

Caring for the Ages



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THE SOCIETY
FOR POST-ACUTE AND
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Managing Chronic Pain in Older Adults: Taking a Holistic and Individualized Approach

By Christine Kilgore

Chronic pain — the complex, multidimensional, highly personal experience that affects more than half of nursing home residents — demands assessment of both the physical causes and the emotional and psychosocial components. Holistic management incorporates nonpharmacological approaches, experts and practitioners from various disciplines told *Caring*.

And when medications are needed, each clinician has to “use a very holistic individualized framework to grapple with the question of what can my patient tolerate for the kind of pain we think they’re having,” said Barbara J. Zarowitz, PharmD, MSW, BCPS, CGP, senior advisor to the Peter Lamy Center on Drug Therapy and Aging at the University of Maryland School of Pharmacy.

Pharmacologically, practice is moving “more and more toward medication safety,” she said. And “awareness about the predisposition of older adults to the adverse consequences of pain medications is creating impetus for improved pain assessment, diagnosis, and treatment.”



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The complex experience of chronic pain requires an individualized, holistic framework to effectively manage pain in post-acute and long-term care.

In interviews about chronic pain and its diagnosis and management — both pharmacological and nonpharmacological — sources shared their experiences and reflected on what’s changing and what may be underappreciated.

The Importance of First Acknowledging Pain

Connie S. Cole, PhD, DNP, APRN, has worked in nursing homes for

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The Case Against Universal Vitamin D Supplementation in Older Adults

By Daniel Haimowitz, MD, FACP, CMD, Carmen Witsken, PharmD, Emily Cofsky, Brittany Henault, Emily Hajjar, PharmD, MS, BCPS, BCACP, BCGP

Vitamin D is frequently seen as part of the medication list of older adults, particularly those in long-term care (LTC). The LTC population is more at risk of vitamin D deficiency due to factors such as little or no sunlight exposure, malabsorption, frailty, and other comorbidities. Our clinical experience has been that vitamin D supplementa-

tion is ordered either because levels were found to be low or simply as a vague expectation that it can’t hurt or that it’s a “best practice.” But is there evidence that truly supports its universal use?

Purported Benefits of Vitamin D

Vitamin D deficiency is extremely common, affecting an estimated 50% of the

U.S. population, 50% to 60% of institutionalized older persons, and up to 1 billion people worldwide (“Vitamin D Deficiency,” StatPearls, July 27, 2022, <https://www.ncbi.nlm.nih.gov/books/NBK532266/>). Additional vitamin D offers a plethora of potential benefits;

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Vitamin D

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the exhortations to use supplementation are found in both the medical and lay press, including a review in *Caring for the Ages* (2022;23[3]:11). These benefits include improved bone health, increased muscle strength, decreased falls and fractures, lessening of infections (including COVID-19), and improvements in many disease states such as cancer, diabetes, depression, cognitive decline, and autoimmune disease.

Vitamin D Research on Older Adults in LTC

Earlier meta-analyses (from 2014) found a link between vitamin D deficiency and all-cause and cardiovascular mortality (*BMJ* 2014;348:g3656) as well as evidence that D3 supplementation (as

opposed to D2) is associated with reduced mortality (*BMJ* 2014;348:g1903). However, more and more evidence has found no support for the benefits of vitamin D supplementation in community-dwelling older adults, and the evidence in the LTC population has been lacking.

In our experience, one major reason many practitioners start older adults on vitamin D supplementation is the belief that it will decrease falls and fractures. Recent studies do not routinely confirm this. For instance, the 2022 Vitamin D and Omega-3 Trial (VITAL), which included only “generally healthy midlife and older adults,” concluded that vitamin D supplementation did not result in a significantly lower fracture risk (*N Engl J Med* 2022;387:299–309). An accompanying editorial on the VITAL trial said that “providers should stop screening” and stop “recommending Vitamin D supplements” entirely (*N Engl J Med* 2022;387:368–370).

However, for LTC residents the outcomes are mixed. A 2019 Canadian Agency for Drugs and Technologies in Health (CADTH) review of the literature found a statistically significant reduction in falls with vitamin D supplementation, but the 2021 update revealed that reductions were not always statistically significant (S. Banerjee et

al., “Vitamin D Supplementation for the Prevention of Falls and Fractures in Residents of Long-Term Care Facilities: A 2021 Update,” Canadian Agency for Drugs and Technologies in Health, 2021, <https://www.ncbi.nlm.nih.gov/books/NBK584609/>). It is worth noting that this review only included three articles, and the authors concluded that further research is needed.

In terms of other health outcomes, our review of the recent literature found only two articles that aim to understand the health impacts of vitamin D supplementation in nursing homes. A 2022 Spanish study looked at differences in depressive symptomatology and in several measures of nutritional status in 100 nursing home patients (*Front Aging Neurosci* 2022;14:880405). Although not the study’s primary end point, the differences between cognitive status groups were statistically significant with vitamin D use, and the researchers concluded that therapeutic serum levels could protect against cognitive decline. Sixty-six residents from a French nursing home were included in a 2020 study that showed giving a bolus of vitamin D3 either in the week after the suspicion or diagnosis of COVID-19, or the month before, was associated with less severe COVID-19 and a better survival rate (*J Steroid Biochem Mol Biol* 2020;204:105771). Neither study established recommendations for dosing, normal values, or routine screenings specific to nursing home patients.

These two papers suggest that vitamin D supplementation could have some benefits for residents in LTC. However, is universal supplementation necessary?

Testing, Screening, Dosage, Current Guidelines

It is commonly known that vitamin D supplementation is not needed in those with normal 25(OH)D levels. However, the current guidelines favor supplementation in those who are vitamin D deficient (“Vitamin D: Fact Sheet for Health Professionals,” National Institutes of Health, Aug. 12, 2022, <https://ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/>).

Deficiency can only be determined through laboratory screening. Recommendations for routine screening of vitamin D levels exist for at least 30 clinical conditions, a list of which can be found in the Centers for Medicare & Medicaid Services Local Coverage Determinations (ID L33771). For all high-risk individuals, the recommendations state to remeasure at three and four months. More than 10 million vitamin D tests are performed in the United States yearly to distinguish between “insufficiency” (levels of <30 ng/mL) and “deficiency” (levels of <20 ng/mL), or as follow up after replacement therapy has been started (*N Engl J Med* 2022;387:299–309).

A standard maintenance dose of 800–2,000 IU/day can be initiated for

vitamin D insufficiency without having to recheck a vitamin D level. There is minimal risk associated with this level of vitamin D supplementation. For those being treated for vitamin D deficiency, a repeat screening may be warranted. Some have advocated for a monthly dose of 50,000 IU, which could reduce the daily pill burden but may affect compliance if the dose is forgotten. Use of bolus dosing is not encouraged (*JBMR Plus* 2021;5:e10567).

Is Universal Supplementation Necessary?

Some have gone so far as to recommend vitamin D supplementation in all LTC residents (*J Am Med Dir Assoc* 2011;12:190–194). However, we do not feel the evidence supports universal vitamin D supplementation. Despite widespread vitamin deficiency in the LTC population and little evidence of harm, there is no clear evidence as to the benefits of universal replacement therapy in this population.

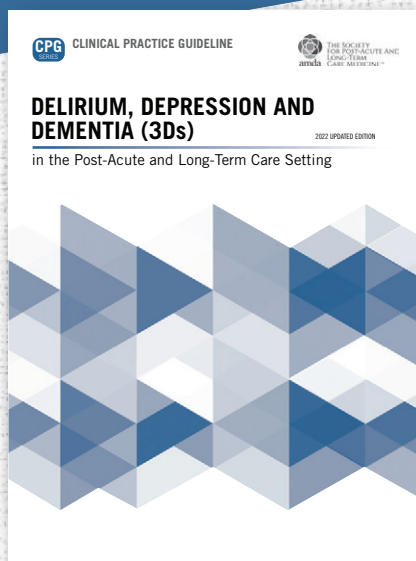
There have also been questions about the cost effectiveness of population screening for vitamin D insufficiency compared with universal supplementation, with one study finding screening to be more cost effective than supplementation (*J Am Geriatr Soc* 2013;61:707–714). However, although testing costs may be low or covered by insurance, they are still a burden on the health care system, with the argument being that laboratory testing shouldn’t be performed if the resulting clinical decision-making isn’t shown to benefit patients.

Ultimately, the decision to prescribe or deprescribe vitamin D is left up to the individual practitioner. Given the lack of clear benefit, added pill burden, and costs, we feel that deprescribing vitamin D is a reasonable option in patients who have serious, life-limiting medical conditions and in those who have a lower risk of fracture or fall, such as patients who can no longer leave their bed or are wheelchair confined.

Additional studies are needed to justify universal supplementation, to prove the benefits of vitamin D supplementation for LTC residents, and to establish standards for testing and dosing. ✎

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Each of the 3Ds –
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