opioids/>.

<sup>131</sup> *See id.*

<sup>132</sup> *Id.*

<sup>133</sup> Greene, *supra* note 36.

<sup>134</sup> Taylor Knopf, *Hundreds of N.C. Doctors Say They’ve Stopped Prescribing Opioids*, N.C. HEALTH NEWS (Oct. 18, 2018), <https://www.northcarolinahealthnews.org/2018/10/15/nc-doctors-stop-prescribe-opioids/>.

<sup>135</sup> *See* Yang et al., *supra* note 36, at 250.

<sup>136</sup> *Nursing Homes*, AM. PLANNING ASS’N, <https://www.planning.org/pas/reports/report185.htm>. (last visited Dec. 9, 2018).

<sup>137</sup> *See* Lorraine Tarnove, *Successfully Managing Attending Physicians*, CARING FOR THE AGES, May 2008, [https://www.caringfortheages.com/article/S1526-4114\(08\)60124-9/pdf](https://www.caringfortheages.com/article/S1526-4114(08)60124-9/pdf).

<sup>138</sup> Aman Nanda & Tom J. Wachtel, *Nursing Home Physicians: Roles and Responsibilities*, 90 MED. & HEALTH R.I. 218, 219 (2007).

sixty patients to see in a day.<sup>139</sup> During each visit, the physician could spend as few as five minutes, but certainly more depending on the reason for the visit, and each visit required charting, progress notes, and occasionally a prescription order if their medication regimen was changed.<sup>140</sup> If a physician has a lot of patients to see in a day, opioid reassessments taken in conjunction with routine visits and as-needed visits could decrease the amount of time a physician spends with any given patient per visit. Therefore, frequent reassessments could impact the quality of care in nursing homes.

Further, reassessment becomes increasingly difficult as cognitive impairment increases in nursing home residents. Nearly two-thirds of all U.S. nursing home residents suffer from a cognitive impairment such as Alzheimer's disease.<sup>141</sup> In the case of Alzheimer's, cognitive decline can occur over a span between three and twenty years.<sup>142</sup> As individuals pass through different stages, eventually verbal abilities and psychomotor skills are generally lost.<sup>143</sup> The CDC recommends the PEG scale to assess pain,<sup>144</sup> but residents who become severely cognitively impaired will likely struggle to accurately report the intensity of their pain and the effect it is having on their quality of life. Thus, if a doctor generously continues to prescribe opioids despite the inability of the resident to communicate their pain, the physician must continually revisit even though the patient will unlikely be able to provide any meaningful report. Rather, the visit will unnecessarily consume more of the attending physician's time.

### *B. The Risk of Abuse and Addiction in Nursing Homes*

In nursing homes, it is less likely that nursing home residents will abuse and divert opioids because they are living in a controlled environment. Residents do not have access to their prescriptions. Rather, nurses and other delegated nursing staff perform periodic medicine passes.<sup>145</sup> During these medicine passes, nurses are instructed to follow the "six rights of medication administration:" "right individual, right medication, right dose, right time, right route, and right documentation."<sup>146</sup> Thus, nurses ensure that only residents prescribed opioids are taking the drugs and at the proper dose.<sup>147</sup> Further, nurses should document whether the patient

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<sup>139</sup> Interview with Marni Smith, *supra* note 117.

<sup>140</sup> *Id.*

<sup>141</sup> Joseph E. Gaugler, Fang Yu, Heather W. Davila & Tetyana Shippee, *Alzheimer's Disease and Nursing Homes*, 33 HEALTH AFF. 650, 650 (2014).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Checklist for Prescribing Opioids for Chronic Pain*, *supra* note 31.

<sup>145</sup> Amy Vogelsmeier, *Medication Administration in Nursing Homes: RN Delegation to Unlicensed Assistive Personnel*, 2 J. NURSING REG. 49, 49–50 (2011).

<sup>146</sup> *BDS Medication Administration Curriculum Section IV*, DEP'T. HEALTH & HUMAN SERVS. 6, <https://www.dhhs.nh.gov/dcbcs/bds/nurses/documents/sectionIV.pdf>. (last visited Dec. 9, 2018).

<sup>147</sup> *See id.* at 6–8.

consumes or refuses the medication.<sup>148</sup> Nurses cannot leave medications with residents for later use.<sup>149</sup> Under this monitoring system, residents cannot consume more opioids than they are prescribed, and they cannot stockpile or divert drugs to other residents or visitors. While there remains potential in any health care facility for nursing staff to divert drugs, there are not statistics to suggest that diversion is any more apparent in nursing homes.

Further, some research suggests that opioid addictions are rare when the medication is appropriately used to treat chronic pain.<sup>150</sup> “Addiction occurs in only a small percentage of persons who are exposed to opioids—even among those with preexisting vulnerabilities.”<sup>151</sup> While patients taking opioids will inevitably develop tolerance and experience physical dependence, this is a phenomenon distinct from addiction.<sup>152</sup> Most patients who are given opioids for chronic pain do not ever exhibit behaviors consistent with the chronic disease of addiction, including craving, loss of control, or compulsive use.<sup>153</sup> “In fact, the presence of [ongoing] pain appears to provide a protective action against the rewarding effects of opiates.”<sup>154</sup>

While diversion and addiction may be less likely to impact nursing home residents, residents taking opioids are still at risk of potential overdose. When opioids are taken in excess, the brain does not properly regulate breathing.<sup>155</sup> This can lead to potentially life-threatening sedation and respiratory depression.<sup>156</sup> Respiratory depression is the most feared of all opioid side effects, but it is the most rare when initial dosages and titration dosages are appropriate.<sup>157</sup> Fortunately, sedation precedes respiratory depression, and sedation decreases over time,<sup>158</sup> so this is a manageable risk in nursing home facilities where medical staff routinely watch and chart resident behavior. However, sedation is not always a negative effect for chronic pain sufferers in nursing homes. For residents who are in high

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<sup>148</sup> Compare *BDS Medication Administration Curriculum Section IV*, *supra* note 146, at 12, with William C. Wilson, *The Refusing Resident: Risk Management Principles*, CARING FOR THE AGES, July 2017, at 14.

<sup>149</sup> *Executing the Perfect Medication Pass*, COLORADO.GOV, [https://www.colorado.gov/pacific/sites/default/files/HF\\_Proper-Medication-Pass-Bob-Harrison.pdf](https://www.colorado.gov/pacific/sites/default/files/HF_Proper-Medication-Pass-Bob-Harrison.pdf). (last visited Dec. 9, 2018).

<sup>150</sup> Fields, *supra* note 10, at 591.

<sup>151</sup> Volkow, *supra* note 115, at 1256.

<sup>152</sup> *Id.*

<sup>153</sup> Andrew Rosenblum, Lisa A. Marsch, Herman Joseph & Russell K. Portenoy, *Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions*, 16 EXPERIMENTAL & CLINICAL PSYCHOPHARMACOLOGY 405, 409 (2008).

<sup>154</sup> Fields, *supra* note 10, at 593.

<sup>155</sup> *Opioid Overdose*, MEDLINE PLUS, <https://medlineplus.gov/opioidoverdose.html>. (last visited Dec. 9, 2018).

<sup>156</sup> Diane L. Chau, Vanessa Walker, Latha Pai & Lwin M Cho, *Opiates and Elderly: Use and Side Effects*, 3 CLINICAL INTERVENTIONS AGING 273, 276 (2008).

<sup>157</sup> Marissa Galicia-Castillo, *Opioids for Persistent Pain in Older Adults*, 83 CLEV. CLINIC J. MED. 443, 448 (2016).

<sup>158</sup> *Id.*

levels of pain but not approaching the need for palliative or hospice care,<sup>159</sup> low levels of sedation may provide relief to patients who might otherwise endure severe pain.

## II. THE IMPACT OF UNTREATED PAIN ON THE SELF AND COMMUNITY

It is not death that the very old tell me they fear. It is what happens short of death—losing their hearing, their memory, their best friends, their way of life. As Felix put it to me, “Old age is a continuous series of losses.” Philip Roth put it more bitterly in his novel *Everyman*: “Old age is not a battle. Old age is a massacre.”<sup>160</sup>

As evidenced from the excerpt above, aging can be a difficult process. Through the process of aging, an independent person becomes dependent on the care of others to function. As decline sets in, it is not uncommon to hear people request a promise from their loved ones that they will never be put in a nursing home.<sup>161</sup> This is a realistic request in some circumstances. Research shows that an individual’s likelihood of avoiding a nursing home increases as they have more children.<sup>162</sup> However, some medical conditions advance to a stage where family members can no longer safely provide for their loved ones.<sup>163</sup>

One author describes distaste for nursing homes as the following:

We end up with institutions that address any number of societal goals—from freeing up hospital beds to taking burdens off families’ hands to coping with poverty among the elderly—but never the goal that matters to the people who reside in them: how to make life worth living when we’re weak and frail and can’t fend for ourselves anymore.<sup>164</sup>

As nursing homes become the predominate end-of-life care, concerns like the excerpt above should not be taken lightly. The clear moral choice is to ensure that elderly persons in nursing homes have the ability to live a high-quality life before their seemingly inevitable passing. However, the CDC’s recommendations put the societal goal of decreasing the rate of opioid prescriptions before ensuring that elderly persons in nursing homes can enjoy pain-free lives in a safe, comfortable living environment.

<sup>159</sup> See *What Are Palliative Care and Hospice Care?*, NAT’L INST. AGING, <https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care>. (last visited Dec. 10, 2018) (describing how palliative care is for seriously ill patients for which there is no cure and hospice care is for terminally ill patients).

<sup>160</sup> ATUL GAWANDE, *BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END* 55 (2014).

<sup>161</sup> Tara Bahrapour, *‘Promise You’ll Never Put Me in a Nursing Home’*, WASH. POST (Feb. 8, 2016), [https://www.washingtonpost.com/local/social-issues/promise-youll-never-put-me-in-a-nursing-home/2016/02/08/1ce8737c-cb62-11e5-a7b2-5a2f824b02c9\\_story.html?utm\\_term=.dc0e625d64e9](https://www.washingtonpost.com/local/social-issues/promise-youll-never-put-me-in-a-nursing-home/2016/02/08/1ce8737c-cb62-11e5-a7b2-5a2f824b02c9_story.html?utm_term=.dc0e625d64e9).

<sup>162</sup> GAWANDE, *supra* note 160, at 79.

<sup>163</sup> See Bahrapour, *supra* note 161.

<sup>164</sup> GAWANDE, *supra* note 160, at 76–77.

### A. Oppressive Pain Impacts One's Quality of Life

In a recent study analyzing the deaths of nearly 8,500 nursing home residents over a span of fourteen years, researchers found that “65% of decedents had lengths of stay less than one year, and more than 53% died within 6 months of admission.”<sup>165</sup> Despite imminent death in what is likely to be a relatively short time period, residents fear a failing body and physical distress more than death itself.<sup>166</sup> Prior to death, residents in nursing homes report a variety of negative psychological and physical discomforts during the dying process. Negative psychological experiences include loneliness and depression, and physical discomforts include pressure sores, dyspnea, thirst, and pain.<sup>167</sup>

Pain, among other physical discomforts, is a known and manageable hallmark of declining nursing homes residents that decreases their quality of life. According to nursing homes residents, chronic pain can be “throbbing, like an electric shock, sharp, gnawing, burning, stinging, aching, dull, sore, awful, bad horrible, like living hell, murder, ugly, terrible, shocking, excruciating, discomforting, distressing, nagging, niggling, or severe.”<sup>168</sup> Although many residents endure intense chronic pain, they still wish to die a so-called “good death,” a death where they are not only treated with dignity, have loved ones are near, and are given a sense of closure, but are also provided freedom from pain and suffering.<sup>169</sup>

Chronic pain compromises the quality of life of nursing home residents by altering their physical and psychological health.<sup>170</sup> Symptoms associated with chronic pain include nausea, migraines, anxiety, incontinence, constipation, diarrhea, and dizziness.<sup>171</sup> Further, “[u]nrelieved pain has far reaching consequences affecting people’s ability to perform activities of daily living; profoundly affecting their psychological well-being, sleep . . . and contributing to dying in distress.”<sup>172</sup> In a qualitative study, a nursing home resident reported that, “[h]er pain was so debilitating that it sapped all her energy, strength, and will. Any small movement of her body caused pain and, like others with pain, there were

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<sup>165</sup> Kelly, *supra* note 38, at 1702.

<sup>166</sup> Nan Greenwood, Emma Menzies-Gow, David Nilsson, Dawn Aubrey, Claire L Emery & Angela Richardson, *Experiences of Older People Dying in Nursing Homes: A Narrative Systematic Review of Qualitative Studies*, 8 *BMJ OPEN* 1, 6 (2018); Genevieve N. Thompson, Malcolm Doupe, R. Colin Reid, Jennifer Baumbusch & Carole A. Estabrooks, *Pain Trajectories of Nursing Home Residents Nearing Death*, 18 *J. AM. MED. DIRS. ASS'N* 700, 700 (2017).

<sup>167</sup> *Id.*

<sup>168</sup> Isabel Higgins, Irena Madjar & Jo Ann Walton, *Chronic Pain in Elderly Nursing Home Residents: The Need for Nursing Leadership*, 12 *J. NURSING MGMT.* 167, 170 (2004).

<sup>169</sup> Isuri Weerakkody, Sarah Hales, Samantha Fernandes, Debbie Emmerson, William O'Neill, Camilla Zimmermann & Gary Rodin, *The Quality of Dying and Death in a Residential Hospice*, 56 *J. PAIN & SYMPTOM MGMT.* 567, 567 (2018).

<sup>170</sup> Zanicchi et al., *supra* note 15, at 126.

<sup>171</sup> *Id.*

<sup>172</sup> Thompson et al., *supra* note 166, at 701 (citations omitted).

times when words were inadequate.”<sup>173</sup> For some residents, this means a retreat from their regular activities. In an interview with a geriatric registered nurse, she described how some residents isolate themselves and develop depression when their pain goes untreated.<sup>174</sup> She reported that “[i]t is sad to see some residents who would never miss bingo, a bible study, or a meal in the dining room choose instead to sit in their rooms in misery.”<sup>175</sup>

Cognitively impaired residents represent a particularly vulnerable population of chronic pain sufferers in nursing homes. Because they cannot recall and characterize their pain, they are at much higher risk of enduring under-assessment and under-treatment of pain.<sup>176</sup> Physicians are generally resistant to prescribe opioids for the cognitively impaired.<sup>177</sup> In one study of nursing home residents, provisional and prescription analgesic use decreased significantly as cognitive impairment increased, and virtually none of the cognitively impaired residents were prescribed opioid analgesics.<sup>178</sup> Thus, the burdens of chronic pain, including diminished quality of life, are likely felt in excess in cognitively impaired residents despite the relief that opioids may provide.

As death nears, chronic pain does not disappear. In fact, in the six months prior to dying in a nursing home, residents report that the frequency and intensity of chronic pain is either constant or significantly increasing.<sup>179</sup> A small percentage of residents report some degree of improvement in the six months preceding their death.<sup>180</sup> While the CDC recognizes exceptions for end-of-life care,<sup>181</sup> determining when residents are entering their final stages of life is often challenging.<sup>182</sup> Thus, residents may endure the physical and psychological burdens of chronic pain that diminish one’s quality of life for several months or years if adequate pain relief is not provided.

### *B. How Untreated and Undertreated Pain Impacts Community Dwellings*

Nursing homes function as communities where individual residents engage with other residents as well as employees. Thus, there is peace when residents and employees interact among each other cordially. Unfortunately, untreated pain may cause patients exhibiting signs of dementia to engage in aggressive behavioral disturbances that disrupt harmony. As dementia impairs the ability to characterize the severity and location of pain, residents with cognitive impairments may

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<sup>173</sup> Higgins et al., *supra* note 168, at 165.

<sup>174</sup> Interview with Marni Smith, *supra* note 117.

<sup>175</sup> *Id.*

<sup>176</sup> Li et al., *supra* note 20, at 471.

<sup>177</sup> *See id.* at 478.

<sup>178</sup> S. José Closs, Bridget Barr & Michelle Briggs, *Cognitive Status and Analgesic Provision in Nursing Home Residents*, 54 BRIT. J. GEN. PRAC. 919, 921 (2004).

<sup>179</sup> Thompson et al., *supra* note 166, at 704.

<sup>180</sup> *Id.*

<sup>181</sup> Dowell et al., *supra* note 28, at 3.

<sup>182</sup> Thompson et al., *supra* note 166, at 704.

manifest their pain through disruptive behaviors.<sup>183</sup> General discomfort can also produce verbally agitated behaviors that can create disturbances in nursing homes.<sup>184</sup> Because nearly two-thirds of nursing home residents suffer from a cognitive impairment, this is a relevant concern.<sup>185</sup>

Aggressive behaviors from untreated pain can be bothersome but also dangerous. In a series of interviews with a geriatric nurse in the Midwest named Marni, she explained that distress from untreated pain can start as complaining but easily escalate to yelling and other forms of verbal abuse.<sup>186</sup> She explained her experiences with verbally agitated residents:

I have been called every profanity in the book. After working in the field for so long, you become numb to that sort of thing. I know some residents who are generally nice people occasionally suffer episodes of extreme pain. As a nurse, I just feel bad that sometimes there is not more that I can do, including giving more pain medication. I guess I somewhat become their boxing bag in hopes that maybe that will at least help ease the pain. Besides, I would rather them be mean to me than another resident. I do try to stop yelling though because other residents are quick to complain and say thing like “I wish so and so would stop yelling!”<sup>187</sup>

Aggressive behaviors can also be physical. Marni also explained that residents occasionally pinch, bite, scratch, punch, and push their wheelchairs into objects when they are experiencing untreated pain.<sup>188</sup> When residents begin to exhibit these behaviors they often have to be redirected away from other residents:

As much as I do not like being pinched or hit, again, this is something that I can handle. However, it is important that all residents feel safe in their own home. Consequently, some physically aggressive patients have to be redirected away from others. The problem with this, though, is that some residents do not take the redirection well, which only increases their agitation and aggression. It seems like a perpetual cycle until we can get them effective pain medication.<sup>189</sup>

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<sup>183</sup> Tomasz Nowak, Agnieszka Neumann-Podczaska, Ewa Deskur-Smielecka, Arkadiusz Stysynski & Katarzyna Wieczorowska-Tobis, *Pain as a Challenge in Nursing Homes Residents with Behavioral and Psychological Symptoms of Dementia*, 13 CLINICAL INTERVENTIONS IN AGING 1045, 1050 (2018).

<sup>184</sup> Jiska Cohen-Mansfield, Maha Dakheel-Ali, Marcia S. Marx, Khin Thein & Natalie G. Regier, *Which Unmet Needs Contribute to Behavior Problems in Persons with Advanced Dementia*, 228 PSYCHIATRY RES. 59 (2015).

<sup>185</sup> Gaugler et al., *supra* note 141.

<sup>186</sup> Interview with Marni Smith, *supra* note 117.

<sup>187</sup> *Id.*

<sup>188</sup> *Id.*

<sup>189</sup> *Id.*

When residents engage in disruptive behaviors, it consumes facility resources. According to Marni, whether residents are being either verbally or physically disruptive, their behaviors need to be charted and monitored.<sup>190</sup> Increased monitoring can become a large burden on top of everyday nursing duties and detract from the time that nursing staff can spend with other residents. For example, nurse Marni explained that sometimes she is stretched thin in meeting all of her obligations depending on whether residents are having good or bad days:

Sometimes there are more problems than charge nurses available. I can recall days where I was being pulled in a million different directions because residents were having bad days either due to poor health or aggressive behaviors. Sometimes it ends up being a time-consuming process when an effective pain medication would do the trick.<sup>191</sup>

As evidenced from Marni's experiences, increased monitoring can be a detriment to the entire community when a simple opioid medication could potentially solve the resident's behavior problem.

## CONCLUSION

While death is inevitable, it is difficult to predict:

For most people, death comes only after long medical struggle with an ultimately unstoppable condition—advanced cancer, dementia, Parkinson's disease, progressive organ failure (most commonly the heart, followed in frequency by lungs, kidneys, liver), or else just the accumulating debilities of very old age. In all such cases, death is certain, but the timing isn't.<sup>192</sup>

However, it is the uncertain nature of death that makes providing effective relief from chronic pain to nursing home residents imperative. Despite the CDC's call for more effective pain relief that decreases the risks of abuse, addiction, and overdose, nursing home residents appear to be caught up in a regulatory scheme that does not address their needs in the final stages of their lives. Instituting the optimization of non-opioid treatments, setting maximum dosage limits, and requiring more frequent reassessments for opioid prescription users inhibits elderly persons in nursing homes from receiving effective pain relief. Because the regulatory scheme fails to recognize how the risks of abuse, addiction, and overdose function differently in nursing homes, residents are enduring pain that is hindering their quality of life. Quite literally, nursing home residents do not have the physical or mental stamina to jump through these hoops.

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<sup>190</sup> *Id.*

<sup>191</sup> *Id.*

<sup>192</sup> GAWANDE, *supra* note 160, at 156–57.