MDS 3.0: A Renewed Focus on Pain Management

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Objectives

1. Identify the risk factors associated with pain in residents residing in long-term care settings.
2. Examine how the MDS 3.0 and the Care Area Assessments (CAAs) affect the assessment and management of residents with pain.
3. Discuss the implications of pain management on the survey process and reimbursement under the new RUG-IV classes.
4. Define options to manage chronic pain in older adults, with a focus on those therapies that may have advantages in older adults and/or those residing in long-term care settings.

Introduction to Pain
Pain Defined

“Pain is whatever the experiencing person says it is, existing whenever he says it does”. McCaffrey 1968

Why Focus on Pain?

• Pain is a symptom most expected and most feared by dying patients.

• Unrelieved pain can have enormous physiological and psychological effects on residents and their loved ones.

Pain Defined

• “An unpleasant sensory and emotional experience”
• A complex phenomenon derived from sensory stimuli
• Interpreted by the individual, there are no biological markers for pain
Why Focus on Pain?

• 45% to 83% of people >65 experience pain
• 60% to 70% of nursing home residents have significant pain, one third in constant pain
• 32% to 36% of older people in the community have pain

  * Core Curriculum for Pain Management Nursing, 2002

Misperceptions about Pain

• Pain is normal aging.
• We must bear pain.
• Pain is punishment for past actions.
• Cognitively impaired persons have a high tolerance for pain.
• Elderly persons are likely to become addicted to pain medications.
• Pain means that death is near.

Some Conditions Associated with the Development of Pain in Elderly People

• Degenerative joint disease (osteoarthritis)
• Rheumatoid arthritis
• Polymyalgia rheumatica or giant cell arteritis (temporal arteritis)
• Osteoporosis (compression fractures)
• Headaches
• Oral or dental pathology
• Gastrointestinal conditions (e.g., constipation, ileus, gastritis, gastroesophageal reflux, peptic ulcers

Some Conditions Associated with the Development of Pain in Elderly People

- Neuropathies (e.g., diabetic neuropathy, occipital or trigeminal neuralgia)
- Post-stroke syndromes
- Fibromyalgia
- Pressure ulcers
- Metabolic conditions (e.g., electrolyte abnormalities, Vitamin D deficiency)
- Peripheral arterial disease
- Urogenital conditions (e.g., bladder distention, infection, kidney stones)

Consequences of Unrelieved Pain

Prolonged stress response triggered by unrelieved pain has negative effects!

- Cardiac
- Respiratory
- GI
- Musculoskeletal
- Cognitive/behavioral
- Future Pain

Consequences of Unrelieved Pain

Cardiac

- Hypercoagulability
- Increased heart rate, blood pressure
- Increased cardiac workload
- Increased oxygen demand
- Increased risk of myocardial infarction
Consequences of Unrelieved Pain

Respiratory
• Diminished respiratory function
• Decreased alveolar ventilation
• Pneumonia
• Atelectasis
• Pulmonary embolism
• Hypoxia
• Slowed wound healing

Gastrointestinal
• Delayed gastric emptying
• Decreased motility
• Ileus
• Anorexia/weight loss

Musculoskeletal
• Muscle spasm
• Impaired muscle function
• Decreased mobility
• Decreased ability to ambulate
• Diminished short- and long-term recovery & rehab
Consequences of Unrelieved Pain

Cognitive

• Mental status changes
• Confusion
• Sleep disturbance
• Depression
• Behavior disturbances
• Anxiety
• Anhedonia

Consequences of Unrelieved Pain on Medication Usage

• Striking out, increasing or recurring agitation
  – ↑ anti-anxiety Rx, ↑ antipsychotic Rx
• Sleep disturbance
  – ↑ increased hypnotic Rx
• Decreased appetite-Weight Loss
  – ↑ Mirtazapine, ↑ Megestrol, ↑ Supplements
• Polypharmacy!!!

MDS 3.0 Discussion
### Background Leading to MDS 3.0 Focus on Pain

**• In 2001, researchers from Brown University published the first nationwide study of pain management in nursing homes**

- 40% of elderly residents who were in pain at the start of the study were still experiencing moderate pain daily or excruciating pain 60 to 180 days later.

### Background Leading to MDS 3.0 Focus on Pain

**• A two-year progress report, released by the CMS in 2004, indicated that nursing homes in general had improved their performance**

- The average nursing home reduced the number of long-stay residents with pain by 38%.

### Background Leading to MDS 3.0 Focus on Pain

**• A study by Hutt and colleagues, published in 2006, found that many nursing-home residents had poorly managed pain because of inadequate medication treatment.**

- Utilized the Pain Medication Appropriateness Scale (PMAS)
- The overall score revealed pain medication usage was 64% of optimal
- 70% of the patients in the study had long-lasting pain, most of them were prescribed medications designed for shorter-term pain.
**Background Leading to MDS 3.0 Focus on Pain**

- National organizations recognize the importance of pain management
  - Both the American Medical Directors Association (AMDA) & American Geriatrics Society (AGS) released pain management guidelines specific to older patients
  - The National Pain Summit 2009
    - Organized by AMA’s Pain & Palliative Medicine Specialty Council.
    - Nearly 30 key medical associations participated including AMDA

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**Background Leading to MDS 3.0 Focus on Pain**

- The CMS recognizes that MDS 2.0 did not support “good” pain assessment and management
- The CMS determines that self-assessment is feasible for nursing home residents and is considered the most reliable way to assess pain

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**Reasons For Expanding Pain Items**

**MDS 2.0**
- Did not support good assessment and treatment
  - Assessed frequency, intensity and site
  - Scales yielded low rate low rates of prevalence (under estimate)
  - Lack self-reporting
  - Did not address cognitive loss

**MDS 3.0**
- Assesses presence of pain
- Assesses frequency of pain
- Non-drug interventions
- Scheduled and PRN medications to treat pain
- Pain Severity
- Intensity (1-10), descriptor
- Functional Impact
- Resident Interview
- Staff Assessment
- Indicators of pain
Pain in MDS 3.0

- Presence: Patient reports pain or hurting at any time in the last five days.
- Frequency: Patient asked how much of the time they experience pain or hurting in the past five days with possible responses of 1) almost constantly, 2) frequently, 3) occasionally, 4) rarely or 5) unable to answer.

MDS 3.0 Pain: Function and Treatment

- Effect on Function: Pain has made it hard to sleep at night and/or has limited day-to-day activities.
- Treatment: Patient on a scheduled pain medication, is receiving as needed pain medications or non-medication interventions for pain now or in the past 5 days.

MDS 3.0: Pain Intensity

- Numeric or verbal pain intensity scale: results of a resident interview asking residents to rate their pain over the previous 5 days on a scale from 1 to 10 using either a scale with numbers or words (mild, moderate, severe, very severe)
- Visual analog scale can be used in appropriate patients
Care Area Assessments (CAAs)

- Replaced RAPs used with the MDS 2.0
- The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings.
- Under MDS 2.0 there were 18 care areas, whereas MDS 3.0 there are 2 new care areas triggered by CATs
  - Pain
  - Return to the community

CAAs Effect on Pain Management

- MDS 2.0 demanded that the RAPs be used for further investigation, but there are no mandated forms that must be used for the CAA process
  - The facility is instructed in the RAI Manual, "To identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources."

CAAs Effect on Pain Management

- Negatives
  - Lack of consistently between facilities
    - The decision as to who fills out the CAAs depends on facility protocol.
    - Documentation of the CAA findings can be anywhere in the resident’s record.
      - discipline-specific flow sheets, progress notes, care plan summaries, a CAA narrative, etc.
    - Members of the IDT with particular expertise may not be included (e.g. pharmacists)
CAAs Effect on Pain Management

- Positives
  - Included Pain as 1 of the 20 care areas
  - Encourages interdisciplinary team involvement
  - Encourages the facility to adopt current guidelines and published tools to assess and treat pain

What is the Overall Intent of MDS 3.0 Related to Pain?

- "Mindful Care"
  - Individualized care
  - Focus on quality of life
  - Resident-centered

- Pain placed in a prominent role in a facility’s quality assurance program.

Pain Assessment and Rehab Considerations

- Poor pain assessment and management can lead to fewer rehab minutes billed
  - Patients may refuse PT, OT, ST due to the pain experienced during the process
  - Pain is associated with depression, anxiety and behavioral problems that may limit their time with rehab services
  - Catch 22- Certain types of Rehab services may help with eliminating pain, however, pain may discourage patient participation
Pain Assessment and Rehab Suggestions

- Pain documentation
  - Pre-treatment
  - During treatment
  - Post-treatment
- Identify the type of pain and choose the appropriate medication
- Notify the Doctor and IDT when significant pain is suspected to be interfering with Rehab
- Too much pain medication can also decrease the ability to participate in rehab
  - Manage patient expectations toward the acceptable level of pain during rehab

General Treatment Considerations

General Treatment Guidelines & Considerations

- Do not delay use of analgesics
  - While the diagnosis and treatment of the underlying cause of any pain is an important part of the medical treatment plan, there is no reason to delay the use of analgesics
  - It is not appropriate to withhold pain management until the investigations and treatment of the underlying disease are complete, or other criteria are met
  - Although research is not yet conclusive, unmanaged pain may lead to changes in the nervous system that could reduce its responsiveness to treatment in the future
  - Equally important, unrelieved pain can have a devastating psychological effect on the individual and family

WHO Guidelines
General Treatment Guidelines & Considerations

• If possible, treat the source of the pain as well as the pain itself. Consider the use of primary therapies directed against the source of pain (e.g., radiation for a neoplasm), if it is:
  – Feasible
  – Consistent with the goals of care

General Treatment Guidelines & Considerations

• Do NOT use placebos
  – Some physicians have advocated the use of placebos to see if patients are really in pain
  – While 30% to 70% of patients will appear to experience some response, there is no ethical or scientific basis for the use of placebos to assess or treat pain.

Pharmacologic Treatment Considerations
### American Geriatrics Society (AGS)
**Pharmacological Management of Persistent Pain in Older Persons**

- Pharmacological management of persistent pain is most common and most risky strategy
- Topics addressed
  - Non-opioids (acetaminophen, NSAIDs)
  - Opioid analgesics
  - Adjuvant drugs
  - Other medications

### American Geriatrics Society (AGS)
**Pharmacological Management of Persistent Pain in Older Persons**

- Non-opioid analgesics
  - Acetaminophen (Tylenol®)
  - NSAID/ COX-2 inhibitors addressed in guidelines
    - Choline magnesium trisalicylate (Tricosal®, Trilisate®)
    - Salsalate (e.g., Disalcid®, Mono-Gesic®, Salflex®)
    - Celecoxib (Celebrex®)
    - Naproxen sodium (Naprosyn®)
    - Diclofenac sodium
    - Nabumetone (Relafen®)

### American Geriatrics Society (AGS)
**Pharmacological Management of Persistent Pain in Older Persons**

- Acetaminophen
  - Consider as initial and ongoing pharmacotherapy for persistent pain, especially musculoskeletal.
  - Absolute contraindication: liver failure
  - Relative contraindication: liver insufficiency chronic alcohol abuse/dependence
  - Be alert for “hidden sources” from combination products
  - Maximum dose 4 Gm./24 hours
  - Acetaminophen is less effective for chronic inflammatory pain (such as the pain associated with rheumatoid arthritis)
**Acetaminophen Toxicity**

- What is the danger of exceeding 4 Gm. (4000 mg.) of acetaminophen per day?
  - Metabolism is a rate-limited so excessive doses of acetaminophen can saturate the process.
  - Any remaining NAPQI (metabolite) that is not metabolized may bind to hepatocytes and cause cellular necrosis
  - Use caution when administering acetaminophen and calculate daily dose, including that contained in combination products.

**FDA Advisory Committee Statement Regarding Acetaminophen**

- Billions of doses of acetaminophen are used safely every year, but over-dosage and toxicity result in
  - 56,000 emergency room visits annually
  - 26,000 hospitalizations annually
  - 458 deaths annually
- These events occurred in patients with underlying hepatic disease or who inadvertently took more than is recommended

**FDA Advisory Committee Statement Regarding Acetaminophen**

- Recommendations
  - The panel of 37 doctors and other experts also said that the maximum total dose for 24 hours, now at 4,000 milligrams, should be decreased.
  - The single adult acetaminophen dose should be no more than 650 milligrams, significantly less that the current 1,000 milligrams often contained in two tablets of certain over-the-counter pain products
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FDA Advisory Committee Statement Regarding Acetaminophen

- Recommendations
  - The committee voted 20 to 17 that prescription products that combine acetaminophen with other medications should be eliminated (APAP/hydrocodone, APAP/Oxycodone, APAP/Codeine).
  - The combination of hydrocodone and acetaminophen, for instance, has been the most frequently dispensed drug since 1997, according to the FDA.

American Geriatrics Society
Pharmacological Management of Persistent Pain in Older Persons

- NSAIDS and COX-2 inhibitors
  - Patient selection: when other, safer therapies have failed, evidence of current therapeutic goals not met, ongoing assessment of risks and complications outweighed by benefits.
  - Consider rarely, with extreme caution in highly-selected individuals.
  - Absolute contraindications
    - Active PUD, chronic kidney disease, heart failure
  - Relative contraindication
    - H Pylori, history of PUD, concomitant use of steroids or SSRIs
  - Older persons taking non-selective NSAIDS should use PPI or misoprostol for GI protection.
American Geriatrics Society
Pharmacological Management of Persistent Pain in Older Persons

- NSAIDS and COX-2 inhibitors
  - Don’t use more than one agent at a time
  -Pts taking ASA for cardioprotection should not also take ibuprofen (May occur with other non-selective NSAIDs as well???)
  - All pts taking nonselective NSAID or COX-2 selective drug should be routinely assessed for GI and renal toxicity, hypertension, heart failure, drug-drug or drug-disease interactions

NSAIDs Mechanism of Action

- Cyclooxygenase (COX) inhibition
- Non-selective agents inhibit both COX-1 and 2
- Selective NSAIDs inhibit COX-2
- COX-1 responsible for GI and platelet effects
- COX-2 responsible for anti-inflammatory, analgesic and antipyretic activity

Non-selective NSAIDs

- Salicylates
- Diclofenac
- Diflunisal
- Etodolac
- Fenoprofen Ca
- Flurbiprofen
- Ibuprofen
- Indomethacin
- Ketoprofen
- Ketorolac
- Meclofenamate
- Mefanamic acid
- Meloxicam
- Nabumetone
- Naproxen
- Oxaprozin
- Sulindac
- Tolmetin
- Piroxicam
COX-2 Selective NSAIDs

- Celecoxib (Celebrex®)
  - 100mg daily maximum dose per AGS guidelines
- Rofecoxib (Vioxx®)
  - Withdrawn from the market because of the associated risk of adverse cardiovascular events
- Valdecoxib (Bextra®)
  - Withdrawn from the market because of the associated risk of adverse cardiovascular events

Topical NSAIDS

- Voltaren Gel® (diclofenac)
  - Safe and effective for short-term use (<4 weeks) per AGS
  - Long-term usage studies are lacking per AGS
- Pennsaid® (diclofenac)
  - Not addressed specifically in AGS guidelines
  - New product as effective as oral diclofenac for knee osteoarthritis but safer
  - Less than 7% systemically absorbed
  - ~$130/month for 1 knee
  - Patient monitoring includes LFTs 4-8 weeks after starting, then periodically

New NSAID Dosage Form

- New dosage form—Sprix® (ketorolac tromethamine)
  - Short term intranasal use for moderate to moderately severe pain, for ambulatory patients who require an analgesic at the opioid level.
  - Not for use more than five days in a row
- Patients reported a statistically significant reduction in summed pain intensity difference over 48 hours following surgery. Study patients required 26% to 36% less morphine than those prescribed placebo.
- Numerous contraindications including; suspected or confirmed cerebrovascular bleeding, those with high risk of bleeding, peptic ulcer disease or a history of gastrointestinal bleeding, patients requiring treatment for perioperative pain in coronary artery bypass graft surgery, those with advanced renal impairment, and those at risk for renal failure due to volume depletion.
**New NSAID Dosage Form**

- The nasal spray should not be used with probenecid or pentoxifylline
- Side effects include mild nasal discomfort, new onset or worsening of hypertension, fluid retention, edema, oliguria, elevation of serum urea nitrogen and creatinine, exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrolysis, and rhinalgia.

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**American Geriatrics Society (AGS)**

*Pharmacological Management of Persistent Pain in Older Persons*

- Opioids
  - All patients with moderate to severe pain, pain-related functional impairment or diminished QOL due to pain should be considered for opioid Rx (3A)
  - Patients with frequent or continuous pain (daily) may be treated on an around-the-clock basis aimed at achieving steady-state opioid therapy (3C)
  - Clinicians should anticipate, assess for and identify potential opioid-associated adverse effects (2A)

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**American Geriatrics Society CPG**

*Pharmacological Management of Persistent Pain in Older Persons*

- Opioids
  - Maximum safe doses of acetaminophen or NSAIDs should not be exceeded when using fixed-dose opioid combination products
  - With long-acting therapy anticipate/assess/prevent breakthrough pain using short or intermediate opioids
  - Only clinicians well versed in the use and risks or methadone should initiate it and titrate cautiously
American Geriatrics Society CPG
Pharmacological Management of Persistent Pain in Older Persons

• Opioids
  – Patients taking opioid analgesics should be reassessed for ongoing attainment of therapeutic goals, adverse effects and safe and responsible medication use.

Extended Release Opioids

• Sustained-release morphine
  – Avinza®
  – Kadian®
  – MSContin®
  – Oramorph SR®

• Sustained-release oxymorphone
  – Opana ER®

• Sustained-release oxycodone
  – Oxycontin®

Extended Release Opioids

• Best to initiate after a response is determined from a short-acting agent
• Toxic metabolites of morphine may limit usefulness in patients with renal insufficiency or when high-dose therapy is required.
• Opioid rotation may be necessary to improve clinical outcomes
• Tolerance to the analgesic effects may occur in at a disproportionate rate with respiratory depression
Transdermal Opioids

• Advantages
  – Avoid “peak/valley” blood concentrations
  – More consistent pain relief

• Potential problems in the elderly
  – Skin friability
  – Changes in absorption
    • Heat, fever, hot packs, hot pads, showers and baths
    • Changes in SC fat e.g., cachexia may alter absorption

• Mechanism of action
  – Controlled release for scheduled period of time
  – Active drug remains at end of patch duration so dispose of carefully
  – Different systems available

Transdermal Opioids

• Systems
  – Drug in adhesive – single or multi layered
  – Reservoir
    • Drug contained in compartment within patch
    • Do not bend
    • Use care not to puncture
    • Do not cut – possible lethal consequences to resident and toxicity to staff
  – Monolithic (Matrix)
    • Drug incorporated into a matrix with controlled release

Transdermal Opioids

• Application
  • Remove adhesive backing
    • May be transparent or same color as patch
    • Apply appropriately and rotate site of application

• Documentation
  – Day, time and location of patch
  – Date, time of application and nurse’s initials
  – Date and time patch will be replaced
  – When writing on patch use waterproof ink

• Removal
  – Document removal of patch
  – Inadvertent administration of multiple patches may have lethal outcomes

• Disposal
  – Documentation with two signatures
Transdermal Opioids

• Disposal
  - Very controversial
  - Documentation with two signatures witnessing disposal
  - Board of Pharmacy and Nursing
  - Environmental considerations
  - Manufacturer’s recommendations
  - Cut up and put in sharps container?
  - Flush?
  - Incinerate?
  - Check placement every shift
  - Survey/citation/criminal considerations

Transdermal Opioids

• Diversion considerations
  - Inspect foil external package for possible tampering
  - Inspect patch for signs of tampering every shift
    • Cuts, needle holes, dried-out appearance
  - Inspect patch every shift and reconcile with MAR
  - Two signatures witnessing actual disposal

Other Opioid Issues

• Tolerance
  - Time to develop
    • Dosage adjustment to respond to tolerance
    • Consider “opioid rotation”

• Prescribing
  - DEA enforcement
    • Nurse as agent of the prescriber
    • Prescription turn-around
    • E-box issues
Opioid Rotation

Opioid Rotation: "a strategy applied during opioid therapy for pain that refers to a switch from one opioid to another in an effort to improve clinical outcomes"

- AGS suggests Oxymorphone (Opana®) may be an alternative to other opioids (has indication for opioid rotation)


Opioid Rotation

- Opioid Rotation
  - In a study of patients with chronic noncancer pain, significantly better pain control was achieved for 59% of the group switched to a new long-acting opioid, while rotating from a short-acting to a long-acting formulation of the same opioid improved pain control in 73% of the patients studied.
  - The failure of a trial of opioid therapy does not predict a lack of benefit from other opioids, and multiple switches may be pursued in some cases to optimize pain therapy.


Opioid Rotation

- Opioid Rotation
  - It may be considered whenever an opioid treatment is associated with poor responsiveness, irrespective of the pain problem.
  - May also be useful if switching opioids eliminates toxic opioid metabolites specific to the initial analgesic.
  - After a drug has been administered for a time, tolerance develops in a receptor-specific manner, and rotation to another opioid may yield further differences because of "incomplete cross-tolerance" to the previously administered opioid drug.

DEA Enforcement Policy on Nurse as Agent of the Physician Prescriber

DON response to national survey

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Mostly Agree</th>
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<tbody>
<tr>
<td>Nurse should be considered physician’s agent and verbal orders should be allowed</td>
<td>66%</td>
<td>22%</td>
</tr>
<tr>
<td>Policy has resulted in residents experiencing pain unnecessarily</td>
<td>56%</td>
<td>22%</td>
</tr>
<tr>
<td>Policy has reduced likelihood of diversion in NFs</td>
<td>10%</td>
<td>15%</td>
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<tr>
<td>Solutions must be developed to meet the needs of DEA and NF residents</td>
<td>67%</td>
<td>28%</td>
</tr>
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Pharmacological Management of Persistent Pain in Older Persons

- Adjuvant analgesic drugs
  - Antidepressants
    - Amitriptyline (Elavil®), Doxepin (Sinequan®), Imipramine (Tofranil®), Duloxetine (Cymbalta®), Venlafaxine, (Effexor®) Milnacipran (Savella®)
  - Anticonvulsants
    - Gabapentin (Neurontin®), Carbamazepine (Tegretol®), Pregabalin (Lyrica®), Lamotrigine (Lamictal®)
  - Antiarrhythmic
    - Mexiletine (Mexitil®)

American Geriatrics Society CPG
Pharmacological Management of Persistent Pain in Older Persons

- Adjuvant analgesic drugs
  - All patients with neuropathic pain are candidates for adjuvant analgesics
  - Patients with fibromyalgia are candidates for a trial of approved adjuvant analgesics
  - Patients with other types of refractory persistent pain may be candidates for certain adjuvant analgesics (back pain, headache, diffuse bone pain, temperomandibular disorder)
American Geriatrics Society CPG
Pharmacological Management of Persistent Pain in Older Persons

- Adjuvant analgesic drugs
  - Avoid tertiary tricyclic antidepressants (amitriptyline, imipramine, doxepin) due to high risk of adverse effects (anticholinergic effects, cognitive impairment)
  - Agents may be used alone, but often effects are enhanced when used in combination with other analgesics and nondrug strategies
  - Start low, go slow based on response and side effects. Caveat, some agents have delayed onset
  - Conduct an adequate trial of therapy before dc’ing a seemingly ineffective treatment

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- Other drugs
  - Reserve long-term systemic corticosteroids for patients with pain-associated inflammatory disorders or metastatic bone pain, not osteoarthritis.
  - All patients with localized neuropathic pain may be candidates for topical lidocaine
  - All patients with other neuropathic persistent pain may be candidates for topical NSAIDs

American Geriatrics Society CPG
Pharmacological Management of Persistent Pain in Older Persons

- Other drugs
  - Tramadol (Ultram®, Ultracet®)
    - Shown to be effective for moderate to moderately severe pain (non-controlled substance)
    - Caution should be used in patients with a history of seizures
    - Has a mixed opioid/norepinephrine/serotonin reuptake activity
    - Was recommended as alternative to propoxyphene during the recent withdrawal
    - May provide an option to NSAIDs prior to initiating opioids.
  - Tapentadol (Nucynta®)
    - Newer CII agent to the market
    - Short-acting agent (50mg = 10mg of Oxycodone)
    - Clinical trials of tapentadol suggest lower incidence of gastrointestinal adverse events than comparator opioids.
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• Other drugs
  – Other topical agents, including capsaicin or menthol, may be considered for regional pain syndromes. (2C)
  – Many other agents for specific pain syndromes may require caution in older persons and merit further research (e.g., glucosamine, chondroitin, cannabinoids, botulinum toxin, alpha-2 adrenergic agonists, calcitonin, vitamin D, bisphosphonates, ketamine) (3C)

Analgesics to Avoid in the Elderly

• Muscle relaxants:
  • Methocarbamol (Robaxin®)
  • Carisoprodol (Soma®)
    • Removed from the European Market
  • Chlorzoxazone (Paraflex®)
  • Metaxalone (Skelaxin®)
  • Cyclobenzaprine (Flexeril®)
  • Baclofen (Lioresal®)

Most muscle relaxant drugs are poorly tolerated by elderly patients, since these cause anticholinergic adverse effects, sedation, and weakness. Their effectiveness at doses tolerated by elderly patients is questionable.

Analgesics to Avoid in the Elderly

• Pentazocine (Talwin®)
  • Narcotic analgesic that causes more CNS adverse events, including confusion and hallucinations, more commonly than other narcotic drugs.
• Propoxyphene (Darvon®, Darvocet®)
  • Approved for use in 1957 in the U.S.
  • Implicated in the death of Elvis
  • Banned in Britain in 2005 and in Europe in 2009
  • 2009 found to be linked to heart rhythm abnormalities
  • Over 1000 deaths attributed to Darvon®
  • FDA advisory committee recommended removal from the market January 2009
Analgesics to Avoid in the Elderly

• Meperidine (Demerol®)
  • Not an effective oral analgesic at tolerated dosages
  • Can cause significant CNS toxicity including confusion and hallucinations
  • Offers no advantages over other narcotic analgesics

• Ketorolac (Toradol®)
  • Has a high potential for GI adverse events and renal toxicity
  • Elderly patients may have underlying GI disorders
  • Use should be avoided (Beers, AGS, Other sources)

Analgesics to Avoid in the Elderly

• Tricyclic antidepressants
  • Amitriptyline (Elavil®), Doxepin (Sinequan®), Imipramine (Tofranil®)
    • Effective and commonly prescribed for neuropathic pain and as an adjunctive treatment for chronic pain
  • Highly anticholinergic (dry mouth, urinary retention, worsening of glaucoma, constipation, confusion)
  • Cardiotoxicity
  • Safer and effective agents are now available with pain data (Certain anti-convulsants, venlafaxine, duloxetine)

Analgesics to Avoid in the Elderly

• Indomethacin
  • Used commonly for pain associated with Gout
  • Of all available NSAIDs it has the highest potential for CNS side effects
    • Headache in >10% of patients
    • Dizziness and Vertigo
    • Somnolence
    • Depression
    • Fatigue
Strategies for Pain Management

Consultant Pharmacist's Role in Pain Management
• Medication regimen review
  – Monitoring for ADR and drug interactions
  – Anticipating and preventing complications
    • Constipation
    • Falls
    • Other
  – Observing patterns of PRN analgesic use
    • Insufficiently treated pain
• In-service education
  – New drugs and dosage forms
• QA/QI activities
  – Policy and procedure development
  – Tracking and documenting facility trends

Consultant Pharmacist’s Role in Pain Management
• Interdisciplinary Issues
  – Working with therapists to maximize resident participation
• Survey issues
  – MAR monitoring for documentation of administration and effectiveness
  – F-tag/survey issues
  – Reconciliation of controlled substances
• DEA issues
  – Reconciliation, documentation, destruction
• Diversion issues
  – Reconciliation of drug count, noting trends, suspicious activities, other activities including risk management
What Everyone Can do to Manage Pain

• Show that you care
• Talk to the resident, even if he/she doesn’t understand. Talk to, not around, the resident
• Make the room pleasant
• Take care of the basics-glasses, hearing aids, dry clothes toileting, food, fluids
• Communicate with the team-let others know what works

What Everyone Can do to Manage Pain, cont.

• Always report pain. Pain IS NOT a normal part of aging
• Understand the care plan for pain-pain management is a team approach
• Use relaxation methods to decrease anxiety and muscle tension
• Use tactile strategies like stroking and massage
• Music, art and meditation can be very helpful
• Don’t forget the team. Pt for mobility and safety, OT for positioning and splints

Adopt an Interdisciplinary Care Plan

• The patient’s underlying diagnoses
• The causes, location, nature, and severity of the pain
• The patient’s preferences or wishes as expressed either directly or in an advance directive
• Availability of experienced providers
• Possible adverse medication effects
• Cost to the patient
Summary

• MDS 3.0 has increased the focus in the area of pain management, but without a tremendous amount of direction
• Organizations specializing in geriatrics have provided guidance in this area
  – AMDA
  – AGS
• Familiarize yourselves with the medications that may be inappropriate, as well as, those with specific utility

Summary

• Consider pain as the 5th vital sign
• Inadequate pain management can lead to fewer rehab minutes in the Med A population
• Pain management is individualized
  – Type of pain
  – On-going monitoring and assessment
  – Patient tolerability and preference
  – Develop comprehensive care plans that involve as many disciplines as necessary to attain the desired outcomes

Conclusion

• We will all experience pain and we should treat our patients as we wish to be treated
• Pain is not an accepted consequence of aging
• Develop a process and procedure that works for your patients, facility, and staff