A Renewed Focus on Pain Management in the LTC Setting

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Symposium Description

The symposium will highlight the renewed focus on chronic pain management in long-term care settings. Participants will be provided with an overview of the prevalence, identification, assessment, diagnosis, and management of chronic pain in residents residing within long-term facilities. A focus will be on the influence of the MDS 3.0 and Care Area Assessments (CAAs) on the renewed focus in assessment and management of chronic pain. There will also be discussions on how chronic pain affects the survey process, the role of new nursing home Quality Measures on defining effective pain management, and how this may influence reimbursement within skilled nursing facilities. Discussions will focus on the different types of chronic pain and options to manage these types of pain.

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July 25, 2012
7:30-8:45am

Learning Objectives

• Identify the risk factors associated with chronic pain in residents residing in long-term care settings
• Examine how the identification, assessment, and management of chronic pain has changed with implementation of MDS 3.0
• Discuss the implications of pain management on the survey process and the role of new Quality Measures in defining effective pain management
• 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

“In any LTC facility, the quality of the pain control will be influenced by the availability of a pain management program and the training, expertise, and experience of its members.”

Painful Facts

• Pain is common in the long-term care setting.
• Unrelieved chronic pain is not an inevitable consequence of aging
• Aging does not increase pain tolerance or decrease sensitivity to pain
• Most chronic pain in the long-term care setting is related to arthritis and musculoskeletal problems
• Pain may be associated with mood disturbances (for example, depression, anxiety, and sleep disorders)
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AMDA Pain Management CPG

1. Recognition
2. Assessment
3. Treatment
4. Monitoring

Recognition

Definition of Pain

An individual’s unpleasant sensory or emotional experience

– Acute pain is abrupt usually abrupt in onset and may escalate

– Chronic pain is pain that is persistent or recurrent
<table>
<thead>
<tr>
<th><strong>Acute v Chronic Pain</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic</strong></td>
</tr>
<tr>
<td>• The causes and</td>
</tr>
<tr>
<td>characteristics of</td>
</tr>
<tr>
<td>chronic pain are more</td>
</tr>
<tr>
<td>likely to have already</td>
</tr>
<tr>
<td>been identified.</td>
</tr>
<tr>
<td>• Individuals with</td>
</tr>
<tr>
<td>chronic pain usually</td>
</tr>
<tr>
<td>need treatment over</td>
</tr>
<tr>
<td>the long term, because</td>
</tr>
<tr>
<td>the causes of pain</td>
</tr>
<tr>
<td>don’t go away.</td>
</tr>
<tr>
<td><strong>Acute</strong></td>
</tr>
<tr>
<td>• But, when a patient</td>
</tr>
<tr>
<td>is in acute pain, both</td>
</tr>
<tr>
<td>causes and characteristics of the pain may have to be identified rapidly.</td>
</tr>
<tr>
<td>• Causes of acute pain</td>
</tr>
<tr>
<td>often—but not always—</td>
</tr>
<tr>
<td>can be corrected.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Somatic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Skin, muscle, and connective tissue</td>
</tr>
<tr>
<td><strong>Examples:</strong> Sprains, headaches, arthritis</td>
</tr>
<tr>
<td><strong>Description:</strong> Localized, sharp/dull, worse with movement or touch</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Visceral</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Internal organs</td>
</tr>
<tr>
<td><strong>Examples:</strong> Tumor growth, gastritis, chest pain</td>
</tr>
<tr>
<td><strong>Description:</strong> Not localized, refers, constant and dull, less affected with movement</td>
</tr>
</tbody>
</table>
### Bone Pain

**Source:** Sensitive nerve fibers on the outer surface of bone

**Examples:** Cancer spread to bone, fx, and severe osteoporosis

**Description:** Tends to be constant, worse with movement

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### Neuropathic

**Source:** Nerves

**Examples:** Diabetic neuropathy, phantom limb pain, cancer spread to nerve plexis

**Description:** Burning, stabbing, pins and needles, shock-like, shooting

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### Pain in the Elderly

**Sources of pain in the nursing home**

Source: Stein et al, Clinics in Geriatric Medicine: 1996

<table>
<thead>
<tr>
<th>Condition causing pain</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low back pain</td>
<td>40</td>
</tr>
<tr>
<td>Arthritis</td>
<td>37</td>
</tr>
<tr>
<td>Previous fractures</td>
<td>14</td>
</tr>
<tr>
<td>Neuropathies</td>
<td>11</td>
</tr>
<tr>
<td>Leg cramps</td>
<td>9</td>
</tr>
<tr>
<td>Claudication</td>
<td>8</td>
</tr>
<tr>
<td>Headache</td>
<td>6</td>
</tr>
<tr>
<td>Generalized pain</td>
<td>3</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>3</td>
</tr>
</tbody>
</table>
Consequences of Untreated Pain

• Poor appetite & weight loss
• Withdrawal from talking or social activities
• Sadness, anxiety, or depression
• Physical/verbal aggression, wandering, acting-out behavior, resists care
• Difficulty walking or transferring; may become bed bound
• Disturbed sleep
• Skin ulcers
• Incontinence
• Increased risk for use of chemical and physical restraints
• Decreased ability to perform ADL's
• Impaired immune function

Pain Misconceptions

• The caregiver is the best judge of pain.
• A person with pain will always have obvious signs such as moaning, abnormal vital signs, or not eating.
• Pain is a normal part of aging.
• Addiction is common when opioid medications are prescribed.

Listen to the Resident

• Resident's self-report of pain is the single most reliable indicator of pain.
  • Pain is what a patient says it is.
  • Pain is totally subjective.

• One person's report of severe pain may seem like almost nothing compared to another.

• Caregiver's challenge is to assess all relevant factors without imposing personal biases.
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Conditions Associated with Pain

- Degenerative joint disease
- Gastrointestinal causes
- Fibromyalgia
- Peripheral vascular disease
- Rheumatoid arthritis
- Post-stroke syndromes
- Low back disorders
- Improper positioning
- Crystal-induced arthropathies
- Renal conditions
- Osteoporosis
- Immobility, contracture
- Neuropathies
- Pressure ulcers
- Headaches
- Amputations
- Oral or dental Pathology

If You See Something, Say Something

- All LTC staff and resident’s family share in the role of pain management.
- Everyone caring for the resident must know to recognize and report pain.

Recognition

- It is important to ask about key characteristics of pain – (1) onset (2) frequency (3) location (4) radiation.
- Consider how pain is affecting the patient’s mood and activities of daily living (ADLs) and note factors that make pain better or worse.
Signs & Symptoms

- Frowning, grimacing, fearful facial expressions, grinding of teeth
- Bracing, guarding, rubbing
- Fidgeting, increasing or recurring restlessness
- Striking out, increasing or recurring agitation
- Eating or sleeping poorly
- Sighing, groaning, crying, breathing heavily
- Decreasing activity levels
- Resisting certain movements during care
- Change in gait or behavior
- Loss of function

Scale

Pain Intensity Scales for Use with Older Patients – Visual Analogue Scale

No pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Terrible pain

Ask the patient: “Please point to the number that best describes your pain.”

Scale has worst possible pain at a # 10

Documenting an Initial Pain Assessment

Pattern: Constant_______ Intermittent_______
Duration: __________
Location: __________
Character: Lancinating____ Burning____ Stinging____
Radiating____ Shooting____ Tingling____
Other Descriptors: __________________________________
Exacerbating Factors: ________________________________
Relieving Factors: _________________________________
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Pain Intensity – (None, Moderate, Severe)
1 2 3 4 5 6 7 8 9 10
Worst Pain in Last 24 Hours (None, Moderate, Severe)
1 2 3 4 5 6 7 8 9 10
Mood: ________________________________________
Depression Screening Score: ______________________
Impaired Activities: ________________________________________
Sleep Quality: ________________________________________
Bowel Habits: ________________________________________
Other Assessments or Comments: ______________________
Most Likely Causes Of Pain: ______________________
Plans: ________________________________________

Assessment

Regulatory Requirements

Federal Regulation
42 CFR Section 483.20 (b), F272
Requires facility to make a comprehensive assessment:
“A facility must make a comprehensive assessment of resident’s needs, using the RAI specified by the state.”
Regulatory Requirements

42 CFR 483.20 (k) F279
Requires facility staff to develop a comprehensive care plan to address pain:
“The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.”

Regulatory Requirements

42 CFR Section 483.25, F309
Requires facility staff to meet the pain needs of the resident:
“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”

Assessment Steps

• Perform a pertinent history and physical examination
• Identify the causes of pain as far as possible
• Perform further diagnostic testing as indicated
• Identify causes of pain
• Obtain assistance/consultations as necessary
• Summarize characteristics and causes of the patient’s pain and assess impact on function and quality of life
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History
- Known etiology and treatments – previous evaluation, pain diagnoses and treatments
- Prior prescribed and non-prescribed treatments
- Current therapies

PQRST
- Provocative/palliative factors
  - position, activity, etc.
- Quality
  - aching, throbbing, stabbing, burning
- Region
  - focal, multifocal, generalized, deep, superficial
- Severity
  - average, least, worst, and current
- Temporal features
  - onset, duration, course, daily pattern

MDS3.0 Section J
- Consists of an interview with resident.
- Conduct a staff assessment only if resident is unable to participate in the interview.
- Pain items assess:
  - Presence of pain
  - Frequency of pain
  - Effect on function
  - Intensity
  - Management
  - Control
J0100A Scheduled Pain Medication Regimen Coding Instructions

- Code 0. No if medical record does not contain documentation that a scheduled pain medication was received.
- Code 1. Yes if medical record contains documentation that a scheduled pain medication was received.

J0100B Received PRN Pain Medications Coding Instructions

- Code 0. No if record does not contain documentation that a PRN medication was received or offered.
- Code 1. Yes if record contains documentation that a PRN medication was either received or offered but was declined.

J0100C Received Non-Medication Intervention Coding Instructions

- Code 0. No if medical record does not contain documentation that a non-medication pain intervention was received.
- Code 1. Yes if medical record contains documentation that:
  - Non-medication pain intervention scheduled as part of the care plan.
  - Intervention actually received and assessed for efficacy.
J0200 Conduct the Assessment

- Determine whether resident is understood at least sometimes.
- Review A1100 to determine whether resident needs or wants an interpreter.
- Make every effort to have an interpreter present if needed or requested.

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J0300 Pain Presence Conduct the Assessment/ Guidelines

- Ask the question as written.
- Code for the presence or absence of pain regardless of pain management efforts.
- Rates of self-reported pain are higher than observed rates.

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J0400 Pain Frequency

Conduct the Assessment

- Ask the question exactly as written.
- May use cue cards to present response options.
J0500 Pain Effect on Function

Conduct the Assessment

- Ask each question as written.

**Over the past 5 days, has pain made it hard for you to sleep at night?**

- Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"
  - No
  - Yes
  - Unable to answer

**Over the past 5 days, have you limited your day-to-day activities because of pain?**

- Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"
  - No
  - Yes
  - Unable to answer

J0600 Pain Intensity

- Numeric Rating Scale (scale of 00 to 10)
- Verbal Descriptor Scale
- Complete only one of these items, not both.

**J0600, Pain Intensity:** Admit to ONLY ONE of the following pain intensity questions (A or B)

**A. Numeric Rating Scale** Ask resident: "Please rate your worst pain over the last 5 days on a scale of 0 to 10 where 0 means no pain and 10 means the worst pain you can imagine."

**B. Verbal Descriptor Scale**

- None
- Mild
- Moderate
- Severe
- Unable to answer

Short Stay Quality Measures (5)

- The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Report a **Decrease in Pain Intensity** or Frequency
- Percent of Residents who **Self-Report Moderate to Severe Pain**
- Percent of Residents with **Pressure Ulcers** that are New or Worsened
- Percent of Residents Assessed and Given, Appropriately, the Seasonal **Influenza Vaccine**
- Percent of Residents Assessed and Given, Appropriately, the **Pneumococcal Vaccine**
Long Stay Quality Measures (12)

• Percent of Residents Experiencing One or More Falls with Major Injury
• Percent of Residents who Self-Report Moderate to Severe Pain
• Percent of High-Risk Residents with Pressure Ulcers
• Percent of Long Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine
• Percent of Long Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine
• Percent of Long-stay Residents with a Urinary Tract Infection

Long Stay Quality Measures

• Percent of Low-Risk Residents Who Lose Control of their Bowels or Bladder
• Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
• Percent of Residents Who Were Physically Restrained
• Percent of Residents Whose Need for Help with Daily Activities Has Increased
• Percent of Long-stay Residents Who Lose Too Much Weight
• Percent of Residents Who have Depressive Symptoms

Pain

• Percent of Residents Who Self-Report Moderate to Severe Pain.
• Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency.

- This measure requires the opportunity to be able to decrease pain intensity; as a result where there was no opportunity for the pain levels to improve because pain levels were at their lowest level possible on the initial assessment this measure does not apply.
- Residents for example that report no pain are not counted as they have no ability to see a decrease in their pain intensity of frequency.
- But in those residents with pain if their pain is not treated, a resident may not be able to perform daily routines, may become depressed, or have an overall poor quality of life.
- This percentage may include some residents who are getting or have been prescribed treatment for their pain, but who refuse pain medicines or choose to take less.
- Some residents may choose to accept a certain level of pain so they can stay more alert.
Treatment

Objective of Pain Management—Treatment

- Adopt an interdisciplinary care plan
- Set goals for pain relief
  - Goal of treatment is to decrease pain, improve functioning, mood and sleep
  - Strength of dosage should be limited only by side effects or potential toxicity
- Implement the care plan

Treatment of Pain

Rules of thumb, common sense rules:
- Use the lowest effective dose by the simplest route.
- Start with the simplest single agent and maximize its potential before adding other drugs.
- Use scheduled, long-acting pain medications for constant or frequent pain, with prn, short-acting medication available for breakthrough.
- Treat breakthrough pain with one-third the 12 hours scheduled dose.
Treatment of Pain, cont.

• If three or more prn doses are used in a day, increase the scheduled dose. Increase by ¼ - ½ of the prior dose. Increase the prn dose when you increase the scheduled dose.
• Be vigilant at assessing the side effects of medication. Treat or prevent side effects, such as constipation and nausea. Change medication as necessary.

Treatment of Pain, cont.

• Use the WHO’s step-wise approach, also called WHO Analgesic Ladder, Subsection 2.7 in Manual.
• Reevaluate and adjust medications at regular intervals and as necessary.
• Do not stop pain medication in terminal patients. Change the route if needed.

WHO's Pain Relief Ladder

1. Non-Opioid +/- Adjuvant
2. Opioid for mild to moderate pain +/- Non-Opioid +/- Adjuvant
3. Opioid for moderate to severe pain, +/- Non-Opioid +/- Adjuvant
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Pain Management CPG– Treatment
Non-Opioid Analgesics Used in the Long-Term Care Setting

<table>
<thead>
<tr>
<th>DRUG</th>
<th>MAXIMUM DOSE in 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>6000 mg (q 4-6 h dosing)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>4000 mg (q 6-8 h dosing)</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>2400 mg (q 6-8 h dosing)</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>1000 mg (q 12 h dosing)</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>50 mg (q 24 h)</td>
</tr>
<tr>
<td>OX – 2 Inhibitors</td>
<td>12.5-50 mg (single dose)</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>10-40 mg</td>
</tr>
<tr>
<td>Tramadol + Acetaminophen</td>
<td>500 mg (q 6-8 h dosing)</td>
</tr>
<tr>
<td>Tramadol</td>
<td>12-50 mg (q 6-8 h dosing)</td>
</tr>
<tr>
<td>Tramadol + Omeprazole</td>
<td>75-300 mg / day</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>50-500 mg q 12 h</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>0.5-5 mg q 12 h</td>
</tr>
</tbody>
</table>

Opioids

- It is important to learn:
  - (1) how to assess patients with pain and make appropriate decisions about a trial of opioid therapy and
  - (2) basic principles of monitoring for signs of drug dependency.

- Administering opioids to frail elderly patients may be associated with an increased risk of symptoms such as anorexia, hypotension, falls, altered mental status and bowel ileus. These risks may be exacerbated by other medications with CNS side effects or those with anticholinergic or hypotensive properties.

- Also, starting with a lower dose and titrating slowly upwards may minimize complications such as respiratory depression.

Pain Management CPG– Treatment
Opioid Analgesics Used in the Long-Term Care Setting (Oral and Transdermal)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Approximate Equianalgesic dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphone</td>
<td>50-100 mg q 6 h</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>30-60 mg q 6 h</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>5-10 mg q 12 h</td>
</tr>
<tr>
<td>Methadone</td>
<td>20 mg q 24 h</td>
</tr>
<tr>
<td>Combination opioid preparations</td>
<td>60-150 mg q 24 h</td>
</tr>
<tr>
<td>Oxycodone extended release formulations</td>
<td>11.3-22.5 mg q 12 h</td>
</tr>
<tr>
<td>Oxycodone extended release formulations</td>
<td>7.5-15 mg q 12 h</td>
</tr>
</tbody>
</table>
**Topical Analgesics**

- **Counterirritants** (menthol, methyl salicylate)
  - Supplied as liniments, creams, ointments, sprays, gels or lotions
  - May be effective for arthritic pain (not multiple joint pain)

- **Capsaicin cream (0.025%) and (0.075%)**
  - Derived from red peppers
  - Depletes substance P, desensitizes nerve fibers associated with pain
  - Main limitations are skin irritation and need for frequent application
  - Need to use routinely for optimal effectiveness

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**Analgesics of Particular Concern**

Chronic use of the following drugs are not recommended:

- **Indomethacin**
- **Piroxicam**
- **Tolmetin**
- **Meclofenamate**
- **Propoxyphene**
- **Meperidine**
- **Pentazocine, butorphanol and other agonist-antagonist combinations**
Non- Analgesic Drugs Sometimes Used for Analgesia

- Neuropathic pain
  - Antidepressants
  - Anticonvulsants
  - Antiarrhythmics
  - Baclofen

- Inflammatory diseases
  - Corticosteroids

- Osteoporotic fractures
  - Calcitonin

PRN

- Intermittent/less severe pain –
  - Start with PRN then switch to regular if patient uses more than occasionally.
  - Start with a lower regular dose and supplement with PRN for breakthrough pain.
  - Adjust regular dose depending on frequency/severity of breakthrough pain.

- More severe pain
  - Standing order for more potent, longer-acting analgesic and supplement with a shorter acting analgesic PRN

- Severe/recurrent acute or chronic pain
  - Regular, not PRN dosage of at least one medication
    - Start with low to moderate dose, then titrate upwards

Non-Pharmaceutical Treatment

- 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. Use relaxation methods to decrease anxiety and muscle tension.
- Use tactile strategies like stroking and massage.
- Music, art and meditation can be very helpful.
Complementary Therapies

- physical and occupational therapy
- positioning with braces, splints and wedges
- cutaneous stimulation such as heat/cold, massage therapy, pressure and vibration
- neuro stimulation such as acupuncture, transcutaneous electrical nerve stimulation
- Chiropractic
- magnet therapy.

- psychological counseling
- spiritual counseling
- peer support groups
- alternative medicine such as herbal therapy, naturopathic and homeopathic remedies
- aromatherapy
- music, art, drama therapy
- biofeedback
- meditation
- hypnosis.

Monitoring

Critical outcomes: The “Four A’s”

- **Analgesia** – Is pain relief meaningful?
- **Adverse events** – Are side effects tolerable?
- **Activities** - Has functioning improved?
- **Aberrant drug-related behavior**
**Monitoring Steps**

- Re-evaluate the patient’s pain
- Adjust treatment as necessary
- Repeat previous steps until pain is controlled

**Next Steps**

When patient is unresponsive to clinical management consider referral to:
- Geriatrician
- Neurologist
- Physiatrist
- Pain clinic
- Physician certified in palliative medicine
- Psychiatrist (if patient has co-existing mood disorder)
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