THE COMPASSUS

GUIDE TO OPIOID STEWARDSHIP

in Hospice and Palliative Care

Kurt Merkelz, MD

COMPASSUS®

About Compassus

Compassus is a nationwide network of community-based home health, infusion, palliative and hospice care services. We are committed to providing the highest-quality hospice and palliative care and responsible, safe prescribing of opioid medications for our patients. Our mission is to offer high-quality, compassionate care to improve the quality of life for patients and their families who are facing serious illness. We support that mission with a commitment to three core values: compassion, integrity and excellence. Our medical staff, led by the Compassus Medical Directors Advisory Council (MDAC), is highly experienced in pain and symptom management with the singular goal of reducing suffering and improving quality of life. The members of the Compassus MDAC set an example for our more than 230 medical directors, serving as a resource and providing guidance on policies and best practices.

Reproduction Rights

The educational information, resources and dosing guidelines included in this guide are for educational and informational purposes only and are not intended as a substitute for professional medical diagnosis or management of an individual patient by a qualified health care professional or interdisciplinary team. Compassus and the Compassus MDAC are not responsible for any legal action taken by a person or organization as a result of information contained in or accessed through this guide, whether such information is provided by Compassus, the Compassus MDAC or by a third party referenced herein. Medical advances and developments are ongoing, resulting in changing national standards of patient care, treatment and safety. The use of information obtained or reproduced from this resource is at the user's sole discretion.

Acknowledgements

Compassus gratefully acknowledges the contributions of Compassus Senior Vice President, Chief Medical Officer Kurt Merkelz, MD, and Vice President of Clinical Education and Development Synthia Cathcart, for their leadership and vision.

Introduction

Opioid medications are a mainstay in the provision of timely and effective pain control at the end of life. Though hospice and palliative care professionals understand the concerns and challenges related to safe prescribing, the national opioid crisis serves as a stark reminder that medications prescribed with the intent of improving quality of life have equal potential to complicate life — sometimes with deadly consequences — when used incorrectly.

This, combined with increased regulatory scrutiny, has left many clinicians apprehensive regarding future prescribing. Though this is not a realistic or medically sound option in the field of hospice and palliative medicine, some physicians have chosen to no longer prescribe opioids. Even when knowledgeable in our prescribing practices, there is still concern about diversion, which potentially harms the patient as well as the individual who takes the medication illegitimately.

But without these invaluable medications, many hospice and palliative care patients would suffer needlessly from the burden of their pain and the inability to experience quality of life at a most critical time. This guide is offered as a review in best practices around safe opioid prescribing and management, as well as a resource in guiding regulatory compliance pertinent to the field of hospice and palliative medicine.

We hope it will help you and your interdisciplinary care team serve your patients and families, optimizing quality of life while better preventing adverse events in the prescribing and management of this important class of medicines.

– *Kurt Merkelz, MD, CMD, FAAHPM, Chief Medical Officer, Compassus*

Using This Guide

Compassus recognizes the importance of understanding the link between responsible pain management and the national opioid crisis. We are committed to partnering with each patient and family to assure the right medications are available at the right time and are used in a safe and responsible manner.

This guide represents an approach to providing opioid medications safely and expects patients and families to be partners in their responsible use. It provides education to the prescriber regarding pain assessment, as well as opioid and non-opioid treatment strategies for management of acute and chronic pain issues. Additionally, this guide provides assessment tools, recommendations and sample policies and procedures that support safe and effective opioid management.

The content of this guide represents strategic steps to maintain a patient-focused, safe pain management program and provide scalable actions in establishing accountability and maintaining a culture of opioid stewardship. We hope you find it useful in your hospice and palliative care work. Thank you for joining our efforts to promote the safe use of opioids for our patients, families and communities.

Goals – Optimize Quality Care:

- Pursue balance in achieving adequate pain control while optimizing function and safety.
- Minimize abuse and diversion potential.

Implementation Core Actions:

- Promote leadership commitment and culture that supports responsible opioid prescribing.
- Support the identification and use of non-opioid pain management strategies.
- Support multimodal pain management approaches.
- Advance clinical knowledge and practice to ensure clinicians understand pain assessment and management.
- Enhance patient and family education.
- Support tracking, monitoring and reporting performance data on opioid prescribing, patient outcomes and adverse events.
- Establish accountability around supporting a culture of opioid stewardship.

Table of Contents

Pain

Pain is often the greatest concern for hospice and palliative care patients and family members. Unmanaged pain of any kind can overshadow everything else in a patient's life and contribute to tremendous suffering by the patient and loved ones. Without effective and consistent pain management, the patient and family members may never get to experience improved quality of life.

In treating hospice and palliative care patients, we are challenged to manage pain of all types: physical, psychological, spiritual and social. The concept of total pain was first coined by Dame Cicely Saunders, founder of the first modern-day hospice. Total pain helps us understand that pain is not confined to just physical causes and influences, but that how we experience and respond to pain can be greatly influenced by spiritual, emotional, social and even functional factors. For example, imagine how frightening chest pain is to an individual who lost a parent at the same age due to a heart attack; this fear can heighten how the individual experiences pain.

Regardless of the type of pain, it is only when we identify its source that we can be most effective in treating it. While the interdisciplinary team (IDT) is, by design, equipped to address total pain, it is critical that the team works together to listen for and respond to the patient's greatest concerns, engaging the members of the team with the expertise best suited for the situation. Total Pain Management cannot be accomplished by the physician or nurse alone.

> *"Few things a doctor does are more important than relieving pain … pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained."*
>
> *–Marcia Angell, MD*

COMPLIANCE NOTICE

The dilemma
Patients, advocate groups and surveyors, like Joint Commission (JCAHO), have demanded aggressive pain treatment, "The Fifth Vital Sign." However, licensing boards and the DEA have aggressively communicated the risk of excessive prescribing and addiction risk to patients.

This section is presented as a reference to guide the team in pain assessment and treatment. While it focuses primarily on physical pain and the use of opioids and other pain relief techniques to manage it, the importance of engaging the entire IDT to assess and treat total pain cannot be overstated.

Understanding Pain

Pain is the most common reason people seek medical care. Each year, approximately 25 million Americans experience acute pain from injury or surgery and millions more live with persistent pain.[1] In 2016, more than 50 million U.S. adults had chronic pain and 19.6 million had high-impact chronic pain, with higher prevalence associated with advancing age.[2]

To those who suffer, pain can be soul destroying — causing not only physical suffering, but also psychological, social and spiritual damage. Even when patients are able to adapt their lifestyle to live with pain, it may have an adverse effect on function, as well as social and psychological well-being. In patients with serious or advanced illness, particularly those receiving hospice or palliative care, it diminishes quality of life and the ability to carry out activities of daily living.

What is pain? The understanding of pain has evolved significantly in recent years. In July 2020, the International Association for the Study of Pain updated its definition of pain to better reflect the cognitive and social factors that influence pain.

Pain is now defined as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Simply put, pain is whatever the patient says it is, existing whenever they says it does.

Included with the new definition are notes that underscore the newfound understanding that pain is a deeply personal experience influenced to varying degrees by biological, psychological and social factors. Because a person's concept of pain is shaped by their own unique life experiences, any report of pain must always be respected. The inability to verbalize or clearly describe pain does not negate the patient's experience.

While the perception of pain may vary from one person to the next, there are different classifications of pain. It is important for patients and clinicians to understand the type and origin of pain since it will determine the best course of treatment.

Acute pain typically follows an injury and resolves over time. It has objective physical signs that are easy to observe, such as increased heart rate, increased blood pressure and respiration, sweating, moaning or crying.

In individuals with **chronic pain**, physical signs may be more difficult to observe. The patient may not "look" like he or she is in pain and may be unable to verbalize their symptoms. There are several different types of chronic pain.

[1] http://americanpainsociety.org/uploads/education/section_1.pdf

[2] Dahlhamer J, Lucas J, Zelaya, C, et al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:1001–1006. DOI: http://dx.doi.org/10.15585/mmwr.mm6736a2

Understanding Pain (continued)

Nociceptive pain is a type of chronic pain that is responsive to opioids. Nociception refers to the neural encoding of impending or actual tissue damage; however, pain refers to the subjective experience of actual or impending harm. As noted in the IASP's updated definition, pain and nociception are different phenomena, and pain cannot be inferred solely from activity in sensory neurons.

There are two types of nociceptive pain:

- **Somatic pain** arises from bone, joint, muscle, skin or connective tissue. It is a constant, aching, gnawing, localized pain that usually doesn't radiate unless swelling is involved. Somatic pain may be caused by a variety of conditions, including bone metastases, surgical pain or decubitus ulcers.

- **Visceral pain** arises from visceral/smooth organs such as the GI tract and pancreas. It is characterized by localized aching or poorly localized cramping caused by infiltration, compression, distention or stretching of tissue. Frequently, it requires an adjuvant such as a steroid or anti-spasmodic. Causes of visceral pain may include pancreatic or ovarian cancers or liver metastases.

Neuropathic pain is pain caused by injury to the peripheral or central nervous system. It is the most difficult pain to control, characterized by sharp, burning and aching pain. Examples of neuropathic pain include peripheral neuropathy and spinal cord or nerve compression.

It is a common myth that neuropathic pain responds poorly to opioids; they are effective — especially when used in addition to adjuvants such as antidepressants, anticonvulsants and antiarrhythmics, which block or inhibit nerve impulses.

Observing pain in the cognitively impaired:

Facial expressions:
frown, grimace, forehead wrinkle

Vocalizations:
sigh, moan, grunt, groan, yelling out, noisy breathing, verbally abusive

Body movements:
guarded, tense, rigid, rocking, restricted movement/mobility

Behavior change:
combative, aggressive, inappropriate, disruptive, withdrawn

Activity change:
not eating, appetite change, increased sleeping, sleep pattern change, wandering

Mental status change:
confusion, irritable, distressed, crying, tearful

Assessing Pain

Pain cannot be managed if it is not assessed. It is only through a comprehensive assessment that the IDT can begin to identify the urgency of the response needed, pain syndromes likely present, holistic factors contributing to total pain *(i.e., social, emotional, spiritual and/or functional areas of suffering)* and the patient's goals and greatest concerns.

Conducting a comprehensive pain assessment is much like a police sketch artist filling in the details of a suspect's appearance. The more specific details the artist has, the more the sketch looks like the suspect. The more vague the details, the harder it is to identify the suspect. Yet, there are many barriers and misconceptions that often delay diagnosis or treatment. For some clinicians, these barriers include:

- Failure to adequately assess pain
- Fear of respiratory depression or other side effects of pain medications
- The belief that pain can be correlated with vital sign changes or evidence of injury
- The belief that all patients readily express their pain
- The belief that chronic pain patients over-report pain because they are addicted to opioids
- Misperception that elderly or cognitively impaired patients do not experience pain as often or as much

> ***Remember:***
> If the patient does not have pain at admission, but does have medication for pain, the patient is considered to have an active pain problem, and the nurse must proceed to a comprehensive assessment of the pain.

Additionally, some patients may be reluctant to report pain out of fear of being a "burden" to loved ones or concerns about the cost of pain medications or side effects.

The first rule of pain management is to believe the patient's report of pain. The patient's self-report is the "gold" standard of assessment. Listen and reassure the patient of your dedication to managing their pain.

Assessing Pain (continued)

A comprehensive assessment of total pain must include:

1. **Screen for pain:** This includes the use of a standardized tool and severity evaluation. Ask the question, "Are you uncomfortable due to pain?" If the answer is yes, use a standardized tool to assess the severity. Common pain assessment tools include the Brief Pain Inventory, the Memorial Pain Assessment Card (MPAC) and the Numeric Rating Scale. Alternative methods commonly based on observation are available for patients who are unable to self-report. Examples include the Wong Baker Faces Scale, the Pain Assessment in Advanced Dementia (PAINAD) Scale and the FLACC (Face, Legs, Activity, Cry, Consolability) Pain Scale, which is often used with children or adults who are cognitively impaired or unable to communicate their pain. Sample forms of these pain assessment tools are provided in the Appendix.

   When assessing pain, it is important for clinicians to set realistic expectations for patients. Achieving a pain score of zero may not be possible for every patient and may even be undesirable. One of the first steps toward the management of any symptom is to establish the individual's health care-related goals. Patients and families should understand that medications have side effects. When taking opioids, such side effects may include nausea, weakness, confusion, fatigue, somnolence, constipation, anorexia, mental dullness and other distressing symptoms. Through shared decision-making, the patient, family and clinician can fully explore the individual treatment goals, considering the risk and benefits of each choice.

   An important step to discuss when starting or reviewing pain medications is the impact on function. Most treatment plans should have an additional goal to provide not only adequate pain control, but also to optimize individual function. A clinician may find that actual perception of pain may stay the same, but overall function has improved substantially. For example, a patient who complains of a pain score of 6/10 is found lying in bed, sheets drawn and disengaged. After appropriate titration or adjustment of pain medications, the individual patient may continue to complain of pain with a level of 6/10, but is now up out of bed, involved with activities and engaging with the provider.

   These outcomes should be fully discussed with the patient and used to establish beneficial and supportive health care goals. The PEG scale (Pain, Enjoyment and General Activity) may be used to assess the effectiveness of any pain-control regimen and track changes over time in relation to activities and quality of life. Sample pain scales are provided in the Appendix.

Assessing Pain (continued)

A comprehensive assessment ... (continued)

2. **Comprehensively assess using the PQRST&E acronym:**
   - **Palliating and provoking factors** – what makes it feel better/what makes it feel worse?
   - **Quality** – what does it feel like?
   - **Region and radiation** – location of pain/does it radiate, move, shoot?
   - **Severity** – intensity/how badly it hurts
   - **Time** – frequency of the pain and duration (how long it lasts)
   - **Effect on function and quality of life** – what does pain make difficult or keep you from doing; how does it impact your overall quality of life?

3. **Identify patient's self-identified threshold (SIT) and functional goals (including their greatest concern):** SIT is recorded as a number on a 0-10 scale and is the number the patient identifies as their threshold goal (the upper limit of the patient's desired pain goal). Any score above the patient's SIT pain exceeds the patient's desired goal and requires intervention. SIT is a patient-centered, patient-identified goal. It should be part of the patient's Plan of Care, and the team should be working toward keeping patient pain levels at or below the patient's SIT. However, the SIT score alone is rarely enough to fully understand the patient's goals. It should always be evaluated in conjunction with the patient's functional goals.

SIT is assessed and documented in the comprehensive nursing assessment at the beginning of service and at each subsequent nursing visit. SIT levels may change over time, and the circumstances should be fully documented in the patient's record and on the Plan of Care.

Examples include:

- As a patient's condition declines, it is common for them to become fatigued with chronic pain and desire pain intervention at a lower number.
- Patients may increase their stated SIT number in response to side effects of analgesics required to maintain SIT at lower number (example: they would rather be more alert than have the sedative side effects that may result from dosages necessary to keep their pain at a very low number).
- Patients who meet their functional goals may express satisfaction with their pain management, even though it is rated above their numeric SIT. When this happens, the discussion and any changes to patient's expressed SIT should be documented and reflected on the Plan of Care.
- SIT scores can be greatly impacted by "Total Pain" factors. By addressing "Total Pain" issues, the physical suffering may become easier to manage, and the patient may identify a change in their SIT.

In patients who are unable to self-report the presence and severity of pain, Compassus uses an observational scale with the acronym FLACC. Since these patients are unable to identify a SIT goal, Compassus assigns a FLACC pain goal of 3 or less.

Assessing Pain (continued)

A comprehensive assessment ... (continued)

4. **Assess for Total Pain factors:** While the nurse is the only member of the interdisciplinary care team who performs a comprehensive pain assessment, the social worker and chaplain also have a pivotal role in the assessment and management of Total Pain. During their initial and ongoing assessments, they identify emotional, social, spiritual and functional issues that contribute to the patient's Total Pain picture.

With a shared focus on maintaining the patient's quality of life, the nurse looks for the impact of physical pain on function while the social worker and chaplain look for functional and quality-of-life issues that are impacting the patient's physical pain.

A Plan of Care for pain must contain:

- **Measurable goals** such as maintaining pain at or below the patient's stated SIT and/or patient goal for function.
- **Delivery of the right medications at the right time** (i.e., around-the-clock analgesic dosing for predictable pain, PRN analgesic dosing for unpredictable/episodic pain, appropriate adjuvant medications and a bowel management regimen when opioids are prescribed).
- **Spiritual and/or psychosocial interventions** for issues contributing to Total Pain.
- **Caregiver WHEN/THEN training** at each nursing visit and during IDT meetings. WHEN/THEN is a tool used by Compassus to train patients and caregivers in what to monitor and, most importantly, how to respond when variances occur. Every discussion of patient pain MUST be an interdisciplinary discussion that includes a nurse, social worker, chaplain and physician. This requires all disciplines to be fully prepared for the meeting and to participate in a concise, professional discussion for the sake of achieving patient outcomes.

Quick guide for WHEN/THEN pain:

When: Pain exceeds SIT **Then:** Take Tylenol® 1000 mg every 6 hours as needed	**When:** Pain exceeds SIT and unresponsive to Tylenol® **Then:** Take morphine 5 mg every 6 hours as needed

Assessing Pain (continued)

A comprehensive assessment ... (continued)

When pain is difficult to manage, the team should reassess for physical and Total Pain causes and ask: Is there something else? What have we missed? What do we need to do now? The interventions must be individualized based on patient goals, disease/pain syndromes and Total Pain factors present.

Additional steps may include:

- Performing a physical examination to understand the alleviating and aggravating factors.
- Inventory of current medications and their effectiveness.
- Assessment of elder considerations, including the presence of cognitive impairment. If the patient is opioid naive, start with a low dose and progress slowly.
- Assessment of additional considerations, including:
  - What is the patient's age and size?
  - Is the patient in renal (kidney) or hepatic (liver) failure?
  - What is the patient's level of hydration?
  - Does the patient have reason to exhibit pain?
  - How does the patient communicate pain?
  - How will you assess the effectiveness of analgesics?
  - What is the most appropriate route of analgesics?

Pain scores are highly subjective

Pain is a multimodal construct impacted by actual tissue damage as well as other factors including mood, social interactions, psychosocial determinants, existential concerns, etc. Pain scores may fluctuate day to day. The clinician should be aware of function and other behavior changes to gauge outcomes.

Related Resource:

Patient/Family Training: Pain Relief Techniques

Appendix A, page 55

Treating Pain

Pain occurs when chemicals called prostaglandins are released from damaged tissue following an injury or trauma. The release of prostaglandins trigger receptors on the body's nerve endings, known as nociceptors, to transmit signals to the brain and spinal cord for the body to feel pain.

Pain medicines work by blocking the release of prostaglandins or the transmission of signals back to the brain.

There are four primary groups of analgesics — a term used to refer to pain-relieving medications:

- **Non-opioids:** Non-steroidal Anti-inflammatory Drugs (NSAIDs)[3], such as aspirin (acetylsalicylic acid or ASA), ibuprofen and naproxen, work by blocking the synthesis of prostaglandins, thereby decreasing sensitization of the nociceptors.
- **Opioids:** While their side effects and dangers are well documented, opioids — such as codeine, fentanyl, hydrocodone, methadone, morphine and oxycodone — block transmission of pain signals by spinal neurons and the connections that carry signals from the brain back to spinal cord[4]. Starting doses are taken orally (po).
- **Adjuvants:** These drugs have a primary indication other than treatment of pain but are analgesic in some situations. Examples include prednisone, corticosteroids, anticonvulsants and topical therapies.
- **Medical Cannabis:** Despite a lack of quality evidence supporting the medical use of cannabis[5] or cannabinoids such as CBD, many patients (and clinicians) report it is effective in managing end-of-life symptoms such as nausea/vomiting, pain and anxiety.

Why are oral medications best?

Opioid medications taken orally last longer and require less frequent dosing, easing the burden on the patient and caregiver.

Pain adjuvants:

- Gabapentin/ pregabalin
- Duloxetine
- Venlafaxine
- Amitriptyline
- Topical capsaicin
- Topical lidocaine
- Steroids
- Muscle relaxants

While a recent study showed growing support for the use of medical cannabis in the hospice setting[6], federal restrictions prohibit hospice providers from providing or administering the drug. In fact, though it is legal in some states, cannabis is still considered a Schedule I drug. As such, members of the IDT must remain mindful of not only the growing use of cannabis among patients, but also our organization's limitations in endorsing it.

Other types of pain may require a more invasive approach. The following treatments should be used only as a last resort:

- Intramuscular (IM) or subcutaneous (SQ) injection
- Patient-controlled analgesia (PCA) intravenous infusions
- PCA SQ infusions
- Trigger-point injections
- Selective nerve root blocks
- Intraspinal delivery systems (epidural or intrathecal, intermittent or continuous)
- Implantable pumps

[3] https://www.drugs.com/drug-class/nonsteroidal-anti-inflammatory-agents.html
[4] https://www.pharmacytimes.com/contributor/jeffrey-fudin/2018/01/opioid-agonists-partial-agonists-antagonists-oh-my
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6406915/
[6] https://www.forbes.com/sites/abbierosner/2019/06/25/cannabis-in-hospice-growing-demand-and-acceptance-for-end-of-life-care/#3a4b7923403a

Treating Pain (continued)

Multidimension pain treatment:

While analgesics are effective in treating most pain, some types of pain can be managed with non-pharmacological interventions such as:

- Relaxation
- Movement or immobility
- Visualization
- Touch
- Distraction
- Acupuncture
- Meditation
- Physical therapy
- Aromatherapy
- Trans-electrical nerve stimulation
- Music therapy
- Massage therapy
- Heat or cold
- Magnets

COMPLIANCE NOTICE

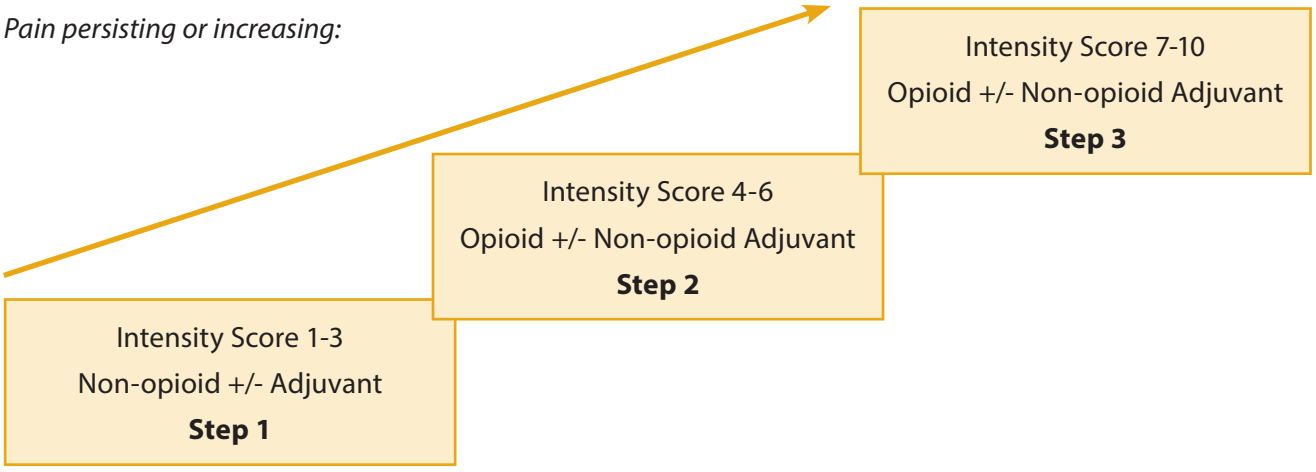
From 1999 to 2013, the amount of prescription pain killers prescribed and sold in the US nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report.

The World Health Organization's Analgesic Ladder

The pain ladder was created by the World Health Organization (WHO) as a guideline to the incremental use of analgesic medications for pain management, beginning with non-opioid medications for mild pain and advancing as a patient's pain persists or increases.

The WHO Pain Ladder

Pain persisting or increasing:



Treating Pain (continued)

WHO interventions

The following guidance may be helpful in translating the WHO Pain Ladder to the care of hospice and palliative care patients.

Intensity Score 1-3 Non-opioid +/- Adjuvant **STEP 1**	**Step 1: Non-opioids** Pain intensity 1-3 • Acetaminophen (Tylenol®) – Must use caution! - Liver toxicity is possible with long-term use. - Elderly/debilitated patients should not receive over 2400 mg daily. Be alert to APAP dosages in combination medications. • NSAIDs - Most are strong anti-inflammatory agents used for bone pain. - Risk of gastrointestinal ulcer disease increases with prolonged use. - For long-term use, protect with omeprazole (Prilosec OTC®) or over-the-counter histamine H-2 receptor antagonists (H-2 blockers) like Tagamet®.
Intensity Score 4-6 Opioid +/- Non-opioid Adjuvant **STEP 2**	**Step 2: Opioids for moderate pain** Pain intensity 4-6 • Opioids work at the dorsal horn of the spinal cord to block neurotransmitters. Consider beginning patients with the following dosages: - Morphine 5-10 mg* - Oxycodone 5-10 mg* (non-formulary status with Compassus due to high risk of abuse and no meaningful benefit over morphine) *Both are available in tablet, liquid, concentrate and suppository.
Intensity Score 7-10 Opioid +/- Non-opioid Adjuvant **STEP 3**	**Step 3: Opioids for moderate to severe pain** Pain intensity 7-10 • These stronger opioids work at the dorsal horn of the spinal cord to block neurotransmitters. Consider beginning patients with the following dosages: - Morphine 10-15 mg* - Oxycodone 5-10 mg po every 3-4 hours* - Hydromorphone 2-4 mg (Dilaudid®) - Methadone 2.5-5 mg po every 8 hours** *Both morphine and oxycodone are available in tablet, liquid, concentrate and suppository forms and come in short- and long-acting forms. **Methadone is available in tablet, liquid, concentrate and suppository forms.

Treating Pain (continued)

Pain medications in hospice & palliative care

While hospice and palliative care providers are largely exempt from growing regulations around opioid prescriptions, there are a number of factors providers must consider when selecting the right pain medication. Some opioids have limitations and dose ceilings, making them a poor choice for most hospice patients.

Drugs we avoid include:

- **Demerol®**
  - Relatively low potency, short duration of action (2-3 hours) and toxic metabolite
  - Only effective intramuscular or IV
  - 50 mg Demerol® po (orally) = 625 mg aspirin

- **Mixed agonist/antagonist**
  (e.g., Talwin® and Stadol®)
  - Ceiling effect for analgesia
  - Not appropriate for patients who need pain relief equivalent to that provided by high doses of opioids

- **Hydrocodone and oxycodone combination products**
  (e.g., Lortab®, Tylox®, Percocet®, Percodan®, Ultracet®)
  - All have ceilings due to acetaminophen, aspirin or ibuprofen content

Commonly used opioids in hospice care include:

- **Short-acting morphine.** Morphine remains the gold standard of opioids due to known metabolites, predictable physiologic profile, multiple routes of administration, good bioavailability and known potency. However, the most favorable opioid for an individual cannot always be predicted. Organ system dysfunction should be considered when selecting an opioid medication (see box).

- **Oxycodone.** The drug's high bioavailability rate (60-87%) compared with morphine (20-35%) allows the drug to be absorbed by the body's circulatory system for fast onset and long-acting relief. While this makes it an extremely effective choice for treating painful or terminal conditions, it is also one of the most commonly abused prescription drugs in the country. With effects that are similar to heroin, oxycodone (OxyContin®) can be abused by crushing and snorting the tablets or dissolving them in water and injecting the solution to bypass the drug's time-release formula and achieve its full effect at once. This potential for abuse, combined with its high street value, put OxyContin® at high risk for diversion.

Treating Pain (continued)

Pain medications ... (continued)

- **The fentanyl patch.** Provides steady pain control for 72 hours. The drug is extremely powerful with one 25 mcg/hour patch being equal to 60 mg of morphine per day. However, the initial dose may have no analgesic effect for 12 to 24 hours, and the titration rate is compromised due to the duration of action of the patch. Therefore, another medication may be needed for breakthrough pain. The patch must be placed on the patient with adequate tissue for distribution. Clinicians should be cautious of skin tears or irritated areas and recognize that fever or hot showers cause rapid absorption. It is also important to be aware that fentanyl is often the target of drug seekers who divide the patches to make "chiclets," which are sold on the street.

- **Sustained-release oral opioids.** Including morphine (MS Contin® or sustained release morphine) and oxycodone (OxyContin®), these provide steady pain control within 24 hours. Both preparations can be titrated every 24 hours for unrelieved pain — increasing dosages by 25-50% every 24 hours for moderate pain or by 50-100% every 24 hours for severe pain.

- **Methadone.** Reference the Appendix for information on methadone prescribing.

Opioid analgesics and organ dysfunction:

SYSTEM	PREFERRED	AVOID
Hepatic	• Hydromorphone • Methadone • Morphine	• Tramadol • Fentanyl
Renal	• Hydromorphone • Methadone • Fentanyl	• Morphine • Tramadol
Hepatic + Renal	• Hydromorphone • Methadone	• Morphine • Tramadol

Treating Pain (continued)

Opioid prescribing

The following algorithm is provided as a guide to opioid prescribing once the need for opioids is determined. In general, start with less-potent opioids, reserving stronger opioids for more severe pain patients. Remember to avoid certain opioids in patients with hepatic or renal failure. Additionally, because it is highly sought after by people with opioid use disorder, oxycodone should be avoided when possible.

When pain is not controlled, assess whether the pain medication is ineffective in relieving pain or if the beneficial effect does not last to the next dose. This will determine whether there is a need to increase medication dose or frequency. To optimize pain control and to minimize abuse potential, maximize use of extended-release formulations.

COMPLIANCE NOTICE

When opioids are indicated, use the lowest dose and fewest number of opioid pills needed (generally no more than a 7-day supply). Leftover pills are often the source for illicit opioid abuse.

Opioid prescribing algorithm:

Always optimize extended-release (ER) opioids when abuse or diversion is suspected or confirmed.

↓

Begin with the lowest-effective dose and frequency.
Remember: Zero pain score is not the goal.

↓

Increase frequency and dose.
Goal: Seek adequate pain control for optimal function (PEG tool).

↓

Consider extended-release opioid when daily morphine milligram equivalent (MME) exceeds lowest extended-release dose and more frequent immediate-release dosing *(i.e., every 8-12 hours).*
Remember: Adjust for incomplete cross-tolerance when changing opioids.

↓

Increase extended-release formulations as needed to minimize immediate-release use.

Treating Pain (continued)

Opioid principles

When administering opioids to hospice or palliative care patients, caregivers should adhere to the following principles for effective pain management:

- In opioid-naive patients, start with low-dose, short-acting opioids and titrate for effect.
- Use a conversion chart to rotate medications.
- Follow the adage, "If the gut works, use it" when deciding how to administer drugs.
- Be aware of first-pass effect[7] metabolism, which may reduce the concentration of the drug before it is circulated throughout the body.
- Base administration schedule on the analgesic's duration of effect. Use sustained-release opioids for scheduled dosing and immediate-release opioids for rescue or breakthrough dosing.
- Titration: Increase by 25-50% for moderate pain; increase by 50-100% for severe pain.
- Consider alternate delivery methods where necessary. For example, most po *(oral)* meds are also absorbed well rectally or vaginally. Concentrated opioids also may be given buccally *(placing the medication between the gums and cheek where it dissolves and is absorbed into the bloodstream).*
- Ensure patients with a long-acting opioid also have a short-acting opioid for breakthrough pain. Only one long-acting and one short-acting opioid are needed.
- Use a multidrug approach. Combine opioids with non-opioids and adjuvant medications.

COMPLIANCE NOTICE

Avoid oxycodone
Oxycodone is intensely rewarding and no more effective than other opioids. Studies show it is twice as euphoric at equianalgesic doses as morphine, hydrocodone and oxymorphone, making it one of the most sought-after oral drugs by prescription opioid abusers.

Breakthrough or "rescue" dosing may be needed to control sudden flare-ups of pain. Caregivers should be mindful of the following guidelines when administering breakthrough doses.

- Oral breakthrough dose is 10-20% of the oral 24-hour baseline dose.
- If breakthrough dosing is required two to three times within a 24-hour period to achieve adequate pain relief with routine activity, consider increasing the long-acting medication dose.
- Re-assess for pain syndromes not responsive to opioids; if necessary, consider adjuvants.
- Adjust bowel protocol as you increase opioids.

[7] https://socratic.org/questions/what-is-meant-by-the-first-pass-effect-of-drugs

Treating Pain (continued)

Opioid principles (continued)

- If the patient does not respond to increasing long-acting opioid doses, consider tolerance and rotate to another long-acting opioid.
- If several (30-50%) dose increases of a long-acting opioid provide only minimal pain relief, suspect tolerance and rotate.
- Due to incomplete cross-tolerance, convert to a lower dose than conversion chart suggests. The new drug may be more effective because of differences of potency or drug availability. Start with 2/3 to 3/4 of the amount calculated by using equianalgesic tables.

Use of adjuvants

Adjuvant medications are not analgesics but have properties that either assist in blocking pain impulses, treat related symptoms or enhance the effects of analgesics. Choose the adjuvant that will benefit the patient's other symptoms as well as the pain. Often, using adjuvant therapy provides improved pain relief with smaller doses of opioids and fewer side effects.

For severe pain, use an adjuvant from several different categories:

Tricyclic antidepressants:	Anticonvulsants:	Steroids:
Indications: Neuropathic pain that is burning or constant **Mechanism of action:** • Alters serotonin and norepinephrine reuptake • Provides analgesia in addition to mood elevation **Medication:** • Nortriptyline 10-25 mg po (orally) at bedtime (Aventyl®) • Amitriptyline 10-25 mg po (orally) at bedtime (Elavil®) • Desipramine 25-50 mg po (orally) at bedtime (Norpramin®)	**Indications:** • Neuropathic pain • Myoclonic jerks • Lancinating pain **Mechanism of action:** • Suppresses neuronal firing **Medication:** • Carbamazepine 100-200 mg po (orally) two times per day (Tegretol®) • Gabapentin 100-300 mg po (orally) at bedtime; max dose 3,600 mg per day (Neurontin®) — fewer side effects and sedation. • Pregabalin (Lyrica®) 25-50 mg po (orally) maximum dose 600mg • Clonazepam 0.5-1.5 mg every day (Klonopin®)	**Indications:** • Acute nerve compression • Visceral distention • ICP • Soft tissue pain **Mechanism of action:** • Decreases edema • Decreases inflammation **Medication:** • Dexamethasone 1-4 mg PO/SC/IV maximum dose 16 mg per day

Treating Pain (continued)

Use of medications to address opioid toxicity

Because opioid tolerance can develop quickly, caregivers must take an active role in managing dosing and carefully monitor for symptoms of opioid toxicity — especially in palliative care patients.

While signs of opioid toxicity often closely resemble the natural signs and symptoms of death, a decreased rate of respiration is a primary indicator of possible toxicity. Other complications may include pulmonary edema, delirium, hypotension, bradycardia, myoclonus, decreased body temperature and urinary retention.

The management options to address the impact of opioid toxicity should be divided into strategies to treat the myoclonus and strategies to reduce the offending opioid. The most appropriate treatment approach should consider the intensity of the symptoms, hydration status and estimated prognosis. If the symptoms are mild and the patient is satisfied with current level of symptom control, education and careful monitoring may be all that are necessary. If the pain is controlled, a trial of opioid reduction — allowing for a drop in the neuroexcitatory metabolites — may be warranted. More distressing symptoms warrant rotation to a dissimilar opioid that allows for a drop in neurotoxic side effects while achieving similar pain control.

Select the new drug on the basis of pharmacologic features, previous experience, availability and cost.

Calculate the equianalgesic dose:

- If switching to any opioid other than methadone or fentanyl:
  - Plan dose reduction of 25-50% (incomplete cross-tolerance)
  - Choose dose reduction of approximately 50%, if high-dose, elderly, frail individual
- If switching to methadone:
  - Follow methadone dosage guidelines
- If switching to transdermal fentanyl:
  - Follow equianalgesic dose included in product information (approximately OME/2)

Treating Pain (continued)

Use of medications ... (continued)

Additional strategies include use of benzodiazepines to reduce myoclonus (although increasing sedation may be an unwanted side effect) and gentle hydration (oral is best), if tolerated to support elimination of toxic metabolites.

If opioid toxicity is suspected in a hospice patient, interventions other than naloxone are encouraged first, such as:

- Decreasing the dose of opioid medication
- Increasing the interval between doses
- Holding doses of the opioid or switching to another opioid class
- Considering gentle hydration of the patient, as tolerated

While not generally recommended for use in hospice patients because of its potential to cause needless suffering, the medication naloxone — an opioid antagonist indicated for the complete or partial reversal of opioid overdose — may be effectively used in palliative care patients.

Opioid toxicity:	Normal changes with dying:
• Confusion • Excess drowsiness • Slurred speech • Inability to wake up • Breathing problems *(slow or irregular)*	• Confusion • Excess drowsiness • Slurred speech • Inability to wake up • Breathing problems *(slow or irregular)*

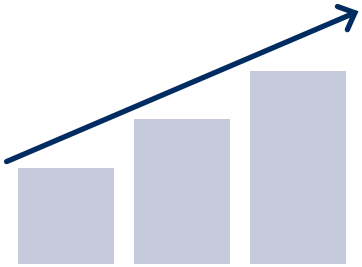
Managing Pain

The pain medication required by any individual patient must be tailored to their needs and titrated up or down to determine the dose that, to the greatest possible extent, reduces the patient's pain while avoiding medication side effects.

Upward titration

Increasing opioid dosage

- **Indications**
  - Inadequate pain relief
  - Tolerance or increased disease process
  - End-of-dose failure
- **Amount**
  - Severe pain: 50%-100% increase
  - Moderate pain: 25%-50% increase
- **Frequency**
  - Acute pain: every hour
  - Chronic pain: every 24 hours

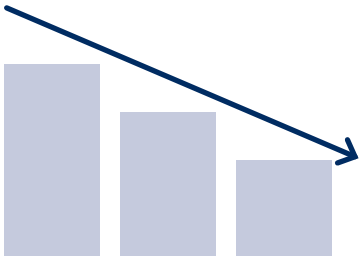


Managing upward titration, or increasing opioid dosage

Downward titration

Decreasing opioid dosage

- **Indications**
  - No pain plus side effects
  - No supplemental dosing
  - Reduction in pain source
  - Interruption in pain transmission
- **Amount**
  - 25%-50% decrease



Managing downward titration, or decreasing opioid dosage

COMPLIANCE NOTICE

Opioids should not automatically be the "go-to" drug. In acute pain, the evidence for effectiveness is weak. Consider non-narcotic treatments first. Also remember you can give non-narcotic treatments with opioids right away, decreasing the amount of opioid that is needed. Consider alternatives and adjuvants such as:

- Acetaminophen
- NSAIDs
- Topical anesthetics
- Bracing
- PT/OT
- TCA/SNRI
- Massage/acupressure

Managing Pain (continued)

Equianalgesic dosing

Side effects may also be managed by rotating between opioids. To determine the appropriate starting dose and whether titration is needed, use an equianalgesic chart, which provides the equivalent dose calculations between different analgesics. Remember to consider breakthrough doses and schedule doses in 24 hours.

To calculate the total daily dose of opioids a patient is taking:

1 – Determine the total daily amount of each opioid the patient takes.

2 – Convert each to morphine milligram equivalents (MMEs) by multiplying the dose for each opioid by its conversion factor using a table provided.

3 – Add them together.

The calculated dose represents an estimated equianalgesic dose. Significant individual patient variation should be expected. The actual dose of the desired drug should be adjusted for a variety of factors including but not limited to age, pain intensity, cross-tolerance and renal/hepatic dysfunction.

Consider the following when adjusting the calculated (estimated) equianalgesic dose:

- 0% reduction: moderate to severe pain, no side effects on current medication
- 25% reduction: mild to moderate pain, no side effects
- 50% reduction: mild or moderate pain, presence of side effects

Please see the Appendix for additional dosing and conversion guidelines. The following dosage calculators may also be useful:

Daily Opioid Dosage Calculator (Centers for Disease Control)
www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Conversion Table (American Academy of Family Physicians)
www.aafp.org/dam/AAFP/documents/patient_care/pain_management/conversion-table.pdf

Managing Pain (continued)

Pain management follow-up guidelines

An assessment of pain should be part of each nursing, social worker and chaplain visit. In addition to using the PQRST&E assessment tool, caregivers may also use the PEG (Pain, Enjoyment and General Activity) scale to assess the effectiveness of any pain-control regimen and track changes over time. Examples of this and other pain scales are provided in the Appendix.

During each assessment, it is important to openly discuss pain-control expectations. While managing pain, maximizing function and enhancing quality of life are always the primary goals, it may not be possible to eliminate pain for every patient. As part of the assessment, caregivers should work with the patient and family to identify the patient's self-identified threshold (SIT), functional goals and greatest concerns. Once these measures are identified, the IDT should continue to tailor the treatment plan to support these goals.

While managing pain, maximizing function and enhancing quality of life are always the primary goals, it may not be possible to eliminate pain for every patient.

While all members of the IDT are responsible for identifying pain, only the physician or nurse can perform a comprehensive pain assessment. IDT members should immediately notify the nurse if they become aware of changes in a patient's pain level so the nurse can intervene. IDT members can support these efforts with actions appropriate to their discipline.

When assessed pain exceeds the pain goal in the patient's care plan:

- The nurse must intervene to bring pain levels in line with the patient's self-identified threshold (SIT).
- The nurse must follow up within 24 hours to ensure patient's pain management has continued; if not met, the nurse must reassess for further interventions.
- The nurse must document all interventions and follow up in the patient's medical record.

COMPLIANCE NOTICE

PQRST&E
Remember, Effect on Function. Opioid treatment should improve both pain and function. Functional improvement is a great measure for pain control outcomes. Actual numeric scores for pain (1-10) may not always improve while the patient is exhibiting increased ability to perform tasks, increase activity, etc. These positive impacts should be documented and communicated with the patient as a measure for improvement. Agree on specific, achievable goals before treatment.

Managing Pain (continued)

Managing opioid side effects

Opioid use can result in a range of side effects that also must be effectively managed for the comfort and quality care of the patient.

Side Effect: Constipation

Opioid-induced constipation is one of the most common side effects of opioid use, with up to 60%[8] of users reporting symptoms. Patients never become tolerant to the constipating effects of opioids. Opioids slow the function of the digestive symptoms and reduce muscle constriction and secretions.

Clinicians should use the following guidelines to proactively monitor and treat constipation:

- Proactively prescribe a mild laxative and stool softener such as Senekot® or PEG® (polyethylene glycol)
- Adjust the protocol as opioid dosing increases
- Assess bowel movement (BM) activity each visit
- Increase Senekot®, if no BM by the end of the 2nd day
- If no BM in three days, add Dulcolax® tablet/suppository or Fleet® enema
- Manage laxative dosing to achieve formed BM every 2-3 days
- Colace® should not be prescribed for the management of constipation

"The hand that writes the opioid order shall also write the laxative order!"

Occasionally, for patients with refractory opioid-induced constipation, methylnaltrexone may be an effective alternative to traditional laxatives. A single dose may be all that is ever required. Available in both pill and injection form, methylnaltrexone works by blocking the opioid receptors in the intestines but does not disrupt the pain relief effect provided by opioids and presents few side effects.[9]

Side Effect: Nausea

The chemicals in opioids may trigger nausea and vomiting in some patients. Though most patients will develop a tolerance to nausea within a few days, clinicians may taper dosing or use an antiemetic such as Compazine®. It is also important to ensure the patient is not constipated or take steps to relieve constipation, if needed.

Side Effect: Respiratory Depression

An opioid is a depressant of the central nervous system (CNS), which also controls our breathing. Respiratory depression is the body's reduced urge to breathe. While opioid tolerance usually develops quickly, this side effect can be treated by decreasing the opioid dose and adding an adjuvant drug.

8 https://www.gastro.org/press-release/medical-management-of-opioid-induced-constipation-differs-than-for-other-forms-of-the-condition-1
9 https://www.pharmacytimes.com/news/methylnaltrexone-may-be-a-solution-to-opioid-induced-constipation

Managing Pain (continued)

Managing opioid ... (continued)

Risk factors include:

- Opioid naive
- IV administration
- Rapid dose escalation
- Removal of painful stimulus
- Relative risk: chronic lung disease (CO2 retention), renal dysfunction

It should be noted that Cheyne-Stokes respiration at the end of life is not the same as respiratory depression.

Side Effect: Myoclonic Jerking

While a lesser known side effect of opioids, some patients experience myoclonic jerking or a quick, involuntary muscle jerk. Hiccups or the sudden jerking people may experience as they drift off to sleep are examples of myoclonic jerking[10]. Tolerance will develop in most people but hydration (subcutaneous vs. oral) or opioid rotation or breaks may provide relief. Clonazepam may also be administered at a dose of 0.5 mg po bid (orally twice a day).

Clinicians can consider the following medications to treat myoclonic jerking:

- Baclofen (Lioresal®) 5 mg po bid (orally twice a day)
- Simethicone
- Reglan
- Decadron
- Haldol
- Thorazine

Side Effect: Sedation Confusion

High doses of opioids combined with sleep deprivation and concurrent medical problems such as hypercalcemia and metastases may also cause confusion or sedation in patients. Most patients will develop a tolerance but reducing the opioid dose and adding an adjuvant may improve symptoms. Caution must be exercised whenever a benzodiazepine is prescribed with an opioid medication.

[10] https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Myoclonus-Fact-Sheet

Addiction & Dependence

An estimated 1.9 million people in the United States suffered from substance-use disorders related to prescription opioid pain medicines in 2014.[11] From 1999 to 2016, more than 200,000 people in the United States died of overdoses related to prescription opioids, with overdose deaths involving prescription opioids five times higher in 2016 than in 1999.[12]

Opioids are fundamental to our treatment of end-of-life pain, which is reported in up to 80% of hospice patients and often increases as the patient gets closer to the end of life.[13] Yet, the national epidemic of prescription opioid abuse creates a challenge for all prescribers, with significant implications for clinicians treating patients with pain at the end of life.

Hospice and palliative care teams must be mindful of the responsibilities and risks associated with opioid prescribing. Opioid medications play an important role in managing the pain of hospice and palliative care patients, but opioid use must always be balanced with the responsibility of the provider to help prevent drug abuse, diversion and addiction.

This section is presented as a reference for the interdisciplinary care team in identifying and managing opioid dependency in both hospice and palliative care patients. It also provides guidance for delivering end-of-life care to patients with active or latent substance-use disorders.

> *"We cannot change the outcome, but we can affect the journey."*
>
> *– Ann Richardson*

[11] https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/what-science-tells-us-about-opioid-abuse-addiction

[12] Primer of Palliative Care, 7th Edition, American Academy of Hospice and Palliative Care (Perisakoil, Denney-Koelsch, White, Zhukovsky, & Quill, 2019)

[13] Gabbard, Jennifer, et al. "Dying on Hospice in the Midst of an Opioid Crisis: What Should We Do Now?" The American Journal of Hospice & Palliative Care, U.S. National Library of Medicine, Apr. 2019, www.ncbi.nlm.nih.gov/pubmed/30352517

Understanding Addiction and Dependence

Addiction is a psychological craving for a drug's psychic effect. Related terms and conditions include:

- **Physical dependence** – a natural physical response to continued use of an opioid
- **Tolerance** – the body's legitimate need for larger doses of an opioid to produce the same effect during an extended period of use
- **Pseudo-addiction** – drug-seeking behavior caused by poor pain management

COMPLIANCE NOTICE

Patients genuinely in pain want to get better and have their pain controlled. Patients in pain will try reasonable treatments. Drug seekers want opioids. Avoid prescription opioids to patients claiming an inability to tolerate or benefit from multiple non-narcotic recommendations.

Risk factors

Because opioid tolerance develops quickly, the risk of dependence or addiction is heightened in both hospice and palliative care patients. However, it is important to note that the approach to managing this risk may vary for each patient population.

While addiction has not traditionally been a primary concern for patients in hospice care, providers must exercise vigilance to ensure safe prescribing that mitigates the risk of abuse or diversion. Additional measures may be necessary to manage the risk of addiction and dependence in palliative care patients since this population often relies on opioids for a longer period, which can increase the risk of misuse. In both populations, clinicians must always be mindful of the risk of addiction these powerful drugs pose to others, including family members.

While anyone can become addicted, the Centers for Disease Control and Prevention (CDC) describe the following risk factors that make people particularly vulnerable to prescription opioid abuse and overdose.[14]

- Overlapping prescriptions from multiple providers or pharmacies
- Taking high daily dosages of prescription opioid pain relievers
- Having mental illness or a history of alcohol or other substance abuse
- Living in rural areas and having low income

Abuse behavior risk factors:

- Family history of alcohol abuse
- Family history of substance abuse
- Family history of prescription drug abuse
- Personal history of alcohol abuse
- Personal history of substance abuse
- Personal history of prescription drug abuse
- History of sexual abuse
- History of psychological disease
  - ADD
  - Bipolar
  - OCD
  - Depression
- Age 16-45

[14] "Opioid Overdose." Centers for Disease Control and Prevention, U.S. Dept. of Health & Human Services, 29 Aug. 2017, www.cdc.gov/drugoverdose/opioids/prescribed.html, accessed July 17, 2019.

Assessing and Managing Risk of Opioid Dependency

Screening at admission

All patients should be screened upon admission for opioid use disorder (OUD). The following algorithm provides an overview of the actions that should be considered if OUD is identified, as well as recommendations for handling abuse and diversion by patients or family members.

COMPLIANCE NOTICE

One prescriber
Patients should receive chronic opioid treatment from one prescribing clinician (or their associate) only.

Abuse and Diversion Algorithm

Screen all new admissions for opioid use disorder (OUD)

NEGATIVE

- Monitor for signs of abuse and diversion each visit

POSITIVE

LATENT

- Opioid contract
- Inform medical director/ attending, pharmacist
- Increased vigilance

ACTIVE

- ***Implement abuse recommendations***
- Optimize extended-release (ER) opioid formulations

Abuse/Diversion Recommendations

SUSPECTED

- Inform medical director/ attending, pharmacist
- Check state PDMP
- Re-educate
- Drug screen
- Optimize extended-release (ER) opioid formulations
- Opioid contract

CONFIRMED

OPIOID CONTRACT

ABUSE

- Inform medical director/ attending, pharmacist
- Check state PDMP
- Decrease prescribed amounts
- Consider alternate medications (methadone, buprenorphine)
- Re-educate
- Drug screen
- Controlled dispensing
  - Lockbox
  - Electronic medication binder (EMB)
- Optimize extended-release (ER) opioid formulations
- Consider other types of pain:
  - Psychological
  - Social
  - Spiritual
- Engage pertinent IDT members (social worker, chaplain); arrange visits and follow up
- OUD resources/referral list
- Narcan®

DIVERSION

By Patient

- Inform medical director/ attending, pharmacist
- Check state PDMP
- Decrease prescribed amounts
- Consider alternate medications (methadone, buprenorphine)
- Re-educate
- Drug screen
- Inform law enforcement
- Seek accountable caregiver

If persists:

- Seek corporate clinical input
- Discharge from hospice

By Caregiver/Visitor

- Inform medical director/ attending, pharmacist
- Check state PDMP
- Decrease prescribed amounts
- Consider alternate medications (methadone, buprenorphine)
- Re-educate
- Drug screen
- Inform law enforcement
- Seek accountable caregiver and use lockbox
- Optimize extended-release (ER) opioid formulations
- Notify Adult Protective Services
- Consider alternative placement

If persists:

- Seek corporate clinical input
- Discharge from hospice

Assessing and Managing Risk ... (continued)

Signs of withdrawal

Virtually all patients who engage in long-term opioid use will develop physical dependence and increased tolerance. If properly managed, pain can continue to be controlled through opioid rotation and dosage adjustment. However, it is important to note that withdrawal can occur when a patient's opioid dose is cut back or discontinued after heavy use of as little as three weeks.

Early symptoms of withdrawal (within the first 24 hours after stopping the drug) **include:**	**Later symptoms can be more intense and include:**
• Muscle aches • Anxiety • Restlessness • Lacrimation (eyes tearing) • Rhinorrhea (running nose) • Diaphoresis (excessive sweating) • Insomnia	• Diarrhea • Abdominal cramps • Piloerection (goose bumps) • Nausea and vomiting • Rapid heartbeat • High blood pressure

The natural course of dying: signs and symptoms and how they differ from opioid side effects

It is imperative for clinicians, patients and caregivers to be aware of the natural course of dying and the common signs and symptoms associated with this process (see chart on page 23). In addition, it is important to understand how signs of opioid toxicity differ from opioid overdose.

Natural signs and symptoms of dying are caused by changes in the body's metabolism as a result of the disease. For example, the patient will spend more time sleeping, it may be difficult for the patient to keep their eyes open, or the patient may be more confused or disoriented. The patient may see people who are not there, and this can be particularly distressing to family or caregivers. Restlessness may also result and require gentle reassurance.

Assessing and Managing Risk ... (continued)

The natural course of dying ... (continued)

Other changes include:

- Decrease in blood pressure; the pulse may increase or decrease
- Fluctuations in body temperature
- Increased perspiration
- Skin color changes; flushed skin with fever or bluish with cold
- Congestion or wet sounding throat
- Breathing changes; periods of increased, decreased or irregular breathing, including no breathing (apnea)
- Arms and legs cool or cold to touch; the hands and feet become purplish at times
- The patient can become completely unresponsive to any touch, voice or other stimulation

Another natural process of dying over time is less intake of food and water. This natural decline combined with the continued provision of beneficial opioid medications may result in the buildup of active opioid metabolites. The result of this buildup may cause symptoms of muscle twitching and spasms. Some patients may present with worsening hallucinations, delirium, as well as changes to respiration. Again, this is a natural process that occurs with dying.

Clinicians should contrast the known common opioid side effects, which include constipation, nausea, itching and urinary retention, with the common symptoms of anorexia, fatigue and even becoming less responsive over time as pain relief allows the patient to finally rest and be at peace.

Sudden Discontinuation of Opioids

Guidance issued by the Food and Drug Administration (FDA)[15] in 2019 underscores the harm that can result when health care professionals abruptly discontinue opioids in a patient who is physically dependent, resulting in withdrawal symptoms as well as uncontrolled pain.

A multimodal approach to pain management, tapering strategies and medication-assisted treatment options are all considerations for creating a patient-specific plan to avoid withdrawal symptoms, worsening of the patient's pain or psychological distress.[16]

> ***Related Resource:***
> Opioid Risk Assessment Tool
> Appendix H, page 70

[15] Center for Drug Evaluation and Research. "FDA Identifies Sudden Discontinuation of Opioid Pain Medicines." U.S. Food and Drug Administration, FDA, 9 Apr. 2019, www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes.

[16] Ibid

Managing Care for Patients with Substance-Use Disorder

In addition to managing risks associated with long-term opioid use, hospice and palliative care teams must also understand the nuances of providing end-of-life care to individuals who may have or have previously experienced a substance-use disorder. As the rate of individuals experiencing substance-use issues continues to grow, this need will become even more urgent.

A patient's history of substance abuse — latent or active — should be identified during the screening conducted upon admission. While the pathways for managing ongoing substance-use issues may differ in hospice and palliative care patients, the interdisciplinary care team should always exercise vigilance and communicate frequently regarding the patient's care plan, pain levels and necessary safeguards that should be put in place.

As detailed in the following pages, additional medications may provide relief — though extreme caution should be used in prescribing them to palliative care patients with a history of substance-use disorder. With the exception of methadone, which can be effective in treating pain in hospice patients when prescribed carefully, medication-assisted therapy (MAT) drugs such as buprenorphine or naloxone are not generally considered appropriate for use in hospice patients. The ability to prescribe these powerful drugs is often beyond the purview of hospice or palliative care physicians, underscoring the need to work collaboratively with a broader interdisciplinary care team. It's important to note the presence of opioid addiction is not a barrier to successful pain management in patients needing supportive end-of-life care. Additionally, clinicians should be aware of the potential for altered pain experiences in individuals with substance use disorder.

COMPLIANCE NOTICE

Check your state's PDMP
What to look for in your state's prescription drug monitoring program site:

- Multiple/overlapping prescriptions
- Multiple providers
- Dramatic changes in dose
- Frequent early refills
- Opioids + benzodiazepines prescribed together

Substance-use disorder and altered pain experience:

- Patients with SUD have less pain tolerance.
- Patients on opioid maintenance treatment have less pain tolerance than matched controls.
- Clinicians will often question the "legitimacy" of need for opioid analgesics.
- Opioid analgesic requirements are often higher due to increased pain sensitivity and opioid cross tolerance.

Managing Care for Patients ... (continued)

Methadone

Methadone is well known as a Schedule II narcotic that can be prescribed for the treatment of pain. Though it is commonly used in medication-assisted treatment to help people reduce or quit their use of heroin or other opiates, it has several unique characteristics that make it an attractive option for pain relief in serious illness. While it can greatly benefit many patients receiving hospice and palliative care, methadone does have nuances that warrant closer review before prescribing. Once aware of the benefits and safety concerns, it can be safely added to the prescribing toolkit.

Not generally considered a first-line therapy, methadone has excellent properties that make it a good choice for hospice and palliative care prescribers. Similar to other opiates, methadone is a mu-opioid agonist.[17] With NMDA-receptor antagonist effects, it may be a good choice for patients with neuropathic pain. Methadone can be used in patients with hepatic dysfunction, and dosage adjustments are not required in patients with renal failure.

Because of its lipophilic properties, methadone can be absorbed well in the oral mucosa, resulting in easy delivery of powerful analgesic dosing in a very small volume, even to lethargic and minimally-responsive patients.

A few concerns about methadone include tricky dose conversion guidelines, long half-life and multiple drug interactions.[18] A 2017 analysis of methadone deaths and prescribing from 2007 to 2014 conducted by the Centers for Disease Control and Prevention (CDC) found that although methadone accounted for about 1% of all opioid prescriptions, overall methadone-related deaths accounted for 22.9% of all opioid-related mortality in 2014.[19] Understanding just some pharmacokinetics and adopting a safe prescribing habit can significantly reduce the risks attributed to this medication and allow it to significantly combat pain for many patients.

Methadone interactions: metabolic inhibitors

- Macrolides – clarithromycin, crythromycin
- Diltiazem, verapamil
- Ketoconazole
- Itraconazole
- Benzodiazepines
- Clopidogrel
- Fluconazole
- Amiodarone
- Ciprofloxacin

[17] https://www.sciencedirect.com/topics/neuroscience/mu-opioid-agonists

[18] https://crediblemeds.org/healthcare-providers/articlesbrochures-library/methadone-interactions/

[19] Faul M, Bohm M, Alexander C. Methadone Prescribing and Overdose and the Association with Medicaid Preferred Drug List Policies - United States, 2007-2014. MMWR Morb Mortal Wkly Rep. 2017;66(12):320–323. Published 2017 Mar 31. doi:10.15585/mmwr.mm6612a2, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657959/

Managing Care for Patients ... (continued)

Drug interactions

There are many potential drug interactions. Most of the concern should be focused on drug interactions that could result in slowing the metabolism and raising serum methadone levels that result in the increased potential for toxicity. The most serious effects could be slowing the respiratory drive and prolonging the QTc interval, or both.

Alcohol, benzodiazepines

Concurrent use of alcohol and benzodiazepines are major concerns. Use of benzodiazepines with methadone warrant careful monitoring, if used together at all. Anytime you start or stop any drug, you should consider the effect it may have on methadone. If the concern is that drug levels of methadone could be raised, consider decreasing the dose of methadone by 25-50%.

COMPLIANCE NOTICE

Avoid opioids + benzodiazepines
Dramatic increase in mortality when these two prescriptions are co-prescribed. If they are used concurrently, a clear rationale should exist.

Other notables

Methadone is known for having a long half-life (6-190 hours). Of note, the metabolite is not active for pain control. It is best to consider methadone having at least a 24-hour half-life and, therefore, limit any dose adjustments to no sooner than every five days. The analgesic half-life of methadone is much shorter — around 6-12 hours — but this allows for a once or twice daily dosing option.

Many QTc-prolonging drugs are used in palliative medicine. Additionally, many patients may have a history of cardiac arrhythmia or even QTc prolongation. This should be considered within the goals of care established for the patient, and careful monitoring alone may be considered adequate for patients in hospice care. Establishing a baseline EKG is recommended when methadone is used in palliative care patients. The EKG should be repeated with dose changes.

Prescribing

Generally, methadone is considered a second- or third-line pain analgesic but can be considered as first-line therapy when good patient education and thorough monitoring are established. Opiate-naive patients or patients whose calculated morphine milligram equivalent daily dose (MME/D) is less than 60 mg/day should be prescribed no more than 7.5 mg of methadone/day in daily or divided doses. For frail elderly patients, consider dosing 1.25-2.5 mg/day or lower as a single dose.

Dose adjustments should not be made sooner than every five days and by dosages no greater than 5 mg/day.

Best practices:

- Have nurse contact patient daily for first five days of use
- Avoid using benzodiazepines with methadone
- Follow dosing guidelines
- **Do not use PRN methadone**

Managing Care for Patients ... (continued)

Dose conversions

When calculating the dose conversions for patients on larger morphine or other opioid doses, multiple conversion methods are available. The most useful employs conversion factors of 10:1 and 20:1 based on MME/D below or above 200 mg (see table) and age. If the patient's age is 65 or over, use the 20:1 ratio. Regardless of the final conversion dose, the maximum daily methadone dose is no more than 30 mg/day (10 mg three times a day). This dosage scheduling may sound low, but it is effective, even for patients who were previously on a very high morphine or morphine-equivalent dose.

Dose adjustments should be limited to no sooner than every five days and by dosages no greater than 5-10 mg/day. Let patients know it takes almost a full week to see all of the benefits and achieve excellent results from using this drug.

Low-dose adjuvant regimen

An additional strategy is utilizing adjuvant dosing of methadone, adding a low 2.5-5 mg/day methadone dose to the patient's current daily pain regimen. Studies have shown that very low doses of methadone can achieve considerable improvement in pain response, even for patients on very high morphine-equivalent doses of other opioids. The addition of low-dose, once-daily methadone may slow the development of tolerance and escalation of the primary opioid dose.

Dosing

Methadone is available as a 5 mg and 10 mg tablet, as well as in liquid form as 10 mg per ml. Methadone should not be prescribed on an as-needed, PRN or breakthrough dosing basis because of its complex pharmacokinetics, significant drug interactions and serious side-effect potential. Continue to use an immediate release morphine, hydrocodone or oxycodone for breakthrough dosing.

Managing Care for Patients ... (continued)

Dosing examples

Example 1	Mrs. G. is on 60 mg of OxyContin® every 12 hours. She takes 10 mg of oxycodone every 4 hours as needed and takes two breakthrough doses daily.	Total 24-hour MME = 210 mg Using a 20:1 conversion = 10 mg of methadone total or 5 mg twice a day	Continue oxycodone for breakthrough.
Example 2	Mr. S. is a 70-year-old male on 60 mg of MS Contin® every 12 hours and uses morphine sulfate immediate release 15 mg every 2 hours as needed. He is having a shooting, burning pain in his neck and back, and it is believed secondary to a neuropathic component. He takes two breakthrough doses daily.	Total 24-hour morphine = 160 mg Using a 20:1 conversion (because of his age) = 8 mg of methadone	Start methadone at 2.5 mg three times a day and continue using morphine sulfate immediate release for breakthrough.
Example 3	Ms. W. is an 88-year-old female with generalized contractures, moans in pain when repositioned and is not currently on any opiate medications.		Start low, likely 1 mg twice or once a day, and monitor. Use Tylenol® for breakthrough.

Managing Care for Patients ... (continued)

Summary

Opioid-naive patients or patients on less than 60 MME/D should receive a maximum of only 7.5 mg/day of methadone given in divided doses. (*Use whole number dosing if using the liquid formulation – 2 mg [0.2 ml], 5 mg [0.5 ml], etc.*) Generally, 5-10 mg twice daily dosing is sufficient for patients being switched from other opioid medication, but base your conversions on following the methadone prescribing guide.

- Remember the maximum dose is 30 mg of methadone per day in divided doses when initially converting patients to methadone from other opioids.
- Liquid formulation dosing allows for dose adjustments without having to order or wait for new prescriptions.
- When switching to methadone, stop the old and start the new. Use short-acting morphine or oxycodone for breakthrough dosing.
- Avoid using PRN methadone due to risk and toxicity.
- Do not increase methadone dose sooner than every five days in an outpatient setting.
- Monitor the effects of methadone, watching for sedation.
- At each visit, monitor respiratory rate. If less than 9, hold next methadone dose until respiratory rate is 10 or greater.
- Remember it takes a few days to kick in and two to three days generally is too short a time to see full results.

COMPLIANCE NOTICE

Avoid methadone unless trained in its use methadone varies wildly from person-to-person and its effect on breathing is disproportionate to its analgesic effect. It's very easy to overdose on methadone and is the reason why it accounts for only 5% of opioid prescriptions but 30% of opioid deaths.

Although often considered a drug of last resort in hospice and palliative care, methadone is an excellent opiate choice, offering a once- or twice-daily dosing option, powerful analgesia in a small volume, with excellent bioavailability and low cost.

Patients to avoid methadone:	Drugs with unpredictable methadone metabolism:	Excellent choice for patients:
• Life expectancy less than seven days • Unreliable caregiver support • Patients with unpredictable adherence to medications *(taking more or less than prescribed)* • Individuals with history of arrhythmia or syncope • Transplant patients • Pronounced liver failure	• Alprazolam • Cannabis • Dextromethorphan • Meclizine • Methylphenidate • SSRIs • TCAs	• Potent analgesic • Lipophilic • NMDA antagonist • Twice-daily dosing option • Drug of choice for patient refractory to other opioids or intolerant

Managing Care for Patients ... (continued)

Methadone Prescribing Guide

Methadone Prescribing Guide[20]

Opiate-Naive Dosing: 2.0-2.5 mg two to three times daily

(consider 2.5 mg once daily in frail elderly)

Do not use > 7.5 mg/day

Do ***not*** increase dose by more than 5 mg/day every five days

CONVERSION TABLE

< 60 mg MME/D	Use	Opiate Naive Dosing
60-200 mg MME/D Age < 65	Use	10:1
> 200 mg MME/D or age ≥ 65	Use	20:1

MME/D = Morphine Milligram Equivalent/Day

DO NOT USE > 30 mg/day regardless of conversion dose

(10 mg three times a day maximum)

Do ***not*** increase dose by more than 10 mg/day every five days

Consider adjuvant dosing: 5 mg daily
Dosage forms tab: 5 mg, 10 mg;
SOL: 10 mg per ml

[20] Safe and Appropriate Use of Methadone in Hospice and Palliative Care: Expert Consensus White Paper J Pain Symptom Manage 2019;57:635-645

Managing Care for Patients ... (continued)

Buprenorphine (Butrans®, Suboxone® and Subutexe®)

Buprenorphine is another medication to treat opioid-use disorder (OUD). While prescribing buprenorphine specifically for OUD requires an 8- to 5-hour course of training followed by an application to the DEA for an "X" waiver, no additional DEA credentialing is required when it is prescribed to treat pain. **Note:** Buprenorphine is also approved in the U.S. as an analgesic, as an IV solution and a transdermal system (Butrans®).

Buprenorphine and methadone each have unique advantages and disadvantages in treating chronic pain, while naloxone is rarely used in hospice care (see page 43). Both drugs have long half-lives, which makes them effective in treating OUD; however, buprenorphine provides patients with powerful analgesic properties without the euphoric high of other opioids. Additionally, it reduces cravings, prevents withdrawal when switching from another opioid and has less potential for abuse. Though methadone also reduces cravings, buprenorphine is only a partial opioid receptor agonist and is, therefore, more effective at preventing euphoria.

Both medications have short- and long-term side effects similar to other opioids. Methadone also has a greater potential for drug interactions. One major advantage of methadone is it is much less expensive than buprenorphine and more likely to be covered by insurance.

Opioid Debt:

Patients who are physically dependent on opioids (methadone or buprenorphine) must be maintained on their daily equivalence before ANY analgesic effect is realized with opioids used to treat acute pain.

Managing Care for Patients ... (continued)

Dosing

If buprenorphine is determined to be appropriate for a patient, prescribers have a choice between a topical and a buccal formulation. An oral regimen is not available due to its strong first-pass effect. Because it is a long-acting medication, buprenorphine cannot be given for breakthrough pain. Additionally, the sublingual formulation is approved for addiction, NOT pain treatment.

The buprenorphine transdermal patch is available in 5 mg, 10 mg and 20 mcg/hour strengths that are dosed weekly. Dosage recommendations[21] vary:

- If opioid naive, start with 5 mcg/hour, titrating every 4-7 days.
- If previously on up to 80 oral MME/day, start with 5 mg to 10 mcg/hour.
- If previously on higher oral MME/day, consider starting with 10-20 mcg/hour.
- **CAUTION:** Doses of 40 mcg/hour or higher may be associated with QT prolongation.

The buprenorphine buccal film (Belbuca®) is available in 75 mg, 150 mg, 300 mg, 450 mg, 600 mg, 750 mg and 900 mcg strengths. Dosing considerations include:

- If opioid naive, initiate treatment with 75 mcg given daily or q12. It is advised to wait four days before considering increasing dose to 150 mcg q12.
- When converting from another opioid to buprenorphine buccal film, taper current opioid to 30 oral MME before converting.
- If previously on 30-89 oral MME, initiate therapy with 150 mcg q12.
- If previously on 90-160 oral MME, initiate therapy with 300 mcg q12, titrating upward as needed.
- If previously on > 160 oral MME, consider alternative analgesic.
- **CAUTION:** Doses should be reduced by 50% in patients with severe hepatic impairment or mucositis.

When treating acute pain in patients on buprenorphine maintenance, consider using short-acting opioid agonists at high enough doses to overcome buprenorphine's partial agonism. Opioids with higher intrinsic activity at the mu-opioid receptor (morphine, hydromorphone) should be considered over opioids with less efficacy (hydrocodone). Patients requiring longer treatment should be considered for having buprenorphine replaced with methadone. A collaborative approach with the patient's addiction/pain specialist will best identify the most effective therapeutic plan.

[21] The Hospice Companion: Best Practices for Interdisciplinary Care of Advancing Illness (p. 145)

Managing Care for Patients ... (continued)

Dosing (continued)

The medication naloxone is an opioid antagonist, indicated for the complete or partial reversal of opioid overdose. While it is an effective tool in the nation's fight to stem the opioid abuse epidemic, the zeal with which it has been embraced by the regulatory community has resulted in unintended negative consequences for patients with serious or advanced illness.

Naloxone:

Naloxone is a medication that rapidly reverses the effects of opioid overdose and is the standard treatment for overdose. It is available under the brand names Evzio™ and Narcan® and is administered as a nasal spray or via injection.

In most all cases, it is best to avoid the use of naloxone in the hospice patient population as its use has the potential to cause needless, undue suffering in terminal patients.

If opioid toxicity is suspected, other interventions are encouraged first, such as:

- Decreasing the dose of opioid medication
- Increasing the interval between doses
- Holding doses of the opioid or switching to another opioid class
- Considering gentle hydration of the patient, as tolerated

Naloxone may be co-prescribed with opioids per some state guidelines; it is, therefore, important to communicate the serious risks and undue suffering this medication can impart patients at the end of life. Hospice and palliative care providers prescribe opioids as clinically indicated to alleviate pain and suffering and to allow patients to experience a peaceful death. Patients and families should be allowed to decline filling naloxone prescriptions and avoid the potential for causing pain and suffering. The final decision to co-prescribe naloxone should be individualized based on a patient's prognosis, caregiver support and individual risk profile.

COMPLIANCE NOTICE

Clinicians should consider prescribing naloxone in case of overdose for patients at higher risk, including:

- History of overdose
- Opioid doses over 50 MMEs/day
- Clinical depression
- Evidence of increased risk by other measures (behaviors, family history, PDMP, risk questionnaire)

The recommended dose is 0.4 mg for IM or 4.0 mg for intranasal use, with a second dose available, if the first is ineffective. Family members can be prescribed naloxone for use with the patient.

Managing Care for Patients ... (continued)

Dosing (continued)

Consideration for providing naloxone should be considered among following groups:

- MEDD > 100 mg/day
- History of unintentional or intentional overdose
- History of substance use disorder

The use of naloxone in the hospice patient population has the potential to cause needless, undue suffering.

Caregivers should be educated on how to properly identify an overdose. Careful consideration and caution must be exercised when providing naloxone for the terminal patient due to the similar appearance of overdose to the signs and symptoms exhibited by the dying patient. The adverse effect that administration of naloxone could cause is severe, and the unnecessary suffering caused by precipitation of a pain crisis in the dying patient is serious. Naloxone should NEVER be administered to an imminently dying patient.

Opioid Control

More than 90% of hospice and palliative care patients are prescribed opioid medications for pain management. These medications are too often diverted for unintended use by family, friends and even colleagues. According to a recent study,[22] 58% of hospices reported at least one case of confirmed or suspected diversion within the past quarter.

These troubling statistics remind us that we must consider the potential for diversion with every prescription. Though diversion is not always preventable, prescribers have an obligation to employ all possible measures to better assure medications are taken appropriately and only by the person intended. In that spirit, the following is provided as a guide in identifying, addressing and preventing diversion while still heeding the call of hospice to bring comfort to those suffering and their families.

> *"Hospice is a philosophy of care that values life from the moment it begins to the moment it ends."*
>
> *– Dame Cicely Saunders,*
> *Founder of the first hospice*

[22] Cagle JG, McPherson ML, Frey JJ, et al. Estimates of medication diversion in hospice. JAMA. 2020;323(6):566-568. doi:10.1001/jama.2019.20388.

Understanding Medication Management

Safeguarding medications in the home of a patient is a shared responsibility between the members of the patient's care team and the patient and family or caregiver. The hospice team must be adept at skillful conversations, providing patient and caregiver education, performing consistent medication reconciliation and continued attentiveness to help ensure the safety of the patient and others who may visit or reside in the patient's home.

Controlled substance prescribing

The Federal Controlled Substance Act is the principal federal law regulating the manufacturing, distribution, dispensing and delivery of drugs that have the potential for abuse or dependence. All drugs that fall under this designation are classified into five schedules as "controlled substances" depending upon their abuse potential.

Federal law states that a prescription for a controlled substance may be issued only by individual practitioners who are authorized to prescribe controlled substances by the Drug Enforcement Agency (DEA) in the jurisdiction where they are licensed to practice their profession. State prescribing laws vary and practitioners, including mid-level providers such as nurse practitioners and physician assistants, are recommended to check their respective state laws. State laws also vary regarding the ability to write or electronically submit prescriptions for controlled substances. You are encouraged to clarify the prescribing standards in your state.

Prescribing laws vary and practitioners are recommended to check their respective state laws.

Generally, unless in emergency situations, oral prescriptions for Schedule II drugs are not permitted. Check with your state's prescription drug monitoring program for specific regulations for prescribing.

Under no circumstance should a practitioner prescribe a Schedule II prescription for themself, their spouse or their children. When providing a prescription for a controlled substance, the prescriber should be aware of the following risk areas:

- Patient: history of abuse; exaggerating pain response; prone to abuse
- Prescriber: over-prescribing; prescribing too high dosage; prescribing for too long without taper; not assessing response; not documenting treatment goal; not documenting reason for prescription; poor record-keeping of prescriptions
- Pharmacist: improper filling or poor security procedures
- Facility: poor recordkeeping, monitoring of drug counts; access; poor disposal practices; education; staff training
- Family/caregivers: improper storage, handling and disposal; poor oversight

Risk reminder:

Oral or faced emergency Schedule II prescriptions should be cancelled if received at more than one pharmacy. If a pharmacy receives an order and then does not have the medication immediately or the patient requests a different pharmacy, cancel the first fax/call before providing the information to another location.

Understanding Medication ... (continued)

Safeguards for prescribers

In addition to the required security controls, practitioners can utilize additional measures to ensure security. These include:

- Keep all prescription blanks in a safe place where they cannot be stolen; minimize the number of prescription pads in use.
- Write out the actual amount prescribed in addition to giving a number to discourage alterations of the prescription order.
- Use prescription blanks only for writing a prescription order and not for notes.
- Never sign prescription blanks in advance.
- Assist the pharmacist when they telephone to verify information about a prescription order; a corresponding responsibility rests with the pharmacist who dispenses the prescription order to ensure the accuracy of the prescription.
- Contact the nearest DEA field office to obtain or to furnish information regarding suspicious prescription activities.
- Use tamper-resistant prescription pads.
- Store prescribing records. Whether a prescription is created electronically or with the proper state paper prescription, records must be kept for a minimum of two years, per DEA requirements.

According to a recent study, 58% of hospices reported at least one case of confirmed or suspected diversion within the past quarter.

Understanding Medication ... (continued)

Medication reconciliation

The responsibility on behalf of the hospice IDT begins at admission with creation of an inventory of all the patient's medications and continues with medication reconciliation on each subsequent patient encounter.

At the first nursing visit, the RN Case Manager (RNCM) should identify the reason the patient is on each medication and complete the first medication reconciliation, which should include:

- Recording the ESIDL (effectiveness, side-effects, interactions, duplications and lab monitoring needed) for each medication
- Determining the ability of the patient and/or caregiver to administer the medications safely and correctly
- Ensuring a correct medication list is in the patient's home (i.e., wherever the patient lives — personal residence, long-term care facility, assisted-living facility, etc.)
- Ensuring the patient has an adequate supply of the medications (at least a 7-day supply)
- Having a conversation with the patient/caregivers about the patient's medications

Safeguarding medications in the home of a patient is a shared responsibility between the members of the care team and the patient and family.

At the first IDT meeting, the RNCM should review the medications with the hospice physician. This review will often result in some combination of deprescribing medications, affirming or adjusting medications and prescribing new medications.

At the second nursing visit, the RNCM should have a conversation with the patient/caregivers about any medication changes and perform another reconciliation. They should also provide and review the education resource "WHEN/THEN" Guide for symptom management.

At each subsequent visit, the RNCM should observe for medication changes and perform medication reconciliation.

At each IDT meeting, the RNCM and hospice physician will review and discuss patient medications.

Understanding Medication ... (continued)

Diversion prevention strategies

The following additional steps provide a framework to support medication reconciliation by the RNCM and help ensure safe management of controlled substances in the patient's home environment:

- Assess the patient's risk of opioid abuse upon admission *(a sample Opioid Risk Assessment Tool is provided on page 70)*.
- Perform a controlled substance drug count to ensure a proper supply of medication is available and medication is being taken as prescribed.
- Confirm the importance of safeguarding medications with the patient/caregiver responsible for proper storage and administration of medications.
- Confirm the patient/caregiver agrees to administer medications according to the prescribed doses and schedule as prescribed by the provider.

Related Resources:

Safe Opioid Use Education for Patients and Caregivers
Appendix K, page 73

Patient/Family Training: Pain "WHEN/THEN" Guide
Appendix L, page 74

Procedure: Controlled Substance Count Shortage
Appendix M, page 75

Opioid Documentation Chart Audit
Appendix S, page 82

Managing Risk of Drug Diversion

Certain signs may indicate drugs are being diverted from the patient, including:

- Significant quantity of medication is missing
- Repeated small quantities of medication missing (short count)
- Claims of lost medications
- Claims the pharmacy did not completely fill the prescription or count was wrong
- Repeated requests for refills on weekends and after hours when case manager is not available

Irregular behaviors:

More predictive of OUD

- Selling prescription drugs
- Prescription forgery
- "Borrowing" medications
- Injecting oral drugs
- Multiple drugs
- Unsanctioned escalation
- Prescription losses
- Resisting change despite indications

Less predictive

- Complaining about need to increase dose
- Drug hoarding
- Specific drug request
- Use of drug to treat other symptoms
- Multiple escalations

If there is concern of possible drug diversion, the RNCM should:

- Inform the supervisor and the prescribing physician as soon as possible
- If more information is needed, or if a high probability of drug diversion is occurring, make plans to prevent further drug diversion with reasonable documentation to include:
  - Name and location of the patient
  - Medication involved and quantity missing
  - How the suspected diversion was discovered
  - Any patient-specific outcomes related to the suspected diversion
  - Name(s) of any individuals suspected of diversion

Managing Risk ... (continued)

Based on review with the hospice medical director, the RNCM may:

- Hold a family meeting to discuss options and concerns
- Initiate a controlled substance agreement
- Place a lockbox in the home
- Consider alternate locations for safe storage
- Limit access to the quantity of medication dispensed
- Change the route or type of opioid medication
- Increase visit frequency
- Increase visits by social worker or other interdisciplinary team members
- Collect urine drug screening sample
- Discuss alternate placement options
- Notify adult protective services
- Notify local police
- Recommend counseling or treatment

For additional information, please review the Abuse and Diversion Algorithm on page 71.

Proper drug disposal

Proper disposal is critical to proper opioid management in hospice. In addition to its obvious importance in preventing diversion, the literature provides tragic reports of overdose deaths of innocent children from unused medications and even used fentanyl patches pulled from the trash.

Until now, unused medications, by law, became the property of the next of kin. Consequently, only with consent, could the hospice team guide in their disposal. With the SUPPORT Act recently signed into law, that barrier is now removed.

A key provision of this new law requires destruction of opiates prior to removal from the site of care. It further stipulates that "to be held in compliance, hospices must document each step taken to dispose of medication."

Reminder:

Medication disposal is indicated not only after the passing of the patient, but also with medication changes during the course of care.

Managing Compliance

State regulations

In response to the opioid crisis, many states are implementing new laws that have the potential to impact the prescribing of opioids to hospice and palliative care patients. For example, many states require health care providers — including those in hospice and palliative care — to query a state Prescription Drug Monitoring Program database before prescribing opioids. Because these laws are highly fluid, providers should monitor state regulations closely and regularly communicate with other members of the IDT to ensure compliance.

Chart audits

Just as we continually monitor the effectiveness of opioids at relieving our patients' pain, we must also assess our own effectiveness in safely prescribing them. These assessments should include regular chart audits to ensure the use of standardized documentation and evidence-based prescribing with attention to quality measures. Additionally, reviewing the Medication Administration Record (MAR) at each IDT meeting cannot be over-emphasized. In addition to assuring evidence-based prescribing and quality measures, such review should describe opioid and non-opioid medications when indicated and ensure medications no longer used have been removed.

The sample Opioid Documentation Chart Audit on page 82 can be used to analyze opioid prescribing patterns, ensure compliance with state prescription drug monitoring programs and identify areas for improvement. For example, physicians and RNCMs should assess whether patient education or a bowel regimen was provided with each prescription. Such checks not only ensure good practices are in place, but also help identify where processes may be breaking down and why. Audit results should be shared with all relevant members of the IDT to ensure a focus on continued improvement.

Conclusion:

Despite our nation's growing opioid crisis, opioid medications remain a critical component of end-of-life care, providing much-needed relief and peace of mind to patients and their loved ones.

As providers of hospice and palliative care, we have an obligation to ensure these powerful medications are used safely and appropriately to provide maximum benefit to the patient while minimizing the risk of abuse and diversion. It is an obligation that requires us to remain ever vigilant in our use and stewardship. We hope the information in this guide is valuable not only in the day-to-day delivery of care, but also as a reminder of the important role hospice and palliative care professionals play in ensuring opioids remain readily available to those who need them most.

Appendices
Forms & Policies

Non-Pharmacological Pain Relief Techniques For Patients and Caregivers

What you can do:

- **Relaxation techniques:** Guided imagery, meditation, prayer, music or deep breathing. With the patient closing their eyes, in a soft, calm voice, guide the patient through images, prayer or deep breathing.
- **Heat/cold application** can be used to ease localized pain. Alternating trials of both may be beneficial.
    - **Cold pack:** Place crushed ice in plastic bag to prevent leakage. Wrap in towel and apply for 10 minutes every hour.
    - **Warm pack**: Beans or rice can be placed in cotton tube sock. Fill, tie knot at end, place tied sock inside second comfy sock, microwave 1-2 minutes. Apply 10 minutes every hour; ensure temperature is not hot enough to burn skin.
- **Comfort positioning:** Adjusting body, pillows, blankets and temperature. Ensure needed items are easily within reach.
- **Touch:** Gentle holding hands and/or massaging of the palm.
- **Aromatherapy:** Lavender, chamomile and rose have been shown to relieve pain, as have peppermint, eucalyptus and lemongrass. Try oils, candles or lotions.
- **Conversation:** Distraction can change the physiologic response of pain transmission. Topics might include family, hobbies or sports. Pain can be reduced by up to 25% through distraction. Use a calm, soft voice and talk with or without questions.
- **Progressive Muscle Relaxation (PMR):** In a calm voice, instruct patient to tighten and relax muscles. Start with the forehead and gradually move down the major muscle groups of the body. *Example:* forehead, jaw, shoulders, back, belly, front of legs, buttocks, calves, feet, etc. Ask them to tense each muscle for 10 seconds, then relax.
- **Massage:** Produces variable and unpredictable results but there is usually a reduction in the intensity of pain during a massage and for a short period after. Consider applying lotion, giving a back rub, neck rub or foot rub. Generally, do not massage legs or calf muscles due to risk of vascular clot.
- **Distraction:** Help change the patient's attention to stimuli other than pain. Types of distraction include TV, movies or listening to music.

Pain Assessment Tools

Brief Pain Inventory

Brief Pain Inventory—*Short Form*

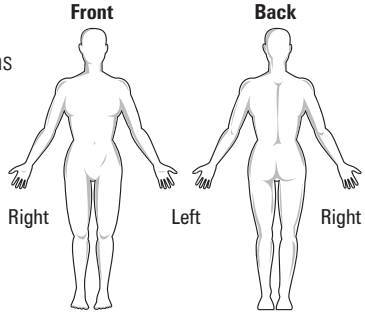
First Name _____ Date _____

Last Name _____ Time _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

❑ Yes ❑ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

5. Please rate your pain by circling the one number that best describes your pain on the **average**.

No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

6. Please rate your pain by circling the one number that tells how much pain you have **right now**.

No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

Cont'd ▶

Pain Assessment Tools

Brief Pain Inventory (continued)

Brief Pain Inventory—*Short Form (cont'd)*

7. What treatments or medications are you receiving for your pain?

_____

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **relief** you have received.

No relief | 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% | Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

B. Mood

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

C. Walking ability

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

D. Normal work (includes both work outside the home and housework)

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

E. Relations with other people

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

F. Sleep

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

G. Enjoyment of life

Does not interfere | 0 1 2 3 4 5 6 7 8 9 10 | Completely interferes

Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. *Ann Acad Med Singapore*. 1994;23(2):129-138.

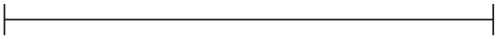
Source:
Developed by Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore. 1994;23(2):129-138.

Pain Assessment Tools

Memorial Pain Assessment Card

Memorial Pain Assessment Card

4 Mood Scale



Worst mood — Best mood

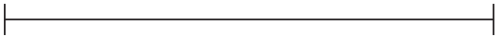
Put a mark on the line to show your mood.

2 Pain Description Scale

Moderate
Just noticeable
Strong
No pain
Mild
Excruciating
Severe
Weak

Circle the word that describes your pain.

1 Pain Scale

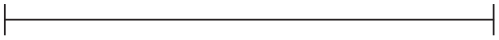


Least possible pain — Worst possible pain

Put a mark on the line to show how much pain there is.

Fold page along broken line so that each measure is presented to the patient separately in the numbered order.

3 Relief Scale



No relief of pain — Complete relief of pain

Put a mark on the line to show how much relief you get.

Source:
https://pubmed.ncbi.nlm.nih.gov/3300951/ Developed by Fishman B, Pasternak S, Wallenstein SL, et al. The Memorial Pain Assessment Card. A valid instrument for the evaluation of cancer pain. Cancer. 1987 Sep;60(5):1151-1158. DOI: 10.1002/1097-0142(19870901)60:5<1151: aid-cncr2820600538>3.0.co;2-g

Pain Assessment Tools

Numeric Rating Scale

The numeric rating scale is one of the most commonly used pain scales in medicine. The NRS consists of a numeric version of the visual analog scale. The most common form of the NRS is a horizontal line with an 11-point numeric range. It is labeled from zero to 10, with zero being an example of someone with no pain and 10 being the worst pain possible. This type of scale can be administered verbally. It can also be administered via paper to be completed physically.

The Pros and Cons of the Numeric Rating Scale:

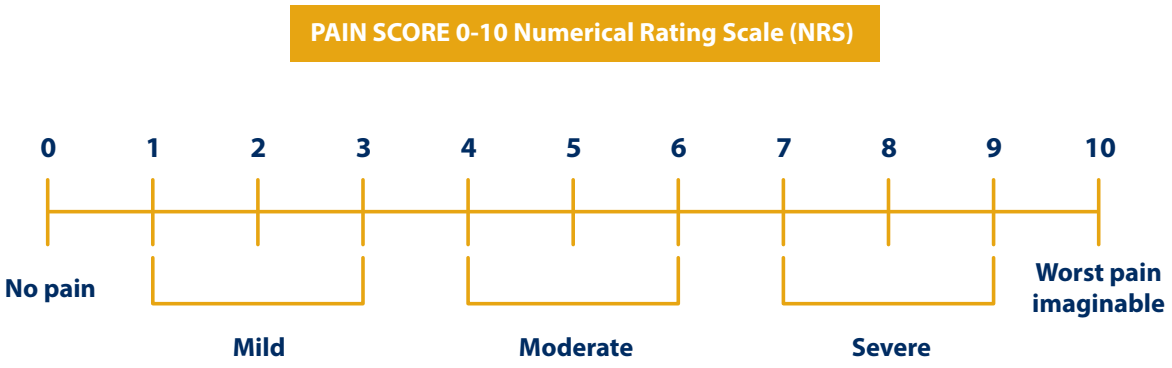
Pros

- It takes less than a minute to complete.
- It takes less than a minute to administer and score.
- The numeric scale allows it to be used internationally without translation difficulties.
- It has been deemed valid and reliable for rating pain intensity.
- It can be administered verbally and in writing, making it accessible for more people.

Cons

- It only evaluates one aspect of pain: intensity.
- It does not factor in past pain experiences.
- It does not factor in fluctuations in pain.
- It only evaluates pain experienced in the last 24 hours or "an average pain intensity."

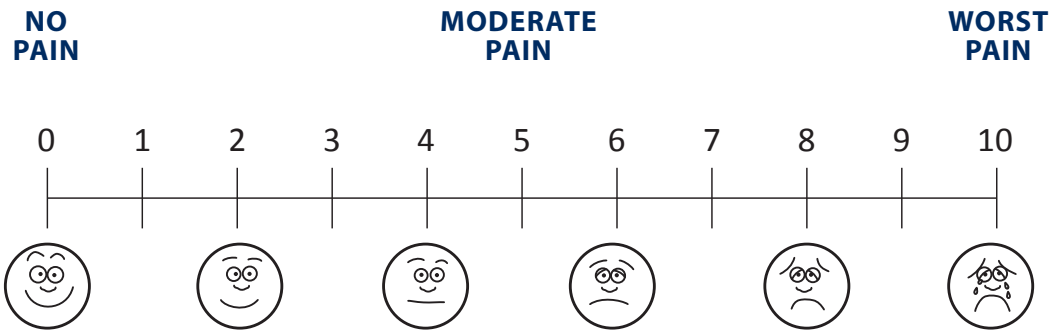
The numeric rating scale is a scale designed to help assess the extent of an individual's pain and improve communication regarding pain with health care providers. This scale can help guide the diagnostic process, track the progression of the pain and more. Many hospitals use the NRS on whiteboards in hospital rooms daily to measure pain levels.



Source:
National Center for Biotechnology Information, U.S. National Library of Medicine. Article Citation Haefeli, M., & Elfering, A. (2006). Pain assessment. European spine journal: official publication of the European Spine Society, the European Spinal Deformity Society, and the European Section of the Cervical Spine Research Society, 15 Suppl 1(Suppl 1), S17–S24. https://doi.org/10.1007/s00586-005-1044-x

Pain Assessment Tools

Wong-Baker FACES® Pain Rating Scale



1-3 = MILD	4-6 = MODERATE	7-10 = SEVERE

Source:
Wong-Baker FACES Pain Scale (From Hockenberry, M. J., Wilson, D., Winkelstein, M.L. (2005). Wong's Essentials of Pediatric Nursing, 7th Ed., St. Louis, MO: Mosby, p. 1259. ISBN 9780323222419

Pain Assessment Tools

Pain Assessment in Advanced Dementia (PAINAD) Scale

Pain Assessment in Advanced Dementia (PAINAD) Scale

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc*. 2003;4(1):9-15.

1

Source:
Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. J Am Med Dir Assoc. 2003;4(1):9-15.

Pain Assessment Tools

Pain Assessment in Advanced Dementia (PAINAD) Scale (Continued)

PAINAD Item Definitions

(Warden et al., 2003)

Breathing

1. *Normal breathing* is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. *Occasional labored breathing* is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. *Short period of hyperventilation* is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. *Noisy labored breathing* is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. *Long period of hyperventilation* is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. *Cheyne-Stokes respirations* are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. *None* is characterized by speech or vocalization that has a neutral or pleasant quality.
2. *Occasional moan or groan* is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. *Low level speech with a negative or disapproving quality* is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. *Repeated troubled calling out* is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. *Loud moaning or groaning* is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. *Crying* is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. *Smiling or inexpressive*. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. *Sad* is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. *Frightened* is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. *Frown* is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. *Facial grimacing* is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. *Relaxed* is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. *Tense* is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. *Distressed pacing* is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. *Fidgeting* is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. *Rigid* is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. *Fists clenched* is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. *Knees pulled up* is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. *Pulling or pushing away* is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. *Striking out* is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. *No need to console* is characterized by a sense of well-being. The person appears content.
2. *Distracted or reassured by voice or touch* is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. *Unable to console, distract, or reassure* is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

2

Source:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. J Am Med Dir Assoc. 2003;4(1):9-15.

Pain Assessment Tools

FLACC (Face, Legs, Activity, Cry, Consolability) Pain Scale

FLACC Scale
(Face, Legs, Activity, Cry, Consolability)

INSTRUCTIONS:

Rate patient in each of the five measurement categories.
Add together to determine total pain score.

	0	1	2
Face	No particular expression or smile, eye contact and interest in surroundings	Occasional grimace or frown, withdrawn, disinterested, worried, look to face, eyebrows lowered, eyes partially closed, cheeks raised mouth pursed	Frequent to constant frown, clenched jaw, quivering chin, deep furrows on forehead, eyes closed, mouth opened, deep lines around nose/lips
Legs	Normal positions or relaxed	Uneasy restless, tense, increased tone, rigidity, intermittent flexion/extension of limbs	Kicking or legs drawn up, hyperonicity, exaggerated flexion/extensions of limbs, tremors
Activity	Lying quietly, normal position, moves easily and freely	Squirming, shifting back and forth, tense, hesitant to move, guarding, pressure on body part	Arched, rigid, or jerking, fixed position, rocking, side to side head movement, rubbing of body part
Cry	No cry or moan (awake or asleep)	Moans or whimpers, occasional cries, sighs, occasional complaint	Crying steadily, screams, sobs, moans, grunts, frequent complaints
Consolability	Calm, content, relaxed, does not require consoling	Reassured by occasional touching, hugging, or talking to, distractable	Difficult to console or comfort

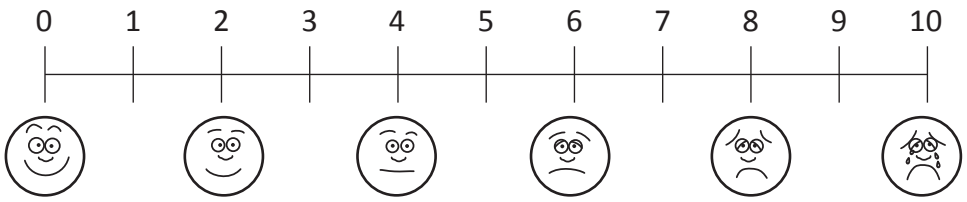
compassus.com

COMPASSUS®

Source:
APA Crellin, Dianne J.a,b,c,*; Harrison, Denise a,b,d; Santamaria, Nicka; Babl, Franz E.b,c,e Systematic review of the Face, Legs, Activity, Cry and Consolability scale for assessing pain in infants and children, PAIN: November 2015 - Volume 156 - Issue 11 - p 2132-2151 doi: 10.1097/j.pain.0000000000000305

Pain Assessment Tools

Pain Enjoyment and General Activity (PEG) Scale



PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Computing the PEG Score.
Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of points.

Using the PEG Score.
The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Source:
Krebs, E. E., Lorenz, K. A., Bair, M. J., Damas, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

APPENDIX C

Pain Management Policy

Summary

Compassus follows strong policies and procedures to ensure appropriate assessment, treatment and prevention of pain. While pain levels, interventions and outcomes are fully assessed and documented by nursing staff at each visit, the patient is the ultimate authority on their pain. Each patient is asked to set a self-identified threshold (SIT) against which pain control efforts should be measured. The patient and IDT members work together to ensure the patient is not only satisfied with the efforts of the IDT, but also their daily pain levels. Nursing staff work closely with physicians to adjust pain medications accordingly and provide continued follow-up to assess and document effectiveness until pain control is achieved.

Compassus colleagues may access the full policy at:
iConnect > Regulatory > Policies & Procedures - procedure C_08A

APPENDIX D

Medical Cannabis Policy

Summary

Compassus provides guidelines for patient use of marijuana, CBD and cannabis-infused products. In recognition of the fact that marijuana is federally listed as a Schedule I compound (no accepted medical use), marijuana is not prescribed. In states where it is legal, the provider must complete an attestation or authorization form that states the reason for use. In addition, use of any CBD, cannabis-infused products and marijuana is included in the medication reconciliation and documented in the medication profile along with the reason for use. Providers also provide patients with suitable alternative.

Compassus colleagues may access the full policy at:
iConnect > Regulatory > Policies & Procedures - procedure C_29H

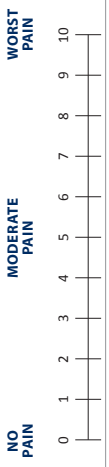
Ensuring Right Meds/Right Time (Dosing Guidelines & Considerations)

ASK about health care goals

FLACC BEHAVIORAL PAIN ASSESSMENT SCALE

Behavior	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position, relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position	Sc sh	
Cry	No cry (awake or asleep)	M wl	
Consolability	Content, relaxed	Re to or to	

Instructions: Rate patient in each of the Add together to determine total pain sc



OPIOID SIDE EFFECTS

CONSTIPATION

- Always co-prescribe a bowel regimen
- Patients do not develop tolerance to this S.E.
- See Bowel Regimen Guidelines below

NAUSEA

- Tolerance generally develops in 3-5 days

TOTAL PAIN MANAGEMENT

CONSIDER all aspects of pain

TOTAL PAIN ASSESSMENT

Ensure Right Meds/Right Time

OPIOIDS

	IV	PO	DURATION	CONSIDERATIONS
Morphine Conc. (20 mg/ml) IR Tabs (15,30 mg) ER Tabs (15,30,60,100 mg)	10 mg	30 mg	3-6 hrs 8-12 hrs	Impaired liver function: Try to avoid; Avoid ER in cirrhosis Impaired renal function: Avoid; build-up of active metabolites DO NOT CRUSH ER TABLETS
Hydromorphone IR Tabs (2,4, 8 mg) Solution (1 mg/ml)	1.5 mg	7.5 mg	4-5 hrs	Impaired renal function: Good alternative to morphine
Fentanyl				See Fentanyl Table
Methadone				See Methadone Table
Oxycodone IR Tabs (5,10,15,20,30 mg) Oxy conc (20 mg/ml) CR Tabs (10, 20, 40, 80 mg)	-	20 mg	3-6 hrs 8-12 hrs	Impaired renal function: Alternative to hydromorphone **OXYCODONE IS NONFORMULARY** **DO NOT CRUSH**
Hydrocodone/APAP Tabs (5/325; 10/325 mg) Soln (2.5/108 mg/5 ml)	-	30 mg	4-6 hrs	Ceiling on dosing due to APAP (<3 gm/day)
Codeine/APAP Tabs (30/300 mg, 60/300 mg)	-	200 mg	4-6 hrs	Prodrug: Requires P450 enzyme (absent in 10% population) to make active drug. Impaired liver or renal function: Avoid
Tramadol (atypical opioid) Tabs (50 mg)	-	200 mg	4-6 hrs	Max: 400 mg/day; Seizure precautions; Avoid with SSRI—risk of serotonin syndrome. Impaired liver or renal function: Avoid

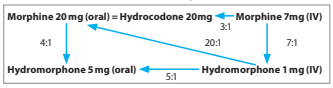
NON-OPIOID MEDICATIONS

NSAID Ibuprofen Naproxen	400-800 mg po 3-4x daily 250 mg po 3-4x daily	Avoid in renal impairment; GI toxicity Max. dose 3,200 mg/day Max. dose 1,500 mg/day
Acetaminophen (APAP)	500 mg -1 gm po 3x daily	Max dose 3 gm/day
Lidocaine 5% — ointment	Apply to affected area 3-4x daily	**LIDOCAINE PATCH IS NONFORMULARY**
Capsaicin Cream (0.025%, 0.075%)	Apply to intact skin 3-4x daily	May cause burning sensation and rash
SNRI Duloxetine (Cymbalta) Venlafexine (Effexor)	30 mg po daily x 1 week then 2x daily 37.5 mg daily x 1 week then 75mg po daily	ADE's: Nausea, dizziness, sweating, constipation Doses higher than 60 mg of no benefit and >SE May need doses >150 mg to see benefit
TCA Amitriptyline (Elavil) Nortriptyline (Pamelor)	10-25 mg po 1x nightly 10-25 mg po 1x nightly	Not recommended in CV disease, glaucoma Titrate (dose range for pain is 75-150 mg/day) Titrate (dose range for pain is 50-150 mg/day)
Gabapentin (Neurontin)	100mg nightly trial; Consider titrate: 300 mg nightly x3 nights then 2-3x daily	Titrate if no effect at lower dose (minimal dose generally useful for neuropathy is 900 mg/day)
Dexamethasone	2-8 mg daily	Adverse effect = high blood sugar, thrush, delirium, dyspepsia

IV PCA (Morphine is the drug of choice; PCA should be initiated after initial loading dose of morphine 5-20 mg)

OPIOID	LOAD	DEMAND	LOCK-OUT	BASAL
Fentanyl	25 mcg	10-25 mcg	every 8 min	10-25 mcg every 1 hr
Hydromorphone	0.5 mg	0.2 mg	every 10 min	0.1-0.3 mg every 1 hr
Morphine	2 mg every 5 min. Max: 20 mg	1 mg	every 10 min	1-2 mg every 1 hr

MORPHINE-DILAUDID EQUIDOSING RULER



METHADONE PRESCRIBING GUIDE

Opiate Naïve	2.5 – 5 mg 2-3x daily	Do not use >7.5 mg/day in naïve patient Do not increase dose by >5 mg/day every 5 days
Age > 65 or < 60 MME/day	use	Opiate Naïve dosing
60 – 200 MME/ day	use	10:1
> 200 MME/day	use	20:1

- Use short-acting opioid (morphine) for breakthrough, do not use methadone as needed.
- Methadone is optimal in setting of impaired renal function, no dose adjustment.
- Methadone has a variable half-life (12-120 hours), which is why no as needed use.
- Consider checking baseline QT, especially for doses greater 100 mg/day (rare).
- Always hold for sedation when initially prescribing or changing doses.
- ***Once daily dosing of 2.5-5 mg is an effective adjuvant dosing strategy***
- **MME = Morphine Milligram Equivalent**

FENTANYL CONVERSION GUIDELINES

- Determine dose by 24-hour morphine equivalent
- 12-24 hrs for peak effect
- Change patch every 72 hrs
- DO NOT CUT PATCH
- Takes 17 hrs for 50% to wear off after patch removal
- Remove patch 6-12 hrs before rotating to another long-acting opioid
- CAUTION: Avoid hot showers, use in high fever which may cause increase in release of fentanyl from the patch

Oral 24-hr MME (mg/day)	Fentanyl Patch (mcg/hr)
30-60 mg	12 mcg
60-134 mg	25 mcg
135-224 mg	50 mcg
225-314 mg	75 mcg
315-404 mg	100 mcg

Tables are guides only.

Equianalgesic doses do not represent starting doses.

Increase doses based on severity of pain:
- Mild-to-moderate pain: increase dose by 25-50%
- Moderate-to-severe pain: increase dose by 50-100%

Titrate dose to clinical response (consider using functional outcomes).

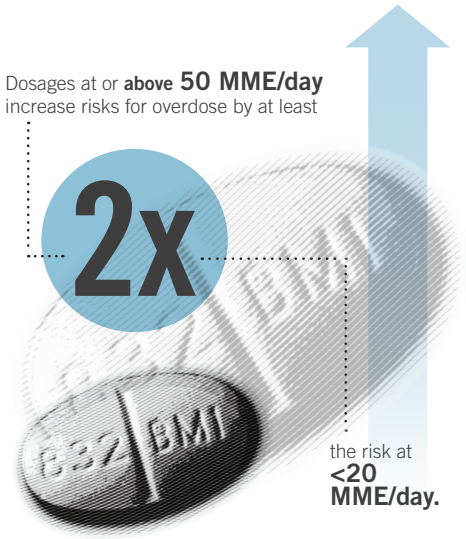
When converting from one opioid to another, decrease the equianalgesic dose by 25-50% to allow for the effect of cross-tolerance between opioids.

Daily Opioid Dosage Calculator (Centers for Disease Control)

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

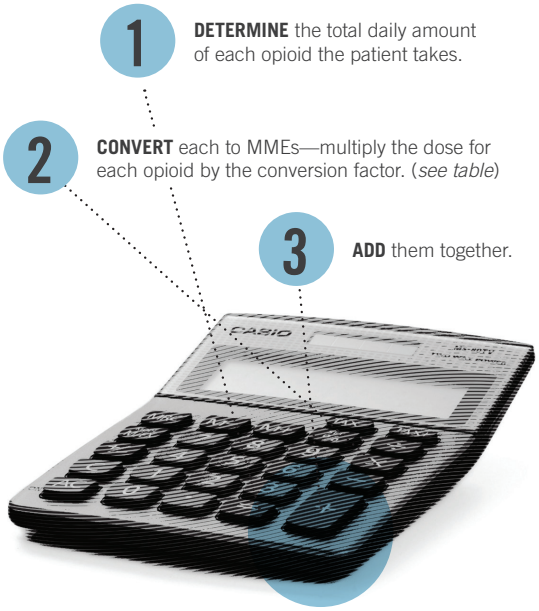
- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Daily Opioid Dosage Calculator (continued)

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Opioid Conversion Table (American Academy of Family Physicians)

Opioid Conversion Table

Chronic Pain Management Toolkit

Calculating total daily doses of opioids is important to appropriately and effectively prescribe, manage, and taper opioid medications. There are a number of conversion charts available, so caution is needed when performing calculations. As with all medications, consulting the package insert for dose titration instructions and safety information is recommended. Treatment should be individualized and begin with lower doses and gradual increases to manage pain.

Once the dose is calculated, the new opioid should not be prescribed at the equivalent dose. The starting dose should be reduced by 25-50% to avoid unintentional overdose due to incomplete cross-tolerance and individual variations in opioid pharmacokinetics. This dose can then be gradually increased as needed.

To calculate the total daily dose:

1. Determine the total daily doses of current opioid medications (consult patient history, electronic health record, and PDMP as necessary).
2. Convert each dose into MMEs by multiplying the dose by the conversion factor.
3. If more than one opioid medication, add together.
4. Determine equivalent daily dose of new opioid by dividing the calculated MMEs of current opioid by new opioid's conversion factor. Reduce this amount by 25-50% and then divide into appropriate intervals.

Calculating Morphine Milligram Equivalents (MME)*			
Opioid	**Conversion Factor** (convert to MMEs)	**Duration (hours)**	**Dose Equivalent Morphine Sulfate (30mg)**
Codeine	0.15	4-6	200 mg
Fentanyl (MCG/hr)	2.4		12.5 mcg/hr**
Hydrocodone	1	3-6	30 mg
Hydromorphone	4	4-5	7.5 mg
Morphine	1	3-6	30 mg
Oxycodone	1.5	4-6	20 mg
Oxymorphone	3	3-6	10 mg
Methadone†			
1-20 mg/d	4		7.5 mg
21-40 mg/d	8		3.75 mg
41-60 mg/d	10		3 mg
≥61 mg/d	12		2.5 mg

**The dose conversions listed above are an estimate and cannot account for an individual patient's genetics and pharmacokinetics.*
***Fentanyl is dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors.*
†Methadone conversion factors increase with increasing dose.

Sample Case

Your patient is a 45-year-old man who is taking oxymorphone 10 mg 4 times a day for chronic pain. You have determined he is an appropriate candidate for a long-acting regimen and decide to convert him to extended release oxycodone.

1. Total daily dose of oxymorphone → 10 mg X 4 times /d = 40 mg/d
2. Convert to MMEs (oxymorphone conversion factor = 3) →40 X 3 = 120 MME
3. Determine MMEs of oxycodone (oxycodone conversion factor = 1.5) → 120/1.5 = 80 mg/d
4. Decrease dose by 25% → 25% of 80 = 20 → 80 - 20 = 60
5. Divide by interval (q 12 hours) → 60/2 = 30

The starting dose of extended release oxycodone is 30 mg q 12h.

Additional Resources

CDC Opioid Conversion Guide
https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

AMERICAN ACADEMY OF FAMILY PHYSICIANS

HOP16091451

Opioid Risk Assessment Tool

Opioid Risk Assessment Tool

COMPASSUS®

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicated low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16–45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
SCORING TOTALS		

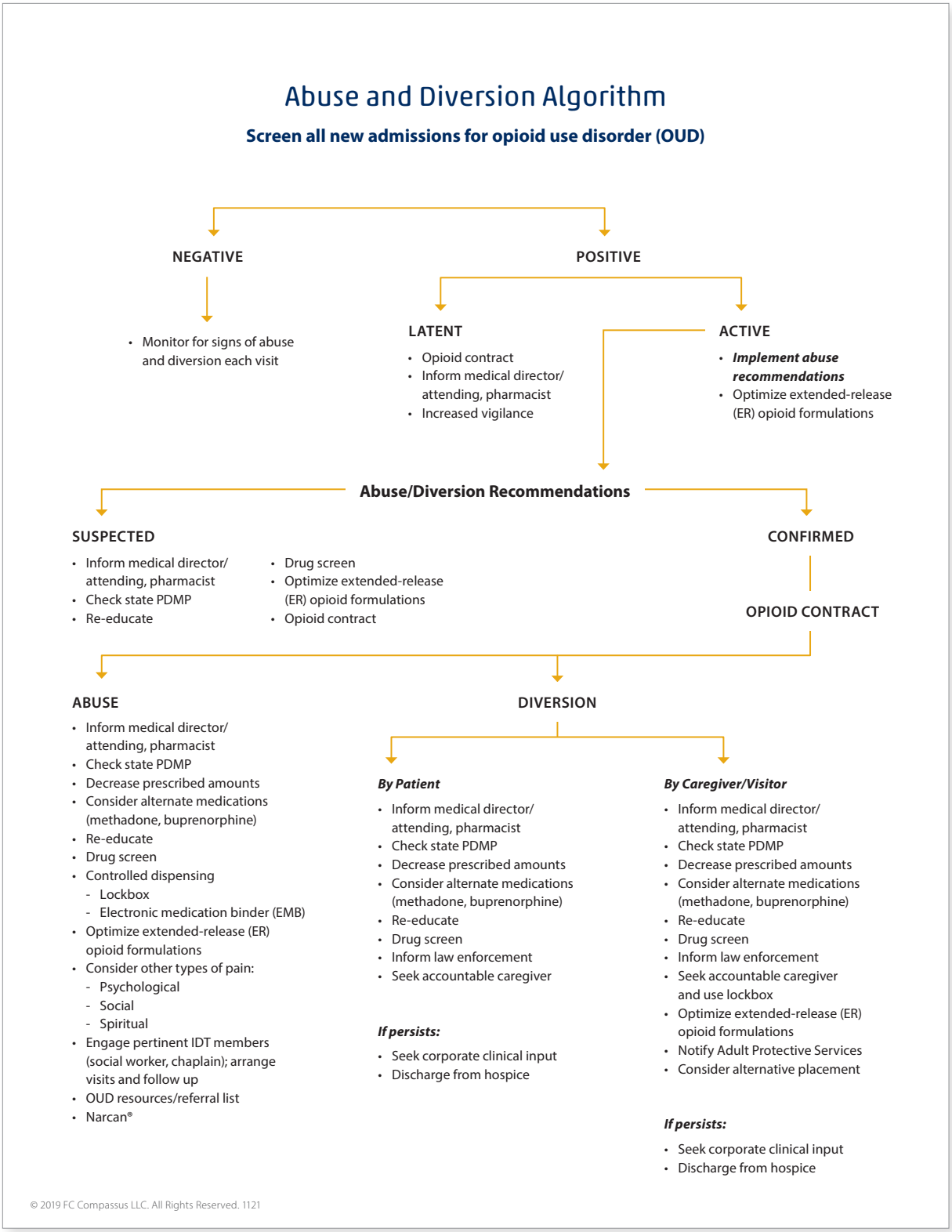
TOTAL SCORE RISK CATEGORY

Low Risk: 0–3 **Moderate Risk:** 4–7 **High Risk:** 8 or more

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.
Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6): 432.

1121

Abuse and Diversion Algorithm



Opioid Prescribing Algorithm

Opioid prescribing algorithm:

Always optimize extended-release (ER) opioids when abuse or diversion is suspected or confirmed.

Begin with the lowest-effective dose and frequency.
Remember: Zero pain score is not the goal.

Increase frequency and dose.
Goal: Seek adequate pain control for optimal function (PEG tool).

Consider extended-release opioid when daily morphine milligram equivalent (MME) exceeds lowest extended-release dose and more frequent immediate-release dosing *(i.e., every 8-12 hours).*
Remember: Adjust for incomplete cross-tolerance when changing opioids.

Increase extended-release formulations as needed to minimize immediate-release use.

Safe Opioid Use Education for Patients and Caregivers

COMPASSUS®

Safe Opioid Use Education for Patients and Caregivers

Our goal is to help you control your pain and avoid serious side effects of medications.

- If the pain medications you are prescribed are not working, call _____.
- Do not adjust your dose on your own as this may increase the risk of side effects.
- The benefits of opioid pain medications include improvement in pain control, level of functioning, sleep and energy.
- Adverse effects include constipation, nausea, sedation, impaired respiration and even death, so it is important to only use these mediations as directed by your physician/provider.
- We advise that you not drive or operate machinery while taking opioid medications or other medications that can slow your reflex time or cause sleepiness, unless directed by your physician/provider.
- Federal and state laws prohibit transfer, use, or further distribution of any controlled drug, including all prescription medications, to anyone other than the patient for whom they are prescribed.
- Only the patient and a family member who has been instructed to help with medications shall have access to your pain medications. Other people could be harmed if they take medications prescribed for you, so it is important that you keep your prescriptions and medications secure and under your control. A lockbox may be necessary to protect medications.
- Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and must be closely safeguarded. It is expected that you will take the highest possible degree of care with your medications and prescriptions. They must not be left where others might see or otherwise have access to them.
- Medications no longer needed for your pain must be disposed of properly.
- We can contact the State Prescription Monitoring Program for prescription review.

Pain "WHEN/THEN" Guide for Patients and Caregivers

Patient/Family Training

Pain

COMPASSUS®

(MILD 0-3; MODERATE 4-6; SEVERE 7-10)

WHEN:	**Mild pain**
THEN:	**Acetaminophen (Tylenol) 1000 mg every 8 hours as needed (do not exceed 3000 mg in 24 hours)**
WHEN:	**Moderate or worsening pain**
THEN:	**If no morphine, take 600 mg ibuprofen and call Compassus (single dose unless otherwise prescribed. Do not take if gastrointestinal, heart or significant renal disease are present)** **If hydrocodone: Take 5 mg every 4 hours as needed** **If morphine: Take 5 mg every 4 hours as needed**
WHEN:	**Worsening pain or no relief after 2 hours or more**
THEN:	**Take additional dose of 5 mg (hydrocodone or morphine) and call Compassus (#_____)**
WHEN:	**Worsening pain or no relief**
THEN:	**_____** **And notify Compassus (#_____)**

COMMON OPIOID SIDE EFFECTS:

- Constipation (very common – ensure concurrent use of laxative)
- Nausea and vomiting (common – call Compassus if present)
- Drowsiness – usually goes away after a few days
- Confusion – may also have hallucinations
- Shaking – (not common – call Compassus if present)
- Dry mouth (very common – frequent mouth care is important)

compassus.com

Controlled Substance Count Shortage Procedure

Summary

Compassus follows strong policies and procedures to ensure appropriate administration of controlled substances, discourage medication shortages and promote consistency in handling controlled substance shortages. All Schedule II, III and IV drugs are regularly inventoried and recorded. In the event of a count shortage, the case manager will discuss the shortage with the patient and family, and notify the director of clinical services, attending physician, medical director and pharmacy of the shortage as appropriate. These team members will work together to determine an appropriate plan of action that may include additional assessment and reporting, as well as modifications to the prescribing schedule, medication administration route or pharmacy packaging.

Compassus colleagues may access the full procedure at:
iConnect > Regulatory > Policies & Procedures - procedure 027

Patient Contract for Using Opioid Medication

Patient Contract for Using Opioid Medication

COMPASSUS®

This is an agreement between: _____ (the patient) and Dr. _____ (the doctor) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not eliminate my pain but is expected to reduce it enough that I may become more functional and it may improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
4. If the medication causes drowsiness, sedation or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
7. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
8. I agree to keep my medication in a safe and secure place. Lost, stolen or damaged medication will not be replaced.
9. I agree not to sell, lend or in any way give my medication to any other person.
10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.
11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

1

Patient Contract for Using Opioid Medication (continued)

Patient Contract for
Using Opioid Medication *(continued)*

COMPASSUS®

12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient signature: _____ **Date** _____

Doctor signature: _____ **Date** _____

ADDENDUM

Sample statement that could be attached to this agreement or included in chart at each visit. Utilizing this additional documentation could help avoid confusion if you are out of the office, if the patient is calling for an early refill or if the patient says you told them something different.

I understand that the medication is prescribed as follows:

Type of medication: _____

Number of pills and frequency: _____

Total number of pills: _____

Next refill due: _____

Patient signature: _____ **Date** _____

Doctor signature: _____ **Date** _____

Notification for Urine Drug Screen Testing

Notification for Urine Drug Screening Test

COMPASSUS®

PATIENT INFORMATION

Patient name: _____ **DOB:** _____

Primary care provider: _____ **Date:** _____ **Time:** _____

Dear:_____

The patient is advised to comply with request within four (4) hours of this notification for a urine drug screening test to monitor therapeutic effects of the following medications:

_____

_____

_____

_____

Thank you for your participation.

_____

Signed by:

Urine Drug Testing Guide

5-PANEL DRUG TEST	
Drug	**Duration (Days)**
Marijuana	Single use 2-7 (chronic use 1-2 months)
Cocaine	Up to 4
PCP	14
Opiates	2
Amphetamines	2
MDMA (ecstasy)	2
10-PANEL DRUG TEST (ABOVE +)	
Drug	**Duration (Days)**
Methadone	3
Benzodiazepines	3
Barbiturates	*2 (short-acting), 14-21 (long-acting)*
OTHER	
Drug	**Duration (Days)**
Alcohol	1-12 hours
Tramadol	2-4

Drug Testing:
Drugs.com. Accessed February 13, 2020 at https://www.drugs.com/article/drug-testing.html
Note: This table should be used as a general guideline only. Many variables may affect the amount of time that a drug remains detectable in the urine or other biological samples. Table adapted from LabCorp/Drugs of Abuse Reference Guide."

Prescription Disposal Infographic

Prescription disposal

Follow these simple steps to dispose of medicines in the household trash.

MIX

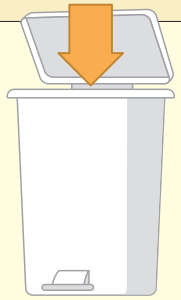
Mix medicines (do not crush tablets or capsules) **with an unpalatable substance** such as dirt, kitty litter or used coffee grounds.

PLACE

Place the mixture **in a container** such as a sealed plastic bag.

THROW

Throw the container **in your household trash**.



SCRATCH OUT

Scratch out **all personal information** on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container.

compassus.com

COMPASSUS®

Drug Disposal Procedure Summary

Summary

Compassus' drug disposal procedures are designed to ensure compliance with local, state and federal laws while providing nursing staff with guidance regarding the disposal of controlled substances when no longer in use. To ensure compliance with state-specific laws, colleagues in Ohio, Michigan, South Carolina, Louisiana and Pennsylvania are subject to separate procedures.

Under the procedure, hospice nurses are responsible for counseling the patient and/or family regarding disposal options. The hospice nurse is also responsible for the destruction of the medication. If the patient or family members refuse to dispose of the medications, the hospice nurse must document this in the clinical record and obtain signatures of the individuals who refused to permit destruction of controlled drugs. Hospice nurses may not, under any circumstances, remove the controlled substances from the home, but they may provide information about community take-back programs or acceptable methods for disposal in the home setting.

Compassus colleagues may access the full procedure at: iConnect > Regulatory > Policies & Procedures - procedures C_29A, C_29B, C_29D, C_29D, C_29E, C_29F

Opioid Documentation Chart Audit

Opioid Documentation Chart Audit

COMPASSUS®

YES - Evidence of documentation = 1 NO - Evidence of documentation = 0

Auditor: _____ Date _____

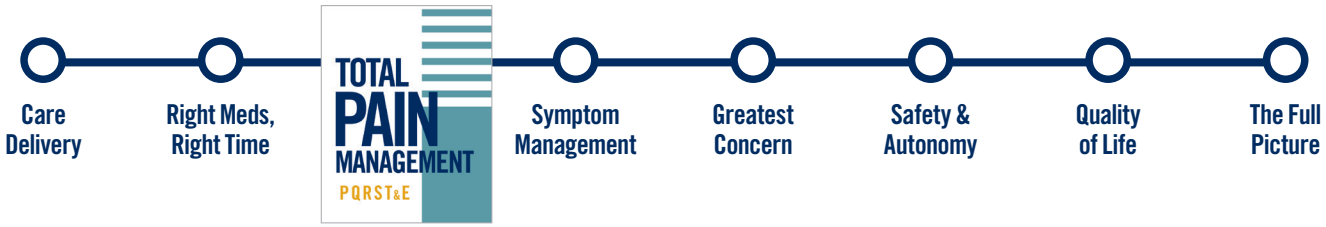
Provider Intl	Patient Intl	Date of Visit	Type of Visit (I/FU)	Opioid Prescribed	Type of Opioid (IR/ER)		Patient Education	Patient consent	Pain Level	ORT	MEDD	PEG	PDMP	Bowel Regimen	Adjuvant	Comments

Guideline				
Comprehensive Pain Assessment	**PEG: Pain, Enjoyment, General Activity Scale**	**ORT: Opioid Risk Tool**	**MEDD: Morphine Equivalent Daily Dose**	**PDMP: State Prescription Drug Monitoring Program**
Document nature (i.e., onset, location, duration, characteristics, aggravating, alleviating factors) and level of intensity	At each visit, the results of chronic opioid therapy are monitored by assessing 5 A's (activity, analgesia, adverse effects, aberrant behavior, affect)	Administered to patients upon an initial visit prior to beginning opioid therapy for pain management	Calculation of oral morphine equivalency for each assessment	Check site prior to ordering controlled substances, determine whether the patient is receiving prescriptions from any other providers and document results obtained from the PDMP in the patient record

Care Delivery, The Compassus Way™

At Compassus, we believe all patients have universal needs at the end of life. *Care Delivery, The Compassus Way*™ creates a process for delivering care that honors patients' self-determined goals and preferences, centered on improving comfort, safety and quality of life while reducing family stresses.

As a key tenet of Care Delivery, Total Pain Management acknowledges the complex interaction of physical and emotional pain and the impact it can have on a patient and family's journey. Compassus' approach includes standardized and sequential steps to address physical, emotional, social or spiritual pain and achieve each patient's unique goals.



Opioids often play a prominent role in Total Pain Management. As such, great care must be taken to ensure these medications contribute to the patient's quality of life without creating unnecessary side effects, risks or burden.

As part of TOTAL PAIN MANAGEMENT, *The Compassus Way*™ we are committed to a standardized approach for managing the safe use of opioids, which includes:

- Acting with urgency to control a patient's pain and suffering.
- Educating patients and caregivers on the safe use and disposal of these medications.
- Exercising proper opioid stewardship through controlled substance counts at each nursing visit and other procedures.

CARE DELIVERY
The Compassus Way™

COMPASSUS®

Attestation of Receipt
Guide to Opioid Stewardship

COMPASSUS®

Date of receipt: _____

I confirm that I received the guide listed above. I understand that as a physician associated with Compassus, it is my responsibility to abide by the policies and procedures included in this guide.

If I have questions about the guide, materials or Compassus policy and procedures, I understand it is my responsibility to seek clarification from the office of the Chief Medical Officer.

Physician signature: _____ **Date:** _____

Print name: _____

Please complete the form, scan it and email it to your Compassus Area Executive of Clinical Operations