



# Multidisciplinary Pain Management in Long-Term Care

## INSIDE THIS ISSUE

- SECTION 1** Pain in the Long-Term Care Facility **1**
- SECTION 2** Nonpharmacologic and Pharmacologic Approaches to Pain **3**
- SECTION 3** Improving Pain Management in the Long-Term Care Setting **6**

### LEARNING OBJECTIVES

On completion of this activity, participants should be able to:

- Describe the numerous challenges in treating pain in LTC residents, including barriers to assessment and treatment.
- Assess the use of various nonpharmacologic and pharmacologic treatment options that are available to treat this patient population.
- Discuss the need for a multidisciplinary approach to pain management in the institutionalized elderly.
- Identify strategies to improve the overall management of pain in LTC residents.

Release Date: October 1, 2005

Valid Until: October 1, 2006

The following monograph was edited by Dennis Bloshuk,\* senior managing editor, Thomson Advanced HealthMarket Strategies™, with input and review by the following faculty:

#### Key Ball, RN, BSN, MSA, CNOR, FAAN

Perioperative Consultant and Educator  
K&D Medical  
Lewis Center, Ohio

#### Cathleen A. Bergeron, RN, MS

Director of Nursing  
Soldiers' Home in Holyoke  
Holyoke, Massachusetts

#### Sharon Elliott-Bynum, RN, PhD, BSN, CDONA/LTC

Nursing Consultant  
CAARE, Inc.  
Durham, North Carolina

#### Grace Forde, MD

Director of Neurological Services  
North Shore Pain Services  
Valley Stream, New York

#### Michael Neville, PharmD

Clinical Associate Professor  
Nell Hodgson Woodruff School of Nursing  
Emory University  
Atlanta, Georgia

#### Terrence E. O'Shea, BS Pharm, PharmD, CGP

Regional Clinical Director, Eastern Region  
Omnicare, Inc.  
Englewood, Ohio

#### Dennis L. Stone, MD, MBA, CMD\*\*

Chief Medical Officer  
Home Quality Management Inc.  
Palm Beach Gardens, Florida

\*Mr Bloshuk has indicated no relevant financial relationships.

\*\*Ms Ball has indicated no relevant financial relationships.

\*\*\*Ms Bergeron has indicated no relevant financial relationships.

\*\*\*\*Ms Elliott-Bynum has indicated no relevant financial relationships.

\*\*\*\*\*Dr Forde has indicated no relevant financial relationships.

\*\*\*\*\*Dr Neville has indicated no relevant financial relationships.

\*\*\*\*\*Dr O'Shea has indicated the following relevant financial relationships: advisory board member, Forest Pharmaceuticals, Inc.; Takeda Pharmaceuticals North America, Inc., and Yamaguchi Pharmaceuticals.

\*\*\*\*\*Dr Stone has indicated no relevant financial relationships.

### TARGET AUDIENCE

This educational activity is designed for medical directors, consultant and provider pharmacists, nurses, and other healthcare professionals who work in long-term care facilities.

### GRANTOR

This activity is supported by an unrestricted educational grant from Endo Pharmaceuticals.

### CE/CME

This activity is jointly sponsored by Thomson American Health Consultants, Atlanta, GA, Thomson Advanced HealthMarket Strategies™, Secaucus, NJ, and Thomson Professional Postgraduate Services®, Secaucus, NJ, and is conducted as a part of the National Initiative on Pain Control®, which is sponsored by Thomson Professional Postgraduate Services®.

To receive the appropriate continuing education credits for this activity, participants should follow the instructions located on page 2 of the monograph.

### DISCLOSURE

This educational activity is intended to provide current information regarding the management and treatment of pain in the long-term care setting. Some of the information, and the agents mentioned, may include discussions of off-label, non-FDA-approved uses. Please refer to each manufacturer's full prescribing information before prescribing any of the agents mentioned in this monograph. Please note: materials in this publication that include discussion of off-label uses are identified with the symbol \*\*\*.

## SECTION 1

# Pain in the Long-Term Care Facility

**P**ain is the most common reason individuals seek medical attention in the United States. Yet, despite the availability of effective medications and management techniques, pain remains underassessed and undertreated. A major contributor to the lack of effective management and treatment of pain in the elderly is the long-held belief by patients and clinicians that pain is a normal part of aging.<sup>1,2</sup>

Pain is more pronounced in the elderly, and this issue is expected to become increasingly important as the US population ages—by the year 2030, the number of individuals aged ≥65 years is expected to double to approximately 72 million.<sup>3</sup>

The presence of pain is even more critical for the estimated 2 million individuals who currently reside in long-term care (LTC) facilities.<sup>3</sup> A recent study indicated that 50% to 80% of LTC residents report some degree of pain,<sup>4</sup> and in a substantial number (25% to 33%) who report daily pain, many do not receive appropriate or adequate treatment.<sup>1,4-7</sup>

Recently, the American Geriatrics Society updated its clinical practice guidelines, which focus on several key areas to improve the clinical management and treatment of pain in the elderly.<sup>1</sup> As the US population ages, greater attention is needed on the proper management of pain in the elderly, particularly among those who reside in LTC facilities. This monograph will address the issues and challenges associated with treating LTC residents, the appropriate use of non-pharmacologic and pharmacologic treatment options, and the importance of a multidisciplinary approach to pain management in the LTC setting. In addition, the monograph will discuss the importance of the “Beers list” when assessing pain treatment options in the elderly, and the impact of the Medicare

Prescription Drug, Improvement and Modernization Act (MMA) on LTC residents.

### Pain Assessment in the Elderly

Taking an accurate and complete medical history is the first step in assessing pain; however, consistent assessment processes, frequent reassessment, and consistent documentation are probably more important when determining the presence of pain.<sup>2,8</sup> It can be difficult for LTC residents to relate the severity and intensity of their pain due to language, communication, and other barriers. Aids such as glasses, better lighting, and hearing aids in those with visual or hearing problems help to improve communication.<sup>9</sup> Framing questions in the present

*A recent study indicated that 50% to 80% of LTC residents report some degree of pain, and in a substantial number (25% to 33%) who report daily pain, many do not receive appropriate or adequate treatment.*

tense and using concrete questions with yes or no answers are helpful. Repetition and the use of validating questions also increase the accuracy of pain assessment.

Cognitive impairment affects more than 50% of LTC residents,<sup>9</sup> which makes the use of standardized pain scales challenging in this population. Therefore,

*Continued on page 2*

*Continued from page 1*



### **NIPC LTC EDUCATION COUNCIL**

**Sumana Alex, PharmD**  
Consultant Pharmacist  
Neighborcare Pharmacy

**Cathleen A. Bergeron, RN, MS**  
Director of Nursing  
Soldiers' Home in Holyoke

**Sharon Elliott-Bynum, RN, PhD,  
BSN, CDONA/LTC**  
Nurse Consultant  
CAARE, Inc.

**Grace Forde, MD**  
Director, Neurological Services  
North Shore Pain Services

**Leonard Gelman, MD, CMD**  
Family Practitioner  
Capital Care Family Medicine

**William N. Hovland, MD**  
President  
Long Term Care of Tidewater

**Jianren Mao, MD, PhD**  
Director, Pain Research Group  
Mass General Hospital Pain Center

**Terrence E. O'Shea, BS Pharm,  
PharmD, CGP**  
Regional Clinical Director  
Omicare, Inc.

**Barbara B. Phillips, DNS-c, GNP-BC**  
President  
NCGNP

**Dennis Stone, MD, MBA, CMD**  
Chief Medical Officer  
Home Quality Management Inc.



© 2005 Thomson American Health Consultants, Thomson Advanced HealthMarket Strategies™, and Thomson Professional Postgraduate Services®. The material in this monograph may not be reproduced without the express written permission of Thomson American Health Consultants, Thomson Advanced HealthMarket Strategies™, and Thomson Professional Postgraduate Services®.

consistent assessment and frequent reassessment are important when evaluating the persistence of pain. Since behavioral changes may indicate the presence of pain,<sup>8</sup> healthcare facilities may rely heavily on protocols that require providers to document baseline behaviors of cognitively impaired residents and regularly monitor the subtle changes that occur. The Wong-Baker Faces Rating Scale may be useful for assessing pain in residents with mild cognitive impairment and those with potential language barriers.<sup>10</sup> Other scales that may be useful for cognitively impaired individuals include the Face, Legs, Arms, Consolability and Cry (FLACC) scale, the Discomfort Scale, and the Pain Assessment in Advanced Dementia (PAINAD) scale.<sup>10</sup>

### **References**

1. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. *J Am Geriatr Soc.* 2002;50(6, suppl): S205-S224.
2. Hanks-Bell M, Halvey K, Paice JA. Pain assessment and management in aging. *Online J Nursing Issues.* 2004;9:8. Available at: [http://nursingworld.org/ojin/topic21/tpc21\\_6.htm](http://nursingworld.org/ojin/topic21/tpc21_6.htm). Accessed May 23, 2005.
3. Federal Interagency Forum on Aging-Related Statistics. *Older Americans 2004: Key Indicators of Well-Being.* Federal Interagency Forum on Aging-Related Statistics. Washington, DC: US Government Printing Office; November 2004. Available at: <http://www.agingstats.gov>. Accessed May 18, 2005.
4. Herr KA, Spratt K, Mobily PR, et al. Pain intensity assessment in older adults: use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. *Clin J Pain.* 2004;20:207-219.
5. Haupt BJ, Jones A. National Home and Hospice Care Survey: 1996 Summary. Washington, DC: National Center for Health Statistics. *Vital Health Stat 13.* Available at: [http://www.cdc.gov/nchs/data/series/sr\\_13/sr13\\_141.pdf](http://www.cdc.gov/nchs/data/series/sr_13/sr13_141.pdf). Accessed May 23, 2005.
6. Clark L, Jones K, Pennington K. Pain assessment practices with nursing home residents. *West J Nurs Res.* 2004;26:733-750.
7. Chodosh J, Solomon DH, Roth CP, et al. The quality of medical care provided to vulnerable older patients with chronic pain. *J Am Geriatr Soc.* 2004;52:756-761.
8. Horgas AL. Pain management in elderly adults. *J Infusion Nurs.* 2003;26:161-165.
9. Ferrell BA. The management of pain in long-term care. *Clin J Pain.* 2004;20:240-243.
10. Winn PAS, Dentino AN. Effective pain management in the long-term care setting. *J Am Med Dir Assoc.* 2004;5:342-352.

### **CE/CME INFORMATION**

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Thomson Professional Postgraduate Services®, Secaucus, NJ, and Thomson Advanced HealthMarket Strategies™, Secaucus, NJ. Thomson Professional Postgraduate Services® is accredited by the ACCME to provide continuing medical education for physicians.

Thomson Professional Postgraduate Services® designates this educational activity for a maximum of 1.0 category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. AHC also is approved as a provider by the California Board of Registered Nursing (provider number CEP 10864). This activity has been approved for 1.0 nursing contact hour.



Thomson American Health Consultants is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program (381-999-05-027-H01) will be available October 1, 2005 to October 1, 2006.

Thomson American Health Consultants has designated 1.0 contact hour [0.10 CEUs] for this program.

### **SOFTWARE REQUIREMENTS**

The accredited providers recommend version 5.x browsers or higher from Microsoft or Netscape. Required software includes Adobe Reader.

### **PARTICIPANT INSTRUCTIONS**

Long-term care professionals who wish to receive the appropriate credit for this educational activity should do the following:

- Read the monograph in its entirety.
- To access the posttest and evaluation forms, which is free of charge, participants should do the following:

**Physicians:** After reading the monograph, go to <http://painmgmt.cmeweb.com> to take your self-assessment test and complete your evaluation. To complete the self-assessment test, click on the post-test link to review the test questions and compare your answers with the correct ones listed. After completing the self-assessment test, you must submit an evaluation form. After your evaluation form is received, your credit letter will be e-mailed to you immediately.

**Pharmacists:** After reading the monograph, go to <http://painmgmtpharmacy.ce-web.com> to take your post-test and complete your evaluation. You must score 100% on the post-test to receive a statement of credit. Upon successful completion of the test and submission of the evaluation, your statement of credit will be e-mailed to you immediately. You will also receive a summary of the correct test answers and explanations.

**Nurses:** After reading the monograph, go to <http://painmgmtnursing.ce-web.com> to take your self-assessment test and complete your evaluation. To complete the self-assessment test, click on the post-test link to review the test questions and compare your answers with the correct ones listed. After completing the self-assessment test, you must submit an evaluation form. After your evaluation form is received, your CE certificate will be e-mailed to you immediately.

# Nonpharmacologic and Pharmacologic Approaches to Pain

**T**he goal of pain management in the elderly is to improve function and quality of life. This often requires the multidisciplinary application of both nonpharmacologic and pharmacologic approaches that are individualized to the resident and provide the most effective outcomes.<sup>1-3</sup>

## Nonpharmacologic Approaches

Nonpharmacologic pain management approaches alone are effective in reducing pain and, when combined with pharmacologic agents, lower the need for and the dosage of analgesic medications.<sup>4</sup> Nonpharmacologic pain approaches include cognitive-behavioral therapy (CBT) and/or physical treatments.<sup>2,5</sup> For LTC residents, providers must determine which options are safest, provide the greatest benefit, and are within the economic means of the family, the LTC facility, or third-party payors.

CBT is a combination of techniques to alter an individual's perceptions of pain, increase sense of control, and decrease maladaptive behaviors. Overall, CBT attempts to improve the patient's ability to cope with pain.<sup>2,5</sup> Relaxation techniques, such as yoga and meditation, reduce muscle tension and stress while decreasing the individual's focus on pain. Biofeedback is a process in which an individual consciously attempts to modify skin temperature, muscle tension, blood pressure, and heart rate. Hypnosis modifies an individual's perception of pain by producing a state of deep relaxation and altered consciousness that helps to reduce anxiety.

There are numerous physical treatments to help manage pain. One of the easiest methods is to apply cold or heat. Cold application is used to decrease pain and swelling from numerous ailments, and the subsequent application of heat can augment motor performance and also reduce pain. Stretching and exercise are simple approaches that can improve flexibility, increase strength, and improve overall health. Exercise combats stiffness, is useful to reduce pain, and may decrease the incidence of falls—a serious concern in the

elderly. Massage is another strategy to alleviate pain by facilitating relaxation and decreasing muscle tension and pain.

Acupuncture involves the insertion of fine needles into the skin at varying depths at specific body locations. This technique causes the secretion of endorphins, which interferes with the transmission of nociceptive information, thus reducing pain. Transcutaneous electrical nerve stimulation (TENS) involves the selective stimulation of cutaneous receptors by applying low intensity current. TENS presumably interferes with the transmission of the pain signals and stimulates the production of endorphins. Physical therapy may also be necessary, and effective, for some LTC residents and may employ several of the above techniques as well as the more traditional therapeutic approaches.

## Pharmacologic Approaches

Although nonpharmacologic approaches are beneficial, many patients require pharmacologic agents to control pain. In general, any LTC resident experiencing pain that affects their daily functioning or quality of life is a candidate for analgesic medication.<sup>1</sup> To maintain freedom from chronic pain, it is recommended that the medications be given “around the clock” (eg, every 8 hours) to allow residents a period of rest between drug administration. In the event a resident requires medication between scheduled doses (ie, for breakthrough pain), it may be given on an as-needed basis. Unfortunately, even with a wide array of available pain medications, many elderly individuals remain undertreated.<sup>2,3,6</sup>

The elderly population is at greater risk for adverse effects from medications, so precautions must be taken to ensure the safe and effective use of any drug.<sup>1-3</sup> Changes in physiology accompany aging and results in altered drug metabolism,

which can increase the potential for side effects.<sup>2</sup> Furthermore, LTC residents often receive multiple medications to treat numerous comorbidities of varying severity.<sup>7</sup> Therefore, it is recommended that the lowest effective dose of a single analgesic medication be the starting point for treatment.<sup>2</sup> Following close monitoring, the drug's dosage should be titrated, as necessary, based on its pharmacokinetic properties and risk for drug interactions or side effects.<sup>3</sup>

Routes of administration must also be considered. Although oral administration is usually the preferred route,<sup>2</sup> it may not always be feasible. In those cases, pain severity and the pharmacokinetics of a specific drug can direct the choice of an alternative route of administration, including topical, intravenous, intraspinal, subcutaneous, rectal, or sublingual. Intramuscular injections should be limited due to the potential for tissue injury, altered absorption of the drug, and patient discomfort.<sup>2</sup>

Nonopioids, considered first-line therapy, are used for relieving various types of acute and chronic pain. Acetaminophen is widely used for chronic and acute pain, especially musculoskeletal pain. It is generally safe unless taken in large doses, which can result in liver damage. In addition, acetaminophen must be used cautiously in those with hepatic or renal disease.<sup>1-3</sup>

***The goal of pain management in the elderly is to improve function and quality of life. This often requires the multidisciplinary application of both nonpharmacologic and pharmacologic approaches.***

Nonsteroidal anti-inflammatory drugs (NSAIDs) provide an advantage over acetaminophen, because they reduce inflammation as well as relieve pain. However, NSAIDs can damage the gastric mucosa and increase the risk for gastrointestinal (GI) bleeding.<sup>1-3</sup> Most NSAIDs are nonselective and block both the COX-1 and COX-2 enzyme isoforms. However, the more selective COX-2 inhibitors (eg, celecoxib) are potentially less toxic to the GI system. Recently published clinical trials have linked COX-2 inhibitors to an increased risk for coronary events and have cast doubt about their use in chronic pain management, particularly among the

*Continued from page 3*

elderly who already have an increased risk for cardiovascular disease. Recently, the Food and Drug Administration (FDA) issued a public health advisory advising physicians to consider that risk when prescribing this drug class.<sup>8</sup> For the elderly in LTC facilities, limiting COX-2 inhibitors to

counter for the treatment of peripheral neuropathic pain and arthritis. However, capsaicin should be used only as adjunctive therapy, and may require several weeks of treatment before it is effective. In addition, some individuals may be unable to tolerate capsaicin due to potential local burning.<sup>9</sup> Another pain-management option in the elderly is the lidocaine patch. Although originally approved by

Overall, the lidocaine patch provides a treatment option that harbors a relatively low risk of systemic adverse events and drug-drug interactions while providing flexibility in dosing and a targeted mechanism of action.<sup>12</sup> The primary adverse effect of the lidocaine patch is mild skin reactions. Caution should be exercised with the concurrent use of lidocaine patches with antidysrhythmic medications.<sup>10</sup>

Opioid agents are used to treat moderate-to-severe pain that is unresponsive to nonopioid treatment. Short-acting opioids are used to manage intermittent and breakthrough pain, whereas long-acting agents should be used for continuous or chronic pain. Despite the effectiveness and relative safety of opioids, both patients and physicians are reluctant to use these medications due to their side effects and fears of addiction. Appropriate education, however, can successfully alleviate these concerns. Other concerns regarding opioids include the potential for tolerance, sedation, and respiratory depression. For opioid use in elderly patients, lower doses may be effective, and any upward titration in dose should be carefully monitored.<sup>2</sup>

The transdermal delivery of opioids such as fentanyl was originally developed for treating postoperative pain.<sup>11</sup> Since then, fentanyl patches have been used to manage different pain types.<sup>\*,11</sup> The most serious adverse side effect of transdermal fentanyl is depressed breathing or hypoventilation. In addition, because of the convenience of the patch, fentanyl also has the potential for misuse and abuse. Toxicity due to fentanyl overdoses has been noted in several studies, and it also has been suggested that the drug's general availability may be responsible for the high incidence of overdoses.<sup>11</sup>

Adjuvant analgesics used in conjunction with other analgesic agents include antidepressants,<sup>\*</sup> anticonvulsants,<sup>\*</sup> and muscle relaxants. These drugs are normally not used as first-line therapy but provide additive analgesic effects or, in some cases, may enhance the response to analgesics.<sup>1-3</sup>

Tricyclic antidepressants (TCAs) are used to treat chronic and neuropathic pain syndromes. These agents, however, have not been approved by the FDA for pain management. Unfortunately, the TCAs are associated with extensive side effects, including cardiotoxicity, sedation, hypotension, and confusion. Consequently, these agents should be used as a last resort, if at all, in the elderly.

The exact mechanism by which

## PAIN MEDICATIONS TO AVOID IN THE ELDERLY

**T**he "Beers list" is a compilation of consensus criteria to identify medications that are potentially inappropriate for this population. The list was formulated by a panel of geriatric care, clinical pharmacology, and psychopharmacology experts following an extensive literature review. The most recent list identifies 48 individual medications or drug classes that should not be used in the elderly, as well as medications that should be avoided in older adults with any of 20 medical conditions and diseases, including heart failure, hypertension, clotting disorders, arrhythmias, chronic obstructive pulmonary disease, seizure disorders, and dementia. Analgesic medications and/or drug classes cited by the "Beers list" as contraindicated in the elderly include:

Propoxyphene, pentazocine, indomethacin, meperidine, and ketorolac, which do not provide substantive advantages over other analgesics and harbor a significantly higher risk for various adverse events.

Numerous non-COX-selective NSAIDs such as naproxen, oxaprozin and piroxicam, due to their ability to produce gastrointestinal bleeding, renal failure, hypertension and heart failure.

Most muscle relaxant and antispasmodic compounds\* because of their propensity to cause anticholinergic adverse effects, sedation and weakness, which might increase risk of falls.

Tertiary tricyclic antidepressants\* (eg, amitriptyline, doxepin) due to their strong anticholinergic and sedating properties.

Long-acting benzodiazepines (eg, diazepam),\* which are sometimes used for muscle relaxation. Use of these agents is discouraged due to the increased risk of sedation, falls, and fractures. Additionally, short-acting agents (eg, lorazepam)\* should be used at lower dosages, since smaller doses may be as effective as well as safer. These short-acting agents, however, have been linked to falls and fractures as well.

### For additional information, please see:

Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults: results of a US consensus panel of experts. *Arch Intern Med.* 2003;163:2716-2724.

\*The use under discussion has not been approved by the FDA.

short-term use (eg, 14 days) should be strongly considered. If long-term use of an anti-inflammatory agent is necessary, nonacetylated salicylates such as salsalate should be attempted.

Topical analgesic therapy has been used to help relieve various types of neuropathic pain. Capsaicin, an enzyme found in hot peppers, relieves pain by depleting Substance P from afferent nociceptive neurons. Cream and patch formulations of capsaicin are available over-the-

the FDA for relief of postherpetic neuralgia (PHN), numerous studies have demonstrated the safety and efficacy of the lidocaine patch in treating other neuropathic and non-neuropathic pain syndromes, including diabetic peripheral neuropathy, refractory pain, and low back pain.<sup>\*,10,11</sup> The lidocaine patch delivers medication topically at the pain site, producing localized pain relief.<sup>10</sup> In addition, because it is a topical analgesic, multiple patches can be applied at the same time.

\*The use under discussion has not been approved by the FDA.

*Continued on page 5*

antiepileptic drugs exert their analgesic effect is unclear. However, it does not appear to be linked to their antiseizure properties since other drugs used to suppress seizures (eg, barbiturates) do not relieve pain. Except for carbamazepine, which is FDA approved for the treatment of trigeminal neuralgia, and valproate and topiramate, which are FDA approved for the treatment of migraine, most analgesic usage of this drug class is considered off-label. Common side effects of these drugs include sedation, dizziness, and nausea. Less common adverse events include liver dysfunction and hypersensitivity reactions.

In summary, key principles to effective analgesic therapy are to:

- Identify and treat the pain source
- Select the simplest approach to pain management
- Select an appropriate medication and establish a management and monitoring plan
- Select a route of administration
- Titrate the medication dose
- Manage side effects

## References

1. Ferrell BA. The management of pain in long-term care. *Clin J Pain*. 2004;20:240-243.
2. Horgas AL. Pain management in elderly adults. *J Infusion Nurs*. 2003;26:161-165.
3. Fine PG. Pharmacological management of persistent pain in older patients. *Clin J Pain*. 2004;20:220-226.
4. Winn PAS, Dentino AN. Effective pain management in the long-term care setting. *J Am Med Dir Assoc*. 2004;5:342-352.
5. National Pharmaceutical Council. Pain: Current understanding of assessment, management, and treatments. Available at: [http://www.jcaho.org/news+room/health+care+issues/pain\\_mono\\_npc.pdf](http://www.jcaho.org/news+room/health+care+issues/pain_mono_npc.pdf). Accessed May 23, 2005.
6. Won AB, Lapane KL, Vallow S, et al. Persistent nonmalignant pain and analgesic prescribing patterns in elderly nursing home residents. *J Am Geriatr Soc*. 2004;52:867-874.
7. Patel RB. Polypharmacy and the elderly. *J Infusion Nurs*. 2003;26:166-169.
8. Food and Drug Administration. 2004 Public Health Advisory: Non-steroidal anti-inflammatory drug products (NSAIDs). Available at: <http://www.fda.gov/cder/drug/advisory/nsaids.htm>. Accessed May 23, 2005.
9. American Pain Society. *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*. 5th ed. Glenview, Ill: American Pain Society; 2003:47.
10. Gammaitoni AR, Alvarez NA, Galer BS. Safety and tolerability of the lidocaine patch 5%, a targeted peripheral analgesic: a review of the literature. *J Clin Pharmacol*. 2003;43:111-117.
11. Young W. Duragesic treatment of pain. 2003. Available at: <http://carecure.rutgers.edu/spinewire/Articles/Duragesic%20folder/Duragesic.htm>. Accessed May 23, 2005.
12. Davies PB, Galer BS. Review of lidocaine patch 5% studies in the treatment of postherpetic neuralgia. *Drugs*. 2004;64:937-947.

## Impact of the MMA Part D on LTC

In December 2003, President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act (MMA), which is the most significant change to Medicare since the program's inception in 1965. A key provision of this legislation is Part D, which authorized the Centers for Medicare & Medicaid Services (CMS) to establish a voluntary prescription drug benefit. This prescription drug benefit will be administered through private plans that contract with Medicare Advantage or through stand-alone prescription drug plans (PDPs). Under the legislation, Medicare Advantage plans will be allowed to offer special needs plans for individuals who are dual eligibles (those enrolled in Medicare and Medicaid and who receive the full range of benefits offered by both programs) as well as those who are institutionalized. Under the new law, dual eligibles will have to enroll separately in a Part D plan, or they will be randomly auto-enrolled into one of several plans.

The new MMA legislation is expected to have a tremendous impact on those residing in LTC facilities. Currently, 1.6 million LTC residents are dually eligible, and their prescription drug costs are covered under Medicaid. In January 2006, prescription drug coverage for dual eligibles will be changed from state Medicaid programs to Medicare Part D (although states may elect to provide some "wrap-around" coverage for medications not covered by Part D plans). There are no provisions in the statute for creating special PDPs for nursing home residents, so all Part D plans will be required to provide medically necessary prescription drug treatment to those residing in LTC facilities. To clarify pharmacy benefit provisions for elderly residents in LTC facilities, CMS is expected to provide additional guidance that reflects standard LTC pharmacy practices.

To ensure that plans offer comprehensive drug benefits under Part D, CMS has required oversight of P&T Committees. This oversight will ensure that formulary decisions are based on scientific and economic considerations for appropriate, safe, and cost-effective drug treatments. In addition, the MMA states that all P&T Committees must include at least 1 practicing pharmacist and 1 practicing physician who are experts in the care of the elderly or disabled.

The United States Pharmacopeia (USP), in conjunction with a Model Guidelines Expert Committee, developed a list of categories and classes of drugs that PDPs may use to design their formularies. The final draft of these guidelines include 146 unique therapeutic categories and pharmacologic classes. PDPs that use the USP Model Guidelines will be required to have at least 2 drugs from each category or class unless only 1 drug exists. If there are 2 drugs in the class, it meets the 2-drug requirement for that category associated with that specific class. If there is no pharmacologic class associated with that therapeutic category, then a plan must provide 2 drugs in the category to meet this requirement. Interestingly, numerous medications cited as questionable by CMS, or included on the Beers list, are in the USP Model Guidelines, including non-COX-selective NSAIDs (ie, naproxen, oxaprozin, piroxicam), meperidine, propoxyphene, and pentazocine. Given the special needs and challenges of LTC residents, including the issue of polypharmacy, a multidisciplinary approach is needed to ensure that appropriate access to a wide array of analgesic medications is provided in order to achieve optimal outcomes while minimizing the potential for adverse events.

### For additional information, please see:

Centers for Medicare and Medicaid Services. Available at: <http://www.ascp.com/public/ga/hfsurvey/changes04/StateOps.pdf>. Accessed May 23, 2005.

United States Pharmacopeia. Medicare Prescription Drug Benefit Model Guidelines: Drug Categories and Classes in Part D. Available at: <http://www.usp.org/healthcareinfo/mmg/finalGuidelines.html>. Accessed May 23, 2005.

Ferrell BA. The management of pain in long-term care. *Clin J Pain*. 2004;20:240-243.

Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults: results of a US consensus panel of experts. *Arch Intern Med*. 2003;163:2716-2724.

## S E C T I O N 3

## Improving Pain Management in the Long-Term Care Setting

**T**he complex medical profile of LTC residents presents numerous challenges in the assessment and management of pain. LTC residents have many confounding factors that make pain management particularly troublesome, including multiple comorbidities, polypharmacy, and cognitive or psychologic impairments. To further complicate matters, the burden to contain costs results in additional stress to an already frail LTC system. Therefore, effective pain management in the LTC facility requires a multidisciplinary effort

***A recent study suggests that improving pain management in the LTC setting requires improved provider knowledge and attitudes, increased diagnostic precision, standardized pain treatment, and increased commitment by the institution.***

involving residents, families, doctors, nursing staff, and others to provide high-quality care that is most effective and efficient.

A recent study suggests that improving pain management in the LTC setting requires improved provider knowledge and attitudes, increased diagnostic precision, standardized pain treatment, and increased commitment by the institution.<sup>1</sup> Unfortunately, achieving these goals can be difficult, because LTC staff are currently overworked, burdened with regulatory guidelines, and limited by costs.

Effective pain management begins with an accurate assessment of pain. Yet, the inability to properly assess the presence and/or intensity of pain is a major obstacle to effective pain management in

the LTC setting. Standardized pain assessment tools are ideal; however, the validity and accuracy of current pain scales to evaluate LTC residents have been questioned. Although self-reported pain should be the first step to assessing pain in older adults, this may be complicated in those who have cognitive impairments or personal misconceptions (ie, accepting pain as a normal part of aging or fear of being labeled a hypochondriac or a complainer). In such cases, nonverbal pain behaviors are considered valid.<sup>2</sup> Although it is important to train

providers to recognize nonverbal pain cues, it is even more critical for nursing staff since they spend the most time with LTC residents. Educational efforts regarding pain recognition and assessment must be ongoing and should especially include unlicensed nursing staff since they are

more likely to have limited knowledge of the signs and symptoms of pain and its management.<sup>3</sup> Given the high turnover rate of all levels of nursing staff, LTC facilities must demonstrate a strong commitment to ensure consistency of care. This includes not only recruitment of new staff but retention of qualified and experienced employees. Studies have shown that LTC facilities with stable staffing develop a team that exhibits stronger involvement, greater gains in knowledge, and more positive attitudes.<sup>3</sup>

Another potential barrier to effective pain management is the sporadic and inconsistent communication of information among LTC residents, nurses, and clinicians. A recent study demonstrated considerable variability in the frequency

with which nurses and clinicians assess pain, how often clinicians are notified about pain, and how frequently pain reassessment occurs.<sup>4</sup> These findings underscore the need for standardized protocols that delineate the frequency of pain assessment and reassessment. Various medical associations have put forward numerous guidelines to address the frequency of pain assessment.<sup>4</sup> Standardizing procedures would add another set of expectations on an already overworked LTC staff; however, this practice would add uniformity and reduce subjectivity in the pain assessment process. Relatively nonburdensome practices, such as nurses and nursing assistants asking residents if they are in pain each time they interact, can be implemented easily and nonintrusively.

Lack of proper and ongoing training is another challenge that hampers effective pain management in LTC healthcare providers.<sup>3</sup> The staff must be knowledgeable about pain and pain medications to dispel any myths and misconceptions about pain management and treatment.<sup>3</sup> Many healthcare experts advocate that pain be viewed as the “fifth vital sign”. Guidelines from the American Geriatrics Society consider education programs essential to this effort.<sup>5</sup> Unfortunately, the development of educational programs can be difficult due to the confusing and often conflicting publications on pain management.

A recent study of 17 nursing facilities in Rhode Island demonstrated, however, that a multifaceted approach can improve the pain-management process of care and outcomes. This quality-improvement intervention consisted of pain-management education, audit and feedback, quality improvement focusing on Plan-Do-Study-Act (PDSA) cycles, one-on-one mentoring for each nursing home, and collaboration between participating nursing facilities. In addition, data from the Minimum Data Set was used to calculate the presence of pain in residents pre- and postintervention.<sup>6</sup>

Following the 15-month study, the use of appropriate pain assessments increased significantly from 3.9% at baseline to 43.8% ( $P < 0.001$ ). There were also substantial improvements in the use of pain-intensity scales (15.6% vs 73.9%,  $P < 0.001$ ) as well as the use of nonphar-

*Continued on page 8*

## B I O G R A P H I E S

**Kay Ball, RN, BSN, MSA, CNOR, FAAN**

Kay Ball, RN, BSN, MSA, CNOR, FAAN is a perioperative nurse educator and consultant working with perioperative nurses, professional organizations, healthcare facilities, industry, and legislative groups. She has served as the Laser Program Director for Mount Carmel Health and Grant Medical Center in Columbus, Ohio, and also has many years of experience in managing an operating room suite and a PACU. She also serves as chairman of Thomson American Health Consultants Nursing Continuing Education Council.

Ms Ball was inducted as a Fellow in the prestigious American Academy of Nursing (FAAN) in 1997 and is also a recipient of the 2003 AORN Award for Excellence, the 2003 Ohio Nurses Association's Excellence in Political Action Award and the 2004 ANA Barbara Thoman Curtis Award, the highest political excellence award to be given by the American Nurses Association.

Ms Ball is a member of numerous professional societies, including the American Society for Laser Medicine and Surgery, the Ohio Nurses Association and the American Society of Peri Anesthesia Nurses. She served as the 1992-93 President of the national Association of periOperative Registered Nurses (AORN) and the President of the AORN Foundation (2000-2001). Ms Ball has authored books, articles, and editorials and has lectured internationally.

Ms Ball received an AND (1974) from Columbus Technical Institute in Columbus, Ohio (received 1998 Alumnae of the Year Award); a BSN (1984) from Otterbein College in Westerville, Ohio (received 1997 Distinguished Alumnae Award); and an MSA (1987), focusing on healthcare administration, from Central Michigan University in Mount Pleasant, Michigan. She has also maintained certification in the operating room (CNOR) since 1981.

**Cathleen A. Bergeron, RN, MS**

Cathleen A. Bergeron, RN, MS, is director of nursing at Soldiers' Home in Holyoke in Holyoke, Massachusetts.

Ms Bergeron is currently president of the Massachusetts chapter of the National Association of Directors of Nursing Administration in Long-Term Care (NADONA/LTC). She is also a founding member of this chapter and was its corresponding secretary until 2002. In addition, Ms Bergeron has been a member of the national chapter of NADONA/LTC since 1991.

Ms Bergeron received her nursing degree from Cantonville Community College and her bachelor's degree in health management from the University of LaVerne in California. Ms Bergeron also received a master's degree in health administration from California State University, Northridge.

**Dennis Bloshuk**

Mr Bloshuk has more than 17 years of experience in the healthcare industry, including publications, advertising, and medical education. As a senior managing editor for Thomson Advanced HealthMarket Strategies™ (AHS), Mr Bloshuk is responsible for the editorial development and support of all educational materials relative to AHS initiatives, both certified and promotional, with particular focus on the evolving and emerging markets. Mr Bloshuk's role is to ensure the delivery of effective, quality content that meets the needs of these highly specialized markets. He also serves as a liaison between faculty, freelance writers and editors, and internal support systems to ensure the delivery of these materials in an efficient and cost-effective manner.

Prior to joining AHS, Mr Bloshuk worked for Thomas Ferguson Associates, a medical advertising firm, where he was instrumental in the launch of several pharmaceutical products,

including Nasacort, Sporanox, and Propulsid. In 1996, Mr Bloshuk joined Thomson Physicians World and served in various capacities before becoming a member of AHS in 2000.

**Sharon Elliott-Bynum, RN, PhD, BSN, CDONA/LTC**

Sharon Elliott-Bynum, RN, PhD, BSN, CDONA/LTC, is a nursing consultant for CAARE, Inc. in Durham, North Carolina. She was previously a nurse manager with Homeplace of Durham.

Ms Elliott-Bynum is a member of numerous professional societies, including the American Nurses Association and the National Association for Directors of Long Term Care, among others. In addition, Ms Elliott-Bynum is on the board of directors for the American Cancer Society and is president of the North Carolina Association of Directors of Nursing Administration. She also serves as editorial advisor for *Long-Term Care Magazine*.

Ms Elliott-Bynum received her RN degree from Watts School of Nursing and her bachelor's degree in nursing from North Carolina Central University. In 2004, she received her doctorate degree from Victory International College.

**Grace Forde, MD**

Grace Forde, MD, is director of neurological services at North Shore Pain Services, Valley Stream, New York, and assistant professor of neurology at New York University School of Medicine, New York. Previously, Dr Forde was director of the Headache Center at North Shore University Hospital, Bethpage, New York.

Dr Forde is a member of the American Academy of Neurology, the American Pain Society, the International Association for the Study of Pain, the Long Island Headache Society, the American Association for the Study of Headache, and the International Headache Society. As part of her research, she has participated in multiple clinical trials assessing the safety and efficacy of medications for the treatment of headache and neuropathic pain syndromes. In 1995, Dr Forde was honored with The Golden Neuron Award, which was presented to the best resident teacher by students in the neuroscience department of the University of California, San Diego School of Medicine.

Dr Forde is board certified in neurology and pain management. She has written and coauthored articles and book chapters on a variety of neuropathologic subjects, including the treatment of trigeminal and postherpetic neuralgia, myofascial pain syndrome, and the diagnosis of low-back pain. She received her medical degree from the Albert Einstein College of Medicine, Bronx, New York, and completed a residency in neurology at the University of California, San Diego School of Medicine and a fellowship in pain management and headache at the University of California, San Francisco School of Medicine.

**Michael Neville, PharmD**

Michael Neville, PharmD, holds a joint position with the Nell Hodgson Woodruff School of Nursing (Clinical Associate Professor) and Emory University Hospital. His primary responsibility at the nursing school is to teach pharmacology to undergraduate and graduate nursing students. Dr Neville also serves as Director of Emory Healthcare's accredited pharmacy residency training program. In this role, he mentors pharmacy residents in their postgraduate training. He also works several hours each week as a community pharmacist.

Dr Neville is a member of the Georgia Society of Health-System Pharmacists, the American Society of Health-System Pharmacists, and serves as chairman of Thomson American Health Consultants Pharmacy Continuing

Education Council. He has been nominated for numerous awards and was the recipient of the Jean Thomas Award for Creativity in Teaching (Sigma Theta Tau) in 1992.

Dr Neville earned his degree from the University of Georgia College of Pharmacy in 1992. He completed a general clinical residency at Emory University Hospital in 1992 and worked as a clinical pharmacist at Crawford Long Hospital from 1993 to 1996.

**Terrence E. O'Shea, BS Pharm, PharmD, CGP**

Terrence E. O'Shea, BS Pharm, PharmD, CGP, is regional clinical director, Eastern Region, for Omnicare, Inc. in Englewood, Ohio. His current responsibilities include the management of geriatric pharmacotherapy coordinators and the successful implementation of clinical programs in 27 pharmacies in 8 states. Previously, Dr O'Shea was director of consultant services and a clinical consultant pharmacist at Beeber Pharmacies, Inc in Englewood, Ohio.

Dr O'Shea is a member of the American Medical Directors Association, the American Society of Consultant Pharmacists, and the Ohio Society of Consultant Pharmacists. He was recently elected pharmacy liaison to the board of directors of the Ohio Medical Director's Association and is a member of the examination development committee for the Commission for Certification in Geriatric Pharmacy. In addition, Dr O'Shea was the only pharmacist selected to be on the Medicare Advisory Commission (MedPAC) Technical Expert Panel for Medicare Reimbursement of Non-Ancillary Services in Skilled Nursing Facilities.

Dr O'Shea, who has written and coauthored several articles and a chapter in *The Merck Manual of Geriatrics*, is a member of the editorial review boards for *Formulary* and *The Consultant Pharmacist*. In addition, he has served as course coordinator and lead instructor for the Cardiovascular I and Cardiovascular II Modules at several American Society of Consultant Pharmacists Midyear Conferences. Dr O'Shea received both his bachelor's degree and doctor of pharmacy from the University of Cincinnati College of Pharmacy.

**Dennis L. Stone, MD, MBA, CMD**

Dennis L. Stone, MD, MBA, CMD is chief medical officer for Home Quality Management Inc. in Palm Beach Gardens, Florida, which operates nursing homes and assisted living facilities throughout the southeastern United States. In addition, he is also corporate medical director for Integritas, an LTC Nurse Practitioner-Physician group practice.

Dr Stone is a member of the American Medical Directors Association and had served at various times as the organization's president, vice president and treasurer. Dr Stone is a member of the American Medical Association, American Academy of Home Care Physicians, and the California Medical Directors Association, serving as its president for an unprecedented 3 years. He has also served on various committees, including the quality committee for the American Health Care Association and the AMA's relative value and practice expense advisory committees. Dr Stone was instrumental in the Health Care Finance Administration's decision to equate relative physician work value of nursing home care with physician hospital care, which shifted millions of new dollars into the area of postacute care.

Dr Stone, who has been published in the *Journal of the American Medical Directors Association*, *Journal of the American Psychiatric Society*, and *Geriatric Review Syllabus*, also coauthored a book entitled, *Behavior Management in Geriatric Long-Term Care*. Dr Stone received his medical degree from the University of Oregon and his MBA from Golden Gate University in San Francisco, California.

*Continued from page 6*

macologic treatments (40.5% vs 81.9%,  $P<0.001$ ). For the nursing facilities that enrolled in the study, their proportion of residents with pain decreased 41.1% (12.2% vs 7.2%,  $P=0.03$ ), whereas the other 78 nursing facilities not enrolled had only a 12.1% reduction in residents' pain (12.7% vs 11.2%,  $P=0.29$ ). The study demonstrated no significant improvements, however, regarding pharmacologic care processes such as prescribing of pain medications, changes in pain medications, and prescribing of around the clock pain medications.<sup>6</sup>

It is clear that, in order to improve pain management in the LTC setting, many educational, procedural and

research gaps must be addressed. These gaps can be narrowed, however, by improving pain assessment tools and procedures, enhancing communication between residents and all pertinent interdisciplinary team members, and providing better pain education to LTC healthcare providers. There also must be greater research and agreement regarding the effective use of medications, especially those with the potential for significant adverse events, to manage pain in LTC residents. Finally, there must be continued dedication of resources and energy to further research regarding the effective use of pain medications in the LTC setting—especially those medications with the potential for significant adverse reactions.

## References

1. Tarzian AJ, Hoffmann DE. Barriers to managing pain in the nursing home: findings from a statewide survey. *J Am Med Dir Assoc*. 2004;5:82-88.
2. Horgas AL. Pain management in elderly adults. *J Infusion Nurs*. 2003;26:161-165.
3. Jones KR, Fink R, Pepper G, et al. Improving nursing home staff knowledge and attitudes about pain. *Gerontologist*. 2004;44:469-478.
4. Jenq GY, Guo Z, Drickamer M, et al. Timing in the communication of pain among nursing home residents, nursing staff and clinicians. *Arch Intern Med*. 2004;164:1508-1512.
5. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. *J Am Geriatr Soc*. 2002;50(6, suppl): S205-S224.
6. Baier RR, Gifford DR, Patry G, et al. Ameliorating pain in nursing homes: a collaborative quality-improvement project. *J Am Geriatr Soc*. 2004;52:1988-1995.



### ABOUT THE NIPC

The National Initiative on Pain Control® (NIPC®) is an integrated CME education initiative that was established in 2001 to help physicians improve outcomes for their patients who have pain. Living with pain has deleterious effects on many aspects of the patient's life, including deterioration of physical functioning, the development of psychological distress and psychiatric disorders, and impairment of interpersonal functioning. Of special concern, less-than-optimal training of physicians in pain disorders has led to the underassessment and undertreatment of patients who are living with pain. The program heightens physician awareness of the impact of pain on patient's daily living in terms of quality of life, lost workdays, and societal/familial consequences.

NIPC addresses the barriers to achieving pain control by providing potential pathways for action and expected amelioration of their patients' pain. By providing physicians with the latest advances and strategies in pain management, they will be better able to translate clinical data into clinical practice.

All NIPC programs are developed and continuously evaluated by the NIPC Education Council, an expert, multidisciplinary team of specialists, researchers, and practicing physicians in pain management. The NIPC Faculty includes nationally respected experts in the pain management field.

*You have received this mail because we believe it may be of interest to you. If you would like your name to be removed from our mailing list, please follow these instructions:*

*Call 1 (800) 873-1362 and leave a message with your name and address indicating that you would like to be removed.*

## Multidisciplinary Pain Management in Long-Term Care



Thomson Advanced HealthMarket Strategies™  
150 Meadowlands Parkway, Secaucus, NJ 07094-2304