A Renewed Focus on Pain Management in the LTC Setting

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Riddle Medical Group
Objectives

- Identify risk factors associated with chronic pain in LTC residents
- Examine how the identification, assessment, and management of chronic pain has changed with implementation of MDS 3.0 and Care Area Assessments (CAA’s)
- Discuss implications of pain management on the survey process and the role of new Quality Measures
- Identify how chronic pain may impact federal reimbursement within RUG-IV categories
- Define options to manage chronic pain in older adults
Surveyor Guidance – F309

• To help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain the facility, to the extent possible:
  – Recognize when a resident has pain
  – Identify circumstances where pain can be anticipated
  – Evaluate the existing pain and the causes
  – Manage or prevent the pain consistent with the comprehensive plan of care, current clinical standards of practice, and the resident’s goals or preferences.
Surveyor Guidance

• Survey Activities Related to Pain
  – Observe residents for signs of pain
  – How does staff respond an assess
  – Interview residents about their pain, if they are included in the care planning process, and if interventions match their preferences
  – Interview nurses aides and other direct caregivers regarding how the resident’s pain is managed
  – Review medical records
  – Interview Nurses, Attending MD, Medical Director, Consultant Pharmacist, and Director of Nursing
MDS 3.0

• Interviews that impact quality
  – Pain interview
    • Treatment Items added
      • Interview captures effect of pain on sleep and day to day activity
  – Customary Routine, Activities, and Community Setting
  – Brief Interview for Mental Status (BIMS)
  – Patient Health Questionnaire (PHQ-9)
MDS 3.0 Quality Measures - Pain

• Pain is common in the long-term care setting.

• Although disorders that can cause chronic pain become more common with increasing age, pain itself is not a normal part of aging.

• Estimates of prevalence of chronic pain in LTC range from 45% – 80%.
MDS 3.0 Quality Measure - Pain

- Pain in LTC is sometimes under-recognized and under-treated.
- Treatment of chronic non-cancer, especially in those with non-terminal illness, is inconsistent.
- Pain in elderly patients often can be reliably detected and effectively treated.
- A systemic approach is needed to recognize and treat pain.
Quality Measure Data

Research suggests 45%-85% of nursing home residents experience pain, yet, only 4% of long-term care residents and 2.1% of short-stay residents are reported to have pain on quality measures nursing homes submit to CMS.

WHY THE DISCREPANCY? – We will discuss barriers to effective pain management later.
55-year-old male with history of COPD, MDD, Anxiety, Hypertension, Hyperlipidemia, Diabetes Mellitus, Chronic Pain and Coronary Artery Disease. He receives skilled restorative OT to provide ADL re-training and PT 5X per week to restore muscle strength.

Medications
Elavil 10 mg BID for MDD and Pain
Percocet 10/325 for 5 – 10 pain Q6 PRN
APAP 650 mg for 1 – 4 pain Q6 PRN
Lopressor 25 BID
Advair 250/50 BID
Metaxalone 800 TID PRN for muscle spasm
Prednisone 10 daily for COPD
Simvastatin 40 mg daily
ASA 81 daily
# Key Labs

<table>
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<tr>
<th>Lab</th>
<th>Result</th>
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<tr>
<td>Total Cholesterol</td>
<td>123</td>
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<tr>
<td>Hemoglobin</td>
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<tr>
<td>Electrolytes</td>
<td>Normal</td>
</tr>
<tr>
<td>Hepatic Profile</td>
<td>Normal</td>
</tr>
<tr>
<td>EKG</td>
<td>RSR with rate 100/min</td>
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MDS CAA Summary

• CAT #19 Pain
  – Triggers secondary to resident reporting pain #7 being the worst pain he has felt in the last 5 days.
  – Referral Made: None
  – Will proceed to care plan to administer pain medication as per MD order, pain assessment every shift and refer to MD, PT, and OT as indicated for discomfort
RUGS IV Impact

• CAT #5 ADL Functional Rehabilitation Potential
  – Triggers secondary to resident requires assistance with ADL’s following a hospitalization for pneumonia, hyperkalemia, and COPD exacerbation.
  – Referrals made: PT, OT
  – Will proceed to care plan to assist with ADL’s and assist and encourage resident to attend and participate in PT/OT 5X/week
Barriers to Effective Pain Management

FLORIDA
Florida Pill Mills

• Florida doctors purchased 89% of all oxycodone sold to practitioners in the United States in 2010 to dispense in their offices and clinics

• The state of Florida, with more than 1,000 pain clinics, had been renamed by some the “Oxy-Express”
Homicide Charge

A Florida physician who worked at a pain clinic was charged with murder by Palm Beach County prosecutors after a patient died from an overdose in 2009, a few hours after that doctor gave him a prescription for 210 pills.
Case Study

• 62 year old male resident of facility X 14 weeks

• History of
  – Osteoporosis (s/p right nondisplaced anterior column acetabular fracture with fracture of the pubic rami after a fall at an adult home)
  – Diabetes Mellitus
  – Anxiety Disorder
  – ETOH Abuse and heavy smoker
Initial Medications/ Orders

- Dilaudid 2 mg PO every 4 hours as needed for pain.
- Seroquel 50 mg HS
- Ativan 1 mg PRN for anxiety
- Zofran PRN
- Lovenox X 30 days
- Transdermal nicotine
- Wellbutrin XL 150 mg daily
- Standing insulin with coverage
- Psychotherapy twice per week
Issues

• When do most admissions arrive from the acute care hospital?
• Regulations regarding time to dispense pain medication?
• On-site availability of narcotic pain medications?
• When are initial orders obtained?
• How many hours typically pass before a comprehensive history and physical are completed and documented?
<table>
<thead>
<tr>
<th>Day</th>
<th>Orders</th>
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<tbody>
<tr>
<td>5</td>
<td>OT 5X/wk X 8 weeks for ADL and functional mobility training and resident/caregiver education</td>
</tr>
<tr>
<td>7</td>
<td>PT X 8 weeks for LE strength, balance training, transfers, gait training, and safety</td>
</tr>
<tr>
<td>8</td>
<td>Ambien 5 mg HS PRN</td>
</tr>
<tr>
<td>28</td>
<td>Increase dilaudid to 4 mg Q4 PRN</td>
</tr>
<tr>
<td>33</td>
<td>D/C from rehab (reached highest potential level of fn)</td>
</tr>
<tr>
<td>36</td>
<td>Reduce Seroquel to 25 mg at bedtime</td>
</tr>
<tr>
<td>39</td>
<td>Discontinue Ambien</td>
</tr>
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</table>
Pain Care Plan

• Vocal complaints of pain
• Moderate pain
• Level 7
• Almost constant
• Interferes with sleep
• Current regimen effective
Predictors for Development of Chronic Pain

- Demographic Variables
- Characteristics of the pain
- Psychological factors
- Context of the injury
Demographic Variables

• Age
• Gender
• Education
• Employment
• Health Status
Pain Characteristics

- High pain intensity
- Long pain duration
- Radiation of pain
- Prior episodes of pain
- Multiple sites of pain
- Multiple somatic symptoms
Psychological factors

- Negative emotion
- Depression
- Anxiety
- Anger
- Fear
- Stress
- Distress
- Catastrophizing
- Hypervigilence
- Self-efficacy
- Neuroticism
- Pain Sensitivity
- Somatization
Context of Injury

• Work related injury
• Litigation
• Reward for remaining injured or disabled
• Social Support from family or others
Pharmacologic Targets in the Nociceptive System

Ectopic Activity
- Na channel blockers
- Ca channel blockers
- Glutaminergic inhibition

Descending Modulation
- Central α-agonists
- TCAs
- SNRIs
- Opioids/Tramadol

Central Sensitization
- Opioids/Tramadol
- Central α-agonists
- NMDA antagonists
- Anticonvulsants

Brain

Spinal Cord

C.N.S.

Peripheral Nervous System
- TCAs
- Anticonvulsants
- Local anesthetics
- Opioids

Terminal

NSAIDs

Adapted from Woolf C, Max M Anesthesiology 2001
Depression in Chronic Pain

• Which comes first: Depression or Pain

• Patients often say “if you take care of my pain the depression will go away”
Evidence Regarding Relationship

• Those with baseline depressive disorders have double the risk for new onset of back pain up to 13 years into the future

• Severe depression triples the risk for incident back pain for 12 years

• Major depression + Dysthymic disorder still increased risk for incident back pain by 75% 13 years later

Larsen et al. Psychol Med 2004
Evidence Regarding Relationship

• Most data supports the concept that depression is also a consequence of chronic pain.

• Treatment of depression improves pain and disability.

Larsen et al. Psychol Med 2004
Do Opioids Cause Chronic Pain?

- Powerful positive reinforcement for use
- Negative reinforcement for disuse (withdrawal and or return of pain)
- Set up of unreasonable standard for pain control
- Injury that interferes with rehabilitation (injury when medications help you forget you are already injured)
- Intoxication produces psychological comfort but worsening functional disability
Low Pain Threshold vs Catastrophizing

• An exaggerated negative mental set that happens during an actual or anticipated painful experience

• Multidimensional cognitive construct
  – Magnification: Fear that something serious will happen
  – Rumination: Can’t stop thinking about how much it hurts
  – Helplessness: Feeling that nothing can be done to reduce the intensity of the pain
Can Outcomes be Modified?

• Interventions
  – Cognitive behavioral psychotherapy
  – Adaptive coping skills training
  – Distraction, relaxation, and visual imagery
  – Social Support

• All interventions are aimed at changing the interpretation of events
Addiction

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
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<tbody>
<tr>
<td>Primary Addiction</td>
<td>• When the drug starts to change the way you interact with the world.</td>
</tr>
<tr>
<td></td>
<td>• When you want more drug despite increasing consequences.</td>
</tr>
<tr>
<td></td>
<td>• Preoccupied with getting drug.</td>
</tr>
<tr>
<td>Pseudo-addiction</td>
<td>Pursuit of a treatment that you can’t imagine giving up even though it has only been marginally effective.</td>
</tr>
<tr>
<td>Dependence</td>
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Avoid putting the focus on the pain
“I’m going to take this medication away from you even though I know you’re suffering”

Put the Focus on the Disease
“I don’t think you’re an addict but I think the medication is doing harm in that you may be having rebound pain or even a new pain that the medication is causing”
Clockwatching
Withdrawing Opioids?

• Examine where the patient is in terms of function, quality of life, and productivity
  – If they are doing well in these areas leave them alone.
• If they are not doing well they need a new treatment plan that may include use of more or less opioids and concert with other interventions.
Cognitive Impairment

ASSESSING PAIN IN ADVANCED DEMENTIA
Pain in the elderly

• Prevalence 49 – 83%

• Often under treated in this group

• Untreated pain can lead to agitation, depression, decreased socialization, and sleep disturbance
Barriers in Managing Pain

• Expected consequence of aging
• Residents don’t or are unable to complain about their pain
• Polypharmacy decreasing efficacy of analgesics
• Altered pharmacokinetics and pharmacodynamics
Is there an Altered Pain Experience

• Limited data

• Case reports of patients with Alzheimer’s having less pain

• Do the neuropathological changes that occur with dementia have an impact on pain pathways?
Effects of Dementia on Pain Perception

• In Alzheimer’s disease, medial pain pathways may be affected.

• In vascular dementia, infarcts can occur anywhere. White matter lesions may have impact.
Assessing Pain
Mild to Moderate Dementia

- Often unable to communicate pain

- AGS Guidelines
  - Direct questioning
  - Ask all questions in present tense
  - Use of multidimensional pain instrument
  - Allow time to answer questions
Assessing Pain
Advanced Dementia

• Monitor behaviors as external markers of internals states
• Issues
  • There are no unique behaviors for pain though they are unique to the individual
  • Do care givers always understand the behaviors?

Herr et al. JPSM 2006 31(2) 170-192
Zwakhalen et al. BMC Geriatrics 2006, 6(3)
Behavior Tools

- PAINAD
- Abbey
- PACSLAC
- Doloplus
- Noppain
- ADD
- Dis-DAT
- PADE
- CNPI
DisDAT

• No specific pain behaviors so that it works better in looking at distress

• Specific to the resident
PAINAD

- Derived from DS-Dat
- Quick and simple to use
- Scores reduced when pain treated in a small sample
Study Results

• 79 participants with severe dementia were recruited from 4 skilled nursing facilities

• 16% were found to be in pain

• 33% had significant scores on the PAINAD scale but were not felt to be in pain

• 51% were not in pain and had low scores
16% found to be in pain

• Causes of Pain
  – Acute Pain due to toothache, cellulitis, DVT
  – Chronic pain secondary to arthritis and contractures

• Management
  – Scheduled doses of analgesics
  – Staff education and training
Causes of False (+) Results

• Anxiety and/or depressed mood
• Anger/ Frustration
• Disturbed by other residents
• Boredom
• Hallucinations
Case Study

• An 83 year old male
• History of dementia with behavior disturbance
• BIMS score 4
• He has had increased levels of agitation during the last 3 weeks
• Both scales yielded high scores.
Chronic Pain Management

RATIONAL POLYPHARMACY
Polypharmacy Defined

• Use of multiple pain medications: > 2 (minor) or > 4 (major)
  – Example: Nebulizer, Statin, Oral diabetic medication, antidepressant

• Intentional use of >2 medications to treat one condition (Opioid + Tylenol to treat pain)

• Use of more medications than clinically indicated

Polypharmacy
Balancing Benefits and Toxicities

Irrational

- Adverse Events
- Decreased Quality of Life

Rational

- Improved Quality of Life
- Symptomatic and functional relief from chronic pain
- Improved outcomes
Prescribing Cascade

• Patient complains of pain
  – Short acting opioid and observe

• 2 weeks later complains of no BM
  – Add docusate

• Few days later: Still constipated and now I’m nauseous as well
  – Add ondansetron PRN
Prescribing Cascade

• “I still can’t move my bowels”
  – Add lactulose, senna, and miralax

• I still have pain and I haven’t slept in days
  – Pain may or may not be controlled. Try Ambien.

• Still nauseous, not always asking for ondansetron
  – Add phenergan

• “The pain just won’t go away”
Rational Polypharmacy

• Many, if not most, patients will only get a partial response to monotherapy

• Many are not able to tolerate adverse events caused by analgesic doses of a single agent (principle of opioid sparing)

• May be able to obtain a positive synergistic effect with combined agents from different medication classes
General Roster of Analgesics

- Non-opioids
  - Acetaminophen
  - NSAIDs
  - COX-2 inhibitors

- Opioids

- Adjuvant Analgesics
  - Antidepressants, Antiepileptics, and topical agents
Importance of Opioids

• Cornerstone of pain management

• Typically the class of choice for moderate to severe pain
  – Acute Pain
  – Traumatic Pain
  – Cancer Pain
  – Chronic Non-Malignant Pain
  – Neuropathic pain when used with adjuvants
  – Breakthrough Pain
Chronic Pain Components

Persistent and Breakthrough Pain

Persisten Pain

Time

Around the Clock Medication

BTP
Chronic Pain Prescribing Pearls

• Long acting opioids are underutilized

• Initial treatment
  – Short acting opioid
  – Usually prescribed Q4-6H even though duration of action is typically 3 – 4 hours
  – Preferred to prescribe as Q4H PRN
Chronic Pain Prescribing Pearls

• Renal Impairment
  – All opioids are metabolized through the liver with renal clearance of active metabolites
  – M3G and M6G metabolites can accumulate quickly on moderate or high doses

• Neurotoxicity
• Seizures
Chronic Pain Prescribing Pearls

• Common adverse events
  – Nausea
  – Sedation
  – Constipation*

• Signs of overdose: respiratory depression, pupillary constriction

• Expected dependence (This is not addiction): Therefore must taper carefully and slowly
Appropriate Dose Increases

• Think in terms of percentage rather than mg
• Total daily dose should increase in 25% - 50% increments
  – Less than 25% increase equivalent to placebo
• For moderate to severe pain increase total daily dose by 50% - 100%
Dosing Rescue Therapy

• One dose of rescue therapy should be 10-15% of the total dose of oral long-acting opioid.

• Pain should be rated prior to and after administering the dose
Constipation

- Constipation during opioid therapy is common if not inevitable and may be different from ordinary functional constipation.
- Anticipate constipating side effects and prescribe a laxative when prescribing the opioid.
- Document prior constipation history at start of therapy to establish the baseline.
Constipation

• Characterizing a person as constipated based only on number of bowel movements per day or per week is not appropriate

• Available evidence does not suggest that opioid induced constipation will respond to increasing fluids or dietary fiber unless the patient is dehydrated and consumes insufficient amounts of fiber
Constipation

- Bulk-forming laxatives are not appropriate in opioid induced constipation because peristalsis is inhibited in these patients.
- Effective treatment requires laxatives, a stool softener, and a stimulant.
Thank You