Pain Management and Compliance with Regulations: A Medical Directors Perspective

JOINT PROVIDER AND SURVEYOR TRAINING MEETING

SEPTEMBER 20, 2016 GRAND RAPIDS MICHIGAN

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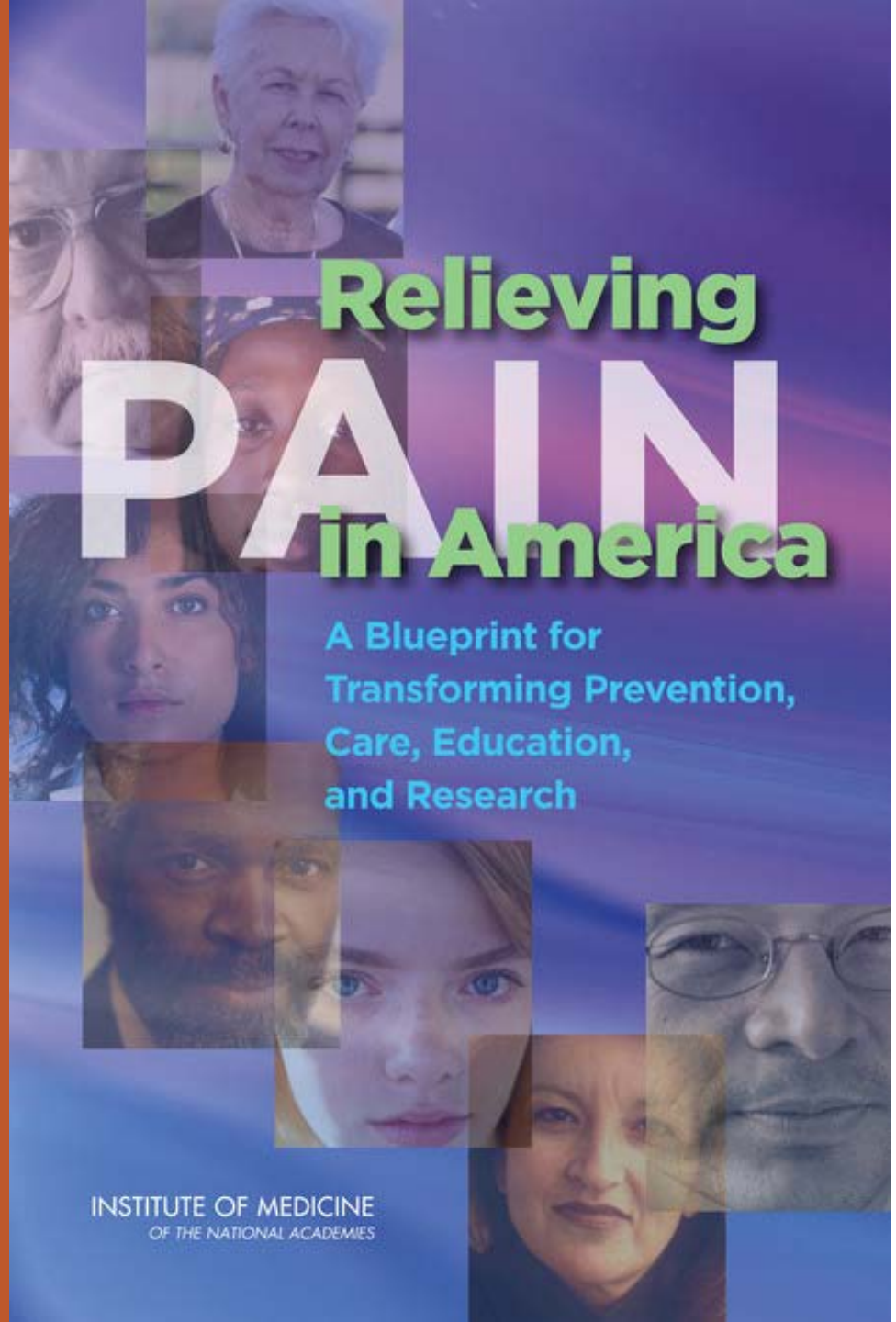


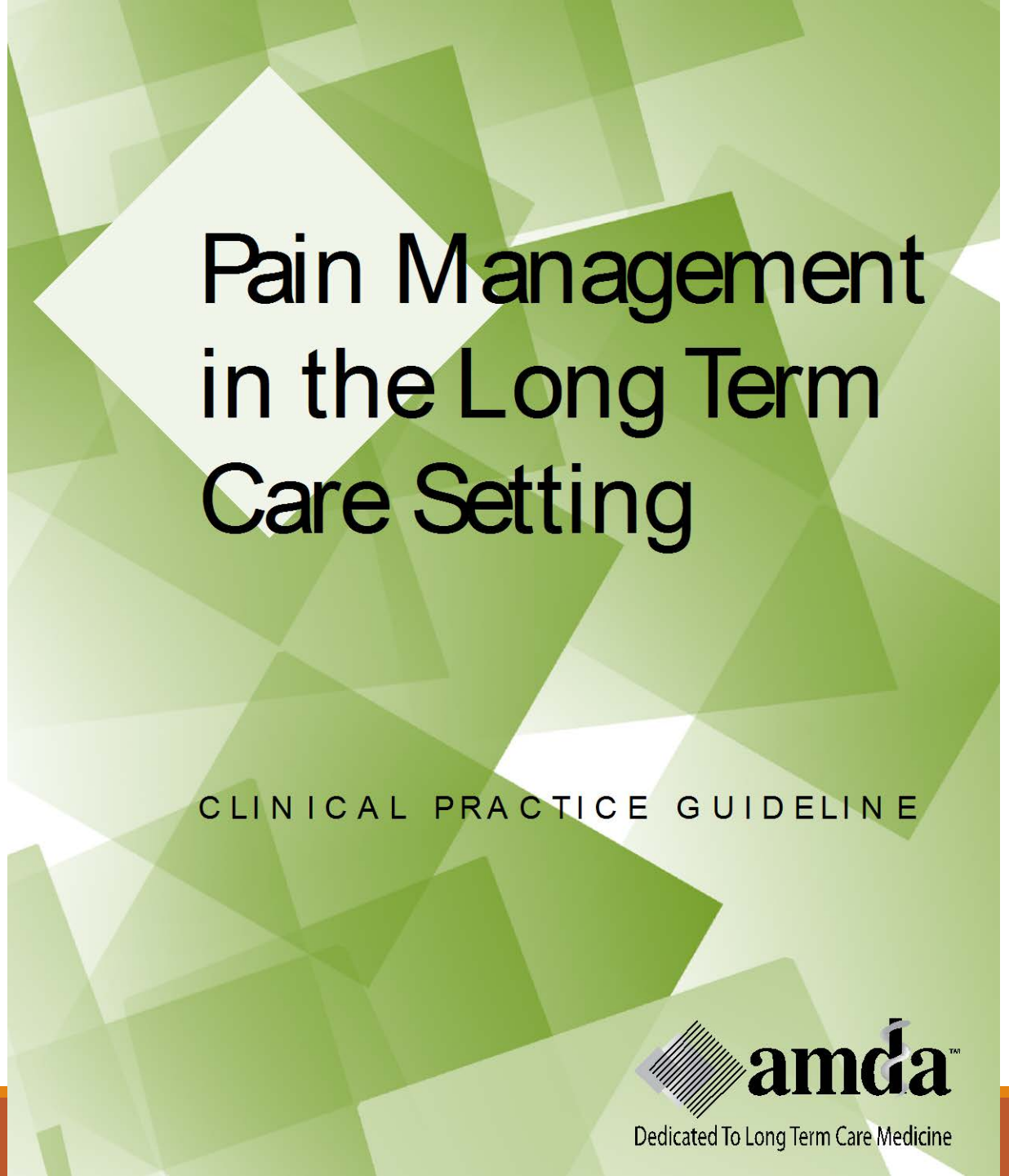
Institute of Medicine Report

June, 2011

100 million American adults

635 billion dollars/year in management and lost productivity

Cultural transformation to prevent, assess, treat and understand pain of all types


Pain Management in the Long Term Care Setting
CLINICAL PRACTICE GUIDELINE
amda
Dedicated To Long Term Care Medicine

Definition of Pain

Unpleasant sensory and emotional experience that can be acute, recurrent, or persistent

- Acute pain
- Chronic pain

Not part of normal aging

Resident/patient report of pain is the best indicator of pain

- Recognize many residents/patients do not or cannot report pain

Prevalence of Pain in SNF/LTC settings

49-83% - self-reporting and chart reviews (Fox, et al, CMAJ, 1999;160(3):329)

39.5-49.5% - MDS data (Teno, et al, JAMA, 2001;285(16):2081)

Conditions That Cause Chronic Pain

80% of residents have some condition that can be associated with pain

Common causes/underlying diseases

- Musculoskeletal
- Neurologic conditions
- Medications
- Diabetes

Nursing Home Quality Measures for Pain

Short stay

- Percent of Residents who Self-Report Moderate to Severe Pain

Long stay

- Percent of Residents who Self-Report Moderate to Severe Pain

Adverse effects of Pain

Depression/Anxiety

Decreased mobility/functional impairment

Agitation/Aggression

Sleep disturbance

Weight loss

Adverse Effects of Unrelieved Pain

Functional decline

Immobility

- Contractures
- Skin breakdown
- Incontinence
- Deconditioning

Quality of Life

- Depression/anxiety/sleep disturbance
- Lack of activity
- Behavior problems

Pain Management: Barriers in the Nursing Home

Poor history taking and standardized assessment

Staff turnover/lack if consistent assignment

Lack of knowledge/education

Cultural bias/ageism/health care beliefs

Access to medications

Pain Management: Barriers in the Nursing Home

Inability to communicate and/or confusion

Fear about addiction and dependence

Limited practitioner involvement and poor prescribing

Lack of family involvement

Pain Management: What Families Should Ask
(Adapted from Advancing Excellence FAST FACTS: Pain Management in Nursing Homes)

How do you measure pain and how often?

How do you document information about pain?

How do you include residents and families in care planning?

How are you treating pain? How do you know it is working?

What do you do if pain treatment is not working?

When do you notify the practitioner?

How do you monitor and mange side effects from pain drugs?

Obstacles to Good Pain Management: Lack of Comprehensive Pain Assessment Protocols

Is pain assessed and reassessed frequently or only with MDS

- Fifth vital sign
- Can't evaluate and treat if you don't ask because you won't know

Do we really have good tools/process for cognitively impaired?

Limited use of non-pharmacologic interventions

Poor prescribing (wrong drugs, dose, interval, etc.)

- Chronic pain management is multi-modal
- Opioids are not the answer to all pain

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-22

DATE: **January 23, 2009**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of Revised Quality of Care Guidance at F309, including Pain Management as Part of Appendix PP, State Operations Manual, Additional Minor Changes Made to Appendices P and PP as Described Below

F-Tag 309 Quality of Care: Key Components of Pain Management (CARE PROCESS)

Assessment/Recognition

Management of Pain

- Non-pharmacologic interventions
- Pharmacologic Interventions

Monitoring, Reassessment, and Care Plan Revision

F-309 and Pain Management: Facility Responsibilities

Assess for the potential for pain

Recognize pain when it is present

Assess pain when identified

Observe for the impact of care, activities, and treatment on pain

Monitor regularly for the presence of pain

- Change of condition
- New pain
- Exacerbation of pain

Pain Management: Recognition

When should pain be assessed

- Upon a patient's admission to a LTC facility and at each quarterly and annual review;
- Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition;
- Whenever a patient exhibits unexpected social withdrawal or signs of depression;
- Whenever vital signs are obtained (i.e., as the "fifth vital sign");
- At least daily, for patients with a known painful condition; and
- Before and after administration of as-needed (PRN) analgesic medication.

Pain Assessment MDS 3.0: Section J

Uses standard questions for residents who can communicate

- Numeric rating
- Verbal descriptor

Has staff assessment for residents who can not communicate

- Non-verbal indicators

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐

Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"

0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐

A. Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"

0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐

B. Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"

0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. Numeric Rating Scale (00-10)

Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. Verbal Descriptor Scale

Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

☐	**C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	**D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
☐	**Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

☐	**A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	**B. Shortness of breath** or trouble breathing **when sitting at rest**

F-309 Management of Pain

Address and treat underlying cause or causes (ie better control of diabetes for diabetic neuropathy)

Development treatment plan based on whether pain is episodic, continuous or both (prn vs standing orders)

Diagnosis: Types of Pain

- Nociceptive
  - Somatic
  - Visceral
- Neuropathic

When Diagnostic Evaluation of Pain May Not Be Indicated

- The patient is at the end of life or has an end-stage condition,
- The patient has requested in an advance directive that certain diagnostic procedures not be performed,
- Identifying the cause of the pain would not change the patient's care plan, and
- The burdens of a diagnostic workup outweigh the potential benefits that would be derived from determining the reason for the pain.

F-309 Management of Pain (cont.)

Treatment plan/interventions are based on:

- Resident's needs and goals
- The source, type of pain, severity and potential for multiple sources (knee pain and abdominal pain)

A variety of treatments may need to be tried (multiple modalities may be needed)

Develop care plan with specific goals (ie pain will be maintained at a level of three or less on the pain scale within 2 weeks over 75% of the time)

F-309: Non-pharmacologic Interventions

Environmental

Physical (heat/cold/compression)

Cognitive/behavioral (ie relaxation, music, aroma therapy)

May combine with pharmacologic (might allow for lower potency/dosing)

F-309: Pharmacologic Interventions

Based on cause, location, severity

Weighs risks and benefits and considers patent/resident goals for pain relief

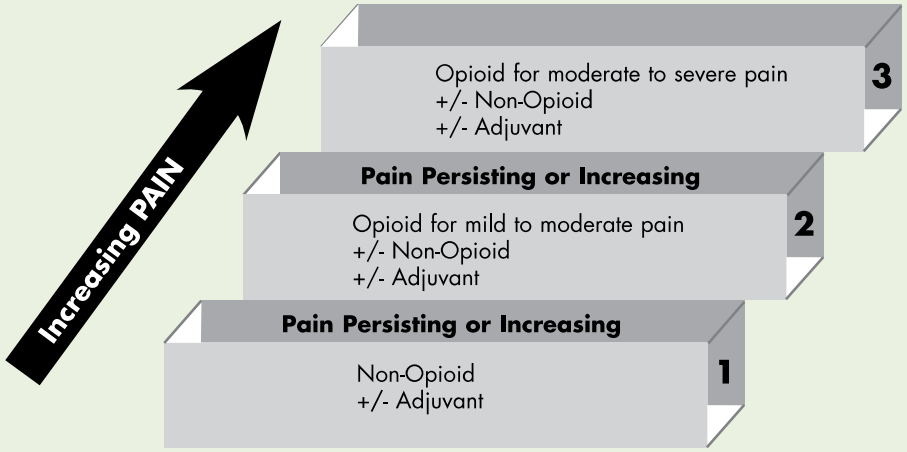
Select route

Follow an accepted approach to medication selection (WHO ladder)

Consider factors that might affect your choice of medication including comorbidities, other medications, severity, cause, and course of illness (ie EOL care and where in that continuum)

Treatment of Pain: Medication Strategies

FIGURE 1
World Health Organization Pain Relief Ladder[41]



F-309: Monitoring, Reassessment, and Care Plan Revision

Monitor over time to evaluate effectiveness of pain management

Use standardized assessment tools appropriate for the resident/patient

Evaluate if care plan needs to be revised

Monitorring of Pain for Individual Patients

- Every day;
- Every shift;
- Before and after administration of analgesics;
- Before, during, and after ADLs; and
- With associated procedures or therapy that may cause pain.

Pain Management: Who is Responsible (ALL IDT Members)

- Nursing staff
- Rehabilitative staff
- Practitioners
- Dietician
- Social workers
- Pharmacists
- Administration
- Patients and responsible parties

Monitoring Pain Management at a Facility Level

Process Indicators

- Facility has adopted policies and procedures that promote a systematic, interdisciplinary, and individualized approach to pain management.
- Facility staff and affiliated professionals receive appropriate education that reflects current standards and practice in pain management.
- Patients are regularly assessed or evaluated for the presence of pain or risk factors for pain.
- Staff members have selected a pain assessment method appropriate for each patient's cognitive level.
- Scope of diagnostic workup for pain (or reasons for limiting its scope) and pain relief measures are documented in the patient's record.
- An appropriate, individualized, interdisciplinary care plan that includes stated care goals is implemented for each patient with pain.
- Environmental and other nonpharmacologic interventions are implemented to optimize function and quality of life for patients with pain.
- Analgesic medications are used and monitored appropriately in patients with pain.
- Patients prescribed NSAIDs are monitored for deterioration in cardiac, cognitive, or renal function and for the onset of GI symptoms and signs (including occult blood in the stool).
- When opioids are prescribed, a bowel regimen is implemented to prevent opioid-induced bowel dysfunction.
- During initiation of opioid therapy, a monitoring plan to address excessive sedation and respiratory depression is prepared and implemented.
- Patients with pain are assessed for depression.
- Charts include appropriate documentation of assessment, treatment, management, and outcomes.

Monitorring Pain Management at a Facility Level

Outcome Indicators

- Increases in
  - Number of patients achieving pain control goals
  - Number of patients with pain showing improvements in function and quality of life
  - Number of patients receiving scheduled pain medications

- Decreases in
  - Number of doses of PRN pain medications
  - Number of patients with severe opioid-related constipation or fecal impaction
  - Number of patients reporting pain on a daily basis

Pain Management: Medical Director Role F-501

Policies and Procedure

- Educate staff on best practices
- Review measures related to pain management
- Participate/support pain management team

Medical Staff Oversight

- Monitor staff performance in identifying, assessing, and managing pain in keeping with principles of good pain management
- Audit charts and provide feedback to practitioners
- Assess individual patients when concerns about management/appropriate prescribing in keeping with principles of good pain management

Pain Management: Practitioner Role

Assess and appropriately document pain (location, duration, severity, what improves/worsens, nature of pain)

Utilize non-pharmacologic modalities when appropriate

Follow principles of “QUALITY PRESCRIBING”

Reassess effectiveness of plan on a regular basis and document in their notes

DEPRESCRIBE

Pain management: AMDA Quality Prescribing

AMDA Quality Prescribing

Key Benefits

Key risks

Risk/Benefit Ratio

Safe Prescribing

Monitoring and Effectiveness

Deprescribing and Diversion

Key References

Pain Medication Orders: A Couple of Caveats

Complete orders only please

Beware of multiple prns-be specific

- No ranges for frequency (every 4-6 hours)
- Specify specific pain/severity if different pain meds (correlate with your pain assessment tools)
  - Acetaminophen for mild pain (define)
  - Oxycodone for moderate to severe pain(define)

ProPublica Nursing Home Inspect December 2015: Deficiencies Related to Pain

324,509 deficiencies overall

5.0% G level or higher

16.1% pain cited in deficiency

52,219 deficiencies with pain in citation

15.1% G level or higher

Changes in Opioid Use in the United States

From 1999 to 2010 we doubled the number of opioid prescriptions

In 2009 hydrocodone was the single most prescribed drug in the United States

Opioid analgesics are the third most common class of drugs prescribed

Cost of 8.4 billion for opioids in 2010

Limited evidence of effectiveness in chronic pain

Prescription Pain Management: Other Regulators

Federal DEA

State PDMPs (Prescription Drug Monitoring Programs)

FDA REMS (Risk Evaluation and Management Strategy) for ER/LA opioids (2012)

DEA and Prescribing Controlled Substances in Nursing Homes

Existing DEA rules see nursing homes as outpatient settings and do not see the nursing staff as agents of the prescriber like they do in hospitals

SNF prescriber must provide a signed prescription to the pharmacy before controlled substance can be dispensed or speak with pharmacist directly

Nurse can not take verbal order from physician and communicate to pharmacy

National Action Plan for Adverse Drug Event Prevention

U.S. Department of Health and Human Services
Office of Disease Prevention and Health Promotion

2014

Opioid Adverse Events

Over sedation

- Yes, you should have naloxone in your emergency box and make sure staff trained to use it

Respiratory depression

Gastrointestinal adverse effects

Opioid induced hyperalgesia

Pruritus

Opioid Adverse Events

From 1999-2010 we quadrupled the number of prescription opioid deaths which now exceeding heroin and cocaine combined

Emergency department visits have doubled since 2004

Need to balance the need for effective pain treatment in parallel with efforts to ensure safest treatment

- Therapeutic use
- Misuse/abuse

National Action Plan for Adverse Drug Reactions: 2014 Opioids

National Action Plan for Adverse Drug Events

Prescription opioid–related deaths are considered to be one of the Nation's leading preventable public health problems.

Access to safe and effective pain care remains an important problem in the United States; efforts to minimize the burden of harms from opioids should be implemented in parallel with efforts to ensure patients suffering from pain receive the most effective and safest treatment available.

National Action Plan for Adverse Drug Events

Distinguishing overdoses that occur during the normal course of care from misuse/abuse will be important in efforts to prevent opioid ADEs.

Future surveillance efforts should capture opioid ADEs on the basis of validated process and outcome measures, differentiate opioid ADEs that occur in the normal course of care from those arising from opioid misuse/abuse, and identify ADEs occurring during transitions of care.

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ADVERSE EVENTS IN SKILLED NURSING FACILITIES: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

February 2014
OEI-06-11-00370

OIG 2014 Report SNF Adverse Events and Temporary Harm Events

22% of Medicare beneficiaries experienced harm events during the first 35 SNF days

- 37% medication related
  - 12% medication related delirium or other change in mental status
  - 4% constipation, obstipation, ileus

11% of Medicare beneficiaries experienced temporary Harm events during the first 35 days of their SNF stay

- 43% medication related
  - 7% medication induced delirium or other changes in mental status

Eight Opioid Safety Principles for Patients and Caregivers©

1. Never take an opioid pain medication that is not prescribed to you
2. Never adjust your own doses
3. Never mix with alcohol
4. Taking sleep aids or anti-anxiety medications together with opioid pain medication can be dangerous
5. Always tell your healthcare provider about all medications you are taking from any source
6. Keep track of when you take all medications
7. Keep your medications locked in a safe place
8. Dispose of any unused medications

Proposed for Consideration by AAPM
www.painmed.org

Other Issues in Pain Management: Prescription Opioid Abuse

Residents/Patients

Staff

Family/Visitors

TECH & SCIENCE

WHEN DRUG ADDICTS WORK IN HOSPITALS, NO ONE IS SAFE

BY KURT EICHENWALD ON 6/18/15 AT 6:07 AM

Emergency Physician Identification of a Cluster of Elder Abuse in Nursing Home Residents: July 2014 Annals of Emergency Medicine

During the next 2 days, 4 additional residents were identified by the nursing home with both a positive urine test result for opioids and symptoms of opioid toxicity. All 4 patients were evaluated in the ED and admitted to the hospital. Blood testing results were positive for high levels of morphine in all 7 patients. A follow-up investigation led to a second-degree murder charge against one of the nursing home nurses, who pled guilty to involuntary manslaughter and 6 counts of felony patient abuse.

Substance Abuse in the Elderly (Mental Health Services Administration 2008)

Not just “younger” residents

One in eight seniors seeks help for substance abuse

- 60% alcohol
- 16% heroin
- 11.4% cocaine

Happy Hour in Assisted Living? Substance Abuse Among Seniors on the Rise

Are senior living facilities equipped to provide addictions counseling to residents?.

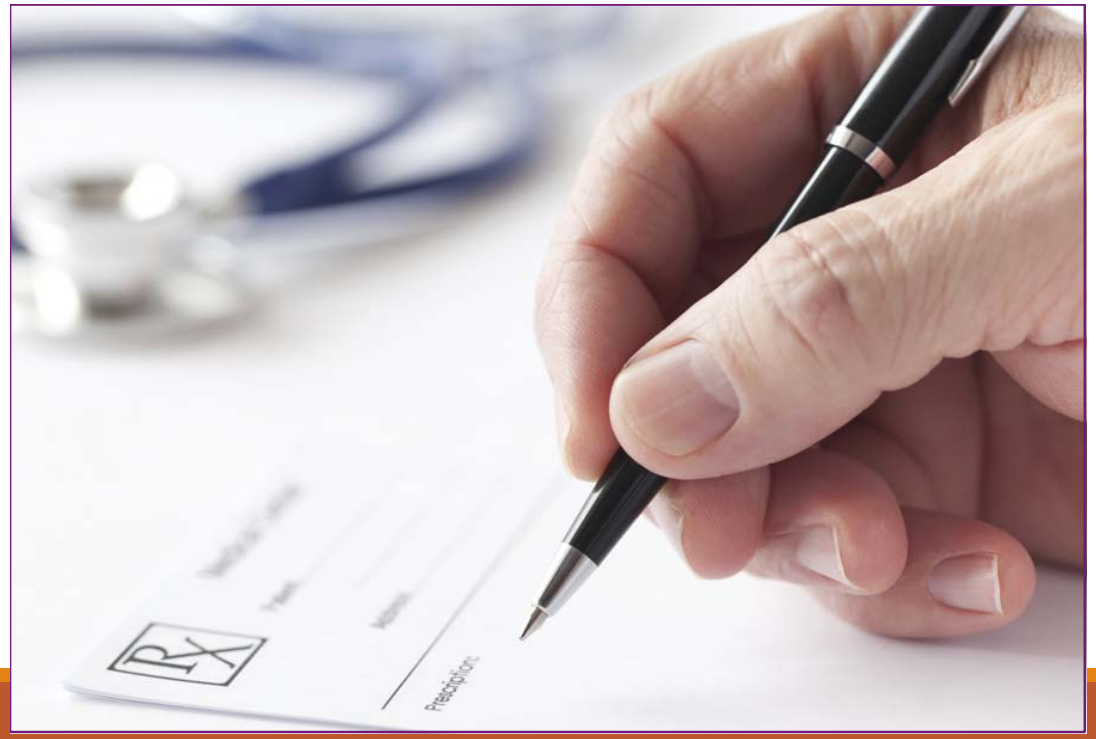
Senior living providers aim to meet the demands of today's active adult lifestyles, happy hour and cocktail parties are becoming increasingly common in independent living and assisted living facilities. These types of activities will present unique challenges should one or more residents have a history of substance abuse.

Substance Abuse: Need Facilities that Have Expertise

Jewish Home Launches First in Nation Nursing Home Based Geriatric Substance Abuse Program

NEW YORK, NY: August 13, 2014—Today, New York City's Jewish Home Lifecare, one of the country's largest and most diversified not-for-profit geriatric health and rehabilitation institutions, will launch the country's first nursing home-based recovery program for older adults dealing with alcohol and/or prescription drug addiction.

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Determining When to Initiate or Continue Opioids for Chronic Pain

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with nonpharmacological therapy and nonopioid pharmacologic therapy, as appropriate.

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

When opioids are started, clinicians should prescribe the lowest effective dosage.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Assessing Risk and Addressing Harms of Opioid Use

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Consider offering naloxone for those a high risk for overdose.

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

TO LEARN MORE
WWW.CDC.GOV/DRUGOVERDOSE/PRESCRIBING/GUIDELINE

National Pain Strategy

!

!

March 18, 2016

National Pain Strategy outlines actions for improving pain care in America

Plan seeks to reduce the burden and prevalence of pain and to improve the treatment of pain

DATE: **September 27, 2012**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: F tag 309—Quality of Care- Advance Copy

Memorandum Summary

- **Revisions:** Revisions have been made to Guidance to Surveyors at F tag 309 in Appendix PP of SOM.
- **Power Points:** Power Point training material with speaker notes for Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) and State Survey Agencies (SAs) to be used to train surveyors on this revision are provided.

Pain Management in End Of Life Care for the Nursing Home Resident

Thorough assessment and frequent re-assessment for presence and cause (may be multiple types of pain present)

Use medications regularly for established pain (same basic principles)

Predict the adverse events (constipation)

Availability of medications

Medicate terminal restlessness

Work with hospice if benefit chosen

The Goldilocks of Medication Management at the End-of-Life: Not Too Little, Not Too Much, Just Right!

Presented by **Mary Lynn McPherson,** PharmD, MA, BCPS, CPE

Professor and Vice Chair Department of Pharmacy Practice and Science
University of Maryland School of Pharmacy

References:

Keith H. Berge,a, Kevin R. Dillon,b Karen M. Sikkink,b Timothy K. Taylor,c and William L. Laniera .Mayo Clin Proc. (2012) ***Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention***. Jul; 87(7): 674–682. doi: 10.1016/j.mayocp.2012.03.013. PMCID: PMC3538481

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Still in draft format but good materials.

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AMDA-The Society for Post-Acute and LTC Medicine. ***Pain Management in the Long Term Care Setting Clinical Practice Guideline***. Columbia, MD:AMDA 2012.