STATEMENT OF

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AMERICAN GERIATRICS SOCIETY

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INTRODUCTION

Good afternoon Chairman Kohl, Ranking Member Corker and Members of the Committee:

I would like to express my sincere appreciation to Senator Kohl and the members of the Senate Special Committee on Aging for allowing me the opportunity to provide testimony and for their willingness to address the issue of pain management and the prescribing of narcotics in the nursing home setting. It is an important, albeit extremely complex, issue.

My name is Cheryl Phillips, M.D. I am a fellowship-trained geriatrician and chief medical officer of On Lok Senior Services, the originator of the PACE (Program of All-inclusive Care for the Elderly). I also serve as President of the American Geriatrics Society, a non-profit organization of 6,400 geriatrics healthcare professionals dedicated to improving the health, independence and quality of life of all older Americans. I am also past president of the American Medical Directors Association (AMDA), the professional organization that represents physicians in long-term care. I have spent the majority of my clinical career in long term care, including over 20 years in nursing home practice in California. Today, I will briefly outline the need for policies that will ensure that frail elders who reside in nursing homes are not in pain. In my remarks, I will address the clinical need for ensuring that older adults receive pain medication when needed and the reality of clinical practice for doctors with patients in nursing homes.

I am here because every day, across the country, the real-life consequence of the Drug Enforcement Administration (DEA) interpretation of the Controlled Substance Act is that, collectively, we are preventing patients in long-term care settings from receiving much needed pain relief and other medications in a timely manner. We can, and should, be doing better. Let's put a face on that pain.

Mrs. M is an 87 year old female with advanced dementia and a recent hip fracture and subsequent surgery. She has been at the nursing home for the past three days. Prior to her transfer from the hospital her pain meds were decreased because her orthopedic surgeon was worried about confusion. Since then, the family has been concerned that she has been in pain that is not managed with the non-narcotic meds prescribed. On the fourth day of her nursing home stay physical therapists worked "a bit harder" to get her moving more and out of bed. By that evening she was tearful and refusing to eat. When the family arrived they recognized she was in pain and requested something stronger to treat her. After a call to her attending

physician which resulted in an order for morphine sulfate the nurse requested from the pharmacist that she be able to access the emergency drug kit and administer the ordered medication. However, because the physician was not able to provide an after-hours signature the pharmacist said she was not able to release the medication. The family became incensed and threatened to "sue the nursing home". At that point, the nurse called the physician back and the order was given to send the patient, via ambulance, to the emergency room for pain management.

I am sure that you will all agree that transfer to the hospital is not the right solution. It adds to the spiraling cost of health care in this country. And, quite frankly, it is unconscionable that we would transfer an elderly woman with advanced dementia to an emergency room just to manage her pain. Yet, that is a scenario that plays out day in and day out as nursing homes, physicians, nurses, and families grapple with the reality of the DEA actions against nursing homes that fail to obtain a physician signature prior to administering controlled substance pain relief.

PERSISTANT PAIN IN OLDER ADULTS

Persistent pain is a common problem for older adults. A Louis Harris telephone survey found that one in five older Americans (18%) are taking analgesic medications regularly (several times a week or more), and 63% of those had taken prescription pain medications for more than 6 months. Older people are more likely to suffer from chronic conditions often associated with persistent pain, such as arthritis, bone and joint disorders, and cancer.

Pain is especially common among nursing home residents. It has been estimated that 45% to 80% of them have substantial pain that is undertreated. Studies of both the community-dwelling and nursing home populations have found that older people commonly have several sources of pain, which is not surprising, as older patients commonly have multiple medical problems. A high prevalence of dementia, sensory impairments, and disability in this population make assessment and management more difficult.

CONSEQUENCES

There are many myths about pain management for older adults. These myths include such false beliefs that pain decreases as we age and that persons with dementia feel less pain. In

fact, untreated pain has serious medical consequences that include poor oral intake and weight loss, inability to sleep, depression, loss of mobility and increased risk of falls, and increased risk of pressure ulcers. Depression, anxiety, decreased socialization, sleep disturbance, impaired ambulation, and increased health care utilization and costs have all been found to be associated with the presence of pain in older people. Although less thoroughly described, many other conditions are known to be worsened potentially by the presence of pain, including gait disturbances, slow rehabilitation, and adverse effects from multiple drug prescriptions.

Poor pain management in the nursing home setting has significant associated costs. Inadequate pain management is associated with increased emergency room transfers and increased re-hospitalization rates.

In short, failure to address pain in the frail elder can begin the downward spiral that leads to decline and death.

THE IMPORTANCE OF PAIN MANAGEMENT

As a geriatrician I recognize the critical importance of adequate pain management for the elderly. The story of Mrs. M is illustrative of how such failure can result in an unnecessary transfer to a hospital because of inadequate pain control. While this may sound extreme, sadly this scenario is all too common across the country. The Centers for Medicare and Medicaid Services have identified that inadequate pain management is a serious quality problem for patients in nursing home facilities. It is known that effective pain management plays a significant role in improving functional status, quality of life, and quality of care in nursing homes.

BARRIERS TO CONTROLLING PAIN

So, since everyone agrees that pain is a serious problem in the elderly and that nursing home providers must do a better job, why does it continue to be such a challenge? I respect the important work of the Drug Enforcement Administration in its law enforcement efforts to control the distribution and use of illegal narcotics. But I would offer that this is not, and should not be a “law enforcement” issue. Patients in nursing homes today are not much different in severity of illness and in their medical needs than hospitalized patients. In fact, in many regions patients may be admitted directly to the nursing home for skilled services in lieu of acute hospital

admissions. As a practicing physician, when there is a change of condition or acute pain issue in the acute hospital I am able to call directly to the nurse responsible for that patient, provide a verbal order for pain medications, have the patient receive that pain medication, and sign the order the next morning.

In the nursing home, however, this is not the case. If I am called after hours or I am covering for another physician and I am notified of an acute pain issue, I cannot merely leave the order for the pain medication for the nurse to fill and unlike most hospitals, most nursing homes do not have in-house pharmacies. In fact, according to the DEA rules, I must identify the dispensing pharmacy and call the pharmacy, most often through a 1-800 number, and leave a message for the pharmacist to return my call. When I am able to speak in person, I must place my order – followed by a fax of that order with my signature. I must then call the nursing home and relay the same order to the nurse where she awaits delivery of the medication or release from the narcotic emergency box by the pharmacist. Even when this goes as described above in perfect order, it is often 30 minutes to an hour to complete the process. However, rarely are the stars so aligned and this potential for error multiplies, as does the potential for patient suffering. In fact, most physicians do not have access to fax machines after hours, whereas nurses at the facility often have access to fax machines that are pre-programmed to the appropriate pharmacy. Upwards of 40% of physicians who practice in the nursing home do not have traditional office practices. When challenged to provide an immediate faxed order and signature, most physicians simply cannot do this. Most physicians typically either practice nursing home medicine as a part-time addition to their office practice or they provide care to patients in a number of facilities. It is a fact that nursing homes are required to provide 24-hour physician coverage for all their patients, but that rarely means that the physicians are on-site. Just like in hospitals, physicians rely on the nurse – who is trained to assess patient pain – to the necessary information for making treatment decisions – including ordering the appropriate drugs and services.

Therefore, several potential outcomes may occur when the physician is notified after hours about a pain management issue in the nursing home:

- the physician identifies a non-narcotic medication to “hold” the patient until the next business day;
- the pharmacist and nursing home go ahead and fill the narcotic medication and obtain the required signature later – facing significant fines and sanctions for doing so;

- the patient goes without pain medication;
- the patient is sent to the emergency room.

None of these scenarios are acceptable when it comes to ensuring that nursing home residents have access to pain control

Poor access to pain control also creates a disincentive for physicians to practice in the nursing home setting in that we have already seen court cases linking poor pain management to elder abuse. In a landmark case, Beverly Bergman, et al v. Wing Chin, M.D., a physician was found liable for elder abuse and the family was awarded $1.5 million because of, among other things, poor pain management in the nursing home. The fact is that physicians are very aware of the liability risks that accompany poor pain control. When they realize that there are such significant challenges to adequately manage pain in the nursing home, the easiest option for physicians is to merely opt out of nursing home practice. Identifying physicians who are willing to provide quality care in the nursing home setting is a significant challenge across the country; this issue just provides one additional, significant barrier.

SOLUTIONS

There is a solution to all of this. The DEA should recognize nursing home nurses as the "agent" of the physician – just as they recognize them as "agent" of the physician in the hospital. If that were the norm, then orders could be managed appropriately and in a timely fashion. There are adequate checks and balances in place:

- each verbal order, including narcotic orders, must be signed by the physician – just as they are in the hospital.
- Nursing staff is required to provide shift accounting for the doses of narcotics and must chart each administration – again, just as they do in the hospital.

And, just as in the hospital setting, occasional diversions occur. And, just as in the hospital, when a diversion does occur, there are state and law enforcement interventions that follow. Multiple safeguards, which are regularly reviewed as part of the federally mandated survey, are present in long-term care facilities, including narcotic lock boxes, inventory of narcotics at shift change, and documentation of drug destruction.

If this was how our system worked, Mrs. M would have received the clinically appropriate pain medicine in a timely fashion. That is the norm we should strive towards.

CONCLUSION

This is an important issue that we must resolve given its negative impact on the 1.38 million older Americans who currently reside in nursing homes. Our frailest citizens are suffering needlessly. Resolution is critical to ensuring both the quality of care and the quality of life for some of our most vulnerable citizens. None of us can imagine our parents or someone we love in severe pain that cannot be treated in a medical setting with licensed nurses, physicians and pharmacists available – only because the law requires a specific set of paperwork steps that cannot be accomplished after hours.

In closing, the AGS agrees wholeheartedly that physicians and other licensed prescribers must remain in control of the prescribing process and support reasonable efforts to ensure the integrity of this process. However, we call on the DEA to modify its policy so that it reflects that nurses in long-term care are agents of the physician – just like nurses working in the hospital. Absent timely remedial action by the DEA, we then ask that Congress provide a legislative solution to ensure that long-term care patients in acute or escalating pain receive the medications they need without delay. We thank you again for inviting us to participate in today's important hearing.

Respectfully,
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