

# © 2021 AMDA – The Society for Post-Acute and Long-Term Care Medicine

## **COPYRIGHT NOTICE – PLEASE READ**

By downloading or printing the Pain Management in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline, you agree to the terms and conditions in this Notice.

The Pain Management in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline is a Copyright © 2021 AMDA – The Society for Post-Acute and Long-Term Care Medicine.

No part of this publication may be distributed, or transmitted in any form, without prior [written permission](#) from AMDA – The Society for Post-Acute and Long-Term Care Medicine. This product is available for purchase at [paltc.org/product-store/pain-management-cpg-pocket-guide](http://paltc.org/product-store/pain-management-cpg-pocket-guide), and group licensing can be arranged by contacting: [ca@paltc.org](mailto:ca@paltc.org).



CLINICAL PRACTICE GUIDELINE



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

# PAIN MANAGEMENT

in the Post-Acute and Long-Term Care Setting






---

**AMDA — The Society for Post-Acute and Long-Term Care Medicine (AMDA) provided the funding for the development of this guideline. The annual dues of the member physicians and other practitioners fund AMDA's work. AMDA does not permit direct company support of the development of clinical practice guidelines or guideline revisions. Work group individuals who developed this guideline are volunteers and not paid by AMDA. Members of the work group are not employees, consultants, or speakers for a company with a commercial product within the subject matter of this guideline.**

**AMDA facilitates and coordinates the guideline development and revision process. AMDA, its members, and peer organizations review, provide feedback, and do not have editorial control over the work group. All recommendations are based on the work group's independent evaluation of the evidence.**

For more information regarding the AMDA guidelines or to order copies of these clinical practice guidelines, call 800/876-2632 or 410/740-9743 or visit our web site at [www.paltc.org](http://www.paltc.org).

To cite this guideline use: AMDA — The Society for Post-Acute and Long-Term Care Medicine. Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: AMDA 2021.



*This Clinical Practice Guideline revision was made possible by a generous grant from the RRF Foundation for Aging. Thank you for your ongoing support!*

---

AMDA–The Society for Post-Acute and Long-Term Care Medicine developed this guideline with the support and cooperation of the following individuals and organizations:

**Pain Management CPG Work Group:**

**Chair:** Steven Levenson, MD, CMD  
Suzanne Cryst, RDN  
Rebecca Ferrini, MD, MPH, CMD  
Robert Hogikyan, MD, MPH, CMD  
Renante Ignacio, MD, CMD  
Paula Lester, MD, FACP, CMD

Victoria Nalls, PhD, GNP-BC, ACHPN  
Fiona Okoroti, GNP, AGPCNP  
Nancy K. Overstreet, DNP, GNP-BC, WOCN  
Barbara Resnick, PhD, CRNP

**Clinical Practice Steering Committee Members:**

**Chair:** Nancy Overstreet, DNP, GNP-BC, WOCN  
James Wright, MD, PhD, CMD (Vice Chair)  
Christian Bergman, MD  
Gwendolen Buhr, MD, MEd, CMD  
Ghinwa Dumyati, MD  
Thomas Edmondson, MD, FACP, CMD  
Rebecca Ferrini, MD, MPH, CMD  
Swati Gaur, MD, MBA, CMD

Timothy Holahan, DO, CMD  
Sarah Howd, MD  
Renante Ignacio, MD, FACP, AGSF, CMD  
Naushira Pandya, MD, FACP, CMD  
Manisha Parulekar, MD, CMD  
Barbara Resnick, PhD, CRNP

**Organizational Participants:**

American Association of Post-Acute Care Nursing  
American Geriatrics Society  
American Health Care Association  
American Society of Consultant Pharmacists  
Gerontological Advanced Practice Nurses Association  
National Association of Directors of Nursing Administration in Long Term Care

**AMDA Staff:**

Erin O. Vigne, RN, MA – Director, Clinical Affairs  
Erica Ford, MS – Project Manager, Clinical Affairs

**Medical Writer:**

Eleanor Mayfield, ELS



# TABLE OF CONTENTS

*Click on any item in the Table of Contents to jump to that section of the CPG.*

- PREFACE .....x
- HOW TO USE THE AMDA PAIN MANAGEMENT CPG .....xiv
- INTRODUCTION ..... 1
  - QUESTION 1: What is pain?..... 1**
    - Definition..... 1
    - ▶ **TABLE 1. SOME DEFINITIONS OF PAIN ..... 2**
    - Purpose of Pain..... 2
    - QUESTION 2: What is the prevalence of pain and conditions that predispose to pain? .. 2**
    - Prevalence of Pain ..... 2
    - QUESTION 3: What are some common challenges in managing pain?..... 3**
      - Common Challenges in Pain Management ..... 3
        - Diagnostic Challenges ..... 3*
        - Impact of Cognitive Biases ..... 3*
        - Variability in Processes and Practices ..... 3*
      - ▶ **TABLE 2. EXAMPLES OF COGNITIVE BIASES THAT MAY AFFECT PAIN MANAGEMENT..... 4**
        - Undertreatment and Overtreatment ..... 4*
        - Challenges Related to Treatment Options ..... 5*
    - QUESTION 4: What preparation/systems/processes does a facility need to support effective pain management? ..... 5**

Facility Preparation to Support Pain Management .....	5
<i>Policies and Procedures</i> .....	5
▶ <b>TABLE 3. COMPARATIVE IMPACT OF UNDER- AND OVERTREATMENT OF PAIN</b> .....	6
▶ <b>TABLE 4. EXAMPLES OF POLICIES AND PROCEDURES RELATED TO PAIN ASSESSMENT AND MANAGEMENT</b> .....	7
<i>References and Resources</i> .....	7
<i>Defining Roles of the Interprofessional Team</i> .....	7
▶ <b>TABLE 5. EXAMPLES OF INTERPROFESSIONAL TEAM MEMBER ROLES IN PAIN MANAGEMENT</b> .....	8
<i>Medical Practitioner Roles</i> .....	8
▶ <b>TABLE 6. MEDICAL PRACTITIONERS' RESPONSIBILITIES IN PAIN MANAGEMENT</b> .....	9
<b>RECOGNITION AND ASSESSMENT</b> .....	10
<b>STEP 1 Screen for pain periodically</b> .....	10
<b>QUESTION 5: When should routine and interim screening for pain be performed? . . .</b>	10
Screening For Pain .....	10
<i>Periodic Screening</i> .....	10
<i>Event-Driven Screening</i> .....	11
<b>STEP 2 Obtain and document details about a patient's pain.</b> .....	11
<b>QUESTION 6: What are key elements of a medical practitioner/nurse assessment for pain? . . . . .</b>	11
Assessment and Documentation of Pain .....	11
<i>Assessment Components</i> .....	11
▶ <b>TABLE 7. KEY ASSESSMENT COMPONENTS RELATED TO PAIN</b> .....	11
<i>Sources of Information</i> .....	12
▶ <b>TABLE 8. EXAMPLES OF SOURCES OF INFORMATION ABOUT A PATIENT'S PAIN</b> .....	12
<b>QUESTION 7: How should we define and characterize an individual's pain? . . . . .</b>	12
<i>Amount of Detail</i> .....	12
<i>Identifying Pain Characteristics</i> .....	13
<i>Impact of Pain</i> .....	13
<b>QUESTION 8: What are key aspects of documentation related to pain? . . . . .</b>	13
<i>General Principles of Pain Documentation</i> .....	13
▶ <b>TABLE 9. QUESTIONS TO ASK ABOUT PAIN</b> .....	14
<i>Pain Assessment and Screening Tools</i> .....	15
▶ <b>TABLE 10. EXAMPLES OF PAIN ASSESSMENT INSTRUMENTS (INCLUDING FOR COGNITIVELY AND VERBALLY IMPAIRED PATIENTS)</b> .....	16
Minimum Data Set .....	17



<b>QUESTION 9: What are key elements of a physical assessment related to pain? . . . . .</b>	<b>17</b>
<i>Physical Assessment For Pain . . . . .</i>	17
▶ <b>TABLE 11. EXAMPLES OF HELPFUL PHYSICAL EXAMINATION BASED ON LOCATION OR SUSPECTED TYPE OF PAIN. . . . .</b>	<b>18</b>
<i>Identifying and Differentiating Nonspecific Findings. . . . .</i>	19
▶ <b>TABLE 12. EXAMPLES OF NONSPECIFIC FINDINGS THAT MAY SUGGEST PAIN . . . . .</b>	<b>19</b>
<b>DIAGNOSIS AND INTERPRETATION. . . . .</b>	<b>20</b>
<b>STEP 3 Identify causes of pain. . . . .</b>	<b>20</b>
<b>QUESTION 10: What are key considerations in diagnosing causes of pain? . . . . .</b>	<b>20</b>
Diagnostic Considerations . . . . .	20
▶ <b>TABLE 13. EXAMPLES OF MEDICATIONS THAT CAN CAUSE OR EXACERBATE PAIN. . . . .</b>	<b>21</b>
▶ <b>TABLE 14. MEDICATIONS THAT MAY CAUSE HEADACHE . . . . .</b>	<b>21</b>
<b>STEP 4 Interpret findings and draw conclusions about a patient’s pain . . . . .</b>	<b>22</b>
<b>QUESTION 11: What are key concepts and vocabulary related to discussing and managing pain? . . . . .</b>	<b>22</b>
Classifying a Patient’s Pain. . . . .	22
<i>Acute vs. Chronic (Persistent) Pain. . . . .</i>	22
Acute or New Pain . . . . .	22
Chronic (Persistent) Pain . . . . .	22
<i>Nociceptive versus Neuropathic Pain. . . . .</i>	23
Neuropathic Pain. . . . .	23
▶ <b>TABLE 15. Revised Categories of Chronic Pain Anticipated in the ICD-11 . . . . .</b>	<b>24</b>
▶ <b>TABLE 16. Comparison of Nociceptive and Neuropathic Pain. . . . .</b>	<b>25</b>
Summarizing Findings and Conclusions . . . . .	26
<b>TREATMENT AND MANAGEMENT . . . . .</b>	<b>27</b>
<b>STEP 5 Implement a pertinent pain management plan. . . . .</b>	<b>27</b>
General Pain Management Principles . . . . .	27
<b>QUESTION 12: What factors influence a pain management plan? . . . . .</b>	<b>27</b>
<i>Pain Management Plan . . . . .</i>	27
<i>Clarifying Patient Expectations and Pain Management Goals . . . . .</i>	27
▶ <b>TABLE 17. FACTORS THAT MAY INFLUENCE PAIN MANAGEMENT . . . . .</b>	<b>28</b>
▶ <b>TABLE 18. EXAMPLES OF POTENTIALLY ATTAINABLE PAIN MANAGEMENT GOALS . . . . .</b>	<b>29</b>
Levels of Pain Management . . . . .	29
▶ <b>TABLE 19. LEVELS OF PAIN MANAGEMENT . . . . .</b>	<b>31</b>

<b>STEP 6</b>	<b>Manage specific pain situations</b>	<b>32</b>
	<b>QUESTION 13: What are additional considerations for pain management in specific situations?</b>	<b>32</b>
	Specific Pain Management Situations	32
	<i>Acute Pain (Including Postoperative Pain)</i>	32
	Postoperative Pain	32
	• <i>Options for Treating Postoperative Pain</i>	33
	<i>Chronic Pain</i>	33
	Chronic Non-Cancer Pain	34
	• <i>Analgesics</i>	34
	<i>Neuropathic Pain</i>	34
	Topical Treatments	34
	Medications	34
	• <i>Antidepressants</i>	35
	• <i>Gabapentinoids</i>	35
	<i>Complex Regional Pain Syndrome</i>	35
	<i>Chronic Cancer-Related (Malignant) Pain</i>	36
	<i>End-of-Life Pain</i>	36
<b>STEP 7</b>	<b>Select and implement specific aspects of pain management</b>	<b>37</b>
	<b>QUESTION 14: What are general considerations for prescribing analgesics?</b>	<b>37</b>
	Interventions for Pain Management	37
	<i>General Considerations for Analgesic Use</i>	37
	▶ <b>TABLE 20. GENERAL ANALGESIC PRESCRIBING PRINCIPLES IN THE PALTC SETTING</b>	<b>37</b>
	<i>Analgesics in Context</i>	38
	<i>Route of Administration</i>	38
	<b>QUESTION 15: What are the approaches to prescribing and administering PRN and standing doses of analgesics?</b>	<b>38</b>
	Standing vs. PRN Analgesic Orders	38
	▶ <b>TABLE 21. USE OF STANDING VS. PRN DOSES IN DIFFERENT PAIN CATEGORIES</b>	<b>39</b>
	<i>Guiding Staff in Selecting PRN Medications</i>	40
	<i>Switching from PRN to Standing Doses</i>	40
	▶ <b>TABLE 22. POSSIBLE REASONS FOR FREQUENT PRN ANALGESIC USE</b>	<b>41</b>
	Specific Options for Pain Management	41
	<i>Nonpharmacological Interventions</i>	41
	Exercise and Movement	41



▶ <b>TABLE 23. NONPHARMACOLOGICAL INTERVENTIONS FOR CHRONIC PAIN</b> . . . . .	<b>42</b>
Cognitive Behavioral Therapy . . . . .	42
<b>STEP 8 Prescribe and monitor analgesics prudently</b> . . . . .	<b>43</b>
<b>QUESTION 16: What are the pharmacological options for managing pain?</b> . . . . .	<b>43</b>
<i>Pharmacological Interventions–Topical</i> . . . . .	43
Topical NSAIDs . . . . .	43
Topical Anesthetics . . . . .	43
• <i>Lidocaine Gel or Patch</i> . . . . .	44
• <i>Counterirritants</i> . . . . .	44
<i>Pharmacological Interventions–Non-Opioid</i> . . . . .	44
Acetaminophen . . . . .	44
• <i>Potential Applications</i> . . . . .	44
• <i>Dosing of Acetaminophen</i> . . . . .	45
• <i>Challenges of Acetaminophen</i> . . . . .	45
Nonsteroidal Anti-Inflammatory Drugs . . . . .	45
• <i>Potential Applications</i> . . . . .	45
• <i>Dosing of NSAIDs</i> . . . . .	46
• <i>Challenges of NSAIDs</i> . . . . .	46
Other Anti-Inflammatory Medications . . . . .	46
<i>Pharmacological Interventions–Adjuvant Medications</i> . . . . .	47
Antidepressants . . . . .	47
• <i>Potential Applications</i> . . . . .	47
• <i>Dosing of Antidepressants</i> . . . . .	47
• <i>Challenges of Antidepressants</i> . . . . .	47
Anticonvulsants (Including Gabapentinoids) . . . . .	47
• <i>Potential Applications</i> . . . . .	47
• <i>Dosing of Anticonvulsants</i> . . . . .	48
• <i>Challenges of Anticonvulsants (Including Gabapentinoids)</i> . . . . .	48
Muscle Relaxants . . . . .	48
• <i>Potential Applications</i> . . . . .	48
• <i>Dosing of Muscle Relaxants</i> . . . . .	49
• <i>Challenges of Muscle Relaxants</i> . . . . .	49
Cannabinoids . . . . .	49
• <i>Potential Applications</i> . . . . .	49
• <i>Challenges of Cannabinoids</i> . . . . .	49
▶ <b>TABLE 24. DOSING INFORMATION FOR COMMONLY USED NON-OPIOID ANALGESICS</b> . . . . .	<b>50</b>

▶ <b>TABLE 25. DOSING INFORMATION FOR ADJUVANT MEDICATIONS COMMONLY USED TO TREAT PAIN</b> .....	51
<b>QUESTION 17: What are the indications, specific considerations, and challenges related to opioid analgesics?</b> .....	52
<i>Pharmacological Options–Opioid</i> .....	52
Perspectives on Opioid Use .....	52
▶ <b>TABLE 26. EXAMPLES OF SITUATIONS IN WHICH OPIOIDS MAY BE BENEFICIAL</b> .....	53
Potential Uses of Opioids .....	53
• <i>Acute pain</i> .....	53
• <i>Cancer-related pain</i> .....	53
• <i>Chronic (persistent) non-cancer pain</i> .....	53
• <i>Nonspecific Symptoms</i> .....	54
Opioid Prescribing Options .....	54
• <i>Morphine</i> .....	54
• <i>Hydromorphone</i> .....	54
▶ <b>TABLE 27. GENERAL PRINCIPLES FOR PRESCRIBING OPIOIDS</b> .....	55
• <i>Hydrocodone</i> .....	55
• <i>Oxycodone</i> .....	55
• <i>Fentanyl, Transdermal</i> .....	56
• <i>Methadone</i> .....	56
• <i>Tramadol</i> .....	56
POTENTIAL APPLICATIONS .....	56
CHALLENGES OF TRAMADOL .....	57
▶ <b>TABLE 28. DOSING INFORMATION FOR COMMONLY USED OPIOID ANALGESICS</b> .....	57
Initiating and Titrating Opioid Doses .....	59
▶ <b>TABLE 29. APPROACHES TO OPIOID TITRATION</b> .....	59
Additional Factors Affecting Opioid Dosing .....	60
Opioid Rotation .....	60
Opioid Conversion Tables .....	61
▶ <b>TABLE 30. APPROXIMATE EQUIANALGESIC DOSING FOR SOME COMMONLY USED OPIOIDS</b> .....	62
Challenges of Opioids .....	62
• <i>Constipation</i> .....	62
• <i>Psychiatric and Behavior Issues</i> .....	63
• <i>Respiratory Depression</i> .....	63
• <i>Other Adverse Consequences</i> .....	63
• <i>Dependence, Tolerance, and Addiction</i> .....	63



Opioid Risk Mitigation . . . . .	64
• <i>Medical Practitioner Responsibilities in Prescribing Opioids</i> . . . . .	64
• <i>Using Opioids in Older Adults in the PALTC Setting</i> . . . . .	65
• <i>Continuing Opioids Begun Elsewhere</i> . . . . .	65
• <i>Opioid Prescribing Influenced by Demand or Expectation</i> . . . . .	65
▶ <b>TABLE 31. Opioid Risk-Mitigation Strategies</b> . . . . .	66
<b>STEP 9</b> Obtain appropriate support for pain management as indicated . . . . .	67
<b>QUESTION 18: When is a pain consultation indicated in managing pain, and how should the staff and practitioners interact with pain consultants?</b> . . . . .	67
Pain Consultation . . . . .	67
<b>QUESTION 19: What is the role of hospice in managing pain, and how should facilities and practitioners interact with hospice providers?</b> . . . . .	68
Hospice and Pain Management . . . . .	68
<b>MONITORING</b> . . . . .	69
<b>QUESTION 20: What should be monitored regarding pain and how should it be done?</b> . . . . .	69
<b>STEP 10</b> Monitor all patients being treated for pain. . . . .	69
Monitoring Pain Over Time . . . . .	69
▶ <b>TABLE 32. COMPONENTS OF ONGOING PAIN MONITORING</b> . . . . .	70
<b>STEP 11</b> Review and revise pain treatments as indicated . . . . .	70
<b>QUESTION 21: How should decisions be made about changing, adding, or stopping analgesics?</b> . . . . .	70
Modifying the Treatment Regimen . . . . .	70
▶ <b>TABLE 33. EXAMPLES OF SITUATIONS IN WHICH TO CONSIDER MODIFYING THE PAIN TREATMENT REGIMEN</b> . . . . .	71
<b>QUALITY, RISK MANAGEMENT, SAFETY, AND SURVEY CONSIDERATIONS IN PAIN MANAGEMENT</b> . . . . .	72
<b>QUESTION 22: How should a facility oversee and review its pain management approaches, including the use of opioids to treat pain?</b> . . . . .	72
Quality Oversight . . . . .	72
▶ <b>TABLE 34. EXAMPLES OF CRITERIA FOR REVIEWING PAIN MANAGEMENT</b> . . . . .	73
▶ <b>TABLE 35. KEY STEPS TO OPTIMIZING OPIOID USE IN PALTC FACILITIES</b> . . . . .	74
Risk Management and Safety Issues . . . . .	75
<b>QUESTION 23: How should a facility monitor for and address issues of opioid-related disorders in patients?</b> . . . . .	75
<i>Drug Seeking and Addiction</i> . . . . .	75
▶ <b>TABLE 36. CLUES TO POTENTIAL SUBSTANCE USE DISORDERS</b> . . . . .	76



<b>QUESTION 24: How should a facility monitor for and address issues of drug diversion among staff, residents, and others? .....</b>	<b>76</b>
<i>Drug Diversion</i> .....	76
Regulatory and Survey Considerations .....	77
<b>QUESTION 25: How should facilities and practitioners take into account nursing home regulations and surveys in managing pain? .....</b>	<b>77</b>
<b>► TABLE 37. DOCUMENTING PAIN MANAGEMENT PROCESSES FOR SURVEYORS .....</b>	<b>78</b>
<b>RESOURCES.....</b>	<b>79</b>
<b>REFERENCES.....</b>	<b>80</b>
<b>ALGORITHM.....</b>	<b>89</b>



# PREFACE

AMDA—The Society for Post-Acute and Long-Term Care Medicine is the national professional association representing medical directors, physicians, nurse practitioners, physician assistants, and others practicing in the post-acute and long-term care (PALTC) continuum. For over 20 years, AMDA has developed clinical practice guidelines (CPGs) to help improve the quality of care in these settings. This Pain Management CPG is one of a series of such guidelines.

These original guidelines are developed by interprofessional workgroups that consist of medical practitioners and others involved in patient care in PALTC facilities. These workgroups obtain information through a thorough literature search and also apply their practice experience to develop a usable guideline tailored to the PALTC setting.

AMDA CPGs are meant to

- Help facilities develop their policies and procedures to guide staff and practitioners, and
- Help the staff and practitioners manage patients with the condition or symptoms covered by a CPG.

In addition to universally applicable information, AMDA CPGs also emphasize specific concerns and common issues in the PALTC setting. While they are comprehensive, these CPGs are not intended to offer an exhaustive review of the topic of interest. They provide many references and resources for those who are interested in more in-depth exploration of the topic.

## **Clinical Practice Guidelines and the Care Delivery Process**


All AMDA CPGs—including this one—follow the care delivery process (CDP), which is the foundation for providing individualized, high-quality care for all patients, symptoms, and situations. The guidelines emphasize the functions and tasks related to recognizing, assessing, treating, and monitoring the medical condition or situation of interest. Figure 1<sup>1</sup> identifies this process and explains its importance in managing all but the simplest situations.

**Figure 1. Clinical Problem Solving and Decision Making Process Steps and Objectives**

<b>Process Step / Objectives *</b>	<b>Key Tasks **</b>
<p><b>Recognition / Assessment</b></p> <p><i>Gather essential information about the individual</i></p>	<ul style="list-style-type: none"> <li>– Identify and collect information that is needed to identify an individual’s conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis</li> <li>– Obtain a personal and medical history</li> <li>– Perform a physical assessment</li> </ul>
<p><b>Problem definition</b></p> <p><i>Define the individual’s problems, risks, and issues</i></p>	<ul style="list-style-type: none"> <li>– Identify any current consequences and complications of the individual’s situation, underlying condition and illnesses, etc.</li> <li>– Clearly state the individual’s issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns</li> <li>– Define significant risk factors</li> </ul>
<p><b>Diagnosis / Cause-and-effect analysis</b></p> <p><i>Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences</i></p>	<ul style="list-style-type: none"> <li>– Identify causes of, and factors contributing to, the individual’s current dysfunctions, disabilities, impairments, and risks</li> <li>– Identify pertinent evaluations and diagnostic tests</li> <li>– Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another</li> <li>– Identify how addressing those causes is likely to affect consequences</li> </ul>
<p><b>Identifying goals and objectives of care</b></p> <p><i>Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met</i></p>	<ul style="list-style-type: none"> <li>– Clarify prognosis</li> <li>– Define overall goals for the individual</li> <li>– Identify criteria for meeting goals</li> </ul>
<p><b>Selecting interventions / planning care</b></p> <p><i>Identify and implement interventions and treatments to address the individual’s physical, functional, and psychosocial needs, concerns, problems, and risks</i></p>	<ul style="list-style-type: none"> <li>– Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial)</li> <li>– Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual</li> <li>– Define anticipated benefits and risks of various interventions</li> <li>– Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences</li> </ul>
<p><b>Monitoring of progress</b></p> <p><i>Review individual’s progress towards goals and modify approaches as needed</i></p>	<ul style="list-style-type: none"> <li>– Identify the individual’s response to interventions and treatments</li> <li>– Identify factors that are affecting progress towards achieving goals</li> <li>– Define or refine the prognosis</li> <li>– Define or refine when to stop or modify interventions</li> <li>– Review effectiveness and adverse consequences related to treatments</li> <li>– Adjust interventions as needed</li> <li>– Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care</li> </ul>

\* Refers to key steps in the care delivery process, related to clinical problem solving and decision making

\*\* Refers to key tasks at each step in the care delivery process



Although preferred treatments may vary and change over time, decision-making principles and processes are enduring and universal. Faithful adherence to the CDP’s clinical reasoning and problem-solving steps by all interprofessional team (IPT) members improves the consistency of care and helps to optimize results, minimize the risks and complications of medications and treatments, and facilitate regulatory compliance.

## **Audience**

This guideline is intended for members of the IPT in PALTC settings. To be consistent with the terminology now used by CMS, the Health Resources and Services Administration (HRSA), National Academy of Medicine (NAM), and other agencies, AMDA CPGs have adopted the term *interprofessional* in place of *interdisciplinary*.

As stated by the World Health Organization, “Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care across settings.”<sup>2</sup> IPT members typically include the medical director, attending physicians and advanced practice clinicians (referred to in the CPGs as “medical practitioners”), director of nursing, nursing staff, consultant pharmacist, and other professionals such as therapists, social workers, dietitians, and nursing assistants who care for patients.


For example, a variety of health care professionals working in the PALTC setting, including nursing assistants, licensed nurses, dietitians, and social workers, may make and document observations (e.g., that a patient does not sleep at night, has become more withdrawn, or has a change in usual eating patterns). However, only some of these disciplines may be qualified to determine the significance of those observations (e.g., the cause of sleeplessness or of a change in eating patterns). In contrast, practitioners may not be present to observe patients in detail or deliver treatments but are responsible for analyzing the significance and causes of symptoms. Therefore, effective CPG implementation requires understanding the specific functions and tasks—not just the roles—of various IPT members.

## **Assumptions**

PALTC facilities care for a variety of individuals, including younger adults with chronic diseases and disabilities, short-stay patients needing post-acute care, and very old and frail individuals with many chronic medical and psychiatric conditions. Practice guidelines for the PALTC setting should be consistent with the fundamental goals of desirable practice in this setting. Patient-centered care means establishing individualized goals of care for each patient.

For example, when patients in the PALTC setting are at or near the end of life, care goals will shift from curative care, functional improvement, or physical stability to end-of-life palliation. A workup may not be indicated if

- The patient has a terminal or end-stage condition,
- The workup findings would not change the management course,
- The burden of the workup is greater than the potential benefit, or
- The patient or his or her legally authorized representative has declined treatment.



AMDA CPGs address such transitions and suggest appropriate modifications of the patient's care plan.

### Organization of These Guidelines

Each guideline includes a narrative portion that covers the definition of the condition being addressed, as well as the following:

- **Recognition and Assessment** refers to identifying the presence of a condition, situation, or risk, and collecting the details needed for cause identification, interpretation, and subsequent management.
- **Diagnosis and Interpretation** refers to the process of defining causes and consequences of a symptom or problem and identifying the meaning and implications of the information gathered during the assessment.
- **Treatment and Management** addresses the selection and provision of appropriate interventions for the identified condition or situation.
- **Monitoring** addresses reviewing the course of a condition or situation as a basis for deciding to continue, change, or discontinue interventions.

Each guideline includes many recommendations for practice. Often, the CPG summarizes the information and recommendations from various references and resources that have used a grading system such as the GRADE Working Group system<sup>3</sup> a framework for rating the quality of evidence and the strength of recommendations. The reader can refer to the references within this CPG to learn more about the evidence basis for recommendations.

### Other Terminology

In addition to people who live in PALTC facilities (residents), many individuals enter these facilities for short-term care (e.g., after hospitalization for surgery or a stroke). AMDA CPGs use the term *patient* because they are addressing individuals within the context of treating a medical condition, even though they take a much broader approach than treating medical issues alone.

When referring to pharmaceutical products, AMDA CPGs avoid the use of brand names and refer to classes of drugs whenever possible.

### References

1. Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Version 1.17.1. October 2019. p. 608. [https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1\\_october\\_2019.pdf](https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf)
2. World Health Organization. 2010. Framework for Action on Interprofessional Education & Collaborative Practice. Reference No. WHO/HRH/HPN/10.3. [https://www.who.int/hrh/resources/framework\\_action/en/](https://www.who.int/hrh/resources/framework_action/en/)
3. Atkins D, Best D, Briss PA, et al; GRADE Working Group. Grading quality of evidence and strength of recommendations. *BMJ*. 2004 Jun 19; 328(7454): 1490. doi: 10.1136/bmj.328.7454.1490





# HOW TO USE THE AMDA PAIN MANAGEMENT CPG

Pain is common in patients in the post-acute and long-term care (PALTC) setting. It often coexists with other issues such as psychiatric symptoms, falls, and anorexia or weight loss. Multiple symptoms may have common causes and a single symptom may have multiple causes. The best results are obtained by managing all such issues in the context of the entire patient picture.

Thus, this Pain Management CPG is not only about pain treatment but also about addressing the many questions and issues that influence—and are influenced by—pain management (e.g., patients with limited cognition and verbal communication, survey-related issues, opioid diversion, substance use disorders).

## How to Use This CPG

A CPG can serve several purposes. It can

- Directly guide clinical practice and individual patient care;
- Help to establish or modify existing policies, procedures, and practices related to a topic; and
- Help to answer specific questions and apply general advice to specific situations.

All interprofessional team (IPT) members can use this Pain Management CPG to help find the information they need, as shown in the [Table](#).



**Table. How Interprofessional Team Members Can Use the Pain Management CPG**

Issue	How to Use the CPG
<p><i>Our facility wants to understand why we should have a uniform, systematic approach to pain management.</i></p>	<ul style="list-style-type: none"> <li>■ Review the Introduction section of the CPG, p. 1-9, and discuss with your staff and practitioners.</li> <li>■ Get an overview of the entire CPG by reviewing the Table of Contents and skimming the sections briefly to understand the approach.</li> </ul>
<p><i>Our patients could benefit from a more organized, consistent approach to pain management.</i></p> <p><i>Our staff and practitioners could benefit from guidance on how to manage pain in various situations, including selecting specific medications and nonpharmacological interventions.</i></p>	<ul style="list-style-type: none"> <li>■ Review the Table of Contents and built-in Q&amp;As, and review and follow Steps 1 through 9.</li> <li>■ Review these recommended practices and evidence-based approaches against your existing systems to see if your facility is doing the best you can.</li> <li>■ Use this information to develop, revise, and implement policies and procedures, including expectations for clinical practices.</li> <li>■ Share the information and expectations with your IPT, including medical practitioners.</li> </ul>
<p><i>We have questions about specific aspects of pain management – for example:</i></p> <ul style="list-style-type: none"> <li>■ <i>How to decide when and whether to modify a patient’s pain management regimen</i></li> <li>■ <i>How to make adjustments between standing and PRN doses of analgesics</i></li> </ul>	<ul style="list-style-type: none"> <li>■ The CPG is set up in Q&amp;A style, so it can be referenced by questions as well as by steps.</li> <li>■ Review the questions in the Table of Contents.</li> <li>■ When you identify the question you wish to have answered, jump to the section of the CPG that addresses it. <i>(Note: The answers to each Question include all of the content up until the next Question; e.g., everything between Question 1 and Question 2 covers Question 1.)</i></li> </ul>
<p><i>Our patients could benefit from optimal prescribing and use of opioids to manage pain.</i></p>	<ul style="list-style-type: none"> <li>■ Review the related content starting with Step 8, Question 17, to guide everyday practice. Review this content with your staff and practitioners.</li> </ul>

**TABLE CONTINUED.**



**Table. (cont.) How Interprofessional Team Members Can Use the Pain Management CPG**

<b>Issue</b>	<b>How to Use the CPG</b>
<i>We want more information about a topic covered in this CPG.</i>	<ul style="list-style-type: none"><li>■ The CPG refers the user to readily accessible online sources of additional discussion and information (e.g., pain documentation tools).</li><li>■ The electronic version facilitates online searching</li><li>■ The CPG includes more than 140 references, many of which contain much more detail about specific topics such as assessing pain in older adults and managing postoperative or neuropathic pain.</li></ul>

In summary, using this Pain Management CPG effectively can help both individual clinicians and entire facilities to improve their practices and outcomes.