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Quality Pain Care for Older Adults in an Era of Suspicion and Scrutiny

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Abstract

In two decades, the pendulum has swung from focusing on the under-treatment of pain by prescribers who fail to use medically necessary opioids, to an intense focus on over-prescribing opioids and the harms they cause. Within these two extremes rests the older adult with pain, and in need of safe and effective care. Today, healthcare providers are practicing in an era of scrutiny with new guidelines and regulations superseding their compassion and clinical judgment about the best treatment options when older adults have pain across the care continuum. Media depicting opioids as lethal, unnecessary and highly addictive that don't distinguish non-medical from therapeutic use; or legitimately versus illegally obtained drugs are widely reported. These reports and legislative focus on treating addiction have silenced and further stigmatized older adults with persistent pain. Patients and professionals treating pain need to provide balance of multimodal pain management strategies to safely manage persistent pain based on a comprehensive assessment and a personalized approach.

Overview of Issues that Impact Clinical Practice

The alarming increase in opioid drug-related deaths has increased scrutiny of prescribing opioid medications for pain. This level of scrutiny has made it more difficult for older adults living with persistent pain to gain access to opioids, even though they may be more safe, effective and affordable than non-opioid options (Alford, 2016; American Geriatrics Society, 2015). The common struggle of older adults living with persistent pain may result from advances in treating previously lethal conditions; late treatments effects (e.g. chronic post-surgical pain, chemotherapy-induced neuropathy, etc.); or lifestyle (e.g. poor diet, activity, stress, &/or sleep) patterns that sensitize the nervous system. Psychosocial factors including a history of childhood trauma and social determinants of health, make older adults particularly vulnerable to developing persistent pain (Macfarlane, 2016).

Caution is warranted to prevent overprescribing opioid medications to older adults, as they are vulnerable to adverse events, including falls and overdose deaths (FDA Consumer Update, 2016). Withholding medically necessary opioid medication, however, may

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inadvertently contribute to the unsupervised use of potentially harmful over-the-counter (OTC) medications or self-treatment of pain with unauthorized prescription drug use, illicit drugs, or alcohol; potentially creating substance use disorders (Alford et al., 2016). Additional harm may result when intense pain sensitizes nerves that escalate pain; diminish physical, cognitive and emotional functioning; produces financial hardships; and negatively impact older adult's quality of life (Aronoff, 2016; Saastamoinen et al., 2012). Thus, it is unclear if the greater threat to older adults' health and longevity is severe persistent pain, or medications used to treat it. The purpose of this article is to provide guidance in safe, effective, and accessible pain management in the context of current legislative and regulatory activities. Barriers involving the patient, professional, healthcare and social systems are discussed. Comprehensive assessment and individualized treatment interventions that are pharmacological and non-pharmacological are considered quality pain management. Strategies to overcome the barriers and provide quality pain management are examined and include the important role of nurses in facilitating access to safe management of pain across the lifespan in every practice setting regardless of the patient's physical and mental health conditions (ANA, ASPMN, 2016).

Barriers to Managing Persistent Pain Management

Although there is no specific chronological age when adults experience the physical and mental changes attributed to aging, those older than 65 are at risk for poor pain control (Institute of Medicine, 2011). A number of factors make older adults more vulnerable to the effects of pain and its treatment than their younger counterparts. Common barriers to pain management are mistaken beliefs, unrealistic fears, and unhelpful attitudes among patients, professionals and the public about pain and its treatment.

Patient Barriers.—Patient barriers include a reluctance to seek help for pain when it is view as an expected part of aging, prior experiences of pain and its management, and the side effects of opioids drugs and other analgesic agents. Older adults may have difficulty talking about their pain, or fear the harm or costs associated with specific treatments. The common fear that using prescription opioids will inevitably result in addiction is contrary to research estimates that more than 90% of individuals prescribed opioid medications for more than 1 year do not abuse them or become addicted (Chou et al. 2014). Patients may have previous experiences in acute care settings when their acute pain was managed with increasing doses of opioid medications expecting persistent pain to reduce in the same manner; however, this strategy does not apply when pain persists. As one ages biologically, physical and mental capacity may decline, making the individual more vulnerable to the potentially harmful effects of pain and its treatment. Opioid drug side effects can hinder clarity of thought, increase the risk of falls, and produce apnea during sleep. Looking at alternatives to opioid medications, nurses are aware that acetaminophen may impair hepatic or renal function, and non-steroidal anti-inflammatory drugs (NSAIDs) increase the risk of potentially fatal gastrointestinal bleeds or cardiovascular events.

Healthcare Professional Knowledge and Attitudes.—Healthcare professionals may harbor conscious or unconscious biases as well as negative attitudes, beliefs, perceptions, and misconceptions about pain in older adults capable of affecting the quality of pain

treatment provided (DeRuddere & Craig, 2016). When treating pain in patients with a current or past SUD, professionals worry that they may aggravate the problem with opioids without realizing that uncontrolled pain can trigger harmful patterns of drug use or exacerbate a substance use disorder.

Healthcare providers are scrutinized and judgments questioned when clinical decisions are made to use opioid medications to treat pain. In this era of scrutiny healthcare providers have been forced to base clinical decisions on legal protections rather than on best treatment of the patient (Krebs, Bergman, Coffing, et al., 2014). Resistance to prescribe opioid medications for pain may be partially due to fear of losing practice privileges, tarnishing reputations, or facing legal actions (St. Marie, 2016; Webster & Grabois, 2015).

Healthcare providers across disciplines believe their education on pain management was inadequate (Upshur, Luckman, & Savageau, 2006; Fishman, Young, Arwood, et al., 2013). Given that pain is the primary reason why individuals seek health care, and that treatments often induce pain, it is unfathomable that health professionals lack consistent high quality training in preventing and alleviating pain. Despite decades of abundantly available continuing education on evidence-based guidelines and clinical strategies to offset barriers to pain management, these are underutilized. Therefore, health care providers continue to poorly manage pain even when this failure is viewed across the globe as “poor medicine, unethical practice, and an abrogation of a fundamental human right” (Institute of Medicine, 2011 p.47).

Systems and Societal Barriers.—In a typical brief primary care encounter with restricted and fixed payments for visits regardless of time spent, providers have limited time to address pain as one of many clinical issues assessed and treated. Capitation payments incentivize a minimalist approach to complex problems like persistent pain. There are lack of resources such as physical therapy, psychosocial counseling, and complementary therapies; and transportation challenges of older adults make non-opioid options inaccessible (U.S. Department of Health and Human Services [DHHS], 2016). Furthermore, insurance companies create barriers, such as single modality coverage, “fail first” rules for medications, limited number of visits, and prior authorization. Although most generic medications are covered, abuse-deterrent medications and non-pharmacological interventions are not covered.

Stigmatization of older adults in pain. The daily barrage of media reports on prescriptions opioid disproportionately focused on non-medical use and the tragedies of substance use disorder and overdose deaths, without providing the balanced account of the more prevalent problem of persistent pain daily afflicting large proportions of the population. Despite the understanding of peripheral and central neurologic mechanisms accounting for many forms of persistent pain, individuals with persistent pain have increasingly been stigmatized. The characterization of pain being a somatoform type of mental illness further contributes to misdiagnosis, under-treatment and unnecessary stigma (Katz, Rosenbloom, & Fashler, 2015). Like other stigmatized groups, those with persistent pain are often blamed for their condition rendering the patient silent, fostering misuse or

substance use disorder relapse from self-management of their condition (Alford, et al., 2016).

In recent years, regulations have lowered the number of opioid medications prescribed and dispensed; however, the numbers of opioid overdose deaths have dramatically increased. Within 100 days of restricting access to hydrocodone, unintended consequences included patients being prescribed less effective medications, higher healthcare costs, and inconvenience (Chambers, Gleason, Kirsh, et al., 2016).

Delivering quality pain care to older adults is challenging as the effects of aging are compounded by the stigma of pain and its treatment; each with their own set of formidable barriers to care. With older adults, treatment choices may be limited by comorbid conditions and drug interactions. A balance approach in managing pain, reducing harm, overcoming stigma, and using evidence-based practices will stand up in the era of scrutiny.

Quality Care for Older Adults with Persistent Pain

Quality of care when older adults experience persistent pain requires an interdisciplinary approach that provides comprehensive evaluation, including spiritual and risk assessment and goal setting. The quality of care improves through using treatments that include multimodal analgesia, psychosocial and spiritual interventions, and evaluation of these interventions.

Interdisciplinary approach.

An interdisciplinary team approach provides a collaboration to improve the quality and safety of treating persistent pain. The interdisciplinary team can capitalize on expertise of professionals with widely diverse backgrounds to tailor a comprehensive treatment plan to the unique needs and responses of the individual with pain (Fishman et al., 2013). Interdisciplinary teams have provided guidelines in the treatment of pain in the older adults (Hadjistavropoulos, Herr, Turk, et al., 2007). The interprofessional dialog helps manage multiple simultaneous, sometimes competing priorities. Ethical conflicts relative to balancing concerns at the individual, organizational, or societal level can also be discussed and resolved.

The interdisciplinary team promotes patient-centered care endorsing the spiritual and social assessment of individuals. Uncontrolled pain contributes to suffering when pain is intolerable, its cause is unknown, duration unending, and meaning is dire. Individuals with pain often withdraw from social interactions or roles and become unable to join in important and meaningful activities (Okifuji & Turk, 2012). Through the experiences of pain, there may be opportunities to restore old relationships or create new relationships through pain support and self-management groups offered by the American Chronic Pain Association or the Arthritis Foundation. For patients with caregivers, time should be taken to ensure caregivers understand the pain treatment plan and can facilitate adherence. It is important for healthcare professional and lay providers to understand that their own verbal or non-verbal communication can worsen pain if perceived as punishing, critical, blaming, or overly protective (Okifuji & Turk, 2012). The most comforting healthcare interactions are with

compassionate, trustworthy people who are genuinely confident the treatment will help. These individuals comfort those with pain by validating concerns and using distraction and humor while prompting patient to use coping skills and adaptive responses. Establishing rapport is necessary because a lack of trust and mutual respect will undermine the therapeutic plan, resulting in treatment failure. Spirituality is not limited to religious traditions; rather beliefs should be included to connect people, communities, nature, and the universe. Exploring the patient's innermost concerns and values are ways of honoring their spiritual needs to diminish their pain-related suffering. The interdisciplinary team engages in a comprehensive biopsychosocial assessment that includes treatment-related risks to develop the partnership needed for mutual goal-setting, treatment planning, and refinement.

Comprehensive assessment.—A comprehensive biopsychosocial assessment of pain forms the foundation for building an effective pain treatment plan. Persistent pain has ripple effects on the physical, psychological, social, spiritual and environmental well-being. An assessment of personal and family history of substance use disorder, mental health and prior trauma is recommended to identify risks that might result from exposure to opioid medications. Understanding social support and level of engagement with family and friends is essential because older adults with persistent pain may become estranged from social support. Uncontrolled pain can result in strong emotions, such as unrelenting anger that severs important ties with family and other support systems (Sofaer-Bennett, Holloway, Moore, et al., 2007). Pain produces deep feeling of isolation as patients struggle to make sense of uncontrollable pain and affliction (Sorajjakool, Aveling, Thompson, et al., 2006). Evaluating these feelings provides useful insight capable of improving compassionate delivery of care and communication skills needed to mend damaged relationships.

Spiritual assessment.: Adding the spiritual dimension to the biopsychosocial model further focuses attention on the meaning of pain. When healthcare professional explores this dimension with patients it shows genuine interested in what and who is important in their life, and will facilitate a rapport necessary in the therapeutic relationship. It also empowers the patient to take responsibility in their own values-based actions (Matteliano, St. Marie, Oliver et al., 2014). This more comprehensive approach also mitigates risks associated with opioid drug misuse by facilitating a values-based and goal-directed dialog (Matteliano et al., 2014).

Focusing only on the medication or procedures to treat pain is a mistake, given the pervasive effect persistent pain has on the mind, body, spirit, and social interactions. Once mood states and belief patterns are understood in how they contribute to distress and disability, professionals can help patients rethink their situation in less threatening ways (Hadjistavropoulos, 2012). The interdisciplinary team includes professionals skilled in assessing mental clarity, cognitive distortions (e.g. catastrophizing), and mood states, as well as those with expertise in educating and counseling patients to improve their ability to cope with these thoughts and feelings. Exploring the context and meaning of pain in the patient's life gains a glimpse into the spiritual domain and may facilitate the processes of grieving, forgiveness, and acceptance that are needed to cope with current and future challenges.

Substance use risk assessment in older adults.: Given the increased trend of older adults entering opioid detoxification programs, it is important to screen every patient regardless of age prior to initiating opioid drug therapy (Arndt, Clayton, & Schultz, 2011). In patients receiving opioid medications for pain with high risk for developing substance use disorder or those with active substance use disorder, co-managing their treatment with professionals having expertise in pain and substance use disorder is advised. Additional assessments of co-morbid diseases and concurrent use of sedating medications are warranted because adults older than 45 are at higher risk of opioid overdoses due to these confounding factors (Centers for Disease Control and Prevention [CDC], 2009; Larney et al., 2015).

In older patients, a trial of opioid drugs as part of a multimodal treatment plan should be considered when pain is not adequately controlled by other means. Before starting an opioid trial, careful assessment of pre-existing risk factors for developing opioid drug misuse is recommended using standardized screening tools (e.g. Screener and Opioid Assessment for Patients with Pain [SOAPP], Opioid Risk Tool [ORT], Current Opioid Misuse Measure [COMM]); and misuse or substance use disorder should be reassessed at each follow-up (Butler, Budman, Fernandez, & Jamison, 2004; Webster & Webster, 2005). Urine drug screens, interpreted by educated clinicians, can provide information so the interdisciplinary team can identify aberrant drug use patterns that might otherwise be missed (Manchikanti et al., 2006; Nikulina et al., 2016; Pesce et al., 2011). Older adults and their caregivers need to be educated on safe storage of medications (Silvestre et al., 2016). Despite older adults having a lower risk for developing substance use disorder, nurses should be aware that behaviors might be less evident in older adults due to fewer role expectations (Reid et al., 2015). Furthermore, some dependent older adults prescribed opioid drugs may be coerced by others seeking access to their medications with threats of violence, refusing transportation, or withholding necessary care (Green et al., 2013; Inciardi, Surratt, Cicero, Beard, 2009). Health care providers must evaluate potential exploitation, neglect, or abuse by others when prescribing opioids.

Goal setting.—An often overlooked component of treatment success is having clear and shared goals. Health care professional goals such as pain reduction, functional improvement, and avoidance of treatment-related harm must be aligned with patients' goals. If goals are unrealistic or vague, they can never be fully achieved. It is important to establish "SMART" (Specific, Measurable, Achievable, Realistic and Time-bound) goals are with patients and measure to help measure their progress towards these aims.

Motivational interviewing is a skill used to help patients understand their choices and likely consequences of continuing behavior patterns that are contrary to achieving their goals. This approach can facilitate change by helping patients and caregivers align behaviors with their goals and values (Barrett & Chang, 2016), including adherence to the medication regimen (Chang, Compton, Almeter, & Fox, 2015). Components of motivational interviewing include opening with questions; providing affirmation of patient's self-efficacy and support; reflecting patient's thoughts, desires, abilities, reasons, needs, and commitments; and summarizing the patient's history to promote consideration of change (Barrett & Chang, 2016). Motivational interviewing facilitates the partnering of patients and providers

necessary to inform, decrease anxiety, and optimize functioning despite the persistence of pain.

Treatments.—Pain treatment plans most likely to succeed are developed and refined based on a comprehensive biopsychosocial, spiritual, and risk assessment; vigilant reassessments; and explicit, shared, realistic goals (Matteliano et al., 2014). A multimodal analgesia approach with judicious use of opioid medications in selected cases (see Table 1) is important to mitigate risks associated with opioid drug misuse. Mitigating risks requires a team approach whereby risks and benefits are assessed through different lenses.

Evidence-based guidelines for managing persistent pain in older adults (Abdulla et al., 2013; American Geriatrics Society[AGS], 2002; AGS, 2009; Reid et al., 2015;) have long advocated for combining pharmacological and nonpharmacological interventions to improve pain management and reduce exposure to medication toxicities that accumulate over time (AGS, 2002; AGS, 2009). Multimodal analgesia is a deliberate combination of pharmacological and nonpharmacological methods with different mechanisms of action and side effect/toxicity profiles (Ghafoor & St. Marie, 2010; Herndon et al., 2016). In the older adult, acetaminophen is the first-line agent, with other medications carefully selected and monitored for side effect, toxicity, drug interactions (Abdulla et al., 2013). If acetaminophen is used, opioid medication dosing can be less. Patient and caregivers need to understand the cautious titration of opioid analgesics and should only be performed with medical supervision.

Opioid medications.: Opioids may be safer for long-term use than NSAIDs or cyclooxygenase (COX) II inhibitors (Abdulla et al., 2013; Institute of Medicine, 2011; AGS, 2009). However, the risk of overdose, drug or disease interactions, and fall-related injuries are legitimate concerns in this population (AGS, 2015 Beers Criteria Update Expert Panel, 2015; Dowell, Haegerich & Chou, 2016). Older adults with sleep-disordered breathing, renal and hepatic insufficiencies; cardiovascular and endocrine disorders may have complications from prescribed opioid medications (AGS, 2015 Beers Criteria Update Expert Panel, 2015). In these cases, other methods of pain control are necessary.

Nonpharmacological interventions.: The integration of complementary and alternative interventions (e.g. acupuncture, massage, guided imagery, etc.) can greatly improve quality of life and functioning (Abdulla et al., 2013; Bruckenthal, 2010). Health care professionals should ask patients about their previous experiences and preferences. Local resources accessible to older adults should be explored, safety and efficacy should be considered on an individualized level, and other barriers should be identified before making specific recommendations (Bruckenthal, 2010).

Treatment plans that incorporate multimodal methods to minimize drug-related risks will stand up to the scrutiny of media, licensing boards, and law enforcement, while helping patients overcome fear and stigma attached to opioid use (Alford, 2016; Lyapustina et al., 2016). Engaging the patient in partnership with the interdisciplinary team and other caregivers enhances self-efficacy, safety, function, and treatment success (Reid et al, 2008).

Modification of the treatment plan will be required according to changes in the patient's physical or mental capacity.

Evaluating and refinement of therapy.—Care conferences can be a tool used to identify treatment expectations; to help patients understand the diagnosis, prognosis, and treatment options; to evaluate outcomes; and refine the treatment plans (Kodali et al., 2014; Parker et al., 2015).

Care conferences further allow the healthcare team an opportunity to listen, acknowledge, and address concerns of families and patients on medical and physical needs, pain, nutrition, hydration, depression, and anxiety. Studies show that families who have participated in care conferences reported benefits and would recommend these for others (Kodali et al., 2014; Parker et al., 2015).

Overcoming the Barriers to Quality Pain Management

Helpful strategies are available to overcome barriers from patients, healthcare professionals, and health care systems. Nurses play a vital role in overcoming these barriers. Strategies can be individualized to the patient or can be addressed at the federal level.

Patient Barriers.

Nurses play critical roles in helping address patient barriers to pain care. Their role often involves addressing the patient's beliefs about pain treatments and expectations regarding treatment outcomes, dispelling misconceptions about pain treatments, and identifying barriers to repeating therapies that did not provide benefit in the past. When older adults say, "I expect the treatment to make my pain go away entirely," they must be assured that everything will be done to help with their pain but eradicating pain entirely is rarely possible. A statement such as, "I tried that before and it didn't work," is a conviction that further treatments are not likely to yield benefit for the patient. This belief can be adjusted through education of pain mechanisms and how treatments helped other patients live with pain, or by providing examples of research results or media reports.

Professional Knowledge and Attitudes.

History of substance use disorder should not disqualify patients from receiving opioid medications for pain. Instead, a tailored treatment plan, seeking input from professionals with expertise in substance use disorder, and vigilant monitoring are needed (Alford, 2016; Substance Abuse and Mental Health Services Administration, 2012). The Institute of Medicine Committee on Advancing Pain Research, Care, and Education (Institute of Medicine, 2011, p.3) stated, "...when opioids are used as prescribed and appropriately monitored, they can be safe and effective..."

Attending quality education on the use of opioids is imperative before prescribing. Participation in a course for Risk Evaluation and Mitigation Strategy (REMS) education for extended-release and long-acting opioids, and ultrashort-acting opioids, provides evidence of education to ensure public safety. In May 2016, a FDA Drug Safety and Risk Management Advisory Committee recommended that REMS courses expand to include all opioids, and

recommended mandatory training for prescribers and other healthcare professionals including nurses (FDA, 2015; Sullivan, 2016).

REMS training contains information on managing pain with opioid medications in all populations, including the older adults. Content emphasizes awareness of comorbid conditions, age-related changes in pharmacokinetics, the importance of proactively reducing risk, and the necessary safety precautions in this population. Healthcare professionals must understand relevant laws to prevent harm to patient or others. Information includes safe storage and use and safe disposal of unused medications. Learning how to mitigate risk specific to the individual and applying this is defensible in clinical practice.

Compassionate, competent professional care that is aligned with the best available evidence will withstand the scrutiny of colleagues, law enforcement and the public. Familiarity with evidence-based pain management guidelines for the care of patients in pain, as well as the practice environment, is essential (American Nurses Association/American Society for Pain Management Nursing, 2016).

System Barriers.

A cultural transformation is needed in healthcare today. This transformation includes: (a) a shift in how healthcare provides care for people in pain; (b) the need for the reimbursement system incentivize interdisciplinary and evidence-based practices; (c) use of technology to facilitate decision support in pain management; and (d) defining and providing support to nursing's role.

To create a cultural transformation in the way pain is assessed and treated pain in the older adults (Institute of Medicine, 2011), healthcare professionals and citizens must support and follow the recommended interdisciplinary, multimodal therapy model (U.S. Department of Health and Human Services, 2016). For this transformation to be achieved, a shift of reimbursement patterns must occur to incentivize access to enough physical therapy visits, psychosocial counseling, and complementary therapies to help patients manage their pain through other means besides opioid medications.

Complementary therapies are rapidly gaining ground as part of health care practice for a variety of diseases including persistent pain. Pain remains a leading reason for seeking integrative therapies with the greatest evidence of clinical success. Some advances have been made by insurance companies' willingness to reimburse consultation visits at many facilities; however, more is needed as they will not pay to receive the services recommended (Institute of Medicine, 2012; U.S. Department of Health and Human Services, 2016; Horrigan, Lewis, Abrams et al., 2012). Incentives must be created to adequately reimburse primary care providers who deliver complementary therapies for pain management, and referral databases for these therapies and pain management centers are needed.

The National Pain Strategy (U.S. Department of Health and Human Services, 2016) endorses a population-based, disease management approach to pain care that is delivered by interdisciplinary, patient-centered teams capable of providing high quality, compassionate pain relief. To succeed, that care model must shift from the current fee-for-service approach

to one based on person-centered care; must better incentivize primary, secondary, and tertiary prevention; and must promote collaboration along the continuum care, across the lifespan.

Perhaps the most important technological advances that will help health professionals provide quality pain management are network learning health systems. With the increasing use and refinement of electronic health records to better integrate meaningful data, it will become easier to provide decision support at the point of care (O'Brien, Weaver, Settergren et al., 2015; Miller, Phipps, Chatterjee et al., 2014). Clinicians will have instant, easy access to best practices, evidence-based guidelines, prescription drug monitoring program data and longitudinal medical records that detail past medical encounters, specialist reports, and laboratory and diagnostic imaging data. Furthermore, the use of population-based registries will help professionals better understand and manage pain in a comprehensive manner. These systems are being refined to enhance the quality and efficiency of care with improved usability for clinicians (Miller et al., 2015).

As stated by Jo Eland, PhD, RN, FNAP, FAAN (2011) in the Presidential Address to the American Society for Pain Management Nursing, "Nurses own pain!" Nurses always have and always will play a vital role in managing pain across the life span through identifying and intervening in deviations in practice. The nurse's role involves assessment and examination of the patient, understanding the goals of the patient and his/her support systems. Through assessment, nurses identify potential risks for over- and underprescribing opioid medications for pain, as well as adherence to the treatment plan. Coordination is a skill within the domain of the nurse as they develop coordinated treatment plans for interdisciplinary assessments and interventions, outpatient care, and discharge from healthcare facilities. Nurse evaluate medication compliance and execute patient education regarding various treatments and safety measures. Nurses are encouraged to learn motivational interviewing to engage patients in their care including establishing and achieving their goals. Through their assessments, nurses can recognize the need for services in the home, and compare the outcomes with the patients' goals. They communicate with patients either by phone or face-to-face to follow up on their care, answer patient or caregiver questions, and identify patients' concerns. Nurses can learn and maintain certification in pain management nursing through the American Nurses Credential Center (access <http://www.nursecredentialing.org>), as a means of public protection.

In many states, nurses can be delegates and access Prescription Drug Monitoring Program (PDMP) data and communicate this to the healthcare team. In addition, nurses can facilitate overcoming scrutiny while safely managing pain by identifying and understanding the regulations in their state. State-specific information is available at <http://www.core-remis.org/>. This website also provides information on PDMP status and procedure, prescribing policies, prescriber status and education requirements, medical marijuana laws, and naloxone regulations including educating selected patients and caregivers on the use of naloxone to reverse an opioid overdose.

Nurses can advocate for their patients by influencing social policy in this era of scrutiny. Templated letters referencing articles published in high impact professional journals can be

sent to insurance companies and legislators. The CDC guidelines remain controversial because some of the recommendations have little to no high quality research supporting them, and because state medical boards and legislators have passed state wide regulations aligning with the guidelines (Dowell et al., 2016). Insurance payer policies have also aligned with the CDC recommendations, and this will ensure further barriers to pain management care (Kaiser Permanente, April 1, 2015). Healthcare professionals of all disciplines should familiarize themselves with the detailed content of these guidelines and those of the AGS (AGS 2015 Beers Criteria Update Expert Panel, 2015).

Conclusion

Pain management for older adults in the era of scrutiny requires change at multiple levels. Change first requires understanding patient barriers, professional knowledge and attitudes, system barriers, and social barriers. Health care professional must comprehend what entails quality care for older adults with persistent pain. An interdisciplinary approach to pain management that is patient-centered is key to quality pain management. The comprehensive assessment includes spiritual and risk assessment, and lays the foundation for patient partnering with the interdisciplinary health care team so that the treatment plan is realistic and consistent with the patient's goals. Treatment interventions, including pharmacological and non-pharmacological, should be personalized based on risks and resources, and provided throughout the continuum of care. These strategies must be made available through incentives by third party payment systems, as opposed to the short-term, narrow view of fee-for-service payments. Nurses are well positioned to influence change and provide safe and effective pain management for the older adult. Located throughout the care continuum, nurses can maximize pain management's reach, retention, and sustainability. The older adult can be monitored so that their physical, psychological, social, and spiritual well-being aligns with their goals. Healthcare professionals are providing pain management in the era of scrutiny, and pain can be treated so it is more tolerable with less functional interference.

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Table 1.**Clinical Recommendations to Assess Pain while Minimizing Risk for Misuse**

- Comprehensive Assessment
- Use of a Biopsychosocial-spiritual model
- Understand Risk Factors for Opioid Use Disorder
- Use of the Interdisciplinary Team
- Use of Multi-modal Analgesia
- Attend Risk Evaluation and Mitigation Strategies Courses
- Mitigate risk
- Establish and guide treatment expectations