Symptom Management and Psychosocial Considerations

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Program Details

- **Title:** Symptom Management and Psychosocial Considerations
- **Dates/Term of offering:** This activity was released on May 18, 2020 and is valid for one year. Requests for credit must be made no later than May 18, 2021.
- **Joint Providership:** This activity is jointly provided by Global Education Group and Hospice and Palliative Board Review.com.

- **Target Audience:** The educational design of this activity addresses the needs of Physicians, NPs, Nurses, and health care professionals interested in learning more about hospice and palliative medicine and those who want to earn continuing education credits and/or prepare for board certification in hospice and palliative medicine.

Program Details

- **Program Overview:** Clinicians and health care professionals are unaware of best practices to be utilized when having goals of care and advanced care planning discussions with patients and family. As such, they do not know how to adequately counsel patients and families on appropriate goals of care and advanced care planning given the patient's disease trajectory and wishes.

- **Faculty:** Eric Bush, MD, RPh, MBA
- **Physician Accreditation Statement:**
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- **Global Contact Information:** For information about the accreditation of this program, please contact Global at 303-395-1782 or cme@globaleducationgroup.com.
- **Fee Information:** There is a fee for this educational activity.

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- **System Requirements:**
- **PC:** Microsoft Windows 2000 SE or above, Flash Player Plugin (v7.0.1.9 or greater), Internet Explorer (11.0 or greater), Chrome, Firefox, Adobe Acrobat Reader*
- **MAC:** MAC OS 10.2.8, Flash Player Plugin (v7.0.1.9 or greater,), Safari, Chrome, Adobe Acrobat Readers*, Internet Explorer is not supported on the Macintoch.

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applicable manufacturer's product information, and comparison with recommendations of other authorities.

LEARNING OBJECTIVES

- Describe how to perform symptom management in the palliative and hospice setting.
- Describe how to counsel patients and caregivers on interventions in this setting and the applicable risk versus benefit for appropriate interventions.
- Describe how to discuss utilization of appropriate personnel allocation in the hospice and palliative care setting
- Describe how to counsel patients and families on appropriate personnel allocation in the hospice and palliative care setting and the benefits for patients and families undergoing this type of care
- Describe how to perform discussions differentiating between hospice and palliative care services with patients and family.

- Describe how to counsel patients and caregivers on differentiating between hospice and palliative care services and appropriate level of care for the patient and family given current best practice.

When to ask about Hospice or Supportive (Palliative Care)

What People Want

- To die at home
- To be free from pain
- To be in the company of loved ones
- To retain control of the care we receive

The Contrast of Reality

- Less than 25 percent of Americans die at home, although more than **70 percent** say that is their wish
- Only 20 to 30 percent of the population have completed an advanced directive
- Dying is often unnecessarily painful and isolating

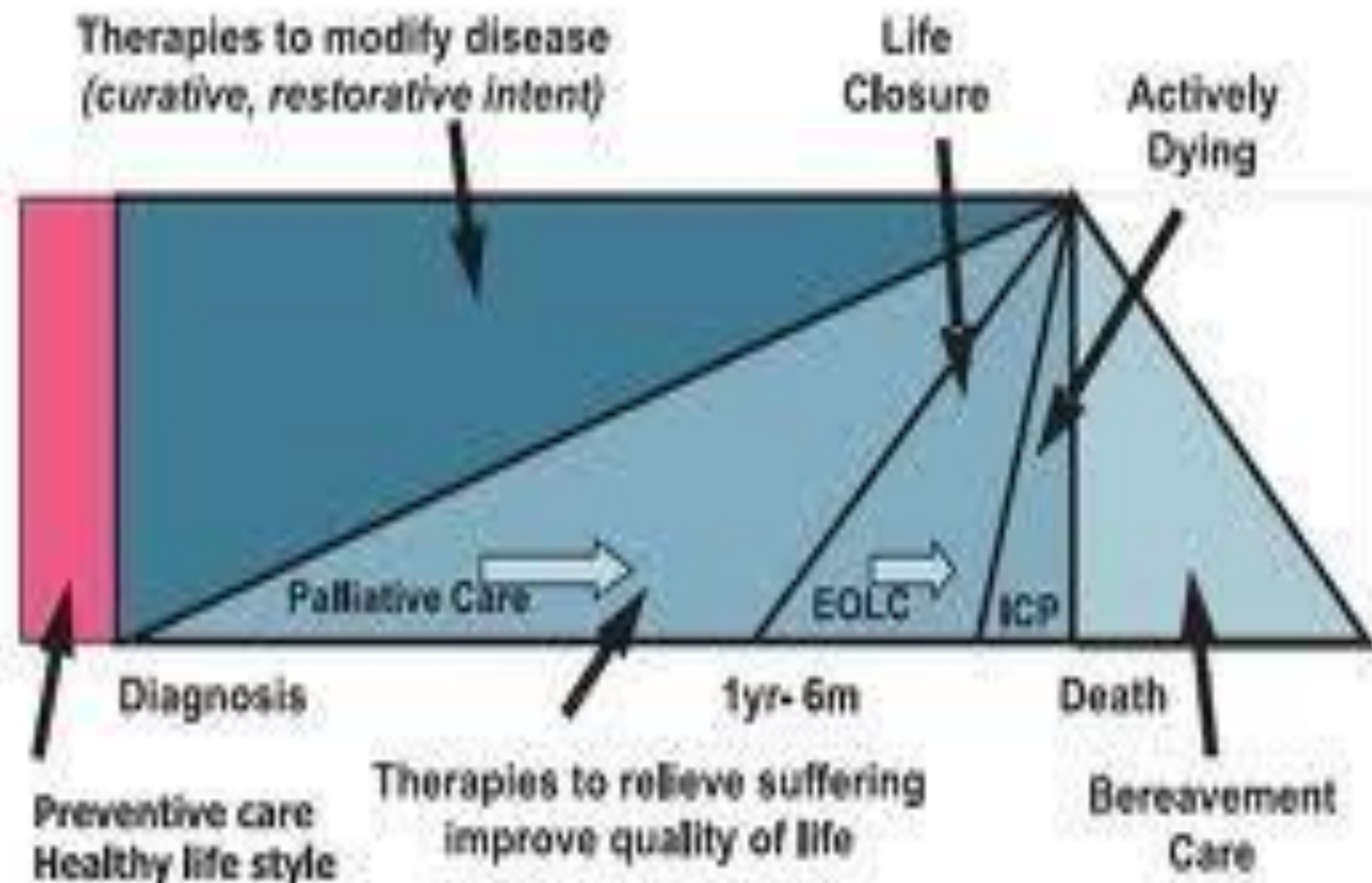
The Reason for this Stark Reality

- Doctors aren’t aware of their patients’ wishes.

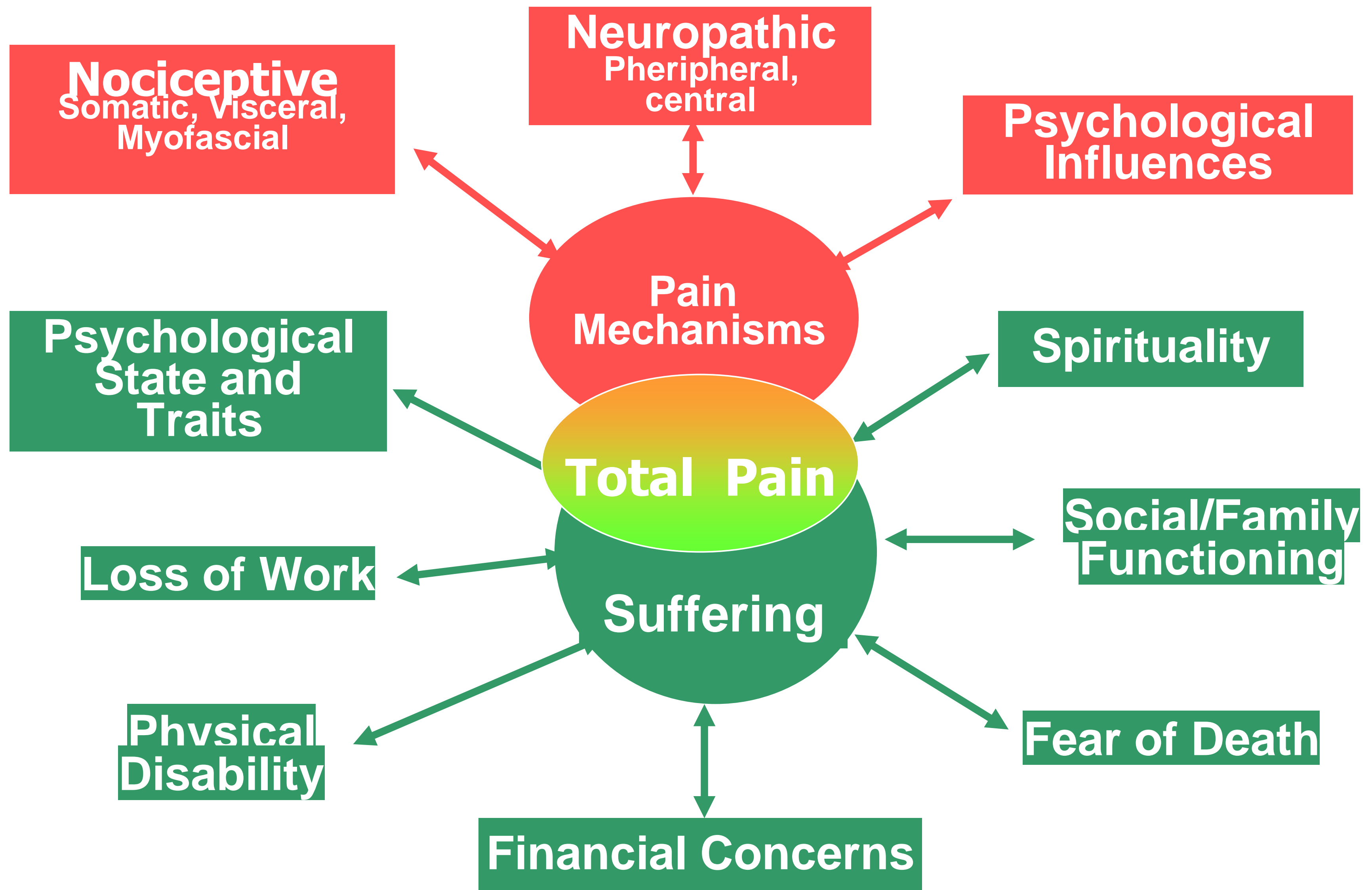
- A major 2007 study found that only 25% of physicians knew that their patients had advance directives on file.
- The end of life is often treated only as a medical moment.

Basic Concepts of Hospice & Supportive (Palliative Care)

Modified from-
http://depts.washington.edu/pallcare/training/ppt.shtml



Nature of Pain(or other symptom)



Supportive Care (Palliative Care)

- Supportive Care is given to improve the quality of life of patients who have a serious, chronic or lifethreatening disease.
- The goal of Palliative Care is to prevent or treat as early as possible, the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social and spiritual problems related to a disease or its treatment.
- In short, symptom management, regardless of where the patient is in the disease process, is utilizing a biopsychosocial approach.

Supportive Care (Palliative Care)

- Primarily Inpt/office based
- Ongoing eval risk/benefit of interventions
- Chaplain and social work svcs available as outpt
- Helps to improve QOL and shown to improve lifespan in Stage 4 NSCLC
- No mechanism for reimbursement for multidisciplinary home based supportive care
- Pt/families often seen while enrolled in HHC

Hospice

- Provides support and care for those in the last phases of life-limiting illness(prognosis <6months)
- Recognizes dying as part of the normal process of living
- Affirms life and neither hastens nor postpones death
- Focuses on quality of life for individuals and their family caregivers

Differentiation

- Hospice - if the disease follows the expected course, a prognosis of six months or less (patients often referred late, NEJM NSCLC study)
- Supportive (Palliative) - symptom focused care anywhere throughout the disease spectrum, can be delivered in conjunction with curative care

Core Aspects of Hospice

- Patient/family focused
- Interdisciplinary

- Provides a range of services:
- Interdisciplinary case management
- Pharmaceuticals
- Durable medical equipment
- Supplies
- Volunteers
- Grief support

Additional Services

- Hospice offers additional services, including:
- Hospice residential care (facility)
- Inpatient hospice care
- Complementary therapies

- Specialized pediatric team
- Caregiver training classes

Hospice Team Members

- The patient's personal physician
- Hospice physician (medical director)
- Nurses
- Home health aides
- Social workers
- Clergy or other counselors
- Trained volunteers
- Speech, physical, and occupational therapists

The Hospice Team

- Develops the plan of care
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for the patient and family
- Provides bereavement care and counseling

Where Hospice is Provided

- Home

- Nursing Facility
- Assisted Living Facility
- Hospital
- Hospice residence or unit
- Prison, homeless shelter – where ever the person is

Who Pays?

- Medicare
- Medicaid
- Insurance
- Private pay

- Sometimes a combination of these…

Admission Criteria

- General
  - Life-limiting illness, prognosis is 6 months or less if disease takes normal course
  - Live in service area
  - Consent to accept services

Physicians *Overestimate* Life Expectancy by What Percent?

a) 10

b) 50

c) 70

d) 90

e)Google

When to ask about Hospice or Supportive(Palliative) Care

- Poor quality of life
- Uncontrolled symptoms
- Treatment plan discordant with wishes
- Multiple hospitalizations but not getting “better”
- Prognosis 6months or less (based on diagnosis)

- Declining functional status/wt loss/overall decline
- Please d/w your family/physician/clergy/HC team

Summary

- Performance status important trigger for appropriate supportive/pall care/hospice referrals
- Patients/families/physicians often receive/refer patients late for palliative/hospice care
- We are there to support you and our patients/families throughout the spectrum of care
- Effort for true patient centered care must be united to be successful, resulting in better outcomes
- Complete your advanced directives, make your wishes known

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A Community that Cares

The care Saul and his wife received from hospice enabled her to live at home until she died. After her death he joined a coalition that organizes caregiving circles to provide care and support to seriously ill people in his community.

How can you help in your community?

It's about how you LIVE.

Download a state-specific living will or healthcare power of attorney

Advance Directive

Free resources on a wide range of end-of-life topics.

Download Now!

Are You Planning Ahead?
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Are You Reaching Your Community?
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Are You a Caring Business?
Learn More

Lotsa Helping Hands
When Friends & Family Need Help

Learn More

FREE Resources Available from *Caring Connections*

- More information about Hospice and Palliative Care
- State-specific advance directives
- Brochures to download or order:
- What is Palliative Care?
- Ask Tough Questions
- Conversations Before the Crisis
- Question and Answers: Artificial Nutrition
- Question and Answers: Cardiopulmonary

- Question and Answers: Dying at Home

It's About How You LIVE!

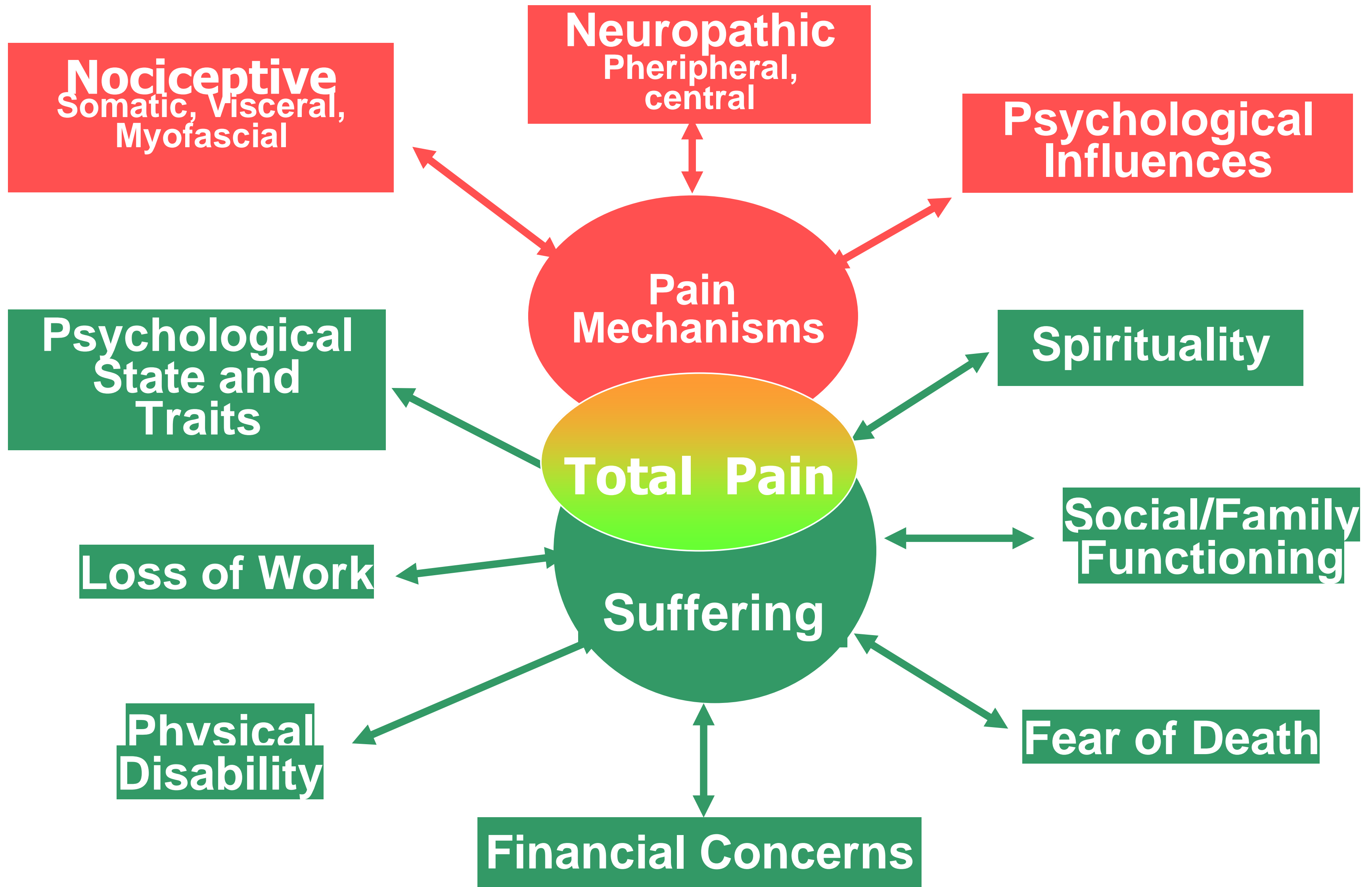
- Learn about your options, choices and decisions
- Implement your advance directive plans
- Voice your decisions about hospice and palliative care
- Engage others to learn more about hospice and palliative care

PAIN, OPIATE CONVERSION & TITRATION

Definition of Pain

- An unpleasant sensation that can range from mild, localized discomfort to agony. Pain has both physical and emotional components. The physical part of pain results from nerve stimulation. Pain may be contained to a discrete area, as in an injury, or it can be more diffuse, as in disorders like fibromyalgia. Pain is mediated by specific nerve fibers that carry the pain impulses to the brain where their conscious appreciation may be modified by many factors.
- The word "pain" comes from the Latin "poena" meaning a fine, a penalty.

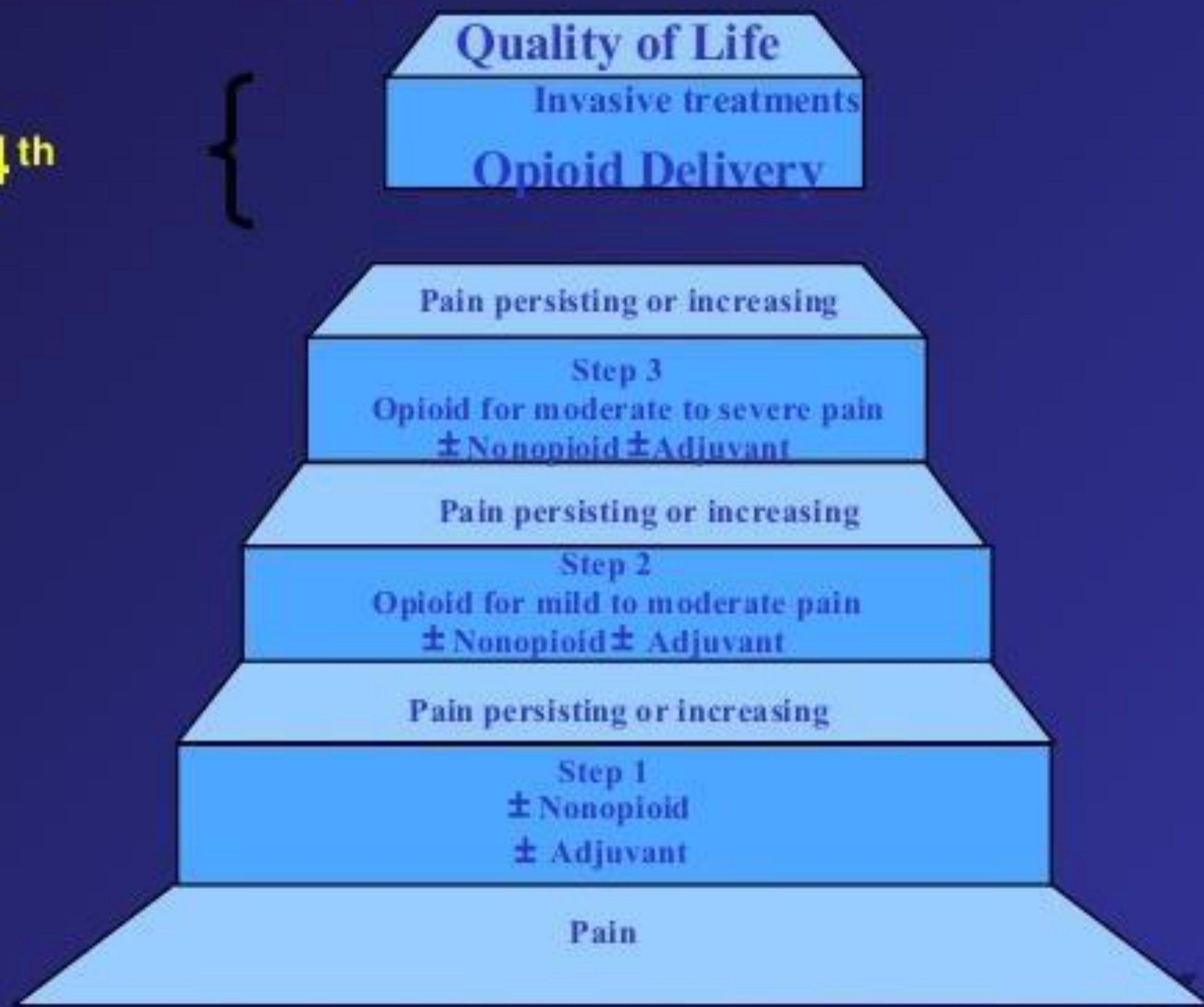
Nature of Pain/QOL



Modified WHO Analgesic Ladder

Proposed 4th Step

The WHO Ladder



Deer, et al., 1999

Opioid Titration

- Goal of care is management of pain with long acting pain medications (overall goal of pain management is **ALWAYS** OPTIMIZE FUNCTIONALITY)
- Use of 3 or more breakthrough doses/24 hour period may be an indication of the need to increase the long acting medication (dose/frequency or both)
- Knowing how to safely titrate pain medications is a core competency for hospice nurses
- Opioid naïve< 30mg DOME (Daily Oral Morphine Equivalents); High dose opiate >90MG DOME

Opioid Rotation

Consider when:

- Lack of therapeutic response - Patient develops tolerance to their current narcotic
- Formulary issues - Change from Oxycodone Extended Release to a preferred narcotic(ie Long Acting Morphine)
- Change from IV/SQ to po or po to IV/SQ
- Changing to Methadone
- Development of adverse effects
- Change in patient status
- Other considerations
- Opioid/formulation availability
- Patient/family health care beliefs

Physician and/or Pharmacist oversight required:

- When changing to or from IV/SQ

- When changing to or from Methadone

COMMUNICATING THE RATIONALE

Explaining WHY to patients, families, caregivers (and other practitioners):

- Improved pain management
- Fewer Peaks/Troughs
- LA oral, transdermal fentanyl and buprenorphine
- Enhanced adherence to opioid therapy
- Improved patient outcomes
- Better analgesic effects
- Better functional status
- Fewer adverse effects

CONVERSION CONVERSATIONS

- Same opioid, one formulation to a another

- Same opioid, one route of administration to another

- From one opioid to another

- Conversions to/from transdermal opioids

EQUIANALGESIC TERMINOLOGY

- Opioid responsiveness

- The degree of analgesia achieved as the dose is titrated to an endpoint defined either by intolerable side effects or the occurrence of acceptable analgesia
- Potency
- Intensity of the analgesic effect of a given dose
- Dependent on access to the opioid receptor and binding affinity
- Equipotent doses = equianalgesic

EQUIANALGESIC OPIOID DOSING

- Use the equianalgesic chart

- Convert current total daily opioid to morphine equivalence (DOME in a 24 hr time period)
- For TD Fentanyl, double the strength of the patch i.e, 100mcg patch is approximately 200mg/day of oral morphine
- Always consider 25% reduction in dose when rotating opiate itself (incomplete cross tolerance)

EQUIANALGESIC OPIOID DOSING

	Equianalgesic Doses (mg)	
Drug	**Parenteral**	**Oral**
Morphine	**10**	**30**
Buprenorphine	**0.3**	**0.4 (sl)**
Codeine	**100**	**200**

Fentanyl	**0.1**	**NA**
Hydrocodone	**NA**	**30**
Hydromorphone	**1.5**	**7.5**
Meperidine	**100**	**300**
Oxycodone	**10***	**20**
Oxymorphone	**1**	**10**
Tramadol	**100***	**120**

LIMITATIONS OF EQUIANALGESIC CHARTS

- Based on single dose studies
- Patient-specific variables

- Weight, adipose layer available, temperature

DETERMINING AN APPROPRIATE DOSE ADJUSTMENT

- Determine 24 hour total of long acting medications actually taken
- Determine 24 hour total of breakthrough doses actually used = DOME
- Determine pain trajectory with the aforementioned
- Is the pain opiate responsive? Are there better alternatives? Adjuvants? Complementaries?

COMFORT ACHEIVED - WITHOUT OPIOID ROTATION

- If the patient reached comfort with the breakthrough dosing taken in the last 24 hours:
- Total the medication used in the past 24 hours (TDD)
- Adjust the LA Opiate accordingly

COMFORT NOT ACHIEVED - WITHOUT OPIOID ROTATION

If patient did not reach comfort with breakthrough dosing in past 24 hours:

- Total opiate use in last 24 hrs (DOME)
- **Increase the total dose by 25% for moderate pain.**
- **For severe pain, 50% increase may be indicated. Requires close monitoring.**
- Adjust LA opiate appropriately

- Breakthrough/Rescue dose is 25% of the new 12 hour long acting dose

MEDICATION CHANGE/ROUTE NECESSARY

Common scenarios:

- Cannot swallow the oral tablet / solution
- No longer has the fatty layer or body temperature to absorb a transdermal patch
- Has lost IV access and does not wish to restart

- Consider using the <u>same</u> drug in a new route
- Consider using a <u>different</u> drug in a new route

SAME DRUG: DIFFERENT ROUTE

- Bioavailability
- The rate and extent to which the active ingredient is absorbed from a drug product and becomes available at the site of action
- Oral bioavailability
- Morphine 30-40% (range 16-68%)
- Hydromorphone 50% (29-95%)
- Oxycodone 80%
- Oxymorphone 10%

CONVERSION EQUATION
Same Drug : Different Route

- Set up the conversion equation
- Use the same drug but determine the conversion fraction based on an alternate route
- (Morphine is 30 Oral to 10 IV or equation of 10/30)
- Cross multiply and solve for "X"
- Obtain the total dose for the new route
- Divide the total dose by 2 for every 12 hour dosing or by 3 for every 8 hour dosing
- Breakthrough dose is 25% of the 12 hour long acting dose
- Individualize for your patient

- HAVE YOUR MATH DOUBLE CHECKED!!!

OPIOID CONVERSION
Same Drug : Different Route

Am is 84 yowith Multiple Myeloma and is admitted to the hospital w/ cord compression and is made npoawaiting corpectomyby neurosurg. Pain previously well controlled on la morphine 30 MG PO Q8H. What is the equivalent IV dose?

A. Morphine 5 MG IV every 4 hours

B. Morphine 10 MG IV every 4 hours

C. Morphine 15 MG IV every 4 hours

D. Morphine 30 MG IV every 4 hours

E. Morphine 45 MG IV every 12 hours

Answer is choice A

OPIOID CONVERSION
Changing to a Different Drug

- AM (same pt) now develops renal failure (preferred agents Hydromorphone, Fentanyl, Methadone) convert pt to equianalgesic IV Hydromorphone regimen
- Use the conversion fraction for the old drug and the new drug in the new route

- (Morphine is 30mg Oral to Hydromorphone 1.5MG IV or equation of 1.5/30)
- Cross multiply and solve for "X"
- Obtain the total dose for the new opioid or route
- HAVE YOUR MATH DOUBLE CHECKED!!!

Calculations

- 1.5/30=x/90, therefore 30x=135, x=4.5 MG of IV Hydromorphone over 24hrs
- Change pt to Hydromorphone 0.75MG IV q4h ATC

Change in Drug and Route

56 yo M with ES CHF and COPD receiving 5MG po/sL Morphine q4h atc for dyspnea (controlled), now for d/c from GIP to home, major adherence concerns. What dose TD Fentanyl:

A)Fentanyl 25MCG TD q48hr

B)Fentanyl 25MCG TD q72hr

C)Fentanyl 12MCG TD q72hr

D)Fentanyl 50MCG TD q72hr

Answer is choice C

Conversion to PCA (IV OR SUBCUT)

JC is 59 yo F with stage 4 NSCLC. Family desires to keep pt at home on hospice. Pain well controlled but now w/significant EOL Dysphagia. Prior regimen is LA Morphine 100 MG PO Q12H and MSIR 30MG PO Q4H PRN (avg 3 BTP dose/24hr). What is PCA Morphine Basal and Bolus dose?

A) Morphine Basal 1 MG/hr Bolus 1mg Q10MIN
B) Morphine Basal 2 MG/hr Bolus 1mg Q10MIN
C) Morphine Basal 3 MG/hr Bolus 2mg Q10MIN
D) Morphine Basal 4 MG/hr Bolus 2mg Q10MIN
E) Morphine Basal 8 MG/hr Bolus 4mg Q10MIN

Answer is choice D

CHANGE IN OPIATE, SAME ROUTE

FY is 74 yo F with stage 4 Breast Ca. Now admit to Hoc, pain stable on oxycodone extended release (non-formulary) 20MG PO Q8H ATC and oxycodone immediate release 10mg PO Q3H PRN BTP (not utilizing); change to long acting (LA) morphine (do not account for cross tolerance).

A) LA Morphine 15 MG PO Q12H
B) LA Morphine 15 MG PO Q8H
C) LA Morphine 30 MG PO Q12H
D) LA Morphine 30 MG PO Q8H
E) LA Morphine 60 MG PO Q12H

Answer is Choice D

Methadone - Benefits

Mu agonist, synthetic opioid

- Has two non-opiate analgesic receptor activities:
- Prevents MAO reuptake in periaqueductal gray
- Prevents N-methyl-d-aspartate (NMDA) receptors
- Lacks neuroactive metabolites
- High bioavailability (79 +/-11 hours)
- Long half life (30 +/- 16 hours)
- Highly lipophilic
- Fecal excretion - safe in ESRD
- Very inexpensive

METHADONE

When converting to Methadone:

- Assess the appropriateness of converting in the home
- Educate to side effects and responses
- Process takes 3-5 days to reach full therapeutic effect
- Breakthrough dosing with another opioid is imperative for transition
- Know the assessment findings that indicate overdose or under dosing

Methadone Precautions

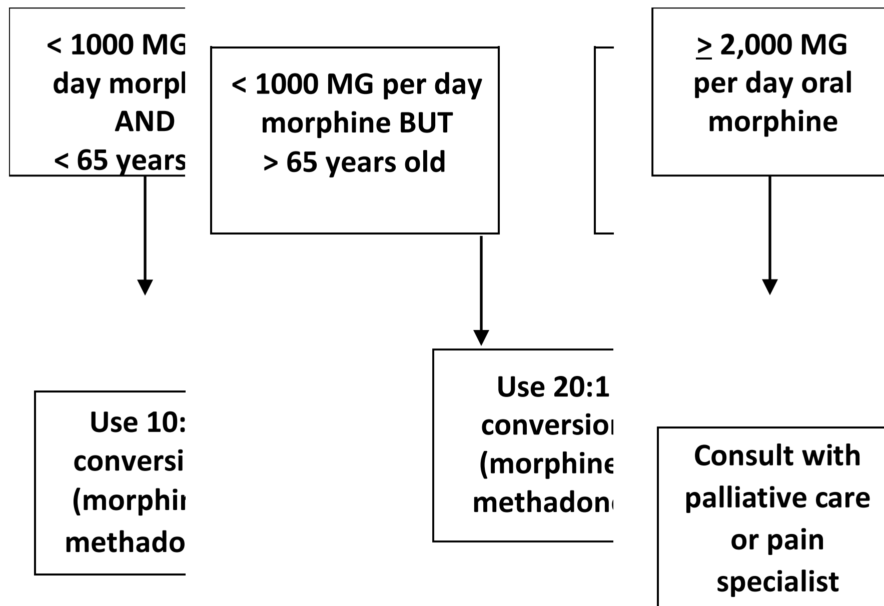
- Lack of caregiver(s) to monitor the patient
- Very limited prognosis

- Increased risk of QT prolongation in patients with known bradycardia or heart failure, patients with hypokalemia or those taking drugs which potentiate QT prolongation.
- Patients with OSA, hypercarbia.

METHADONE DOSES

- Initial dose for opioid naïve patients: 1-2.5MG at bedtime or twice a day
- Use their previous opioid or morphine for breakthrough pain
- With careful oversight, can use methadone for breakthrough(rare) in case of allergies etc..

Conversion from Morphine to Methadone



Methadone

- Analgesic and plasma t1/2 differ

- Onset of 15 min with peak in 1 to 2 hrs
- Analgesic t1/2 of 4 to 6 hrs
- Plasma t1/2 of ~24hrs
- Clinical implications of pharmacokinetic properties
- IV methadone is twice as potent as oral

Dosing Dilemmas

- Half life (30+/- 16 Hours)
- Recommended dosing intervals (3-24 hours)
- Duration of analgesia for a single dose (4-6 hours)
- Rapid absorption-distribution
- Accumulates in tissues-initial q4hour dosing may stretch to bid

Clinical Uses

- Neuropathic pain and/or mixed nociceptive pain not responding to morphine and co-analgesic
- End-stage renal failure
- True morphine allergy
- Cost

What is an Adjuvant Analgesic?

Any drug that has a primary indication other than pain, but is known to be analgesic in specific circumstances

What are the Indications to Use an Adjuvant Analgesic?

- Poor response to optimal opioid therapy
- Type of pain experienced is more responsive to the adjuvant
- Patient has a marked predisposition to opioid toxicity

What Types of Pain are Adjuvants Indicated?

- Neuropathic pain
- Bone pain
- Visceral pain
- Myofascial

Is The Patient Experiencing Neuropathic Pain?

- Etiology
- Injury along the afferent and efferent pathways

- Tumor infiltration
- Treatment: chemotherapy, radiation, surgery
- Description
- Burning, electrical, pinching, shooting; numbness, tingling, "pins & needles"

What Sensory Disturbances Does The Patient Experience?

- Hyperalgesia: increased perception of painful stimuli
- Allodynia: exaggerated pain induced by non-painful stimuli
- Hyperpathia: exaggerated pain response
- Dysesthesia: deep aching, pressure, cramping, painful sensations

- Hypesthesia: numbness, decreased feeling
- Paresthesia: tingling, spontaneous, non-painful sensation

Neuropathic Pain: What To Do?

- Anticonvulsants
- SNRI for co-morbid depression
- Tricyclic antidepressants
- Benzodiazepines
- N-Methyl-D-Aspartate receptor antagonists
- Corticosteroids
- $Alpha_2$ adrenergic agonist
- Antiarrythmics
- Topical anesthetics

Refractory Pain

- 57 yo F with widely metastatic breast ca
- Intractable pain on Oxycodone Extended Release 80MG po q6h atc with Oxy IR 30MG po q3h prn(taking ATC)
- What to do?

A)Methadone 10MG po tid,oxy ir 30MG po q3prn

B)Methadone 40MG bid,oxy ir 45MG po q3prn

C)Methadone 40MG tid,oxy ir 45MG po q3prn

D)Methadone 60MG bid,oxy ir 45MG po q3prn

Answer is B

Knowledge Check

- 38 yo F with cervical CA
- On Hydromorphone PCA with basal 18MG/hr
- On gabapentin as adjuvant, pain poorly controlled, primarily neuropathic

Knowledge Check (continued)

Start methadone PCA at basal of 9mg/hr with upward titration based on symptoms

Clinical Pearls

- Methadone safe and effective when used judiciously
- Consider when failing other opioids/difficult to control pain
- QTc issues can be concern in conjunction w/other agents affect cardiac conduction(TCA's etc.)

Summary

- Works well for bone pain, neuropathic pain pt who have failed multiple other opiates and refractory pain, co-morbid addictions (Etoh, etc), patients with ESRD, patients who cannot afford other opiates
- Be careful of pt with OSA, sedation on day 4/5, withdrawl on day 7+, drug interactions, QTc issues, ESLD

Final Thoughts

1. Be alert for clinical scenarios that may indicate opioid switching should be recommended
2. Always consider adjuvants/complementaries and other elements of pain (is the pain opioid responsive?)
3. Understand/consider principles of opioid responsiveness, potency, equivalence and bioavailability
4. Follow approved labeling for switching in opioid tolerant patients
5. Use a fair balance equianalgesic dosing chart and understand limitations (approach these systematically)
6. Consider timing of switches

7. Document your interventions and EDUCATE patients and practitioners

BEST PRACTICES

- Dosage calculations should be double checked by another practitioner (nurse, pharmacist, MD)
- Know your dose prior to calling the MD for orders
- Understand that you are responsible for the dose you give, even if the MD order was not prudent

- Patients who have pain meds increased or medications changed should have a check in call and/or skilled nursing visit 24 hours after the change

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- Opioid Use for Pain Management After Implementation of a Medicaid Short-Acting Opioid Quantity Limit. Riggs CS, Billups SJ, Flores S, Patel RJ, Heilmann RM, Milchak JL.J Manag Care Spec Pharm. 2017 Mar;23(3):346-354
- https://www.jpsmjournal.com/article/S0885-3924(15)00855-6/abstract
- https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/whatare-best-safety-practices-use-methadone-treatment-pain
- https://www.jpsmjournal.com/article/S0885-3924(18)31114-X/pdf

APPENDIX

What People Want – Page 11: Notes

Citations:

- Item 1:
- Institutes of Medicine Report *Dying in America*, 2014: http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Qualityand-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- As reported by PBS Frontline, *Facing Death* (sourcing a Time/CNN Poll from 2000: http://www.pbs.org/wgbh/pages/frontline/facing-death/factsand-figures/)

- Items 3 and 4:
- Institute of Medicine (IOM) Report *Dying in America*, 2014: http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Qualityand-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- The Journal of the American Medical Association, *SUPPORT Study* , 1995: http://jama.jamanetwork.com/article.aspx?articleid=391724

The Contrast of Reality – Pg 12: Notes

- People often don't receive the care they want – almost everyone has a "horror story" of a loved one dying in pain or isolation that could have been avoided.

- Citations in Order
- 1.a Reported by PBS Frontline, sourcing the Centers for Disease Control, 2005: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-andfigures/
- 1.b Harvard Business Review *Tackling Social Problems*, 2012: https://hbr.org/2012/01/tackling-social-problems/
- 2. IOM, Dying in America, 2014
- 3. Reported by PBS Frontline, sourcing The Associated Press, 2010: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-andfigures/
- 3. Reported by National Health Care Decisions Day (NHDD) sourcing The Pew Research Center, *More Americans Discussing – and Planning – Endof-Life Treatment,* 2006: http://www.people-press.org/files/legacypdf/266.pdf

The Reason for this Stark Reality – Pg 13: Notes

- Reported by PBS Frontline sourcing Critical Case Journal, 2007:

http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-andfigures/

- Reported by National Health Care Decisions Day (NHDD): http://www.nhdd.org/facts/

Core Aspects of Hospice – Pg 21: Notes

- As defined by HMB

Additional Services – Pg 22: Notes

Not all programs offer these – based on needs in community, mission, resources, skills

Hospice Team Members – Pg 23: Notes

Also from the HMB – palliative care programs don't need to include all these disciplines

The Hospice Team – Pg 24: Notes

- These are primary services offered by hospice. Not all patients/families avail themselves of these services.
- Develops the plan of care with the family
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for care needs of patient and family
- Provides bereavement care and counseling to surviving family and friends

Where Hospice is Provided – Pg 25: Notes

- Delivered across care setting

- Man on the porch

www.caringinfo.org 800.658.8898 – Pg 31: Notes

- www.caringinfo.org is a national consumer website, sponsored by NHPCO, with specific information on:
- Advance care planning
- Caregiving
- Pain
- Financial Planning
- Hospice and palliative care
- Grief
- Plus a consumer helpline number is available to answer your questions. Will mail advance directives for FREE

FREE Resources Available from *Caring Connections* – Pg 32: Notes

- The FREE resources available from Caring Connections are:
- State-specific advance directives
- Advance Care Planning information
- Some of the brochure topics available to download or order:
  - *Advance Directives and End-of-Life Decisions*
  - *Health Care Agents: Appointing One & Being One*
  - *Conversations Before the Crisis*
  - *You Have Filled Out Your Advance Directive…Now What?*
  - *Ask Tough Questions*

It's About How You LIVE! Pg 33: Notes

- Overall – IT"S ABOUT HOW YOU LIVE!
- Think about how you want it to be for yourself, your loved ones and your community and decide what actions you need and want to take when you walk out the door
- You can **Learn** more about your options and choices about hospice and palliative care

- You can **Implement** a plan to ensure your wishes are honored by completing your advance directives and other plans for future health care. FREE advance directive forms are available at www.caringinfo.org
- You can **Voice** your decisions about hospice and palliative care by talking to your loved ones and doctor
- You can **Engage** in personal or community efforts to improve end-of-life care by helpng others to learn more about hospice and palliative care

- We are here to help you take that next step with whatever you decide. To contact us……
- Thank you for your time.

Methadone – Pg 63: Notes

I want to call your attention to methadone. Methadone has garnered the reputation of being the opioid of choice for neuropathic pain because not only is it an opioid that works at all of the receptors, it's also a serotonin reuptake inhibitor and an NMDA blocker. So theoretically, this ought to be a good drug for neuropathic pain.

POSTTEST/QUIZ

Please click on the link below to be taken to this activity's quiz. After successful completion, you can then fill out an evaluation and application for CME credit.

Symptom Management and Psychosocial Considerations