Virginia Long-Term Care Clinician Network Monthly Forum

March 20, 2024

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care. During the presentation we can mute ourselves until it is time for more interaction.

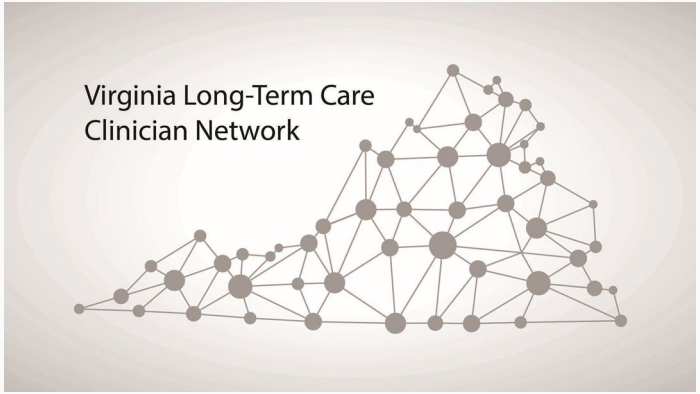
Please use the chat box:

- **Your name and region/city/town**
- **Best thing at AMDA if you got to go**

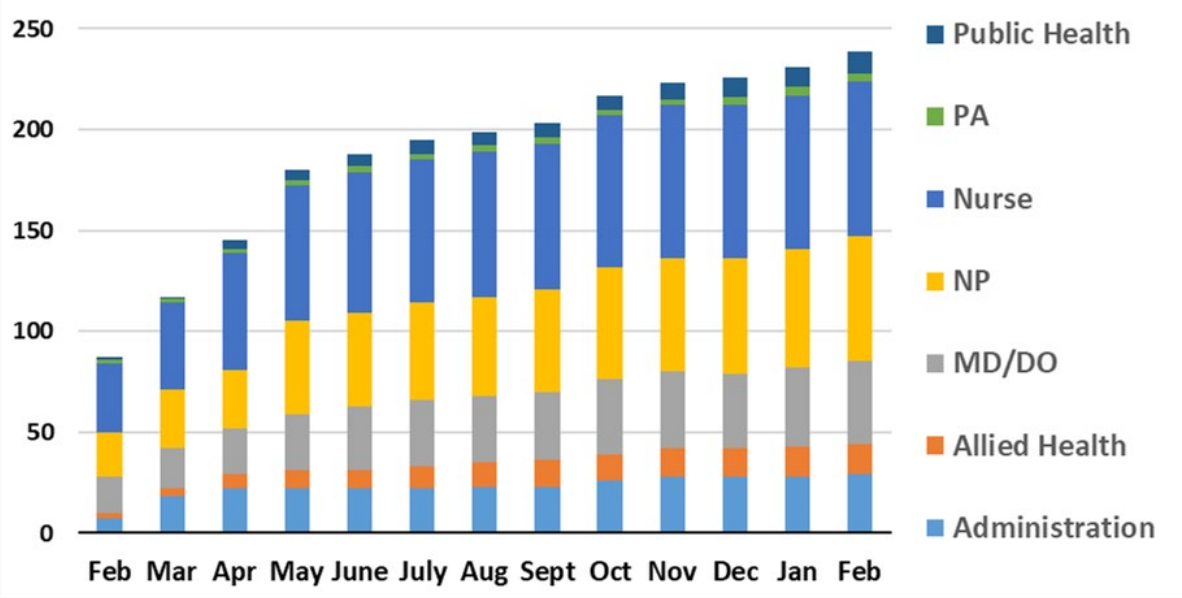
ltccn.vcu.edu

Welcome New Members!

Janaya Ogunware, ACNP - Central
Alexander Hendrick, NP - Northwest
Shaun Thompson, MD - Southwest
Aaron Shives, MD, CMD - Northwest
Murali Ramadurai, MD - Eastern
JoAnn Wang, DO - Northwest
Lingshu Wang, FNP - Eastern & Central
Nasiffa Hossain, MD - Central
Susan Ackman, RCAL - Northern
Anthony Kangea, FNP-BC - Eastern
Brandi Baker, RN - Southwest



245 members ~ and still growing!



ltccn.vcu.edu

Chat Waterfall

Answer in chat, but do not press ENTER until we count down:

How do you help correct misinformation (like drinking bleach to fight COVID or getting COVID is better protection than vaccination) and foster critical thinking skills in your settings?

Pain in PA/LTC: a Discussion

Christian Bergman, MD, CMD, FACP
Assistant Professor, Division of Geriatric Medicine, VCU

Learning Objectives

1. Provide an overview of pain management with a focus on treatment.
2. Discuss LTC specific issues in regards to pain management and F tag 697.
3. Discuss strategies around pain management compliance and screening for adverse behavior.

Note: *10 anonymous poll questions will pop up for group participation*

Guidelines

AAPM
American Academy of Pain Medicine

Wide range of topics:
- Multidisciplinary spine care
- Challenges with Implementing Opioid Guidelines
- Using IV Ketamine Infusions for Acute Pain Management

https://painmed.org/clinical-guidelines/

More narrow list of topics:
- Epidural, joint injections, regenerative medicine, sedation
- Opioid guidelines, risk stratification

https://asipp.org/guidelines/

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS
THE VOICE OF INTERVENTIONAL PAIN MANAGEMENT

PAIN MANAGEMENT
in the Post-Acute and Long-Term Care Setting

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

https://paltc.org/products/pain-management-2021-cpg

ltccn.vcu.edu

Pain – Background

Adequate Pain Control

- Acute and chronic pain are common (80%) and affect measures of patients' wellbeing such as mood and the ability to perform activities of daily living.
- Pain management should be considered a patient's right in the LTC setting.
- Optimal pain management in this setting is often challenging due to regulatory and transient relationship with patients in SNF setting.

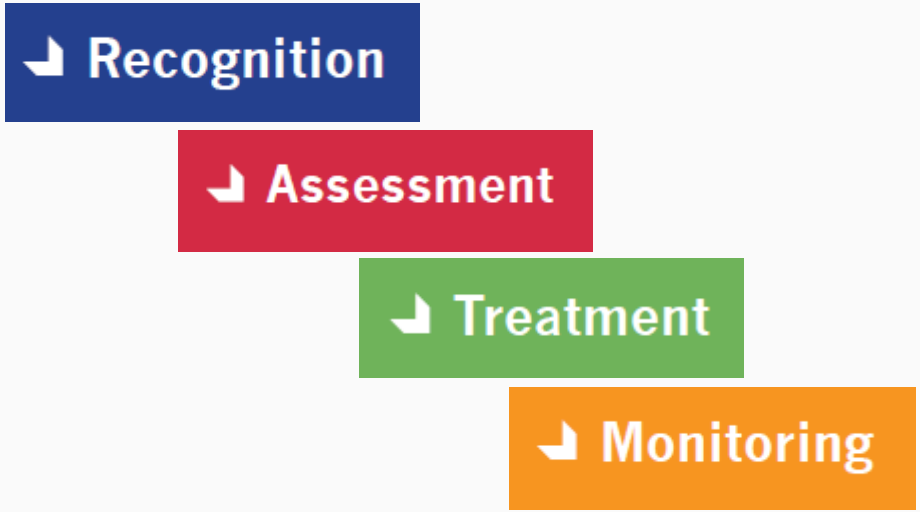
Potential for Opioid Misuse

- 11-40% of US adults live with chronic pain.
- 1/3 of those patients receive a pain medication.
- 21-29% of patients who are prescribed an opioid will misuse them
- 10,300 people over age 55 died from opioid overdose in 2019 compared to 500 in 1999.
- ER visits re to opioid misuse rose by 220 percent in people 65 and older from 2006 to 2014.

https://www.aarp.org/health/conditions-treatments/info-2022/opioid-deaths-rising.html

Pain – Conceptual Framework

1. Pain Assessment
2. Functional Assessment
3. Pain Management
4. Opioid Prescribing
5. Opioid Use Disorder (OUD)



Consider facility policy, procedures, staff development and QAPI endeavors around this framework

https://www.aafp.org/family-physician/patient-care/care-resources/pain-management/aafp-chronic-pain-management-toolkit.html

Question 1

Do you ask ALL patients during the initial H&P (or first visit) whether they are in pain?

A. Yes (>80% of the time)
B. No (<20% of the time)
C. Mostly (20-80% of the time)

Question 2

Do you observe for non-verbal signs of pain for ALL patients during the initial H&P (or first visit)?

A. Yes (>80% of the time)
B. No (<20% of the time)
C. Mostly (20-80% of the time)

Question 3

Do you ask the nurse whether the patient has reported pain during your initial visit with the patient?

A. Yes (>80% of the time)
B. No (<20% of the time)
C. Mostly (20-80% of the time)

Question 4

For your SNF patients, do you ask the therapist (PT, OT, etc.) whether the patient has reported pain during your initial visit with the patient?

A. Yes (>80% of the time)
B. No (<20% of the time)
C. Mostly (20-80% of the time)

Pain Management - Barriers

Physician Factors

- Misunderstanding
  - Addiction / dependency
  - Uncontrollable side effects
- Questioning of patient
- Inability to empathize
- Not relating pain to function
- Federal / State regulatory burden

Patient Perspectives

- Pain is inevitable consequence of disease
- Don't want to "complain"
- Don't want to complain of pain as it is "worsening of disease"
- Addiction concerns
- Altered perception of pain

Pain Management - Barriers

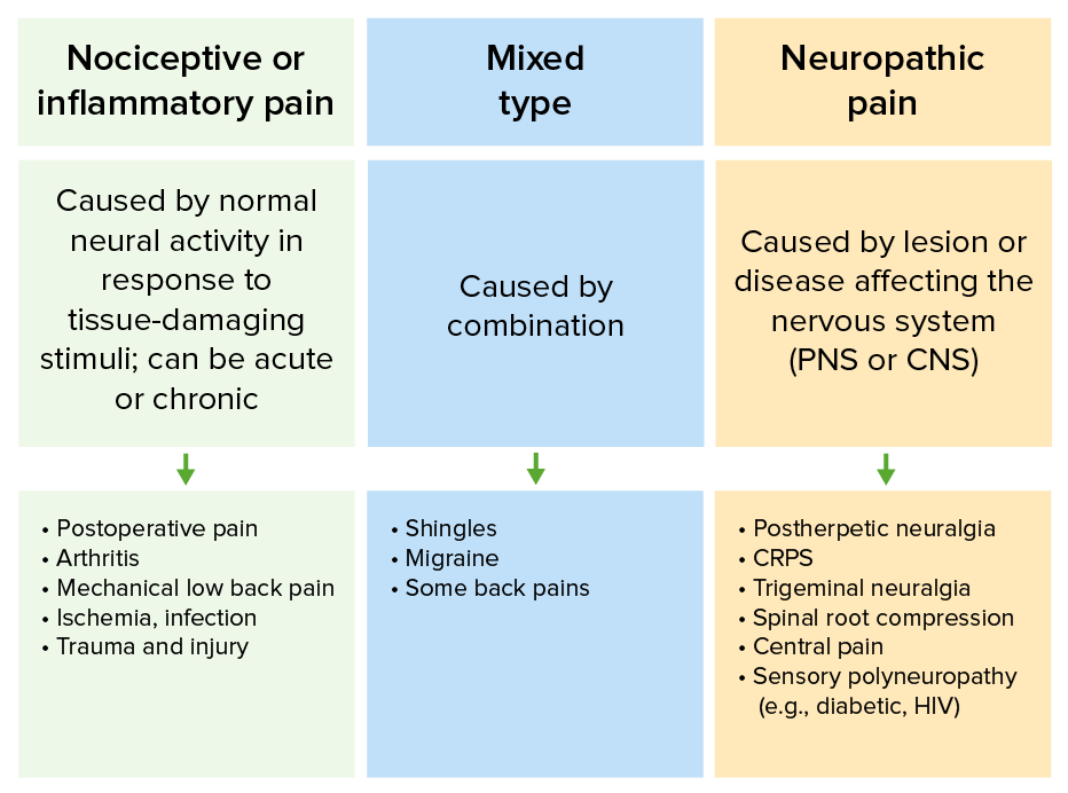
Nurse Factors

- Misunderstanding
  - Addiction / dependency
  - Uncontrollable side effects
- Questioning of patient
- Inability to empathize
- Fear of overdosing
- Fear of calling doctor

Cultural / Societal Factors

- Racial / Ethnic / Gender bias
- Substance abuse history

Types of Pain



https://www.lecturio.com/concepts/physiology-of-pain/

Case 1: Mrs. Key

Mrs. Key is an 85 y.o. year old female with a h/o prior stroke with left -sided weakness and contractures, hyperlipidemia, hypertension, dementia, and essential thrombocytosis who was first admitted to SNF secondary to a hospital admission related to possible elder abuse. She has been a long-term care resident under your care for a few years. You are asked by nursing staff to follow up on her crying episodes. On talking to the nursing staff, they report that she has lost 20 -30 lbs over the last 6 months, doesn't eat much, and has ongoing crying spells. Last done 2 months ago show a stable thrombocytopenia and hemoglobin without an elevated WBC and normal kidney function. Last time you saw her a few weeks ago, she was cheerful and likes to reflect on her native country and share memories of her childhood. When you asked her how she was doing she would smile and say "don't worry about that."

Question 5: Does she have chronic pain?

A) Yes

B) No

C) I don't know

Case 1 Discussion

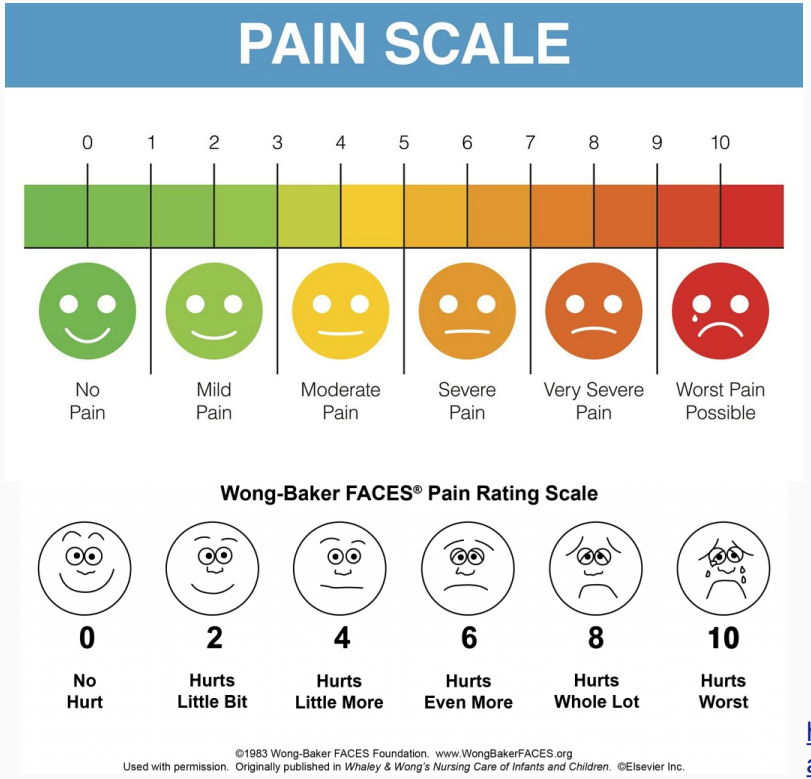


Table 2: **Pain Assessment in Advanced Dementia (PAINAD)**

Items	0	1	2	SCORE
Breathing (Independent of vocalization)	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low level of speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad, frightened, frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
TOTAL				

https://www.verywellhealth.com/pain-assessment-1131968

https://www.jems.com/patient-care/painad-scale-offers-alternative-to-assessing-pain-in-the-dementia-patient/

Case 1: Mrs. Key

Question 6:

How would you manage possible pain associated with a depressive disorder?

A) Frequent re-assessment of pain and mood

B) Start an anti-depressant

C) Schedule non-opioid pain medications such as acetaminophen

D) All of the above

Case 2: Mr. Jones

Mr. Jones is a 30 y.o. year old male with a h/o incomplete spinal cord injury 2/2 a car accident a few years ago and asthma who was hospitalized secondary to inability to care for himself at home and caregiver stress. He was stabilized in the hospital and discharged to SNF care and subsequently transitioned to LTC due to loss of primary caretaker. He has been on oxycodone 5 mg q12H for several months. Oxycodone was initially started due to a pressure injury requiring extensive wound care. In prior conversations, you have attempted to wean him off the pain medications but he insists that he is still in pain. You are asked to see him for new pain. He endorses new onset toe pain. On physical exam, it appears he has an abscess. You tell him you need to perform an I&D and start an antibiotic. He immediately tells you, “you are going to increase my pain medicines too right? This hurts doc!”

Question 7

How do you approach the conversation with Mr. Jones

A. Explain that the pain can't be that bad, it doesn't require an escalation of his oxycodone.
B. Explain to him that we have talked about this before, we agreed not to escalate pain medications.
C. Increase his oxycodone to 5 mg q4H as needed but make it clear to him that it is only temporary for 7 days after the I&D.
D. Discuss opioid risks and keep conversation on outcome patient is seeking, with a goal of not eliminating the pain.

Case 2 Discussion

MICHIGAN SAFER OPIOID PRESCRIBING TOOLKIT

How to Have Difficult Conversations About Pain Management

Resources for providers on how to have conversations about pain management with their patients.

Principles:

1) Keep the primary focus on outcomes patients care about.
2) When discussing risks, focus on the drugs.
3) Develop a differential diagnosis for patient behaviors that cause concern.
4) Redirect clinical encounters to focus on what patients can do to improve their quality of life.

https://injurycenter.umich.edu/opioid-overdose/michigan-safer-opioid-prescribing-toolkit/background-on-opioid-use-pain-and-pain-management/difficult-conversations/

Case 2 Discussion

"I want to talk with you about how what we know about opioids has changed based on the latest science and clinical recommendations..."

"It's my job to weigh up the potential benefits and potential harms, and to prescribe medications only when the benefits are greater than the harms. In your situation, I'm worried the risks outweigh the benefits, so I can't keep prescribing them for you."

"We used to think people suffering from pain did not become addicted to prescription pain medicines. We now know that you can become addicted to pain killers used for chronic pain, even if you haven't had problems with drugs or alcohol in the past."

"We used to think the dose didn't matter as long as we went up slowly, but now we know higher doses lead to higher risks of serious injuries and accidental death. And, higher doses don't seem to reduce pain over the long-run."

"Remember, you might feel a little worse before you feel better. I want to see you again in four weeks to check how you're doing. By then, your pain should be evened out again."

"I want to work with you to find a better pain management plan."

"My experience is that patients who taper opioids end up with clearer thinking and more energy to engage in positive activities that help them focus less on their pain."

https://injurycenter.umich.edu/opioid-overdose/michigan-safer-opioid-prescribing-toolkit/background-on-opioid-use-pain-and-pain-management/difficult-conversations/

Case 3: Mr. Morris

Mr. Morris is a 58 year old male with a h/o ESRD on iHD TTS, DM, HTN, prior right THA due to avascular necrosis who was hospitalized last year due to new onset seizures and found to have metastatic small cell lung cancer with CNS mets. He was discharged to IPR where he stayed for 12 days before being admitted to SNF. He has now returned after being re-hospitalized for acute respiratory failure, diagnosed with aspiration pneumonia, and new spinal bony mets. He started to receive radiation therapy and you are asked to see him today for pain assessment. On physical exam, he is kyphotic, sitting in his wheelchair, he appears visibly in pain and is slightly tachycardic. On history, he tells you that he refused to go to HD yesterday due to the pain. He reports that the hydromorphone only works “for 1 -2 hours” then stops working. He reports that he is currently in 9/10 pain and states that he just had his 4 mg hydromorphone about 2 hours ago.

Question 8

Which opioid medication should probably be avoided in patients on hemodialysis or advanced CKD?

A) Fentanyl
B) Methadone
C) Morphine
D) Oxycodone

References

Table 5. Recommendations for Opioids in Renal Impairment

Opioid	Recommended Use
Codeine	Not recommended due to accumulation
Fentanyl	Appears safe, but renal dosage adjustment may be necessary
Hydrocodone/oxycodone	Use cautiously; adjust dosage
Hydromorphone	Use cautiously; adjust dosage
Methadone	Appears safe; however, renal dosage adjustment may be necessary
Meperidine	Not recommended due to metabolites
Morphine	Not recommended due to metabolites
Tramadol	Not recommended

Source: References 9, 16.

Table 3. Recommendations for Opioids in Hepatic Impairment

Opioid	Recommendations
Codeine	Not recommended; in severe hepatic dysfunction codeine is not converted to morphine, leading to poor analgesia
Fentanyl	99% metabolized in liver; studies have not demonstrated PK alterations; careful monitoring is warranted
Hydrocodone	Use with caution; monitor for overdose due to parent compound not being converted to metabolites
Hydromorphone	Undergoes phase II reaction; however, use with caution due to its intermediate extraction ratio
Methadone	Use with caution; risk of accumulation because of increased free drug
Meperidine	Not recommended; toxic metabolite, normeperidine, may accumulate
Morphine	Use with caution; monitor for overdose due to high extraction ratio
Oxycodone	Use with caution; dose adjustment recommended (1/2 to 1/3 of original dose)
Oxymorphone	Contraindicated in moderate-to-severe hepatic impairment
Tramadol	Not recommended; significant PK changes in moderate-to-severe hepatic impairment

PK: pharmacokinetics. Source: References 8, 16.

https://www.uspharmacist.com/article/opioid-dosing-in-renal-and-hepatic-impairment

Question 9

You have decided that he needs a long acting opioid and decide on using immediate release hydromorphone for PRN pain and oxycodone ER for his long-acting regimen. In talking to the nurses, he has been taking on average 5 tablets of 4 mg hydromorphone per day, what is his approximate daily morphine milligram equivalent (MME)?

A) 10 mg
B) 40 mg
C) 80 mg
D) 140 mg
E) 200 mg

Calculating morphine milligram equivalents (MME)

Opioid (doses in mg/day except where noted)	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone:	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
>=61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

https://www.cdc.gov/drugoverdose/training/dosing/accessible/index.html

Question 10

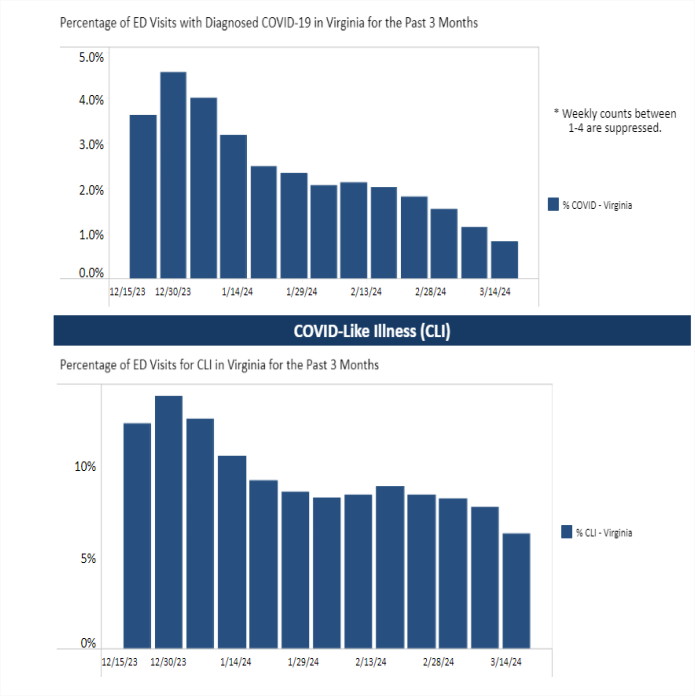
In a few weeks, you decide that his cancer related pain appears better controlled on oxycontin 40 mg BID, but he continues to have breakthrough pain a few times a day. You decide you want to add back his hydromorphone as PRN. What dose of PRN hydromorphone every 4 hours would be appropriate?

A) 0.5 mg
B) 1 mg
C) 2 mg
D) 3 mg

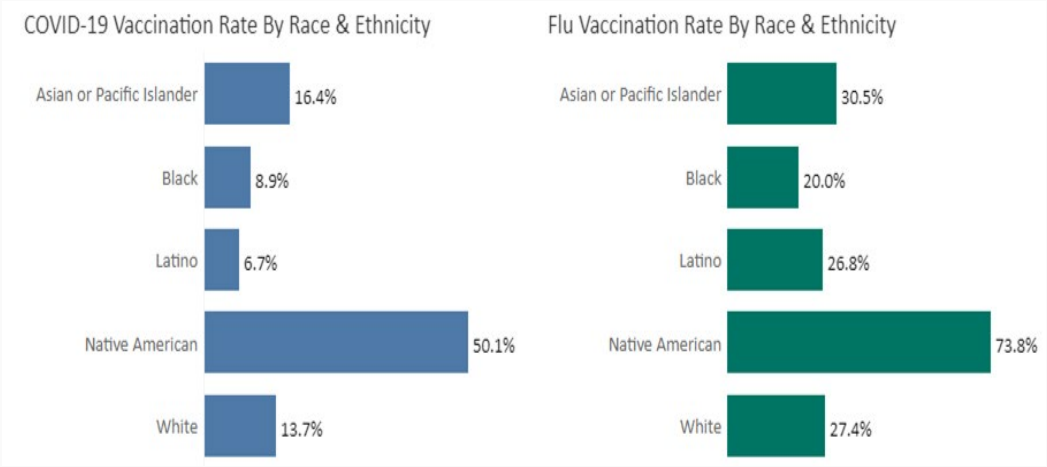
Open Forum

Share an idea. Anything you need help with? What's new in your Virginia Health District? Any announcements?

VDH Dashboard Snapshot



Graphs Not LTC Specific



LTC Staff vaccination up-to-date in VA: 10%

https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-in-virginia/

ltccn.vcu.edu

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of ***1.00 AMA PRA Category 1 Credits***^{TM}. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for ***1.00 AAPA Category 1 CME credits***. PAs should only claim credit commensurate with the extent of their participation.

Disclosure of Financial Relationships

Disclosure of Commercial Support:

We acknowledge that no commercial or in-kind support was provided for this activity.

Claiming Credit

Submit Attendance

1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: ##### *(within **5** days of the event)*

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

Thank you for joining us!

Next Newsletter - coming to you in **April**

Next Monthly Forum - **Wednesday, April 17, 2024, 4-5 pm Billing, Coding and Documentation by Teri Molsbee,** CPCO, CPC, CRC, CDEO, Director of Quality Coding and Provider Compliance, LTC ACO

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at ltccn@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu

Disclosures

The speakers and presenters for today have no relevant financial conflicts of interest.

Funding Disclosure: This work is supported by the Virginia Department of Health, Office of Epidemiology, Division of Healthcare-Associated Infections (HAI) and Antimicrobial Resistance (AR) Program and the Centers for Disease Control and Prevention, Epidemiology and Laboratory Capacity (ELC) Program under federal award number NU50CK000555 and state subrecipient number VCULTC603GY23 in the amount of $820,002. The content presented is solely the responsibility of the authors and does not necessarily represent the official views of the Centers for Disease Control, the Virginia Department of Health, or Virginia Commonwealth University.

Virginia Long-Term Care Infrastructure Pilot Project (VLIPP) funding will be utilized in nursing homes and long-term care facilities to assist with the ongoing COVID-19 response and to bolster preparedness for emerging infections. The projects are based on identified needs that align with funding objectives.