



Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call

Moderated by: Leah Nguyen
September 18, 2018—1:30 pm ET

Table of Contents

Announcements & Introduction.....	2
Presentation	2
Opioid Use in Post-Acute and Long-Term Care	3
Brief Opioid History.....	3
The Opioid Crisis.....	5
Opioids in Skilled Nursing Facilities	6
Key Points/Summary	10
The Impact of Opioid Use on Persons Living with Dementia	12
Significance	12
Adverse Effects	12
Using Opioids or Pain.....	13
What We Know.....	13
Barriers to Assessment	16
Resources.....	19
Question & Answer Session	20
Additional Information.....	23

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. This transcript may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.



Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network call on Dementia Care, Opioid Use and Impact for Persons Living with Dementia.

During this call, gain insight on opioid use in the post-acute and long-term care setting; also learn about the impact of opioid use on person's living with dementia. Additionally, CMS shares updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question-answer session follows the presentation.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL -- go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I would like to turn the call over to Dr. Shari Ling, Deputy Chief Medical Officer within the Center for Clinical Standards and Quality here at CMS.

Presentation

Dr. Shari Ling: Hi. Good day, all, and thank you for the introduction, Leah. And I want to begin by saying thank you to all of you who have joined this call and, more importantly, for the work that you do to improve health outcomes on behalf of our beneficiaries who likely represents the most vulnerable, frail segment of the CMS beneficiary population.

In a few minutes, I will give you a high-level overview of some of CMS' focus areas and -- on the topic of opioids and, importantly, CMS really fits into the overall HHS that is Health and Human Services...

Leah Nguyen: Dr. Ling, are you still there?

Operator: Dr. Ling's line has disconnected.

Michele Laughman: Okay. This is Michele Laughman, Coordinator with the National Partnership to Improve Dementia Care in Nursing Homes. We'll go ahead and move along with the presentation. As Leah mentioned earlier, our first presentation will be on opioid use in post-acute and long-term care.

Our speaker for this presentation will be Dr. Karl Steinberg, Chief Medical Officer for Mariner Health Care. Additionally, Dr. Steinberg is the chair for the Public Policy Committee for AMDA, the Society for Post-Acute and Long-term Care Medicine; as well as the Editor-in-Chief of Caring for the Ages, AMDA's monthly news magazine.



Dr. Steinberg, I will now turn it over to you.

Opioid Use in Post-Acute and Long-Term Care

Dr. Karl Steinberg: Great. Well, thank you and thanks for having me I've got a lot of content to try to blow through in 30 minutes, so I'll be talking fast. Sorry for the people that are transcribing.

I hope you have the slides in front of you, and I'm going to start.

Slide number 2 has some of the acronyms we'll be using, and my slides start at number 5.

So, we're going to talk about opioids; their history; you know, the good, the bad, and the ugly; and talk a little bit about the opioid crisis that has sort of prompted a lot more attention recently. Then, we'll talk about specifics that relate to opioid use in skilled nursing facilities. We'll talk about some regulatory concerns, and I think most important when discussing this topic is keeping the resident and, you know, pain control and doing the right thing by the resident person-centered care in the forefront as it should be for everything that we do.

Brief Opioid History

So, slide 6, a little history on opioids and we used to call them opiates, but opioid is a little bit broader because opiates would be just kind of naturally occurring. Opioids would be chemically-altered ones. It would include both.

So, they come from the opium poppy and, among the natural alkaloids that are found in the poppy are morphine and codeine. And then, there's a lot of metabolites and so on that also are active. They work on opioid receptors in the brain, central nervous system, the gut, all over. And the main actions that they have are on the opioid mu receptors. Those are the ones that cause most of the effects that we typically associate with opioids.

So, the main thing that we use opioids for is pain control, right. The -- it's been known from -- way back in ancient times that opium had analgesic properties and, you know, it made people feel good. So, it caused euphoria, and, because of that, you know, back -- also back many centuries, it's been known that people could kind of get hooked on it.

So, opioids are very useful in the field of medicine. I think there is really nothing better when it comes for a treatment of pain. And also, other uses that we use opioids for is shortness of breath or dyspnea and it's got kind of a bad reputation that, you know, you can cause respiratory depression and kill somebody by giving them opioids.

It actually takes a -- quite a bit of opioids even in opioid-naïve patients to really cause significant respiratory depression. That's a higher risk in people with -- who are being given benzodiazepines too and that's why there is now black box warning for that combination. They are also very good antitussives, right, so it's a good cough suppressant and they're very good anti-diarrheals.



The side effects on the – other hand-- and obviously, they make you really drowsy, they constipate you, they make people nauseated, and they also can cause significant itching. And, I'm just noting here from Dame Cicely Saunders who originated the whole hospice movement -- paraphrasing -- "The hand that writes the opiate prescription should also write a laxative prescription." And that is very important I'm sure. Many of you have seen when that is not done people wind up much more miserable than they were from whatever was causing their original pain when they have, you know, a giant brick in their colon.

So next, slide 7, a little continued history on opioids. Ever since the early days back into the -- into the 19th century, there's been a search for safer and less addictive opioid alternatives. Heroin was a big one. It was -- you know, it was thought that that was going to be the savior; you know, it was going to get all these civil war veterans off of morphine. It turned out to be, of course, even more habituating and so on. Pentazocine or talwin, some of you will remember, it was the first of the opioid mixed agonist/antagonist and, similarly, it was -- it was also found to be quite addictive and have similar problems. And pentazocine is similar to the buprenorphine that we see now that's gotten a lot more useful to talk about later. And then, methadone, of course. Methadone actually was developed back around World War II. It's got a much longer half-life, but probably -- I mean, certainly the withdrawal from methadone is worse than it is from shorter-acting opioids. So, you know, the -- so the search hasn't really been very successful, but we have found some very potent agents such as fentanyl that are, you know, also very useful.

Okay. So, in 1970, the Controlled Substances Act was passed and all of the -- you know, the really good opioids are considered Schedule 2, so that means they can't be called in and they can't be refilled. There are some nuances around that we'll talk about later that relate to the skilled nursing facility setting.

The only opioids that are not Schedule 2 are codeine combinations, tramadol or ultram, the mix agonist/antagonists like suboxone, and the anti-diarrheals like lomotil. So, unfortunately, I think some people, because it's more convenient to -- those can be called in and so on, maybe using drugs that are not optimal and I hope that's not happening in your facilities. Obviously, in the U.S., heroin and these illicit fentanyl derivatives that are coming in from China now are considered Schedule 1, meaning there's no legally-recognized use.

Okay. So, slide 8, we'll talk a little bit about, you know, prescribing habits around opioids. So back when I was in medical school in the '80s, it was -- they were pretty tightly controlled. You know, generally, opioids were reserved only for severe post-operative pain or, you know, trauma pain; people with terminal cancer; you know, maybe for dental procedures and things like that, but it was -- it was pretty strict.

In the 1990s, that became more relaxed. You know, we started calling pain the 5th vital sign and really concentrating on that which -- you know, it's a double-edged sword. We obviously want to make sure that people are getting good pain control, but to focus in on it so much perhaps and it's so subjective, so there's been a lot of talk recently about kind of removing that. And then, you know, the advent of these pain specialists, I think that really allowed for a lot more freedom I guess in prescribing.

In the 2000s, you know, there were a lot of new opioid formulations that became available for treatment of pain. And I'm also a hospice medical director. In hospice they've got these real fancy delivery systems for fentanyl or, you know, they've got nasal and, you know, these little buckles that -- film that you can put inside



the mouth and all kinds of fancy stuff and the transdermal that you're aware of like the fentanyl or Duragesic patches.

So now, we get to the 2010s and the recognition of this opioid epidemic has rapidly – and perhaps overly rapidly returned us to a very highly restricted use. There is -- there are some areas where facilities reportedly are refusing to even admit residents who are on opioids, particularly if they have a history of addiction or those that are on maintenance therapy or what they call MAT, medication-assisted treatment for addiction like with buprenorphine, suboxone, or methadone and those things and that's not really appropriate to exclude people just because they have this condition.

In any event, in 2014, over 200 million opioid prescriptions were filled in the U.S. mostly for acute pain, but 10 million patients were receiving chronic opioid prescriptions. Many are being diverted and when I say that I'm not talking about from the nursing home, I'm talking about out in the community where people go in and get a, you know, prescription for a large dose of oxycontin and then they go out and sell it because, you know, you can fetch a pretty good price for those.

There are a lot of new opioid formulations that have deterrents that will help -- that will keep people from, for example, you know, grinding them up and injecting them and things like that. That's not a new concept, but there's a lot of newer and fancier types of deterrents out there; where, for example, they'll mix it with an opioid antagonist that wouldn't be active orally.

There have been tons of laws and regulations passed within the last year or so. I mean, I think there was one week when congress passed, like, 7 or 8 bills around opioids. So, these are -- and then, states obviously have their own deals.

So, there are limits on how long a prescription can be filled, what the maximum dosages are. And, of course, there are -- there are workarounds -- you know, there is -- you can get exceptions on these things, but it's definitely put a big damper on opioid prescribing, which is probably good in the general sense but may also result in some harm for people who really need them.

The other issue that we've seen particularly in hospitals is that parenteral opioids, you know, IV, morphine, and dilaudid, and things of that nature have been in very short supply. So, they're having to figure out ways to, you know, get those to the patients who really need it.

The Opioid Crisis

Okay. Slide 9. So, obviously, the use of opioid -- this is -- we're talking about the crisis now over the last 20 years because of the increased use of opioids and the increased availability, people started to be kept on opioids long term for chronic pain even though the evidence for that is very weak. And, you know, if you Google it, you'll see people -- there's just no evidence that it's particularly effective. There are certainly some people for whom it may be appropriate, but I think it's been wildly overused. And not to bad mouth our pain specialists, but I think that is where a lot of these prescriptions are coming from. So clearly, abuse, misuse, and addiction also increased.



You know, it's remarkable that opioids are killing more people than -- you know, per -- on a monthly basis than auto accidents or even AIDS at the peak of the epidemic and it's predicted that 50,000 Americans will die of opioid overdoses in 2018, and that's a shocking number. So, you know, traditionally, like, back in the '70s and '80s, opioid -- the opioid addiction was heroin and it was very expensive, you know. It was illicit and there wasn't a lot of it and it was very highly -- you know, the penalties were very high. So, addicts would have to spend maybe \$100 or more a day to stay -- stay on heroin, so they typically would have to participate in clinical activity.

Methadone clinics started to gain hold in the '70s, and they allowed people to, you know, stay on opioids, but maintain jobs and things like that. In England, you may not be aware, they actually use heroin maintenance, so people -- you know, addicts sign up and they go in and they're administered shots of heroin. And that -- those, you know, at least keep them off the streets I suppose and from doing crimes.

So, I think a combination of factors drove this crisis. Obviously, you know, physicians feeling comfortable prescribing, you know, large amounts of opioids and chronic opioids to people made it -- you know, it's available in a lot of people's medicine cabinets.

There has also been a much larger supply of illicit opioids and this probably goes back 15 years or 20 years to -- when heroin became much more accessible. And now, we've got this huge influx of these super potent fentanyl derivatives coming in from China and so on, so that's part of it.

And then, drug companies marketed their opioids and kind of, you know, help to destigmatize it and that's -- that came both from the drug companies and from, you know, the people that were importing illegal drugs and the whole sort of profile of a person who uses heroin has really changed and, you know, now a lot of -- you know, it might be younger sort of more privileged people and not, you know, socially disadvantaged population.

So, I would really highly recommend to all of you this article from New York Magazine by Andrew Sullivan. Just a really fabulous article that gives a lot of history. It's a fairly long read, but I -- it's probably the best thing I've ever read about opioids, and I've read a lot of things about opioids.

Opioids in Skilled Nursing Facilities

So, slide 10, now we'll talk -- we'll get to the nursing home setting. So, we've also seen a significant increase over the last 20 years of, let's say, percentage of our patients who come in from the hospital on opioids and percentage of patients who are maintained on chronic opioids.

And I can just -- you know, back in the -- I don't know, back in the late '80s or early '90s, I can remember calling in a prescription for some low-dose morphine for somebody with shortness of breath and the nurse said to me, "I'm not going to give -- you know, I'm not going to put this patient down like a dog." And, you know, now we've kind of gone in the other direction and we use -- seem to be using opioids much more indiscriminately at least, you know, up until the last couple of years.

Anyhow, chronic pain is extremely common in post-acute and long-term care residents. They've got arthritis. They've got just a whole host of things that cause pain.



So, what do we do with pain? Probably the first choice should be acetaminophen and it should be given on a routine basis instead of PRN. And, you know, it's not super strong, but you'd be amazed how much it can help for some people. So, you know, you can do a gram 3 times a day or 650 mg four times a day routinely and it can really help.

You know, another traditionally-used category of drug is non-steroidal anti-inflammatories like ibuprofen, naproxen, and so on. And these are good. They're better than acetaminophen for pain, but they have significant side effects. They've got, you know, higher risk of ulcers; they, you know, have renal and cardiac issues associated with them.

I would note specifically that celecoxib or celebrex is probably safer and stronger than a lot. So, if you're considering using a non-steroidal on a chronic basis, I would recommend it. It's a lot less expensive than it used to be, and it's a good product.

Anyway, some data that were recently published from 2012 indicates that one out of seven nursing home residents were being maintained on chronic opioids and yet -- and I'm sure most of you on this call can relate to this -- in spite of that, most of them continue to report moderate to severe pain, and they wind up, you know, triggering on our quality measures and so on.

So really if they're having moderate to severe pain, do they -- you know, is the opioid even really helping? And again, there are no good data to support the efficacy of opioids for chronic non-malignant pain, and there are specific studies in the geriatric population that are pretty conclusive about that. Again, I'm not at all suggesting that nobody should be on chronic opioids, but I just think that they've probably been used a lot more than they should have, and I'm also guilty of that.

So, a lot of our patients come out of the hospital on opioids. You know, maybe they've just had a -- you know, a surgical procedure or something like that. You know, how -- you know, at the hospital everybody gets put on proton pump inhibitors, opioids, sleeping pills, maybe a little anti-psychotic to help them sleep, and we're well aware of those issues.

So I think, you know, de-prescribing is important, and I think it's really important to consider when they come in do they really need it; are they actually using it; and, you know, should we go ahead and assume that there's a stop date, particularly if it's somebody that's got pain that should be coming to an end, you know, like, after a surgery or something.

There are some data indicating that people who take prescription opioids for — longer than three weeks often don't ever get off them and that's a little scary. So, we've got, you know, typically in that window of opportunity, let's try to get them off.

Okay. Slide 11. So most guidelines by medical societies and, you know, the evidence-based guidelines, including the ones that AMDA put out that I assisted with recommend if somebody is predictably going to have pain, and they're going to need opioids, it's better to give them routine, around-the-clock dosing preferably with long-acting agents because the ones that have, you know, the rapid acting like, you know, oxycodone; you know, percocet or the norco, vicodin, hydrocodone products -- those give you a rapid rise in your serum level so, you know, people get that sort of a -- you know, a bump that can be reinforcing and can -- it can cause



people to want to stay on it because it makes them feel good. So, the longer-acting agents are probably preferable if people are going to need them.

Obviously, by keeping somebody on something around the clock, it's going to keep their pain levels, you know, better controlled because it takes more to treat pain once it occurs than it does to sort of keep it at bay and prevent it. So, when somebody is having postop or post-traumatic pain and they've been on routine opioids, it's best to taper them rather than just go cold turkey for obvious reasons. You know, abstinence from -- the abstinence syndrome or withdrawal syndrome from opioids is very unpleasant. You know, it -- you can have severe diarrhea and cramping, a lot of bone and muscle pain, shaking, and just feeling extremely unhappy.

So now, adjuvant medications can be helpful to potentiate analgesic effects of opioids or make them, you know -- so that you require less opioid. And, in many cases, you can use some of these meds in place of opioids. So, there are a lot of specific meds that you can use for neuropathy, both diabetic neuropathy; you know, herpes-related neuropathy and also radiculopathy or, you know, spine-related, you know, nerve root pain.

Some of these are anti-convulsant and some of them are like SNRI-type agents like effexor or cymbalta. They can be very helpful. Sometimes psychostimulants like ritalin can be helpful. You know, they can help people stay more awake if they're on opioids and they also potentiate the effect.

Steroids can be extremely-- extremely helpful because they are such potent anti-inflammatories. They obviously have a whole host of side effects as well, but a little prednisone can really go a long way. And sometimes you can do just a burst and, you know, kind of break that pain cycle.

Topical meds -- capsaicin. They have the diclofenac gel, they've got these lidocaine patches and so on. They can be helpful especially when there is localized pain. And then, there are a lot of other things -- you know, there are compounded medications with, let's just say, a range of evidence base, some of them are -- you know, there's not a lot of evidence behind them.

And then, there is a whole bunch of non-pharmacological measures, also some of which have pretty good evidence; others, you know, not so much, but cognitive behavioral therapy can be extremely helpful, different types of modalities like ultrasound or, you know, heat, ice, massage, acupuncture, manipulative therapies, and so on. And one thing to remember is that staying more mobile generally improves pain.

You know, we used to tell people with -- when they threw their back out just, you know, do seven days of bed rest and we've found that's a really terrible idea and particularly in our population that's -- you know, the more they can get up and around and kind of work through the pain, the better.

Okay. Slide 12. The DEA back in about 2012 stopped allowing us to -- physicians and other prescribers to call in an opioid prescription directly to the nurse. We had -- now have this contact with the pharmacist. I'm sure many of you are aware of that.

There have been some kind of workarounds like a contract that can be signed between an individual doctor and an individual nursing home nurse, but it has definitely caused some delays in residents receiving necessary pain medicine and this even applies to dispensing from emergency kits. So, we've been -- AMDA



and AHCA and a lot of other organizations are continuing to work on trying to make that less -- that process less onerous, but we haven't succeeded so far.

Now, faxes are Okay in long-term care facilities under federal regs, and you don't have to send an original. So that part is a little bit simpler than it would be in the community. I think we'll see more and more e-prescribing and, hopefully, that will make things a little bit simpler.

It's acceptable for a prescriber to order up to 60 days of a C-II in a nursing home pharmacy and a long-term care pharmacy can do partial fills. And they're -- I think more and more you're seeing them send smaller amounts, but the prescription is still good for the total amount.

And on Schedule 3 through 5, you can do up to 6 months' worth of refills up to 120 days of supply. And that one you can -- you can just call in. It does -- they don't require a signature for those. So, I want to make a point that it's important to get your meds reordered before the resident runs out of the opioid on the med card. So, I hope you all have processes to ensure that doesn't happen.

Okay. Slide 13. As you know, controlled substances cannot be returned. It can only be used for the person to whom it was prescribed, and so, it has to be destroyed, which is -- it's very wasteful, but that's been the law for many, many years. And there have been instances where returned -- or, I mean, unused medications have been diverted. So, I also encourage you to have very robust processes both for counting, you know, as you're -- you know, what is on the cart and also destroying the unused medications and make sure that happens and that they're not left someplace where somebody could snag them and take them and sell them or whatever.

So, in 2014, hydrocodone products, it used to be controlled Schedule 3, it became C-II, making those more difficult to prescribe. And so, really, you know, the only ones that can be easily called in now are the acetaminophen with codeine or Tylenol with codeine and tramadol or ultram. And they're not ideal products, and so, you know, I hope that prescribers are not going to that just because of convenience. That's really not appropriate.

Anyhow, in the proposed rule for the 2016 revision of the requirements of participation, opioids were initially going to be considered a psychotropic and that was -- that was removed. So -- but obviously, they do have significant effects on the central nervous system.

Okay. Slide 14. Just a little bit about the F tags here. The old F329 that most of you are familiar with and now they have -- it's now F757 and F756, what's considered an unnecessary drug which can be anything given in excess of dose, excess of duration without adequate monitoring, without indications for use, and in the presence of adverse consequences indicating that the dose should be reduced or discontinued.

So, I mean, that puts a lot on the surveyor, you know, to decide, you know, is it because obviously the doctor prescribed it. But just keep in mind that that's what they're going to be looking at. And certainly, some people are on multiple opioids. They may be on one long acting, one short acting; and, in some cases, are on, you know, multiple short acting for whatever reason. If you have that going on, please make sure you get your prescriber to document why, you know, so you don't run into survey problems.



Then, we now have F697, which is under quality of care, specifically as it relates to pain management. And this means that the facility has to ensure that residents receive treatment and care, you know, in accordance with current standards of practice and, you know, the specific individualized plan of care and the resident's choices as it relates to pain management.

And obviously, some people -- you know, for some people they'll say, "Look, a pain level of 7 is Okay with me. I don't care -- you know, I just want to be with it. I want to be able to communicate. Others say, "Hey, I want to be -- I don't care how dopey and drowsy I am. I don't want to have pain. I don't want my level above a 2." And so, that needs to be care planned.

I'd say a best practice is to, if somebody is on opioids, have a specific opioid care plan that includes realistic goals. You know, not the pain level would be less than 0, but something realistic. And please be sure when you're -- when you're -- have a patient on opioids, particularly short-acting opioids, you should be doing pain levels both before and after the dose and don't just say improved because, hey, if somebody goes from a 9 to an 8, they have improved.

And when they do, a medical legal review it always -- it's just surprising how sloppy that documentation can be at times. And then, use pain scales appropriate to the individual resident because, clearly, you know, somebody with profound dementia isn't going to be able to tell you that their level is a 3.

Key Points/Summary

Okay. So, slide 15. I got two summary slides here and then we'll be finished. Remember that opioids, they are wonderful drugs. They are the most effective pain reliever available, and they also have a lot of other positive effects, you know, on other symptoms. And so, let's not throw the baby out with the bathwater just because there's some -- you know, a lot of 20-year-olds are overdosing on it. You know, that's not happening in our buildings, okay.

And the opioid crisis though is real and must be addressed by our society, right so I think, you know, we should also do better with our processes, including tapering opioids, using adjuvants whenever possible, or other analgesics, using non-pharmacological measures just as we do with anti-psychotics, right? We -- you know, if we can avoid putting a foreign substance in their body, then, by all means, we should.

Now, the constraints on opioid prescribing do not apply to hospice enrollees although they -- if somebody is receiving palliative care that's not hospice. The same -- the same kind of limits or regulatory issues do occur. Also keep in mind there is no ceiling -- no dosage ceiling for pure opioids and many of you have probably seen people who require a 1,000 mg or more of morphine a day because they developed tolerance to it over time.

Order ongoing opioids in plenty of time before your resident runs out on the cart. It's really not a kindness to have them, you know, go into withdrawal or have to get a workaround, you know, something off the e-kit just because somebody wasn't thinking ahead. I'm sure everybody has naloxone or narcan on their -- on their e-kit, but that's something that I believe is very important because it can immediately reverse respiratory depression from opioids although you will have an unhappy person when they wake up, but they'll be alive.



Okay. And then use caution when prescribing and administering opioids with benzos because of the risk of respiratory depression. But, you know, they've been used together for many, many years and there aren't that many adverse effects. So, I'm not saying you should never do it. I'm just saying that you should do it with caution and with informed consent preferably.

Last slide, 16. For residents who have potential issues with addiction, you know, the usual measures, right. So, if -- I think every state now has prescription drug monitoring program. You can, you know, see what their opioid history is.

Make sure that you observe them taking it. Use abuse-deterrent formulations. Use long acting rather than short acting and consider medication-assisted treatment with buprenorphine, methadone, or whatever is available. And, you know, if you need an addiction specialist to help out with that, there is plenty around.

Please treat addiction like any other disease, not a character defect. You know, these are not bad people. They are sick people. And even though they may have some other behaviors that are -- that are difficult or challenging, they have a right to treatment just like everybody else.

Have strict policies about destruction of unused medications. Be vigilant for diversion of opioids and unusual behavior by your nursing staff. Be realistic in your goals of pain management and also, you know, just as we do with other things, we need to create realistic expectations for residents and their families and not say, "Look, we're going to get your pain level to a 0, but just we're going to do the best we can and we're going to walk this path with you and try to keep you as comfortable as we can."

And then, always consider pain as a cause of behavioral disturbances in people that are cognitively impaired. So sometimes agitated behavior or striking out or things like that in residents with dementia may be because of pain and sometimes an empiric trial of pain medication to see if it helps is worthwhile.

Slide 17. I've got some resources and before I -- before I stop, I just want to put in a plug for Caring for the Ages. Even if you're not an AMDA member, you can -- you can basically get an electronic subscription free. Just go to caringfortheages.com. I'm biased because I'm the editor, but I think it's a really wonderful little periodical.

And that's it and we'll take questions at the end. Thank you very much.

Michele Laughman: Thank you, Dr. Steinberg. Unfortunately, Dr. Ling had a connection issue, so we weren't able to reconnect with her. So, we're going to go ahead and move on to our next presentation, which will focus on the impact of opioid use on persons living with dementia.

Our speaker for this presentation will be Dr. Abraham Brody, Associate Director at the Harvard Institute for Geriatric Nursing, Associate Professor of Nursing and Medicine at New York University, and Researcher and Nurse Practitioner at the Geriatric Research, Education and Clinical Center within the James J Peters Bronx VA Medical Center.

Dr. Brody?



The Impact of Opioid Use on Persons Living with Dementia

Dr. Abraham Brody: Thank you so much, Michele, and good afternoon everyone. So, you've already got a wonderful primer on opioids in general and opioids in nursing homes. I am going to spend our time together focusing down really on to the person living with dementia. A lot of this will focus equally on persons who are in the community, as well as those who are in facilities, long-term care, sub-acute rehab et cetera.

Significance

So, I'll start with slide 19. And just to give you an idea, within community-dwelling older adults at large about 50 percent have some form of pain and somewhere between 35 percent and 61 percent of nursing home residents have some form of pain. And I can't give you a reason why there are such wide variations in what percentage, but that's what kind of different datasets have shown us. And one of the biggest things that we think about as we're trying to work with patients who have dementia or other sorts of brain injuries or deliriums where they can respond is to think about what chronic medical conditions and acute medical conditions are typically associated with pain.

And we know that about 80 percent of older adults have some form of a chronic medical condition that is typical associated with pain and these things can include rheumatoid or osteoarthritis, gout, pressure ulcers, cancer, post-herpetic neuralgias that are coming from shingles, back pain of any different types of causes, musculoskeletal or if through vertebral fractures, and diabetic neuropathy are the ones we tend to see most. Obviously, this is not a comprehensive list, but these are some of the primary chronic conditions that lead to pain in older adults.

Adverse Effects

And so, if we look at slide 21, we can see what the adverse effects of that pain are and how older adults live, and this includes depression and sleep issues. So, if you were to create a -- what's called a symptom cluster, which means a set of symptoms that cluster together and are dependent upon each other, pain, sleep, and depression all go hand in hand, where if you're not treating all three of them, none of them will fully get better. And so, these are the things that we like to focus on the most in terms of when we see a person who is having pain that they're likely to have these other things as well, and we need to treat them as a person and treat all three.

Some of the other issues that can arise are that pain can cause agitation in persons with dementia in particular. This is how we often will see pain expressed as -- what's called agitation or resistant to care is sometimes the label that's given and often that's due to pain; not always, but often.

Pain leads to loss of function. It can lead to withdrawal or decreased socialization, to burden, depression, and burnout amongst the caregivers who are caring for someone who have pain and that can be formal or informal caregivers, so that's family caregivers, but that's also paid caregivers.

And we also know that it increased health care utilization and cost and, particularly in the nursing home population, is a significant indicator that a patient is more likely -- or a resident is more likely to return to the hospital and readmitted. And knowing where the reimbursement structure and incentives are these days and



referral sources, we know that's a key thing that both nursing homes and other post-acute providers are trying to focus on.

So, when we think about pain in the population, we do need to think of the whole -- the whole person and not just pain isolated in and of itself. And we need to think about what's causing that pain in order to treat it effectively.

Using Opioids or Pain

I'm sorry there's a typo here, but in terms of -- on slide 22, we think about -- used to think about a step-wise approach to using opioids for pain. And so, we would start with a non-opioid and then if the pain was persisting, we move to a mixed opioid usually with acetaminophen like Percocet or Vicodin and then to a strong opioid.

And here's the problem with this ladder. It wasn't based on any evidence, and it was focused on cancer pain. So this was a group of scientists who came together and decided this would be a good thing to do thing based on what they had seen largely in a cancer pain population. We, for some reason, decided that we were going to apply it to everyone and it has since then been one of the many contributors to the overuse of opioids.

There are some fascinating books out there, some are more sensationalistic than others about the use of opioids for pain and kind of origin of the drug crisis. I'm not going to get to that and, you know, our first speaker spoke a little bit about that. But what I will focus on is that opioids are not always the answer for pain, and we're starting to see a lot more evidence to that effect.

What We Know

So, if we look on slide 23, one of my collaborators on another trial came out with the space trial in Journal of the American Medical Association now about six months ago and it looked to -- at the effect of opioid versus non-opioid medication on pain-related function in patients with chronic back pain, or hip pain, or knee pain due to osteoarthritis.

And what they found was that opioids were not superior -- did not result in any significantly better pain-related function than using acetaminophen, or ibuprofen, or other NSAIDs. This is not to say that we base all of our treatment decisions on a single study, but we're starting to see more studies mirror this.

And so, we really need to think about what we're prescribing opioids for, in particular, things that are more chronic lower back pain, osteoarthritis; we tend to think that opioids have limited efficacy. And we also know that opioids have limited efficacy in neuropathic pain, so diabetic peripheral neuropathy, herpes zoster, HIV/AIDS neuropathies, chemotherapy-induced neuropathies. All of these have really limited data to say opioids are superior to anything else.

So, in this case, what ends up happening patients end up on opioids and then they end up being sequentially increased because their pain is not being controlled and leading to significant side effects, including the increased risk for falls.



And so, we really need to think carefully about when we're going to use an opioid; is it the right indication. And we now have some data that suggests that chronic back pain or hip and knee arthritis pain are not good reasons for opioid use and neuropathic pain is generally not good for this type of pain as well.

Now, that being said, for neuropathic pain, we do sometimes still use opioids, particularly methadone when patients are having these neuropathies that are not relieved by other adjuvant pain medicines that we've tried. At this point, it really should be a pain or palliative care specialist that's helping to chime in on this to help optimize the symptom management.

What we do know is that pain is associated with disinhibition and irritability. So if we even think about ourselves, if you've ever stubbed your toe or had a headache or just been uncomfortable for some reason that they, chances are you may end up taking some of that out on someone else or something inside the executive function part of your brain is saying, "Wait a second, I'm not really angry at this person. I'm just uncomfortable, and then, I'm going to hold back a little bit." Now, that takes a really self-aware person to be able to do that part and a lot of good executive function.

So, when we think about persons with dementia, if they're uncomfortable, they've already lost a lot of their executive function and communication skills depending on where in the trajectory their dementia is. And so, therefore, disinhibition and irritability are two very common symptoms that we will see in persons with dementia who have pain.

What we also know is that opioids only very modestly reduce the use of benzodiazepines and anti-psychotics. So, we know there's been some chatter out there both in the trade magazines as well as in some editorials and some small papers about opioids replacing benzodiazepines and anti-psychotics in nursing homes in particular due to CMS' focus on reducing psychoactive medication. What we know that with that opioids really don't do a whole heck of a lot to reduce those other two things.

What we also know though on the positive side is that opioids do not likely have long-term effects on cognition. So, while they may make you a little bit sleepier, they may make you a little bit fuzzier, to begin with, those things you develop tolerance to as you're on opioids for longer periods of time and, therefore, the cognition tends to return. We also know that opioids do not tend to cause psychosis in most persons with dementia.

And finally, long-acting opioids are very frequently inappropriately prescribed in persons with dementia in the nursing home. For instance, patients are just started on a trial of 0.5 microgram patch of fentanyl when they are opiate naïve. They've never had any opioids before. And then, they're going to be sedated, they may overdose. They're going to be highly somnolent.

Now, that may be a benefit in terms of managing some behaviors, but it's also reducing the resident's function to the point where it causes a host of number of other F-tag violations and can also just lead to poor quality of life for the patient that even, once you've removed the opioid, can continue because now they've become debilitated even more so than they might have been before.

Other things that we do have to worry about are nausea, vomiting, constipation, drowsiness, some short-term cognitive effects and respiratory depression. The -- and, as we've mentioned earlier, itching can be an issue as well.



We find that nausea, vomiting is worse in some of the older pain medications, particularly Tylenol with codeine, which used to be used a lot more frequently. It can still happen in the other ones, but not quite as frequently.

Constipation, as we've said before, when there is an opioid on board, there is also some form of laxative. Docusate does nothing for older adults. There are multiple trials that says docusate is not effective in helping in any way, shape, or form. It is a waste of a pill.

I encourage all of you that have never gone to the Jerry Powell blog to go observe the taste test that three physicians from USCF have done and see what their experience is with the taste test of docusate throwing that on top of the fact that it doesn't do anything and it's an extra pill, and please to start de-prescribing that in your facility. On the flipside, MiraLAX is usually a first-line medication as are Senokot and lactulose for reducing constipation risk in populations who are going to be on opioids.

Respiratory depression, unless you improperly prescribe is -- or someone improperly prescribes or give an overdose compared to what is prescribed, is a very low risk factor. It's what people are scared about the most, but it's the least likely thing to come to fruition and so all of these other things that are much more likely to incur unless it's a poorly-prescribed order or someone has some kidney or hepatic dysfunction that we didn't -- that wasn't known about when the order was prescribed.

So, the big question is what does all of this mean? It means opioids are not appropriate for use in some of the more typical painful conditions in older adults like arthritis and lower back pain. Older adults who are opiate-naïve should not be placed on long-acting opioid like fentanyl patches that have a black box warning specifically for this. And opioids should not be used to replace anti-psychotics and sedative/hypnotics.

Also, if we move down to slide 27, we think about what -- where is it appropriate. So, opioids are appropriate in cancer pain; in acute pain caused by injury, so hip fracture, broken ribs, vertebral compression fracture -- for time-limited periods. This should not revert over to a chronic pain medication.

It's usually -- and I generally tend to practice with hip fracture -- hip fracture patients. That's who I see currently -- really, we start to wean patients off somewhere between three to seven days post the hip fracture and the large majority of the population is going to be okay with that as long as we're giving them Lidoderm patches and acetaminophen to go along with that.

The other thing to be aware of in these acute bone-related issues like hip fractures or rib fractures, vertebral compression fractures is that's a case where we wouldn't be starting a patient on NSAIDs because it's inhibits bone regrowth.

Other times where we might appropriately use opioids are new pressure injuries, pressure ulcers. I've actually seen patients where they've developed new pressure ulcers and all of a sudden, they either become highly agitated or highly hypoactive, delirium where just kind of sitting there but have lost their personality, aren't really talking. And as soon as they've gotten small doses of opioids have returned to their prior behavioral state.



And so, this is one of the places where I think we actually under-medicate because patients aren't -- or residents aren't able to tell us, particularly in patients with dementia, that they're having pain. And so, they express their pain with this or this agitation or the hypoactive type of behavior.

The other thing where it is appropriate, severe flares of chronic conditions; dyspnea that's caused by severe chronic obstructive pulmonary disorder or congestive heart failure. Small amounts of opioids are appropriate there. Or when a patient is terminal and is having either agitation or tachypnea. Those are largely where we should be focusing our opioid use. Otherwise, we should be effectively using other pain control modalities that were discussed earlier in this conversation.

Now, if we focus specifically on older adults and then, specifically, even more on persons with dementia, older adults in general, particularly the great generation are very reluctant to report pain. As we change over geriatrics and gerontology into the baby boomer generation, this is actually changing because we are seeing more -- the baby boomer generation is more likely to share all of their concerns, whereas the great generation is more likely to minimize pain.

Older adults are often also going to use different terminologies, so it may be the arthritis; you know, the back is acting up. "I'm just not feeling well, I've got soreness. I feel pressure," all of those things. It might not be discomfort. It might not be pain that they use.

There are maybe fear around addiction to analgesics and, therefore, patients are unwilling to talk about their pain because of that. And then, cognitive impairment. And the most severe that a patient becomes, the harder it is for their -- for them to report their pain. And so, we'll go into that a little more in a moment.

And then finally, clinician knowledge and attitudes. In our RN or LPN, RCNA populations in long-term care and post-acute facilities, sometimes we just miss the boat in how we talk those groups to a fast, managed, or observed pain behaviors and ask about pain.

Barriers to Assessment

So when we assess pain in older adults, if they do tell us they have pain, we are still going want to understand what the intensity of the pain is, when it started, what the duration of it is, its frequency, its location, whether it's -- what does it feel like, what causes it occur, what makes it worse, and what makes it better. However, how the questions are asked may change as we deal with patients with more cognitive impairment because we're going to ask more simple questions and, eventually, we may be much more reliant on informant report.

And so, we start kind of by asking some other questions. Are you having any difficulty getting out of bed? Are you having any difficulty with walking or moving? Do you have any discomfort, soreness, achiness, or are you having any of the arthritis or the gout? These types of things are much more likely -- they're more specific and they're much more likely to engage the older adult and lead to affirmative answers.

In the person with dementia, we have to circumscribe this even more. Oftentimes, for instance, if it's Alzheimer's disease, they have poor short-term memory. We need to assess their pain at rest and with movement. And if they have mild to moderate pain -- or sorry, mild to moderate Alzheimer's, they may be able to tell you they have pain in the moment, but they weren't able to tell you that they had pain 10 minutes ago.



And so, this is really the person who often will sit still in the chair or sit still in bed, and they say they're fine, but if they move or you start to move them, they start to verbalize or express other pain behaviors. So, these are some of the things to look out for. So, we do need, particularly in the person with dementia, to look at rest and with movement in the moment because they can't necessarily recall what happened previously.

So, when we're doing our assessment, in addition to moving and not moving, one of the things that's very helpful in older adults is to understand what scale they prefer. There are a number of studies that have shown that different older adults prefer different scales and so that's why I like using the scale that I've put on slide 33 because it has the faces pain scale, but not a Wong-Baker version which is very childish. It's more based on an adult face. It also has the verbal descriptor scale and the numerical ratings scale, the 0 to 10 scale. And so, you can allow the resident, the patient to choose which scale they most prefer, and you'll then get a much more accurate idea of their pain. And this is what we use even with persons with mild and sometimes even moderate dementia. We're still trying to get a report out using this.

Once we get into moderate and severe dementia though, we will move into using an observational pain scale. The one I tend to recommend the most because it's easiest for staff to use is the PAINAD. It's what's used in a large number of post-acute settings that I have worked in, as well as in acute care settings.

And the nice thing about it is it's asking about what they -- the person is observing over 5 different domains. And as long as they hit 4 points, they likely have pain. It's not like the 0 to 10 scale where, when you get to scale, they have much more pain than when they have a 4. It's just, if they have a 4, they are likely to have a painful experience at that time.

The key again with something like this is that we are looking at both rest and with movement because if you just look at rest, you're going to miss a lot of residents who are not presenting at rest but are presenting with movement. And so, those types of patients, residents are the ones where the CNA says, "Whenever I try and move them, they yell at me or they hit -- try and hit me or they get verbally agitated, they're resistant to care. They don't want to go to the bathroom," a lot of that though not all, some of it can be related to relational issues. It can be related to trust issues. It can be related to issues of not knowing where the person with dementia -- not knowing where they are. But a lot of it can also be attributed to pain behaviors as well.

So other things we need to do regardless of whether the patient has pain or not -- or sorry, whether the patient has dementia or not is monitor for relief from analgesics. So, if we are going to use some of those opioids because it's an acute exacerbation or acute injury or a cancer pain, something like that that we are monitoring for relief because if we're -- if the patient is not receiving relief, we either need to dose adjust up or decide that this is maybe not the right medication for what they have.

We need to educate both the staff and the patient if feasible about assessing pain, about taking breakthrough medication when the pain becomes really bad. In persons with dementia, they're not going to be able to ask for additional pain medicine once they're more in the moderate to severe realm and, in general, we know that PRNs are not -- tend not to be given in nursing homes at high frequency.

So if we have patients or residents who have lower levels of chronic pain, so, for instance, from osteoarthritis, back pain, musculoskeletal-type pain; we will start them on acetaminophen, 1,000 mg three times a day in



order to make sure that they are receiving some pain medicine that is not going to severely cause side effects, but will help improve their quality of life and their ability to function.

The only time we give less than 3 grams is if the patient has end-stage liver disease, in which case, we'll give 2 grams a day. So, we might break it up into three 650 mg doses instead of three 1,000 mg doses.

In older adults, there is kind of the adage that we're not supposed to go over 3 grams of acetaminophen a day. I've tried to go through and find where the evidence for that comes from, and it's not entirely clear that there is a lot of evidence. But there is also non-evidence that going from 3 grams to 4 grams is going to improve analgesic effects. So, I think some of it relates to the slowdown in liver function that occurs naturally as we age. But there still is no real good evidence behind that that we still tend to follow within geriatrics.

Finally, encourage non-pharmacologic treatment. So, everything that was mentioned before, physical activity is the biggest one. It works for arthritis; it works for back pain. The more physical activity the resident, the patient has; the better off they are in terms of their mood, in terms of their pain. It's getting them over the hump of having pain when they're moving.

So, if they have arthritis or things like that, that's where we really need to make sure that we're giving them the acetaminophen or even occasionally if they've having a bad day in end-stage or COX-2 inhibitor for a time-limited period of up to six weeks to help manage that pain. We don't want to give those NSAIDs for longer because of the heart attack risk and the other cardiovascular disease risks and GI bleed risks, but it can be given for time-limited periods when patients are having flare-ups of their chronic conditions.

By encouraging activity, exercise -- TENS units are great for patients who have musculoskeletal pain, not great in persons with dementia because they don't understand the shock. The shocks aren't particularly comfortable, so that doesn't tend to work for that population.

CBT can work in mild dementia. Other things like -- sorry, I just lost my train of thought. Other non-pharmacologic interventions that are appropriate for persons with dementia include massage, heat, ice, ultrasound are all also effective and should be used in addition too.

We often forget the simple things like alternating heat and ice, but some of those are the easiest. And massage is one of the most easiest things. It just requires time and I know that can sometimes be difficult for staff members.

So, with that, I'll leave you with a few resources, so the Hartford Institute for Geriatric Nursing, hign.org. Off of that website they're about to be consolidated. We have consultgeri.org. It's about so fall within hign.org.

It's a huge website that have best practices on everything related to care of the older adult, including pain assessment and management, how to manage behavioral symptoms within persons with dementia, a lot of which do relate to pain et cetera.

We also have Aliviado which is our implementation program for community-based organizations for home health and hospice where we help home health and hospice organizations to implement dementia-friendly programs. We will eventually move that into long-term care as well.



We have geriatricpain.org which is a fantastic website with lots of resources on care of the older adult in relationship to pain particularly those persons with dementia. And then the -- and AMDA has been opioids page as well which is fantastic. So, these are the resources I'll leave you with.

And thank you so much for being on the call. And I think following this I'll hand it back to Michele and we're going to take some questions, right?

Resources

Michele Laughman: Great. Thank you, Dr. Brody. Before we turn it over to the moderator for the Q&A session, I just wanted to provide a few updates about the National Partnership to Improve Dementia Care. Many of you may know, but we recently announced the release of an updated version of the Hand in Hand training series for nursing homes.

The updated training opportunity is still available on CMS' surveyor training website. Hand in Hand is now available in two formats. One is a self-paced online training, as well the downloadable instructor-led course. And you'll receive links in an email that will be sent after this call, so that you can access that.

So, the training focuses on caring for residents with dementia and also on the prevention of abuse. And several years ago, CMS, supported by a team of training developers and subject matter experts, created the training to address the need for nurse aides and service training on these important topics. Federal law requires that nurse aides complete in-service training on dementia management and resident abuse prevention.

Additionally, facilities must provide dementia management and resident abuse prevention training to all facility staff, contractors, and volunteers. In turn, this training is recommended for all nursing home staff. And when you're trying to access that, if you have any issues with registration or other technical concerns, you can contact the survey or training website help desk which is [cmstraininghealth](http://cmstraininghealth.com) -- it's all one word -- at hendall.com and that's H-E-N-D-A-L-L dot com. And again, links will be included in an email that you'll receive after this call.

Additionally, CMS Central Office has launched the Civil Money Penalty Reinvestment Program or CMPRP, which is a multi-year effort to drive improvements in both quality of life and quality of care for nursing home residents. This effort is funded by the federal portion of CMPs or Civil Money Penalties to conduct activities that both support and protect nursing home residents.

The program really builds on other CMS initiatives like the national partnership. We awarded a contract to Deloitte Consulting to support CMS with four specific objectives. One is to reduce adverse events, improve staff efficiency, competency and performance; of course, improved dementia care; and also support of other activities such as CMP application review.

For the dementia care objective, we are utilizing a multi-pronged approach that focuses on our late adopters. Through this multi-pronged approach, we will be providing both technical assistance as well as using a breakthrough community collaborative model. The ones who want technical assistance will address unique barriers and motivate disengaged nursing homes.



A trainer and the nursing home will work in tandem to identify issues, develop interventions, and adopt practices to improve dementia care. The breakthrough community model that the CMPRP is using to achieve breakthrough improvement in health care. It involves a peer-to-peer learning environment to improve dementia care with a focus on reducing the use of anti-psychotic medications. Interventions that are tested in the breakthrough community will ultimately be used to support nationwide quality improvement in nursing homes.

So, thank you, everyone, for your participation in today's call. And just a big thank you to all of our speakers. I'm now going to turn it over to Leah Nguyen for some additional announcements.

Question & Answer Session

Leah Nguyen: Thank you, Michele. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right Dorothy, we are ready for our first caller.

Operator: To ask a question, press star, followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Once your line is open, state your name and organization. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Cathy Stone.

Cathy Stone: Yes. Thank you for taking my question. I know that the doctors both strongly stressed evidence-based information and so forth, but I'm very curious why they are not considering or if they are considering the future use of ancient medicines, herbal medicines, that their evidence is based over generations of use and proof of efficacy both in Chinese medicine and Ayurvedic medicine, and then the more modern alternative of aromatherapies and so forth, especially in folks with dementia. Thank you.

Dr. Abraham Brody: This is Ab Brody. I will say we do use aromatherapy. I have it on a separate slide deck than this one and it -- can be effective as one adjuvant for relaxing because there is a cognitive component to pain. So, it certainly is one treatment.

Some of the herbal remedies that exist have not been through any sort of clinical trials and so we only recommend things that are based on clinical trials of some sort. So, until that evidence exists, and there are some trials that are currently ongoing with Chinese traditional medicines and other things, there are some good acupuncture trials where acupuncture in persons with dementia tends not to work very well because people are getting needles put in them and persons with dementia often have difficulty reconciling that issue or staying



still during that. So, there are some traditional Chinese medicine and eastern medicine approaches that are helpful.

On the flip side, some of the -- herbal medications are both not consistent in their preparation and can interfere with other medications that the patient is always already on. And so, we are very weary without understanding what the -- what the interactions are to include those especially if there hasn't been true efficacy shown.

Dr. Karl Steinberg: This is Dr. Steinberg and I agree with Dr. Brody. I would say the other issue is, you know, the survey teams come in and they I think will especially be scrutinizing things that are not FDA approved and so on. So, there's that whole other layer.

I do think there's at least some evidence for some of the herbal and traditional medications. The quality control is an issue. And then, you know, the pharmacy is probably not going to -- you know, it's going to have to go and be blister packed and so on. But it is a residence rights issue and if somebody is clamoring for it, then by all means.

Leah Nguyen: Thank you.

Cathy Stone: I like that answer. I very much like that answer. Are you still there?

Leah Nguyen: Yes. Can we take the next question?

Operator: Your next question comes from the line of Jessie Dwyer.

Jessie Dwyer: Hi. My name is Jessie. I worked in long care -- long-term care for quite a while. My -- it's not so much a question; it's a comment, I guess. Working in long-term care, we are not allowed to use heat on residents. We can use ice, but heat is not allowed at all.

Is there anything you can foresee changing in that or ways to get around that because I do think that the alternating heat and ice would be a great benefit as far as being controlled, but also just -- it's -- you know, it feels nice, it's relaxing and it's beneficial all the way around.

Debbie Lyons: Hi. This is -- this is Debbie Lyons here at CMS, and I would just say that our requirements and expectations are that the treatment be according to standards of practice. Heat is absolutely -- when safely applied according to manufacturer directions and specifications, can be a therapeutic modality that, you know, we certainly would encourage in the right circumstances. So, there's no -- there's no regulation that says, you cannot use heat on residents that we're aware of. So, I'm not sure where...

Jessie Dwyer: I think maybe it's a -- it's a -- like a facility-based rule then.

Debbie Lyons: Yes. It could very well be a policy or procedure from the particular facility. But, you know, what we -- what we stress at CMS and our guidance is that the treatments be in accordance with standards of practice -- you know, professional standards of practice.

Leah Nguyen: Thank you



Jessie Dwyer: Sure.

Dr. Karl Steinberg: This is Karl Steinberg and we use heat in some of our facility -- I mean, heating pads are sort of looked askance at because of the risks of burns and so on. But, you know, the over-the-counter -- the -- either the kind that you can put on a microwave or the kind that is -- kind of time limited, I don't -- I'm not aware of any regulations that don't permit their use of those. And again, it's a resident's rights issue.

Operator: Your next question comes from the line of Ellen Blackwell.

Ellen Blackwell: Hi, Dr. Steinberg and Dr. Brody. I'm actually with CMS, and I wanted to thank you for doing such a great job today and also just make an observation that many of the principles and recommendations that you made can not only apply to individuals living in nursing homes but also beneficiaries who are living in group homes, assisted-living facilities, and other community-based setting.

Dr. Karl Steinberg: Thank you.

Operator: Your next question comes from the line of Annette Simon.

Annette Simon: Yes. My question is you recommended a dose reduction of acetaminophen for patients that have chronic pain and also had liver -- end-stage liver disease. What would you recommend for chronic arthritis pain or back pain for person or resident that has end-stage kidney disease?

Dr. Abraham Brody: This is Dr. Brody. So, with end-stage kidney disease acetaminophen is not contraindicated. It's the end-stage liver disease where we need a dose reduction. That dose reduction is not necessarily mean less efficacy. It means that because the liver takes longer to clear out that medication, it will hopefully maintain its potency with the lower dose. It's not an exact science though. With kidney issues, acetaminophen is actually still a highly effective medication. And because its liver excreted, there aren't issues in that way.

Dr. Karl Steinberg: And if you are specifically asking about opioids, there are some opioids that are better than others for people with advanced kidney disease and, you know, I've checked with the prescribers. But generally, for example, methadone there are really no renal issues around that; whereas with morphine there are, you know, some toxic metabolites that can accumulate.

Dr. Abraham Brody: Yes. We use dilaudid or fentanyl usually within our kidney population if we're going to use an opioid.

Dr. Karl Steinberg: Yes.

Annette Simon: Thank you.

Leah Nguyen: Thank you.



Operator: As a reminder, if you would like to ask a question, please press star, then the number one on your telephone keypad.

One moment for your next question.

Your next question comes from the line of Tally Wills.

Tally Wills: I'm sorry, I had you on mute. I wanted to also thank you for the presentation today. I am a home health-based director of clinical services and a lot of these side effects actually play a huge part in our dementia patients in the home. So, this has been very helpful.

My question is, moving forward, looking at the future of pain management, I just wanted to see if anybody would weigh in on the medical marijuana movement, not only for pain management but also symptom management in the home as it relates to dementia patients.

Dr. Karl Steinberg: This is Karl Steinberg. Well, this is a CMS call, so I think anything we say about marijuana - I mean, it's still federally -- you know, it's still considered Schedule 1 and considering, you know, what the current administration's role -- take on that is. But that being said, there is pretty good evidence that cannabinoids are effective particularly for neuropathic pain. I think the evidence for things like the CBD oil that are less psychoactive are not quite as strong.

But, again, I think there's not a lot of good evidence in this population anyway because people don't do studies on them. So, I think we have to be pragmatic at times. And I certainly would not count that out in places where that is, you know, not against the law.

Tally Wills: Thank you.

Operator: Your next question comes from the line of Martin Hujinsky.

Martin Hujinsky: Hi. I was just curious what you might recommend for pain relief in the patient with chronic liver disease. I recently had an insurance company refuse to approve tramadol because they said it wasn't safe.

Dr. Karl Steinberg: It's Karl Steinberg. I think, you know, tramadol, it's a little bit more risky in people with advanced liver disease. There's nothing, say, you can't use traditional opioids in that -- in that population or non-steroidals or low-dose acetaminophen. So, I think insurance companies sometimes maybe overstep what they -- I mean, ultimately, it's prescriber who should be deciding. That's my opinion.

Leah Nguyen: Thank you.

Operator: And there are no further questions at this time.

Additional Information



Leah Nguyen: Great. Thank you. We hope you'll take a few moments to evaluate your experience with today's call. See slide 37 for more information. An audio recording and transcript will be available in about two weeks at www.cms.gov/npc.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the National Partnership to Improve Dementia Care in Nursing Homes. Have a great day, everyone.

Operator: Thank you participating in today's conference call. You may now disconnect. Presenters, please hold.