OBRA REGULATIONS AND CLINICAL PRACTICE

By Steven Levenson, MD, CMD

Highlighting Key Principles and Practices of Pain Management

Pain is a vast and complex topic with many detailed aspects. As with so many other conditions and symptoms, pain management remains challenging. There are already many guidelines and articles on the topic. Instead of covering specific clinical aspects of pain management, the goal of this month's column is to highlight some key considerations that I have found particularly useful over time as a medical director, across all patients and settings.

In 2016, the Centers for Disease Control and Prevention issued a report with 12 key recommendations for using opioids more appropriately to manage pain. As a result of this report and the growing problem of substance use disorders in the country, considerable legal and regulatory pressure was asserted to limit opioid prescribing. It became something of an overreaction, but the basic concerns were warranted.

At the time, many post-acute and long-term care (PALTC) practitioners believed that the 2016 recommendations did not apply to patients in PALTC. However, my own assessment of the situation was that at least nine were relevant to PALTC practice.

Then, in 2022, the CDC issued an updated report that recommended liberalizing some of the recommendations about indications, doses, and duration of use for opioids in certain pain situations. However, there were no major changes to the basic principles of prescribing espoused in 2016.

What are we to make of all of this?

There is nothing remarkably new in 2023 to help assess and manage pain. Ultimately, pain management exemplifies the need for clear thinking about a complex topic. Simply stated, the universal and enduring principles and processes — recognition, problem definition, cause identification, interpretation of findings, management, and monitoring — apply to pain management just as they do to any symptom. This includes more careful assessments, searching for specific underlying causes, and adapting generalities to specific patient situations. But, because we as practitioners have limited time to think in fast-paced health care settings, we often need collaboration with the rest of the interdisciplinary team (IDT) to identify and organize complex information.

Assessing the Situation: Gathering Details

Sometimes pain is straightforward, and the answers are relatively apparent. But much of the time, such as when the origins of pain are unclear or simple measures are unsuccessful, more details are essential.

The challenges of getting enough accurate details about patients' pain complaints are well known; this process is hampered, for example, by limited objective findings and patient and staff variability in reporting and describing pain. In a PALTC facility, the rest of the IDT has likely already assessed and documented details about a patient's symptoms. It is not unreasonable for practitioners to rely on others' work, but this information may be inadequate and unreliable.

Unavoidably, facility staff must collaborate with the medical director and medical practitioners to push for sufficient detail. This includes not just the severity (intensity) of pain (e.g., "7-out-of 10"), but also its frequency, precise location, and duration, along with a chronological story and the pain's characteristics (sharp, stabbing, dull, aching, etc.). This information is usually enough to guide appropriate pain management.

A facility that cannot or will not follow this process routinely is likely not managing pain safely and effectively. For example, it is common to see opioids used based on progress notes that describe simply "leg pain" or "arm still hurts." This is not enough information to help choose the most appropriate and lowest risk interventions.

The Impact of Cognitive Bias

Cognitive biases can have a major impact on all clinical practice. Assumptions may be acceptable in simple situations or when the results are satisfactory, but they can otherwise be problematic. Pain management is no exception. For example,

- Grimacing in a nonverbal patient does not necessarily reflect pain.
- New onset pain in someone with cancer could be due to something other than cancer.
- Certain pain descriptions such as burning, stabbing, or shooting cannot automatically be assumed to reflect neuropathic pain or pain that is due to diabetes.
- Minimal effectiveness of opioids is not an automatic indication to give more opioids; conditions such as fibromyalgia or inflammation are not opioid sensitive.

Treatment Challenges

There are many opinions and recommendations about treating pain. Every analgesic has pros and cons. They may work for one type of pain or condition or patient but not for another. When a pain intervention is not as successful as anticipated — especially after repeated adjustments — it is prudent to reconsider the causes and current treatments, rather than just do more of the same. Empirical (trial-and-error) approaches based on evidence are sometimes necessary, but guessing without supporting evidence is much less successful.

To aid in treatment selection, it is useful to try to categorize pain as acute or chronic, and then to subdivide chronic pain further (e.g., chronic widespread or chronic cancer-related). For help with this process, see AMDA – The Society for Post-Acute and Long-Term Care Medicine's "Pain Management in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline," and the Pocket Guide (pp. 22–25, available from https://bit.ly/painCPG). Opioids, for example, are not necessarily appropriate for more severe pain, depending on the situation. And gauging severity alone is less helpful in many cases of chronic pain.

Discussion about treatment with opioids often centers around whether to use or switch to long-acting opioids (LAOs). The advice is often to switch patients to long-acting opioids if they use more than occasional doses of short-acting opioids. LAOs should be given with care and prescribed only by practitioners who are familiar with their appropriate use and appropriate dosing, frequency, selection, and checking for side effects.

When it comes to pain management, too much of a good thing can become a bad thing because of adverse consequences and interactions. It is not uncommon to see medical practitioners keep increasing LAOs despite little or no relief. Although this is sometimes warranted, it is also essential to consider whether opioids were the right choice or even indicated to begin with.

Fentanyl is becoming the latest drug disaster to afflict the United States (U.S.

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designed treatment plan will incorporate mitigation around potential adverse drug events, overuse, overdose, and availability of naloxone.

Tapering and deprescribing must be carefully assessed before implementation, and, if appropriate, must be carried out slowly with the acknowledgment of the patient or resident to reduce the risks associated with opioid dependence. Written opioid overdose policies should be available in facilities that include education of facility staff on how to identify a potential overdose occurrence. Many organizations have created resources that contain their policies and procedures, which can be tailored to the individual needs of the facility or organization.

Legislation Changes the Game in the Efforts for Access to Treatment Medications

Of recent importance is the Consolidated Appropriations Act of 2023, signed into law at the end of 2022, which includes a provision to relax the requirements for obtaining the "X-waiver" to prescribe buprenorphine, one of the US Food and Drug Administration's approved medications to treat opioid use disorder (H.R.2617, https://bit.ly/3XEyskP). For more information, see

- Substance Abuse and Mental Health Services Administration (SAMHSA), "Removal of Data Waiver (X-Waiver) Requirement," Jan. 12, 2023, http://bit.ly/3koOJvU.
- American Society of Addiction Medicine (ASAM), "ASAM Praises Congress for Passing Vital Provisions in End-of-Year Legislation that Will Increase Access to Addiction Care and Save Lives," Dec. 23, 2022, http://bit.ly/3ZGEu6s.

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Drug Enforcement Administration, "Fentanyl Awareness," https://www.dea.gov/fentanylawareness). That reflects its potency (30–50 times stronger than heroin) and high potential for serious if not fatal complications, especially (but not solely) when taken together with many other medications. Using it for patients with serious underlying illness such as metastatic cancer is one thing, although alternatives often exist; giving it to 80-year-olds with chronic back pain is rarely appropriate.

Nonpharmacological interventions are often helpful if not definitive. As with behavior management, the challenge is to select the right combination of interventions from among many options.

Thoughtful Monitoring Is All-Important

Treatment adjustments follow from detailed monitoring. Monitoring is nothing more than a recycling of previous steps in the care delivery process. Often, though, something has been done or changed. Thus, the objective is not just to get updates but to think about whether and to what extent the new or revised interventions are working and whether they are causing any complications such as vomiting or psychosis.

Monitoring simple and successful interventions can be straightforward and limited. But more complex or less successful situations require much more than just the occasional check-in and a pain score.

For example, too much opioid medication or even reasonable doses given for too long can cause an exaggerated pain response (hyperalgesia), delirium, or major psychiatric and behavioral symptoms (e.g., anxiety, agitation, euphoria, dysphoria, depression, psychosis, hallucinations) (*Med Lett* 2002;44[1134]:59–62). By contrast, undertreatment can lead to exhaustion, limited activities of daily living, sleep deprivation, and other issues.

Appropriate Use of References and Resources

Most clinical topics — including pain — are too complex and too vast to be handled from memory or with limited personal knowledge. It is essential to look things up as they arise until we are familiar enough to do them right without having to keep looking them up all the time.

Excellent references and other resources on pain are widely available. However, they are only valuable if they are sought and used. For example, the Society's clinical practice guideline is a uniquely organized process-based approach that can be beneficial to staff and practitioners as well as patients.

The trick is to learn to use the hyperlinks and other shortcuts in these documents as well as doing quick and reliable internet searches in real time as needed (see my article "Google-Searching for Better Care," *Provider Magazine*, June 1, 2020, http://bit.ly/3XJyI2A). Computers are universally available, and search engines are very reliable and valuable. But the ability to do good internet searches requires effort and practice. Many nursing home staff and practitioners could be and should become much more adept at doing such searches.

A facility that has a process for identifying and applying reliable sources of information about pain assessment and management is more likely to have safe and effective pain management. Conversely, those that lack such an approach may not do well trying to practice from memory and limited knowledge and skill.

Pain management is a complex, sometimes confusing aspect of care. This month's column has highlighted key strategies that I have found over the years to provide a stronger foundation for pain management, no matter the setting, situation, or patient.

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