Clinical challenges such as pain, wounds, and heart failure are prevalent in the PA/LTC setting and managing these conditions effectively requires that the interprofessional team develop a plan of care that supports patient-centered goals that are both realistic and achievable while striving to provide optimal care to each patient. Pain in the PA/LTC setting affects rehabilitation and mood and pain management should be considered a patient’s right in the PA/LTC setting. However, with the opioid epidemic and new rules it is essential to follow the regulations, but also address pain effectively. Pressure ulcers and other wounds remain a major cause of morbidity and mortality, affecting an estimated 2.5 million patients per year and costing up to $11.6 billion dollars per year in the United States. Readmission after a hospitalization for heart failure is still common among PA/LTC patients, with almost half of the patients readmitted within 6 months. Furthermore, for each of these conditions, older adults almost always have multimorbidity that influences the treatment of the primary condition. The workshop will utilize the clinical practice guidelines and their accompanying pocket guides as a framework for discussion of common patient scenarios involving acute and chronic pain, wounds, and heart failure. During the workshop, there will be specific attention to strategies for utilization and implementation of the evidence-based guidelines in the real world.

Learning Objectives

- Discuss best practice methods to promote the interprofessional implementation of clinical practice guidelines in their facilities.
- Incorporate the pain management, pressure ulcers and other wounds, and heart failure clinical practice guidelines in their facilities.

Presenter(s): Deborah Way, MD, CMD; Gabriel Brandeis, MD, CMD; Gwendolen Buhr, MD, MEd, CMD; Manisha Parulekar, MD, CMD; Robert Hogikyan, MD, MPH, CMD; Victoria Nalls, GNP

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
The “How To” Implementation of Pain Management, Pressure Ulcers and other Wounds, and Heart Failure Clinical Practice Guidelines in PA/LTC

Gwendolen Buhr MD, CMD, Robert Hogikyan, MD, CMD, Deborah Way MD, CMD, Gabriel Brandeis, MD, CMD, Victoria Nalls, GNP, Manisha Parulekar, MBBS, CMD

Speaker Disclosures

All speakers have disclosed that they have no financial relationship(s).

Learning Objectives

By the end of the session, participants will be able to:

1. Discuss best practice methods to promote the interprofessional implementation of clinical practice guidelines in their facilities.
2. Incorporate the pain management, pressure ulcers and other wounds, and heart failure clinical practice guidelines in their facilities.

AMDA Clinical Practice Guidelines

- Designed for the entire IDT
- Emphasize key care processes
- Follows the medical care delivery process
  - Recognition
  - Assessment (root cause analysis)
  - Treatment (based on assessment), and
  - Monitoring.
- Pain Management
- Pressure Ulcer and Other Wounds
- Heart Failure

Pocket Guides as Tools

- Quick reference to the recognition, assessment, treatment, and monitoring approach
- Based on the CPG
- Updated information
- Algorithms

Changing Behaviors – What Works

- Interactive education
  - Motivate the Emotional side, Direct the Rational side, Shape the Path
  - Using intervention theories more likely to be successful
- Economic incentives
- Locally created guidelines linked to clinical work
  - Targeting specific care tasks more likely to produce positive outcomes than those requiring global practice change

Changing Behaviors – What Works

- Personalized feedback
- Interventions with positive outcomes for residents tended to change staff behavior
- Automated real-time decision support
- Reminders concurrent with clinical work
- Multifaceted Interventions

- Not necessarily more successful than single interventions


Pain in Post-Acute and Long Term Care

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Case

- 90 year old man recently admitted to nursing home for rehabilitation post hospitalization for fall.
- PMH moderate dementia. Dependent in IADLs, able to feed and dress self if set up provided. Ambulation/transfers not steady, but he is impulsive and cannot use a walker. He keeps leaving it behind and “wall walks” using rails in halls. Requires extensive assistance of one person with toileting and bathing
- “New” diagnosis of prostate cancer with local invasion to bladder and distant metastases to bone. When asked, he denies pain, but he has been losing weight and is frequently seen grimacing and rubbing his upper legs.

Why is this important?

- Pain is common
- Pain affects measures of well-being
- Treatment of pain is a patient’s right
- We have a professional obligation to prevent needless suffering

Related Regulations

- F Tag 697 2017
- CDC Guidelines March 2016 (reviewed 8/9/17)
- Joint Commission Standards

Four Basic Steps

- Recognize
- Assess
- Treat
- Monitor
Recognize Pain

- Pain is not a normal part of aging
- Pain associated with many conditions in the elderly
- Pain can masquerade as behaviors
- Pain is hard to assess in cognitively impaired patients

Assess

- Educate (early and often)
- Pain assessment tools
- Communication
- Staffing
- Regular evaluation
- What effect on function and quality of life?
- PRN evaluation

Treatment - Care Planning

- Patient centered interdisciplinary care plan
  - Cause of pain, if found, co-morbidities, patient and family goals of care, prognosis
  - Consider pharmacologic and non-pharmacologic interventions
  - Balance benefits and burdens
  - Set goals for pain relief

Treatment - Pharmacologic

- Consider evidence based recommendations
- If pain persistent, prescribe at least one scheduled analgesic
- Provide a PRN medication
- Reassess and adjust
  - Medication half life, patient’s comorbidities to determine dosing interval
  - Monitor and minimize/manage side effects

WHO Pain Relief Ladder

Oral Non-Opioid Analgesics

- Acetaminophen, NSAIDs, salicylates
  - Alone or with opioids
  - Ceiling dose
  - Limited if hepatic/renal impairment, drug-drug interactions, other medical issues
- Tramadol
  - Ceiling dose
  - Limited if renal impairment
  - Serotonin syndrome/seizures/hypoglycemia
### Topical Analgesics
- Counterirritants — creams, gels, liniments
- Capsaicin
- Topical NSAIDs — gel, patch
- Lidocaine - patch

### Opioid Analgesics
- Many adverse effects especially dangerous in frail elderly
- Oral immediate release – Start low, go slow
- No ceiling – only limit is intolerance
- Prevent and treat constipation

### Immediate Release Opioids
- Morphine
- Oxycodone
- Hydromorphone

### Long Acting Opioids
- Oral
  - Morphine
  - Oxycodone
  - Methadone
- Transdermal
  - Fentanyl
  - Buprenorphine

### Adjuvant Medications
- Anticonvulsants
- Antidepressants
- Steroids
- Muscle relaxants
- Calcitonin

### Non-Pharmacologic Treatment
- Set goals for pain relief
- Massage/healing touch
- Relaxation
- Music/Pet/Art Therapy
- Acupuncture
- Chiropractic
- PT/OT/brace
- Other
Pressure Ulcers and Other Wounds

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Consistency is Important
- Use one scale
- Protocol/care plan and stick to it
- Use MDS criteria for now
- Know your formulary

Team Approach to Wound Management
- CNA
- Nurse
- Physician, NP, or PA
- Dietician
- Others such as wound consultant

Standardize the Documentation
- Determine who documents stage/measurements
- Classify wounds as maintenance and/or palliative
Recognition
• CNAs must be involved
• Set schedule for wound rounds
• Know the risk factors
• Know the surveyor guidance

Assessment
• Document all contributing factors
• Use the MDS definition for pressure ulcer staging
• Designate one person to document the details
  • Size
  • Location
  • Exudate, odor, pain, etc.
• Differentiate wound types
  • Pressure, arterial, venous, skin tear

Treatment
GENERAL SUPPORT
• Hydration
• Nutrition
• Pain management
• Psychosocial support to patient and family
WOUND SPECIFIC
• Know your formulary for specific products
• Colonized/infected
  • NERDS

Monitoring
• Standardized form
• Follow MDS section for documentation
• Include relevant information
  • Location
  • Timeline
  • Size
  • Stage
  • Current Conditions
Heart Failure

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Case
- 88 yr old male with a hx of AS, grade 2 diastolic dysfunction, s/p TAVR was admitted to SNF 5 days ago after TKR
- Nurse called you for evaluation of palpitations
- Prescribed ibuprofen for postoperative pain
- He has had weight gain for last 3 days, total 4 lbs
- Pt c/o feeling tired and SOB with activity
Heart Failure Key Points

- Leading Cause of Hospital Admissions
- Rate of death at one year 1 in 5
  - 2.3 to 3.6 years ages 67 to 74
  - 1.1 to 1.6 years ages 85 and older
- HF is one of the top causes of 30-day hospital readmissions
  - inadequate staff training and education, provider unavailability, and failure to adhere to standard guidelines for care all contribute to increased rate.

Key Points

- Leading cause of disability and decreased quality of life
- HF in older adults is often multifactorial in origin
- HTN most common antecedent CV condition
  - 60-70% women; 30-40% men
- Other common causes – valvular heart disease and nonischemic dilated cardiomyopathy

Definitions

- HF with reduced ejection fraction (HFrEF) – EF ≤40%
  - Up to 90% of HF patients < 65 years old have this form of the disease
- HF with preserved ejection fraction (HFpEF) – EF ≥ 50%
  - Affects 40% of men and two thirds of women > 65 years old with HF
- HF with mid-range ejection fraction (HFmrEF) – EF 40–49%

Recognition: Symptoms and Signs that Could Indicate HF

- Often atypical and nonspecific
- Most common: exertional shortness of breath, fatigue, orthopnea, and leg edema
  - Exertional symptoms may be less prominent in older adults because of a more sedentary lifestyle
  - Prevalence of atypical symptoms increases with age
  - Decreased mental acuity, confusion, lethargy, irritability, anorexia, abdominal discomfort, or altered bowel function

Symptoms of Heart Failure

- Most common symptom is shortness of breath (when lying flat or with activity)
- Weight gain (2-3 lbs. in 1 day or 5 lbs. in 1 week)
- New or increasing lower extremity swelling
- Abdominal symptoms (nausea, pain, distension)
- More difficulty breathing with or without exertion
- Unexplained cough
- Disturbed Sleep (unless propped on a pillow)
- Functional decline and or lethargy
- Anxiety or restlessness

Assessment – Diagnosing Heart Failure

- CXR
  - most useful initial test for detecting pulmonary congestion and pleural effusions
  - Also excludes pneumonia as a cause of shortness of breath
- Echocardiogram
  - Provides EF and defines structural heart disease
- Electrocardiogram
- B-type natriuretic peptide (BNP) and N-terminal pro-BNP (nt-proBNP)
  - Valuable to distinguish shortness of breath due to HF from noncardiac causes
  - But specificity decreases with age
Using Functional Assessment to Cue Advancing Disease/Guide Directives

Class I
- No limitations of physical activity. No shortness of breath, fatigue, or heart palpitations with ordinary physical activity.

Class II
- Slight limitation of physical activity. SOB, fatigue, heart palpitations. Patient comfortable at rest.

Class III
- Marked limitation of physical activity. SOB, fatigue, heart palpitations. Patients comfortable at rest.

Class IV
- Severe to complete limitation of activity. SOB, fatigue, heart palpitations, even at rest.

Nonpharmacologic Treatment
- Restrict dietary sodium intake to ≤ 2 g/day
- Most patients with HF should also engage in regular exercise such as walking, stationary cycling, swimming, or water aerobics
  - Exercise duration and intensity should be adjusted to the individual patient’s level of conditioning, severity of HF, and comorbidities
  - Patients should keep an ongoing record of their daily weight

Pharmacologic Treatment
- ACE inhibitors, ARBs, β-blockers, and mineralocorticoid antagonists reduce morbidity and mortality from HF with reduced ejection fraction (systolic HF)
  - Optimal medical therapy for HF with preserved ejection fraction is undefined
  - Optimal management of HF in older patients often requires a multidisciplinary approach

Diuretics for Fluid Retention and Mineralocorticoid Antagonists
- Helps the kidneys produce more urine which in turn, reduces stress on the heart.
  - Best given first thing in the morning. If dosed twice daily – 6 a.m. and 2 p.m
    - The effects of the medication start within an hour and usually last less than 6 hours
  - Potassium Supplement may or may not be needed
  - Mineralocorticoid antagonists decrease mortality in HFrEF

ACE Inhibitor (ARB if ACE intolerant)
- Reduce mortality in HFrEF
- Relax the arteries so the heart can pump blood out easier
- Consider discontinuation of potassium supplement
- Check K, Cr, BP within 1 week

Treatment Overview
- Goals are to decrease symptoms and improve quality of life, reduce acute exacerbations requiring hospitalization, and increase survival
- Hypertension, hyperlipidemia, and diabetes should be treated in accordance with current guidelines
- Smoking cessation
- Alcohol intake should be limited to no more than 2 drinks/day in men and 1 drink/day in women
### Beta Blockers
- Indicated for all patients with stable HFrEF in the absence of contraindications
- Should only be started when euvolemic
- Act by reducing the heart’s tendency to beat faster which may cause heart failure
- Take pulse rate prior to giving medication

### Digoxin
- Can be used with beta-blockers for rate control in atrial fibrillation
- Should be taken only once a day
- Monitor pulse
- May decrease symptoms and hospitalizations for HF in patients with HFrEF
- Use doses ≤0.125 mg daily
- Serum concentrations should generally be ≤1.0 ng/mL

### Vasodilators
- Help blood vessels relax reducing the workload of the heart allowing it to pump easier
- Combination of hydralazine and isosorbide dinitrate may decrease mortality or morbidity in HFrEF in African American patients

### New Pharmacology
**SACUBITRIL/VALSARTAN (ARNI)** (ANGIOTENSIN NEPRILYSIN INHIBITOR)
- In a RCT comparing sacubitril/valsartan with enalapril in symptomatic patients with HFrEF tolerating an adequate dose of ACE or ARB, ARNI reduced the composite endpoint of cardiovascular death or HF hospitalization significantly, by 20%
- The use of ARNI is associated with the risk of hypotension and renal insufficiency and may lead to angioedema

**IVABRADINE**
- Can be beneficial to reduce HF hospitalizations for patients with symptomatic (NYHA class II-III) stable chronic HFrEF who are receiving beta blocker at maximum tolerated dose, and who are in sinus rhythm with a heart rate of 70 bpm or greater at rest

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### Implantable Cardiac Defibrillators
- Reduces mortality from sudden cardiac death in patients with HFrEF, EF ≤ 35%
- Prophylactic placement is advised for patients with NYHA class II or III HF, LVEF ≤ 35%, and life expectancy ≥ 1 year
- Defer placement for ≥40 days after acute MI and ≥90 days after a new diagnosis of dilated cardiomyopathy
- LV function often improves after initiation of β-blocker and ACE inhibitor therapy

### Cardiac Resynchronization
- A biventricular pacemaker with one lead in the right ventricle and a second lead inserted retrograde into the coronary sinus to stimulate the left ventricle
- Indicated in patients with dyssynchronous LV contraction, most commonly related to left bundle branch block, present in up to 30% of patients with systolic HF
- Improves symptoms, exercise tolerance, quality of life, and survival in selected patients with advanced systolic HF and persistent severe symptoms (NYHA class III or IV) despite conventional medical therapy
Monitoring
- Daily Weights
- Serum Electrolytes and Kidney Function
- Recognition of symptoms and signs by multidisciplinary team

Clinical Process and Outcome Indicators
- 1. Recognition: Urgent/emergent recognition of HF signs/symptoms on admission or with change in condition, communication within the team
- 2. Assessment: Risk factors, reversible causes, documentation of EF
- 3. Treatment: appropriate meds/advance directives
- 4. Monitoring: weights, symptoms, labs, effectiveness, adverse effects, complications, need for specialist/end of life care

Table Discussion Utilizing Case & Pocket Guides

Discussion and Wrap-Up

Final Thoughts and Questions