NYSNA Continuing Education

The New York State Nurses Association is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

The New York State Nurses Association is accredited by the International Association for Continuing Education and Training "IACET" and is authorized to issue the IACET CEU.

This course has been awarded 4.0 Contact Hours and 0.4 CEUs and is intended for Nurse Practitioners and other healthcare prescribers who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number. In order to receive contact hours/CEUs, participants must read the course material, pass an examination with at least 80%, and complete an evaluation. Contact hours/CEUs will be awarded for this independent study course until June 20, 2020.

In addition, prescribers must attest to their own completion of this program. The certificate of completion must be maintained by the prescriber for a minimum of six (6) years from the date of the attestation.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the Professional licensing board within that state.

NYSNA has been granted provider status by the Florida State Board of Nursing as a provider of continuing education in nursing (Provider number 50-1437).

NYSNA wishes to disclose that no commercial support or sponsorship has been received.

NYSNA planners and presenters declare that they have no conflict of interest in this program.

How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. At this point, you should print the certificate and keep it for your records.

Course Objectives

Upon completion of this course, the learner will be able to:

- Describe New York State and Federal requirements for safe prescribing controlled substances.
- Recognize appropriate prescribing guidelines for opioid analgesics for acute and chronic pain.
- Outline prevention, screening and signs of addiction.
- Identify responses to abuse and addiction.
- Discuss Palliative and End of life care.

Introduction

Course Description: The use of prescription and non-prescription opioids has dramatically increased in New York State. Healthcare providers who prescribe opioids must understand and demonstrate ongoing knowledge in regard to the following topics:

- Federal requirements for prescribing controlled substances;
- New York State requirements for prescribing controlled substances;
- appropriate prescribing;
- managing acute pain;
- palliative care;
- pain management, prevention, screening and signs of addiction;
- responses to abuse and addiction; and
- end of life care.

Purpose: The purpose of this activity is to satisfy the Public Health Law (PHL) §3309-a (3), available here: https://www.hanys.org/download/2017/2017-03-02_public_health.pdf.

Target Audience: The Public Health Law mandates prescribers licensed under Title Eight of the Education Law in New York that treat humans and who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three (3) hours of course work.

This training will encompass:

- pain management
- palliative care
- addiction

This includes:

- physicians
- advanced practice nurses who prescribe
- registered nurses
- residents
- physician assistants
- dentists
- pharmacists

The **New York State Department of Health** (NYS DOH) has provided a FAQ sheet in response to potential questions a prescriber may have about the mandatory NYS Prescriber Education. To read this FAQ please visit the following web address: https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/docs/faq**.**

Additionally, the NYS DOH has provided guidance for courses to be considered acceptable training. To read this guidance statement please visit the following web address: https://www.health.ny.gov/professionals/narcotic/docs/mandatory_education_guidance.pdf

Compliance and Attestation

Provider compliance: This course must be completed by July 1, 2017 and every three (3) years thereafter. If you are licensed on or after July 1, 2017 you must complete the training with in one (1) year of receipt of your license and every three (3) years thereafter.

Provider attestation: To comply, prescribers must file the self-attestation by July 1, 2017 and once every three (3) years thereafter. To submit your attestation online, access your Health Commerce System (HCS) account and follow these steps:

After logging in to the HCS website (https://commerce.health.state.ny.us/public/hcs_login.html):

1. Top Right under “my content”
2. Select “ALL applications” then
3. Browse by letter “N” and the first application name is “Narcotic Education Attestation Tracking (NEAT)”
4. Select “NEAT” - Follow the steps provided (https://www.nyacp.org/files/NEAT%20Prescriber%20Instructions%203_30_17.pdf)

Prescribers that do not have access to a computer can request a paper attestation form by calling the Bureau of Narcotic Enforcement (BNE) toll-free at 1-866-811-7957. They may then complete the form and return it by mail to the address provided.

About the Author

Jennifer Klimek Yingling, Ph.D, RN, ANP-BC, FNP-BC

Jennifer Klimek Yingling, Ph.D., RN, ANP-BC, FNP-BC, is both an Adult Nurse Practitioner and a Family Nurse Practitioner with more than 20 years of experience in the field of nursing. Dr. Yingling is currently an Assistant Professor of Nursing and Health Professions at SUNYIT, while maintaining her nursing skills and competency by working in the Emergency Room at a nearby hospital. One of Dr. Yingling's many accomplishments was her work in a first-of-its-kind pilot study, the "Prevalence of Horizontal Violence in New York State Registered Nurses." The study was published in The Journal of the New York State Nurses Association.

Pain

Pain is defined as a "subjective and unpleasant sensory and emotional experience associated with actual and or potential tissue damage…Pain is always subjective…It is unquestionably a sensation in a part or parts of the body, but it is also unpleasant and therefore also an emotional experience" (Bonica, 1979; International Association for the Study of Pain, 2012; Merskey & Bogduk, 1994).

Pain symptoms may be exacerbated or manifested by psychological attributes:

- anxiety/fear
- loss of familial roles
- functional or occupational roles
- sleep disruption, and/or
- substance abuse

It is thought that pain is a protective, warning signal that motivates the individual to minimize harm, protect from re-injury and allow healing.

Pain: Acute & Chronic

Pain is divided into two categories: acute and chronic. Acute pain has a sudden onset and has a clear etiology and is expected to have a short duration (Institute of Medicine of the National Academies, 2011). Acute pain can result from trauma, surgery or illness. Acute pain resolves once the underlying cause is treated (Berube, Choiniere, Laflamme, & Gelinas, 2016).

Examples of acute pain include and are not limited to the following:

- trauma
- muscle sprain
- fractured bones
- myocardial infarction
- ectopic pregnancy
- labor
- appendicitis

Acute pain can also can be a repeated problem with periods of pain remission. The goal of treatment in acute pain is to treat the underlying cause.

Chronic pain is pain that originates as an acute pain and continues for greater than three (3) to six (6) months or past the time of normal tissue healing ([International Association for the Study of Pain [IASP, 1986; IASP, 2012]). Chronic pain is considered a chronic disease. The focus of treatment in chronic pain is lessening pain, maximizing function and to reduce disability. Chronic pain can affect employment, activities of daily living and interpersonal relationships (Committee on Advancing Pain Research & Care and Education, 2011). Chronic pain is reported to affect 100 million American adults.

Common sources of chronic pain include and are not limited to the following:

- back pain
- migraine headaches
- endometriosis
- fibromyalgia
- cancer
- shingles, and/or
- diabetic neuropathy

Comparison of Acute and Chronic Pain

Pain Type	Length of Pain	Examples
Acute Pain	< 3 months	Appendicitis Burns Childbirth Infectious diseases Renal calculi Surgery Trauma: fractures, lacerations Untreated dental conditions Wound infections
Chronic Pain	> 3-6 months, or past the time expected for normal tissue healing	Arthritis Cancer Chronic interstitial cystitis Diabetes Endometriosis Fibromyalgia Irritable Bowel Syndrome Low back pain Migraine Shingles Sickle cell disease Temporomandibular Joint Disorder Trauma or post-surgical pain Vulvodynia

(IASP, 1986; IASP, 2012)

Assessing Pain

Pain assessment is multifactorial and self-reported. Essential to obtaining an accurate assessment of pain is the establishment of provider patient trust.

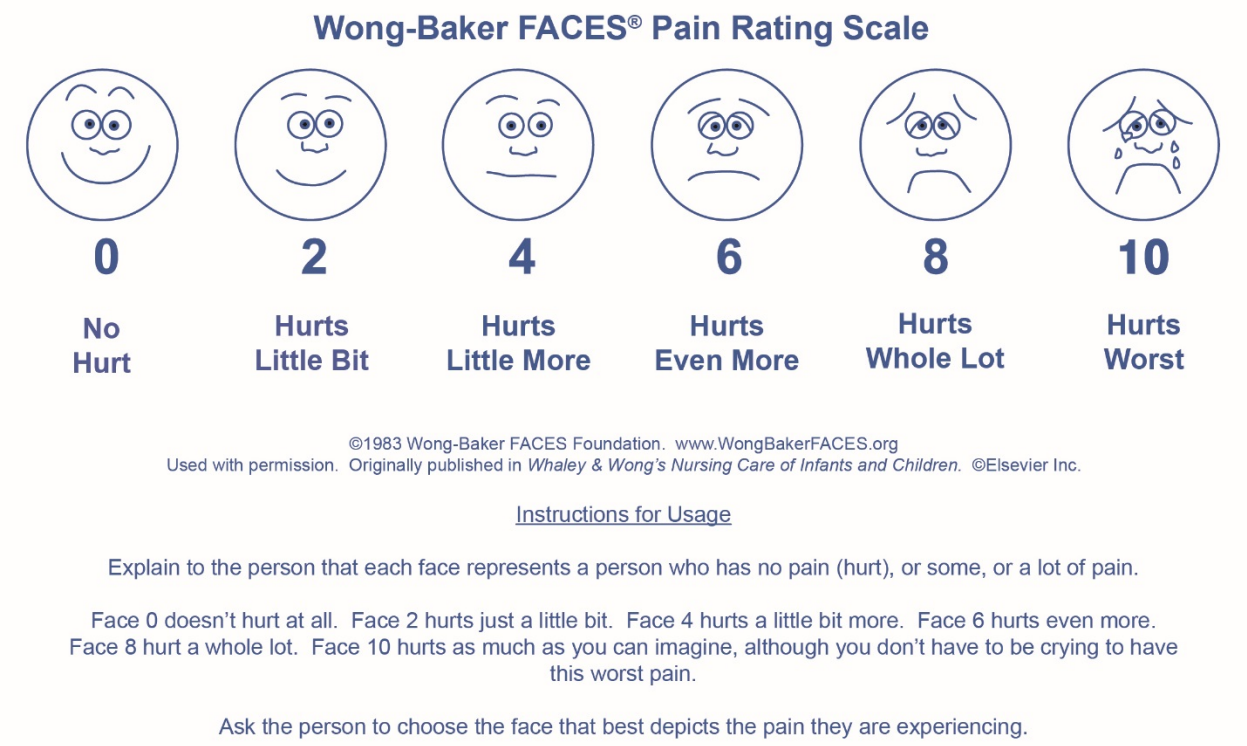
Steps to building patient trust include:

- ✓ effective communication;
- ✓ thorough assessment including history and physical examinations;
- ✓ expression of empathy with validation; and
- ✓ education and anticipatory guidance.

Specific to pain management anticipatory guidance, it is important that the patient understands the importance of accurate pain scores. Patients may assume that pain complaints are not taken seriously, this sometimes will cause them to exaggerate their level of pain (Yadav, Desai, & Chaturvedi, 2017).

Prescribers may use mnemonics to guide the assessment of a pain history to include: Character, Onset, Location, Duration, Severity, Patterns and Alleviating or Aggravating factors (Turk & Melzack, 2011). Additionally, it may be helpful to inquire if the pain experienced radiates to another body part(s), time periods that pain occurs and if pain is related to activity (e.g., sitting, standing or walking). To assess acute pain, unidimensional intensity scales may be utilized that include visual analogue scale (VAS) and numerical rating scale (NRS). The NRS defines pain as mild (1-3), moderate (4-6) or Severe (7-10) (McCaffery & Beebe, 1989). Due to the multidimensional aspect of chronic pain, VAS and NRS scales are not well suited for the assessment as they may not provide the prescriber with adequate information. The Pain, Enjoyment, General activity (PEG) is a validated 3-question screening that was developed from the Brief Pain Inventory (BPI) for use in primary care settings (Krebs, Lorenz, & Blair, 2009). The PEG activity is useful to track subjective patient responses to medications and therapy.

Screening Tool for Acute Pain



Source: Wong-Baker FACES Foundation (2017).

Screening Tool for Chronic Pain

Pain, Enjoyment, General Activity (PEG) Scale Assessment
In the past week: 1. What number best describes your pain *on average*? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (As bad as you can imagine)
In the past week: 2. What number best describes how, during the past week, pain has *interfered with your enjoyment of life*? (Does not interfere) 0 1 2 3 4 5 6 7 8 9 10 (Completely interferes)
In the past week: 3. What number best describes how, during the past week, pain has *interfered with your general activity*? (Does not interfere) 0 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

(Krebs, Lorenz, & Blair, 2009).

Prevention, Screening and Signs of Addiction

Predisposing Factors

It is important for prescribers to screen for substance abuse disorders prior to prescribing opiates. Balancing risks against potential benefits should be carefully thought out when selecting the treatment for pain control.

Risks include:

- overdose;
- respiratory depression;
- misuse of opioids by household members;
- physical dependence and tolerance;
- interactions with other medications and or substances; and
- neonatal withdrawal syndrome.

(Chou et al., 2009, FDA, 2014).

Predisposing factors for opioid overdose include:

- male sex
- age 16-45
- non-Hispanic white race
- low income
- sexual abuse
- mental health problems

(Paulozzi, 2012)

Screening Questions:

Single item screening questions can be used to identify alcohol and drug use in the clinic setting (Smith, Schmidt, Allensworth-Davies, & Saltz, 2009; Smith, Schmidt, Allensworth-Davies, & Saltz, 2010).

For alcohol the first question is:

"Do you sometimes drink beer, wine or other alcoholic beverages?"

If the patient answers "yes," a second question is asked:

"How many times in the past year have you had (5 for men / 4 for women) or more drinks in a day?"

Any number greater than zero is considered a positive screen and further screening with the CAGE questionnaire should be done.

Screening for substance abuse is an important component of the pain history as prescribing opiates with concurrent illicit drug use is prohibited and more importantly deadly. A single question screening test can be used to screen for illicit drug use or inappropriate use of prescription medications. The screening question is:

"How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

A response greater than one (1) requires further screening to determine if the patient has a drug abuse disorder. The DAST Drug abuse screening test should be completed; this tool can be found on the U.S. Preventive Services Task Force (USPSTF) webpage. For screening resources, the USPSTF has multiple resources available for health care professionals.

Click on the following link to review the USPSTF website**:**
https://www.uspreventiveservicestaskforce.org/Page/Name/tools-and-resources-for-better-preventive-care .

If either the substance abuse screening or the alcohol screening are positive, it is important for the prescriber to recognize that this patient is at risk for misuse of drugs, alcohol or prescription medication and substance abuse disorders.

Addiction is defined by the American Society of Addiction Medicine (2017) as:

> "…a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
>
> Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

The CAGE Questionnaire

The CAGE is a screening acronym that is used to screen for alcohol use (Ewing, 1984).

The CAGE questionnaire has the following questions:

1) Have you ever felt you should cut down on drinking?
2) Have people annoyed you by criticizing your drinking?
3) Have you ever felt bad or guilty about your drinking?
4) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eyeopener)?

Each question is scored zero (0) or one (1), one (1) indicating a positive answer. A total score of two (2) or greater is considered clinically significant (Ewing, 1984).

Signs of Opiate Use Disorder

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies the following as signs of opiate use disorder:

1) Strong desire to use opioids;
2) inability to control or reduce use;
3) trouble meeting social or work obligations;
4) having legal problems due to drug use;
5) spending large amounts of time to obtain opiates;
6) development of tolerance (meaning the need to use larger amounts over time); and
7) having withdrawal symptoms after stopping or reducing use.

Withdrawal symptoms include, but are not limited to:

- sweats
- enlarged pupils
- tremors
- abdominal cramping
- nausea
- vomiting
- diarrhea
- body aches
- rhinitis
- gooseflesh
- insomnia
- depressed mood

On the contrast, symptoms of opioid misuse include but are not limited to:

- analgesia
- sedation
- euphoria
- respiratory depression
- constricted pupils
- itching skin
- slurred speech
- “nodding” constipations
- nausea
- vomiting

New York State Opioid Deaths and Overdose

Healthcare providers wrote 259 million prescriptions for opioid pain medications in 2012 in the United States (Centers for Disease Control and Prevention, 2014). Opioid misuse has triggered a significant public health crisis contributing to an increase in divergence, emergency department utilization, hospitalizations, overdoses and opioid related deaths.

In the United States, drug overdose is the leading cause of accidental death.

(Rudd, Seth, & Scholl, 2016)

Opioid related deaths and overdoses in New York State (NYS) increased more than any other state in the country, with prescription opioid deaths increasing by four (4) times in 2014 as compared to 2005 (NYS Office of the Budget and Policy Analysis, 2016). Healthcare providers are in a crucial position to assess the benefits and risks of opioid analgesics. Echoing the 2011 report by the Institute of Medicine (IOM), Federal and State governments have placed a priority on prescriber training to inform, and address the opioid crisis.

Please review the IOM report in entirety here:
http://www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf.

Opioids

Opioids are a class of drugs that are unique, as it includes the illicit drug heroin and prescription pain medications. Opioids produce euphoria, decreased pain perception and reaction to pain while increasing pain tolerance (McLeane & Smith, 2007).

Opioids are associated with several adverse drug events, including:

- constipation
- nausea
- vomiting
- urinary retention, and
- respiratory depression

(Kane-Gil, Rubin, Smithburger, Buckley, & Dasta, 2014)

Prescription opioids act on the same brain pathways as heroin and morphine producing euphoria posing an abuse and addiction risk. Opioids employ several mechanisms to produce pain control by activating opioid receptors by turning on the descending inhibitory systems on the mid-brain, preventing ascending pain signals, inhibiting C-fiber terminals in the spinal cord, and inhibiting activation of peripheral sensory receptors. Non-medical use of opioid medications can be deadly as often to increase the euphoric effect the medication is crushed injected or snorted and combined with other drugs and/or alcohol (Volkow, 2014). Opioids are a class of analgesics that prescribers need to be well versed in to prevent opioid related misuse, overdoses and opioid related deaths.

Education and a review of the current literature and regulations will inform the prescriber and influence clinical practice. Opioids have become the mainstay of post-operative pain control. This was articulated clearly by Kessler, Shah, Gruschkus, & Raju (2013) who reported that 99% of surgical patients in the United States receive opioids after surgery. Prescribing trends and habits may have a significant impact on patient outcomes. Evidence supports that 3-5% of opioid naïve patients will become long-term users after filling an initial opioid prescription (American Society of Addiction Medicine, 2016; Clarke, Soneji, Ko, Yun, & Wijeysundera, 2014; Deyo, et al., 2017). It is also reported that males and individuals over 50 years of age are at risk for long-term opioid use post-operatively (Sun, Darnall, Baker, & Mackey, 2016). Additionally, Sun et al. (2016) reported that patients with a preoperative history including: drug abuse, alcohol abuse, benzodiazepine use, antidepressant use and depression, are vulnerable for long-term opioid use post-operatively.

Long-Term Opioid Use

Long-term opioid use often starts with the treatment of acute pain (Dowell, Haegerich, & Chou, 2016). Additionally, the practice of titrating up opioids has led to high dose long-term opioid therapy. It has also been found that the total number of pills prescribed is much more than what the patients need or take (Weiland et al., 2015). This has resulted in leftover opioids that are not disposed of and are available for intentional or unintentional diversion. This is significant as there is growing evidence postulating a relationship between increased non-medical use of opioids and heroin abuse in the U.S. (International Narcotics Control Board, 2009). The transition to heroin is often occurs when there is chemical tolerance toward prescribed opioids, it is difficult to obtain prescription medications illegally or as a cheaper substitute (Volkow, 2014).

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) non-medical use of prescription pain relievers was the second most prevalent type of illicit drug use after marijuana use among the U.S. population aged 12 or older (Center for Behavioral Health Services and Quality, 2015).

Please review the SAMHSA report in entirety here:
https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Pain Management

Guidance for the treatment of pain can be found from the following credible authorities:

- American Pain Society
- American Society of Regional Anesthesia and Pain Medicine (ASRA)
- American Society of Anesthesiologists (ASA)

High quality evidence with strong recommendation endorse the use of multimodal analgesia. Multimodal analgesia uses a variety of analgesic medications combined with non-pharmacological interventions for the treatment of postoperative pain. Multimodal analgesia builds on the principals of peripheral sensitization, descending inhabitation and central sensitization (Finnerup, Sindrup, & Jensen, 2010; Mao, Gold, & Backonja, 2011; Woolf, 2004).

Descending Inhibition

Descending inhibition disrupts the pain impulses that are sent from the brain to the spinal cord via the monoamine neurotransmitters norepinephrine (NE) and serotonin (5HT).

Examples of pharmaceutical that disrupt this pathway are:

- ✓ Opioids
- ✓ tricyclic antidepressants (TCA)
- ✓ serotonin and norepinephrine reuptake inhibitors
- ✓ Tramadol and Tapentadol

Peripheral Sensitization

Peripheral sensitization is responsible for pain sensed in the absence of external stimuli and is thought to be related to sodium channel expression (Finnerup, Sindrup, & Jensen, 2010). The pathway that peripheral sensitization occurs is between peripheral nervous system and the spinal cord.

Drugs that disrupt this pathway include:

- ✓ Non-steroidal anti-inflammatory drugs (NSAIDs)
- ✓ Opioids
- ✓ TCA
- ✓ Lidocain

Central Sensitization

Central sensitization is associated with the development and continued chronic pain (Mao, Gold, & Backonja, 2011; Woolf, 2004.

Drugs that treat central sensitization include:

- ✓ Gabapentin
- ✓ Pregabalin
- ✓ TCA
- ✓ Opioids

Non-opioids and Adjuvant Analgesics

Non-opioids that are commonly used for pain control include: NSAIDs, Salicylates, Acetaminophen. There are also adjuvant analgesics which are medications that are primarily indicated for treatment of discarders.

Examples of adjuvant analgesics are:

- ✓ anti-depressants
- ✓ anti-convulsants
- ✓ anti-spasmodics
- ✓ neuroleptics

Pain Medications

Peripheral Sensitization	Central Sensitization	Descending Inhibition	Non-Opioids	Adjuvant Analgesics
NSAIDs	Gabapentin	SNRI	NSAIDs	Anti-depressants
Opioids	Opioids	Opioids	Aspirin	Anti-convulsants
TCA	TCA	TCA	Salicylates	Anti-spasmodics
Lidocaine	Pregablin	Tramadol	Acetaminophen	Muscle relaxants
		Tapentadol		Neuroleptics

Appropriate Prescribing

NYS has implemented several programs to decrease opioid related diversion, misuse and overdose deaths that are highlighted in the table below.

NYS Methods to Decrease Opioid-Related Overdoses
➢ I-STOP Prescription Monitoring Program ➢ E-prescribing ➢ Legislation requiring prescriber education: NYS Bills S8139/A10727 ➢ Require CME on pain management by physicians and other healthcare providers ➢ Mandate insurance coverage for needed inpatient treatment services ➢ Limit initial opioid prescriptions from 30-day supplies to 7-day supplies for acute, non-cancer pain ➢ Require pharmacists to provide additional education and counseling to those receiving opioids

Managing Acute Pain

Acute pain is defined as pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last a short period of time. Managing acute pain needs to have a balance of risk versus harm. As discussed above, initial opioid prescriptions can lead to long-term use and misuse. For the initial treatment of acute pain non-opioid medications should be used. Acetaminophen in combination with an ibuprofen have been found to provide pain control superior to opioids for acute pain in several Cochrane reviews (Derry, Derry, & McQuay, 2009; Holdgate & Pollock, 2005 & Moore, 2013).

It is also important to use non-pharmacological methods such as:

- ✓ physical therapy
- ✓ relaxation techniques
- ✓ heat or cold therapy
- ✓ rest
- ✓ ice
- ✓ elevation

The FDA has approved several non-opioid medications that have shown promising results for treatment of chronic-pain disorder, including: gabapentin, pregabalin, and duloxetine (Caniff, Woodcock, & Ostroff, 2016).

The CDC Guidelines for prescribing opioids recommend when using opioids for acute pain, prescribe the lowest effective dose of immediate release opioids. (Dowell, Haegerich, & Chou, 2016). Prescribers need to be aware of the quantity of opioids needed for the expected duration of pain. It was recommended that three (3) days or less is often sufficient and it is rare that more than seven (7) days of opioid medication is needed (Dowell, Haegerich, & Chou, 2016).

Effective July 22, 2016, in NYS a practitioner may not *initially* prescribe more than a seven-day supply of an opioid medication for acute pain.

Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid.

In NYS, in the emergency department if the practitioner prescribes less than a 5-day supply of a controlled substance they are exempt from the duty to consult the I-STOP registry.

At any time, during treatment, if there is a question of substance abuse or diversion, the prescriber should use urine drug screening with confirmation, pill counts, utilization of I-STOP and assure that a proper screening for risky behavior and or substance abuse takes place promptly. If addiction is detected, a referral to a pain management specialist with experience with addiction should be made.

It is important not to prescribe controlled substances when a patient has identified, un-treated addiction.

Recommendations for Prescribing Controlled Substances for Acute Pain		
Center for Disease Control	**NYS Emergency Department**	**NYS Acute Pain**
✓ Start with lowest therapeutic dose. ✓ Less than 3 or less days of medication sufficient. ✓ More than 7 days medication is rarely needed.	✓ Less than 5 Days exempt from I-STOP.	✓ May only prescribe MAXIMUM 7 days of medication for acute pain.

In New York, there is a limit of a 7-day supply for an original controlled substance prescription. ***(*Some exemptions apply.)***

Managing Chronic Pain

In NYS, a prescriber may not initially prescribe more than a 7-day supply of opioid medication for acute pain.

***Chronic pain, such as with cancer, hospice, end of life and palliative care, are *exempt* from the 7-day rule.**

Upon any subsequent consultations for the same pain, the prescriber may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid. Pharmacists are NOT required to verify.

The CDC Guidelines for prescribing opioids for chronic pain delineate best practices for the use of opioids and non-opioids for the treatment of chronic pain.

Please review the CDC Guidelines for prescribing opioids for chronic pain:
https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Chronic pain is considered pain for greater than six (6) months. Determination of the classification of chronic pain must be assessed before the initiation of treatment.

Nociceptive pain is divided into two categories:

1. Superficial
2. Deep

Superficial nociceptive pain is derived from the skin and tissues proximal to the surface, whereas deep pain can be visceral from the internal organs or deep somatic from the musculoskeletal system. Neuropathic pain can be either peripheral or central. An example of peripheral neuropathic pain is neuropathies. Central neuropathic pain arises from the brain or spinal cord. The treatment for these chronic pain disorders varies depending on the classification. The table below highlights evidence based treatment modalities.

Treatment of Chronic Pain

Chronic Pain Classification	Treatment
Nociceptive Superficial	✓ Non-opioid pharmacological treatment ✓ Surgical management ✓ PT and Exercise
Nociceptive Deep pain	✓ Non-opioid pharmacological treatment ✓ Surgical management ✓ PT and Exercise
Neuropathic Peripheral	✓ Non-opioid pharmacological treatment ✓ Antiepileptic medications ✓ Surgical management only after failure of therapy and rapid worsening
Neuropathic Central	✓ Non-opioid pharmacological treatment ✓ Antiepileptic medications ✓ Surgical management only after failure of therapy and rapid worsening
Somatosensory Disorder (SSD)	✓ Behavioral health therapy ✓ Multidisciplinary approach

Requirements for Prescribing Controlled Substances

Federal requirements for Prescribing

A prescription for a controlled substance **must** include the following information:

1. Date of issue – Patient's name and address
2. Practitioner's name, address, and DEA registration number
3. Drug name
4. Drug strength
5. Dosage form
6. Quantity prescribed
7. Directions for use

Per the DEA, prescriptions must be written in ink and signed by the practitioner. **In NYS, controlled substances must be electronically prescribed unless there is a waiver in place.** A prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, veterinarian, nurse practitioner, physician assistant or other registered practitioner who is:

1. Authorized to prescribe controlled substances by the jurisdiction of licensure.
2. Registered with DEA or exempted from registration via Public Health Service, Federal Bureau of Prisons or military personnel.
3. An agent or employee of a hospital or other institution acting in its normal course of business or employment under the registration of the hospital or institution.

See: https://www.deadiversion.usdoj.gov/pubs/manuals/pract/section5.htm.

The lists of Schedule II controlled substances are issued by the federal government and may vary by individual state requirements.

Patient Records

Prescribers must be careful to keep patient records for any patient that they prescribe for in clinical practice. NYS Law at 10 NYCRR §80.62 mandates prescribers shall maintain a written patient record to include administration, dispensing and prescribing of all controlled substances. The record must contain sufficient information to justify the diagnosis and warrant the treatment.

Documentation at a minimum must include the following information:

- ✓ Patient identification data;
- ✓ chief complaint;
- ✓ present illness;
- ✓ physical examination as indicated; and
- ✓ diagnosis.

In addition, it is the responsibility of the prescriber to be knowledgeable and adhere to state and federal prescribing laws.

Review NYS Law 80.62 here: https://regs.health.ny.gov/content/section-8062-use-controlled-substances-treatment

Review Federal requirements for prescribing controlled substances at the link below.
Federal Controlled Substance Act: https://www.deadiversion.usdoj.gov/21cfr/21usc/index.html

Prescribing Controlled Substances in NYS

Laws addressing prescribing of controlled substances in New York State can be found in Public Health Law, Article 33, Title 10, Administrative Rules and Regulations, Part 80 – Rules and Regulations on Controlled Substances. Review the entire document here:
https://www.health.ny.gov/regulations/controlled_substance/part/80/docs/80.pdf

Additional NYS & FEDERAL Controlled Substances Regulations
➢ To prescribe controlled substances, the practitioner must be registered with the Federal Drug Enforcement Agency (DEA) and have obtained a DEA number. ➢ Controlled substances must be prescribed for legitimate medical purposes only, in dosages that are therapeutically sound and recognized as sufficient for proper treatment. ➢ Controlled Substances must not be prescribed prior to examination of the patient. ➢ Practitioners are not allowed to prescribe controlled substances for themselves. ➢ No prescriptions can be written or filled for controlled substances in Schedule I. ➢ All prescriptions for controlled substances must be filled within 30 days of the date of the prescription written by the prescriber. ➢ No additional prescriptions or refills may be issued by the prescriber to a patient for the same controlled substance that has already been written unless the patient has exhausted all but a 7-day supply of controlled substance.

Additional Resources for NYS Prescribers

Review NYS Law §6810. Prescriptions here:
http://www.op.nysed.gov/prof/pharm/article137.htm#sect6810

Review NYS E-Prescribing here:
https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/
http://www.nyacp.org/i4a/pages/index.cfm?pageid=3700

For further inquiries and clarification contact the NYS Prescription Monitoring Program and E-Prescribing Help-Desk at 1-866-811-7957.

The controlled substance schedule includes medications with a high abuse, misuse or addiction potential. They are divided into five (5) categories that are outlined in the table below.

CONTROLLED SUBSTANCE SCHEDULE		
Schedule	**Medications**	
I.	These are medications that have no accepted therapeutic use, and a high potential for abuse, such as Heroin, Mescaline, Ecstasy, Peyote. Exception: medical marijuana in some states—check the specific states current laws as laws are changing frequently	Prescriptions are NEVER written for CI.
II.	These medications include narcotics, amphetamines, barbiturates, stimulants and anabolic steroids. Schedule II medications have the high potential for abuse, though less abuse potential than Schedule I drugs, with use potentially leading to severe psychological or physical dependence. Drugs such as Hydrocodone, Methadone,	CII Anabolic Steroids, Max 30-day supply. NO REFILLLS

	Hydromorphone, Demerol®, Fentanyl, Ritalin, Morphine, Codeine, Oxycodone, Cocaine	
III.	These medications are combinations of Schedule II and non-controlled medications, and includes certain barbiturates. They are drugs that have moderate to low potential for physical and psychological dependence. Drugs such as Tylenol with Codeine, Ketamine, Anabolic steroids, Testosterone, Buprenorphine, Marinol	CIII Max 30 days supply • Max 5 refills / 6 months -If indicated
IV.	These medications include long acting barbiturates, such as phenobarbital, some analgesics and benzodiazepines which have low potential for abuse and low risk of dependence. Examples are Xanax, Darvon, Valium, Ativan, Ambien, Tramadol	CIV Benzodiazepines, Maximum 30 day supply, NO REFILLS All other CIV Max 30 day supply • Max 5 refills / 6 months -If indicated
V.	These medications include syrups such as narcotic antitussives. These drugs have the lowest, of all scheduled drugs, potential for abuse and contain limited quantities of certain narcotics. Examples include Lomotil, Lyrica, Robitussin AC.	CV Max 30 days supply • Max 5 refills / 6 months -If indicated

It is important to note that some NYS Laws supersede Federal law. Individual states may elect to enforce additional rules when prescribing. See the table below as an example.

Federal	New York State
Allows controlled Rxs to be communicated to a pharmacist by an employee or agent of the individual PR	**Only the PR may orally prescribe controlled substances to a pharmacist -In any venue!**
The Federal CSA states that a prescriber may issue 3 prescriptions for the same controlled substance at the same time to a patient	**No. Has Condition Codes (See table below)**
Electronic prescribing optional	**Electronic prescribing mandatory**

For example, the Federal Controlled Substance Act states that a prescriber may issue three (3) prescriptions for the same controlled substance at the same time to a patient. This is NOT allowed in NYS, rather condition codes are used for specific disorders to issue additional prescriptions. See the table below that highlights NYS Condition Codes.

NYS Condition Codes for Controlled Substances.	
May provide up to a three (3) month supply as determined by the directions for use, for substances used for the treatment of (Codes A – E).	
Code A -	Panic disorders
Code B -	Attention Deficit Hyperactivity Disorder
Code C -	Chronic debilitating neurological conditions characterized as a movement disorder or exhibiting seizure, convulsive or spasm activity
Code D -	Relief of Pain....suffering from diseases known to be chronic and/or incurable
Code E -	Narcolepsy
Code F -	Anabolic steroids used to treat hormone deficiency states in males, gynecologic conditions that are responsive to treatment with anabolic steroids or chorionic gonadotrophin, metastatic breast cancer in women, anemia and angioedema. May prescribe up to 6 month supply.

Medical Marijuana

As set forth in 10 NYCRR §1004.1(a), practitioners seeking to issue certifications for their patients to receive medical marijuana products must meet the following criteria:

> …be qualified to treat patients with one or more of the serious conditions set forth in Public Health Law §3360(7) or as added by the Commissioner. The law currently identifies the following severe, debilitating or life threatening conditions: cancer, HIV infection or AIDS, amyotrophic lateral sclerosis (ALS), Parkinson's disease, multiple sclerosis, spinal cord injury with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathy, chronic pain as defined by 10 NYCRR §1004.2(a)(8)(xi), and Huntington's disease. Patients must also have one of the following associated or complicating conditions: cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms.

“Prescribers of medical marijuana must be licensed, in good standing as a physician and practicing medicine, as defined in article one hundred thirty one of the Education Law in New York State, or be certified, in good standing as a nurse practitioner and practicing”, as defined in Article 139 of the Education Law, in New York State, or be licensed, in good standing as a physician assistant and practicing in New York State, as defined in article 131-B of the Education Law, under the supervision of a physician registered with the New York State medical marijuana program. Prescribers also must complete a four-hour course approved by the Commissioner; and need to register with the New York State Department of Health (NYSDOH).

Visit the following site to review NYS Mandated Practitioner Education, Medical Use of Marijuana Course
https://www.theanswerpage.com/new-york-state-practitioner-education-medical-use-marijuana

Visit the following site to review DEA Denial of Rescheduling of Marijuana from class I to class II
https://www.deadiversion.usdoj.gov/fed_regs/rules/2016/fr0812.pdf

The Expanded Syringe Access Program

The Expanded Syringe Access Program (ESAP) became effective in New York State in January 2001 and is now a permanent program as of summer 2009 (New York State Department of Health, n.d.). This program allows persons over the age of 18 to access 10 or less hypodermic needles and/or syringes from authorized providers without a prescription, when disposing of used needles and syringes at registered sites. Review the ESAP in detail here: https://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm

The clean needles and syringes must include a Safety Insert, which includes the following information:

1. The proper use of hypodermic syringes and needles.
2. The risk of blood-borne diseases that may result from the use of hypodermic syringes and needles.
3. Methods for preventing the transmission or contraction of blood-borne diseases.
4. Proper disposal practices for hypodermic syringes and needles.
5. The dangers of injection drug use and how to access drug treatment.
6. A toll-free number for information on the human immunodeficiency virus.
7. A statement that it is legal for persons to possess syringes and needles obtained through the Expanded Syringe Access Demonstration Program.

Prescription Monitoring Program (PMP) Registry

NYS implemented a prescription monitoring program registry called the Internet System for Tracking Over-Prescribing (I-STOP) in 2013. Prescribers must consult the registry prior to prescribing or dispensing any controlled substance on schedule II, III or IV. It is optional to consult the registry for Schedule V. The prescriber may check the PMP registry up to 24 hours in advance of prescribing. The prescriber must document that they checked the PMP. If they do not consult the PMP registry, they should document why they didn't, and the reason given must be an approved exception.

Exceptions to duty to Consult I-STOP
1. Veterinarians.
2. Methadone programs.
3. A practitioner administering a controlled substance.
4. A practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser.
5. A practitioner prescribing a controlled substance in the emergency department of a general hospital, provided the quantity of a controlled substance does not exceed a five-day supple if the controlled substance were used in accordance with the directions for use.
6. A practitioner prescribing a controlled substance to a patient under the care of a hospice.
7. A practitioner when: it is not reasonably possible for the practitioner to access the registry in a timely manner, no other practitioner or designee authorized to access the registry, pursuant to paragraph of this subdivision, is reasonably available and the quantity of controlled substance prescribed does not exceed a five-day supply if the controlled substance were used in accordance with the directions for use.
8. A practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient.
9. A situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation.

10. A practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation, and in the discretion of the commissioner.

Missing Prescriptions

Prescribers who use the PMP registry often will ask,

"Why can I not find a patient I know had a controlled prescription filled?"

Several factors can affect the way the prescription is cataloged. The format for how the information is entered is name specific. For example, a patient Patricia may have had her name inputted in several ways: Pat vs Patricia vs Patrice vs. Patty vs Patti. There also may be a transmission error by the pharmacy or the wrong prescribers name or DEA number. Electronic prescribing allows you to review the pharmacy you transmitted the electronic prescription to. If you feel there is an error, best practice is to contact the pharmacy directly.

Review NYS Internet System for Tracking Over-Prescribing (I-STOP) E Prescribing Updates here:
http://www.nyacp.org/i4a/pages/index.cfm?pageid=3700

Review the NYS Prescription Monitoring Program here:
https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/

NYS E-Prescribing

New York Education Law §6810 - all prescriptions must be transmitted electronically. NYS is the only state to mandate e-prescribing of controlled and non-controlled substances. This does not include over the counter medications and herbals. Federal law currently states that electronic prescribing is optional. Remember that state legislation can apply additional and more restrictive regulations as compared to federal mandates.

E-Prescribing Controlled Substances

To sign a controlled substance prescription, the electronic prescription application must require the prescribing practitioner to authenticate using two of the following three factors:

1. Something only the prescriber knows, such as a password or response to a challenge question. It is a *felony* to give the password to someone else.
2. Something the prescriber is, for example biometric data such a fingerprint or iris scan.
3. Something that the prescriber has such as a device (hard token) separate from the computer to which the prescriber is gaining access.

NYS E-Prescribing
1. The practitioner must use e-prescribing software that has been certified and audited in accordance with U.S. Drug Enforcement Agency (DEA) regulations. The EPCS software application meets all the federal security requirements which can be found on the DEA website: https://www.deadiversion.usdoj.gov/ecomm/e_rx/.
2. The practitioner must also complete an identity proofing process and obtain two factor authentications in accordance with the DEA regulations.
3. The practitioner must register the controlled substance e-prescribing software with the

Bureau of Narcotic Enforcement (BNE). The registration with BNE needs to be updated at least every two years or whenever the DEA requires a new third party audit of the software, whichever occurs first.

4. If the practitioner works at multiple locations and different e-prescribing software is used at such sites, the practitioner will need to register each software program used to prescribe controlled substances.
5. A prescriber must make a notation in the patient's medical record indicating when he/she has issued a paper prescription noting the applicable statutory exception for why an e-prescription was not possible.
6. All electronic prescriptions must include the prescribers National Provider Identification (NPI) number, digital signature and delineate whether the prescription must be dispensed as written (DAW).

Exceptions NYS E-Prescribing

After March 27, 2016, it became mandatory for practitioners to issue electronic prescriptions for controlled and non-controlled substances. Official New York State Prescription forms may only be used in the event of a power outage or technical failure or if the practitioner meets criteria for an exception.

Exceptions NYS E-Prescribing
The e-prescribing regulations include several exceptions to the mandate including when: 1. Prescriptions are issued by veterinarians; 2. Electronic prescribing is not available due to temporary technological or electronic failure; 3. Prescriptions are issued by a practitioner under circumstances where the practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition. In addition to these circumstances, the quantity of controlled substances cannot exceed a five-day supply if the controlled substance were used in accordance with the directions for use; 4. Prescriptions are issued band dispensed by a pharmacy located outside the stat. This includes federal institutions such as VA facilities, Indian Reservations, Military Bases; and/or 5. Practitioners have received a waiver from the requirement to use electronic prescribing.

Commissioner of Health Blanket Waivers

The Commissioner of Health has instituted blanket waivers, effective until **March 28, 2018**, according to PHL §281(3) to include the following:

- A prescription containing certain elements required by the Federal Food and Drug Administration (FDA) such as an attachment;
- approved protocols under expedited partner therapy;
- approved protocols under collaborative drug management;
- response to a public health emergency that would allow a non-patient specific prescription;
- approved research protocol; and
- a non-patient specific prescription for an opioid antagonist.

Review the Commissioner of Health Blanket Waivers Effective until March 25, 2018, PHL §281(3), here: http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/2016-03-16_blanket_waiver_letter.pdf

Palliative Care

Palliative Care

"Palliative care" means health care treatment, including interdisciplinary end of life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of the Public Health Law. Palliative care is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Palliative care is about addressing the patient's symptoms and psychosocial burden—it is not prognosis-based.

Elements of palliative care include:

- ✓ Specialized medical care for people living with serious illness; and
- ✓ a focus that provides relief from the symptoms and stress of a serious illness to improve quality of life for both the patient and the family.

Care is delivered by a team of palliative care doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support.

Public Health Law Section 2997-d requires the "attending health care practitioner" to offer to provide patients with a terminal illness (or their surrogates) with information and counseling regarding palliative care and end-of-life options appropriate for the patient.

Information should include:

1) Prognosis;
2) Range of options appropriate to the patient;
3) Risks and benefits of various options;
4) Patient's "legal rights to comprehensive pain and symptom management at the end of life."

Public Health Law Section 2997-d requires that hospitals, nursing homes, home care agencies, special needs assisted living residences, and enhanced assisted living residences provide patients and their surrogates access to information and counseling regarding options for palliative care appropriate to patient with advanced life limiting conditions and illnesses. These providers and residences must also facilitate access to appropriate palliative care consultation and services, including associated pain management consultation and services, consistent with the patient needs and preferences.

Review the PHL Section 2997-d here:
https://www.health.ny.gov/regulations/public_health_law/section/2997d/

Review the NYS Palliative Care Information Act here:
https://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm

Review the NYS Palliative Care Access Act here:
http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/phl_2997_d_memo.htm

Effective Communication during Difficult Conversations

Effective communication is key to the introduction and discussion about palliative care with patients. SPIKES is a six-step protocol for delivering bad news. Difficult conversations are often serious discussions between the health care provider and the patient pertaining to results, behaviors, prognosis and end of life care. Although stressful, keep in mind patients want the truth. Often healthcare providers are mandated by legislation like the NYS Palliative Care Information Act and it has been found that discussions with education often impact quality of life even in dire situations (Baile et al., 2000).

The Six Steps of Spikes (Baile et al. 2000)			
Step 1	**S**	**Setting** up interview	Privacy-curtain, interview room, close door. Involve significant others - if large family, ask who is the representative/spokesperson. Sit down. Make a connection with patient - eye contact, hold hand. Manage time constraints and interruptions - silence phone.
Step 2	**P**	Assessing the patient's **Perception**	Before you tell, ask. Use open ended questions. For example: *"What have you been told thus far?"* *"What is your understanding of the reasons we did the MRI?"*
Step 3	**I**	Obtaining the patient's **Invitation**	Some patients want full information about diagnosis while others do not. Ask for permission before sharing new information.
Step 4	**K**	Giving **Knowledge** and information to the patient	Use I statements to begin conversation. For example: *"Unfortunately I've got some bad news to tell you"* or *"I wish I had better news to tell you that…"*. Consider using, "I wish…" rather than, "I'm sorry…" Use non-technical terms. Avoid excessive bluntness. Avoid terms like "I am sorry there is nothing we can do for you". Acknowledge the uncertainty.
Step 5	**E**	Addressing the patient's **Emotions** with **Empathetic** responses	Use pauses to listen and observe reaction. An empathetic response has 4 steps: 1. Observe for any emotion on the part of the patient. This may be tearfulness, a look of sadness, silence, or shock. 2. Identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling. 3. Identify the reason for the emotion. This is usually connected to the bad news. However, if you are not sure, again, ask the patient. 4. After you have given the patient a brief period to express his or her feelings, let the patient know that you have connected the

			emotion with the reason for the emotion by making a connecting statement.
Step 6	**S**	**Strategy** & **Summary**	Treatment Plan Prognosis Use ranges of time: Months to a few years, Weeks to a few months, Days to a few weeks, and/or Hours to a few days Palliative Care options Hospice Options Check the patient's understanding again, before you finish.

When to Initiate Palliative Care?

Palliative care can occur in any setting. Acute, critical care settings offer opportunities for health care providers to discuss and/or offer palliative care. The table below delineates patients who may present to emergency departments and/or intensive care units

Palliative Care	
Emergency Department Patients	**Intensive Care Patients**
➢ Multiple recent prior hospitalizations with same symptoms/problems. ➢ Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders. ➢ Patient previously enrolled in a home or residential hospice program. ➢ Patient/caregiver/physician desires hospice but has not been referred. ➢ Consideration of ICU admission and/or mechanical ventilation in a patient with metastatic cancer and declining function, with moderate to severe dementia, one or more chronic diseases, and poor functional status at baseline.	➢ Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., dementia). ➢ Two or more ICU admissions within the same hospitalization. ➢ Prolonged or difficult ventilator withdrawal. ➢ Multi-organ failure. ➢ Consideration of ventilator withdrawal with expected death. ➢ Metastatic cancer. ➢ Anoxic encephalopathy. ➢ Consideration of patient transfer to a long-term ventilator facility. ➢ Family distress impairing surrogate decision-making.

HOSPICE Care

HOSPICE Care is palliative care for patients who appear to have a life expectancy of six months or less. These services are covered under Medicare Part A and many commercial insurance plans and NYS Medicaid also provides hospice benefits. HOSPICE services are provided by hospice care agencies, in coordination with the patient's primary physician. HOSPICE is a program that specializes on end-of-life care. In the next table, end of life considerations are outlined for the healthcare provider to assist them in focusing on comfort.

End of Life Care - Focus on Comfort

As patients near end-of-life, *discontinue* medical treatments that:

- Will not improve quality of life,
- cause excessive pain,
- are expensive for the patient, and/or
- that cause burdens or side effects that outweigh the benefits.

Eliminate unnecessary medications/treatments that may no longer be beneficial. For example:

- cholesterol medications
- dementia medications
- vitamins
- protein supplements
- minerals
- DVT prophylaxis
- compression devices
- antibiotics
- anti-diabetic meds

Stop any intravenous fluids. Recognize that giving intravenous fluid while someone is actively dying usually causes burden without benefit (increased strain on heart and kidneys while causing dyspnea, pleural effusions, and edema).

Limit vitals – Only monitor HR and RR as markers of distress (goal HR<100, RR<24) – Checking BP is uncomfortable.

Morphine given intravenously or sublingually or subcutaneously can be helpful in end of life care. The initial dose for opioid naive patient is:

Oral morphine (2.5-5 mg), Parenteral (IV/SQ) morphine (1-2 mg).

Foley catheters will allow kidney function monitoring.

Dyspnea management:

Turn on a fan or open the window as the flow of air eases breathing.
Avoid BIPAP as it would not resolve underlying issue and can be very uncomfortable because it is tight on the face for the patient. When dyspnea is acute and severe, give morphine every 5-10 minutes until relief. Morphine also will help dry sections, and help relax the patient as dyspnea is known to create anxiety for the patient.

A continuous opioid infusion, with a PRN dose will provide the timeliest relief in the inpatient setting. Lorazepam is an anxiolytic that given intravenously or sublingually to reduce the anxiety component of dyspnea. Starting dose usually 0.5mg given intravenously q8h PRN or Oral liquid dose is 2mg/ml, so give 0.5mg (0.25ml) sublingually q6h prn.

Offer social work or pastoral services.

Update caregivers/family and patient. Keep communication open.

Provide realistic expectations and emotional support.

Explain that not eating/drinking is a natural part of the dying process and it is not uncomfortable for the patient.

Encourage families on how to express their love and concern:

• Cultural traditions • touch • hand holding	• music • massage • prayer • reading

Advanced Directives

Advanced directives allow for advanced planning goal setting and preferences about care to be known and honored. This is particularly important as life expectancy is increasing with people living longer with chronic illnesses. Technology and interventions have assisted in increasing the life expectancy of patients but also afford more complex decisions to be made regarding medical interventions and procedures. It is best to attempt to address advanced directive before a time of crisis when decisions are more stressful. It is also better for the patient to discuss advanced directives with their primary care provider as this discussion is best initiated with a healthcare provider the patient is familiar with.

Advanced directives should be considered at:

- every healthcare visit
- prior to hospitalization for elective surgery or procedure
- emergency department visits
- acute hospitalization, including return visits after a recent hospitalization
- follow up office visit, especially with chronic illness
- when a diagnosis of serious or life threatening illness is made.

Conversations about cardiopulmonary resuscitation (CPR) and other life-sustaining treatments should be based on evidence. It is also important that the healthcare provider avoid medical jargon when discussing advanced directives to help increase the patient's understanding. It is important for the patient to understand the purpose of CPR is to prevent sudden, unexpected death, and that it is not indicated in cases of terminal, irreversible illness when death is expected or when prolonged cardiac arrest dictates the futility of resuscitation efforts. For the past five (5) years, the American Heart Association reports adult out-of-hospital CPR success rates between 9.5% -12% and adult in-hospital CPR success rates 22.7%-25.5% (American Heart Association, 2017). It is also important that healthcare providers are careful to explain to patients that do-not-resuscitate orders do not exclude patients from access to any other life sustaining treatments.

Advanced care planning is expected as a standard of practice and the health care provider can bill Medicare for this service. It is important for the healthcare provider to document this encounter appropriately.

Documentation should include:

- ✓ An accounting of the discussion with regard to the voluntary nature of the encounter;
- ✓ a sum and substance of the explanation of advance directives;
- ✓ a record of completion of the legal forms;
- ✓ when the forms were executed;
- ✓ who performed the execution;
- ✓ who was present for the encounter; and
- ✓ the time spent in the face-to-face conversation.

The table below highlights the CPT codes for advanced care planning.

Advance Care Planning Medicare Codes		
CPT Code 99497	**CPT Code 99498**	*Does the beneficiary or practice have to complete an advance directive to bill the service?* No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.
Advance care planning includes: ➢ Explanation and discussion of advance directives by physician or other qualified health care professional. ➢ First 30 minutes, face-to-face with patient, family member(s), and/or surrogate.	➢ Each additional 30 minutes. ➢ List separately in addition to code 99497.	

Types of Advanced Directives and Decision-Making Documents

Power of Attorney

In NYS, a power of attorney is document designating a person to make financial and other non-health care decisions**.**

Health Care Proxy (HCP)

A Health Care Proxy is a legal document that appoints a Health Care Agent to make decisions in the event patient is unable to do so due to illness or injury.

Review *Health Care Proxy: Appointing Your Health Care Agent in NYS* here: https://health.ny.gov/publications/1430.pdf

Living Will

A living will is a document that outlines medical procedures that patients do or do not want in case they are unable to do so for themselves due to a terminal, irreversible condition. A living will is not a legal document, but does help to establish clear and convincing evidence of the patient's preferences**.**

Organ & Tissue Donation

In NYS, an individual can enroll in the New York State Donate Life Registry several ways: online through NYS Department of Motor Vehicles and NYS Department of Health; through the NY State of Health Marketplace while enrolling for health insurance; by mailing a printable paper form, in person, at the NYS Department of Motor Vehicles when applying for application of a non-driver's license or when renewing a driver's license; and when registering at the Board of elections.

Visit the following site to review the NYS Department of Health web page that provides links and explanations of all the above methods to enroll for organ and tissue donation. https://www.health.ny.gov/professionals/patients/donation/organ/

Access the Department of Health Donor Registry Enrollment Form here: https://www.health.ny.gov/forms/organ_donation_enrollment_form.pdf

Actionable Medical Orders: Non-Hospital Do Not Resuscitate

Non-hospital Do Not Resuscitate (DNR) Orders are legally recognized statewide for DNR requests occurring outside of article 28 licensed facilities. Non-hospital DNR orders must be recorded on a state specific form DOH-3474. In NYS, only a physician can sign either a non-hospital or inpatient DNR order.

While a hospital DNR Order is issued in a health care facility such as a hospital, nursing home, or a mental hygiene facility licensed by New York State, the non-hospital actionable medical DNR order is intended for those patients originating from home. Copies of the form can be kept on ambulances and made available to patients, facilities, or physicians as a part of community education. Health care providers need to explain to patients that actionable medical DNR orders do not exclude the patient from access to any other life sustaining treatments.

Visit the following page to review the State of New York Department of Health Non-Hospital Order Not to Resuscitate. https://www.health.ny.gov/forms/doh-3474.pdf

Actionable Medical Orders: Medical Orders for Life-Sustaining Treatment (MOLST)

The MOLST form allows doctors to record the patient's preferences regarding cardiopulmonary resuscitation (CPR), mechanical intervention, and other life sustaining treatments onto one form. Hospital

DNR orders can be made in the health care proxy, living will or MOLST form. The MOLST form is authorized in NYS for documenting both DNR and DNI orders. MOLST is the only medical order form approved under NYS Public Health Law that emergency medical services (EMS) can follow regarding both DNR and DNI orders in the community. MOLST forms also address and provide specific medical orders (feeding tube, IVF, antibiotics, Do Not Hospitalize).

Patients who would benefit most from MOLST are those who:

- have one or more advanced chronic conditions, or a serious new illness with a poor prognosis;
- have specific preferences regarding medical interventions (which may change as the condition progresses);
- live in a nursing home or receive long-term care services at home or in an assisted living facility;
- their clinician's educated guess would be that the patient would not survive the next year;
- have decreased function, frailty, progressive weight loss, or two or more unplanned hospitalizations in last 12 months.

While the MOLST form may help centralize the patient's end-of-life wishes and summarize their advance directives, it is not intended to replace the health care proxy form and/or the living will. MOLST simply translates the patient's current medical treatment preferences into physician orders, whereas the health care proxy and/or living will guides future medical care.

Checklist for DNR Orders	
Valid Hospital DNR Order Checklist	**Valid Non-Hospital DNR Order**
✓ Patient, health care agent, or surrogate may give written or verbal consent to a Hospital DNR order. ✓ Verbal consent must be witnessed by two adults, one of whom must be a doctor in the facility where the patient is admitted. ✓ Written consent must be signed by two adult witnesses. ✓ Patient's doctor can issue the DNR Order. NYS does not require written or verbal consent to be recorded on a state form. ✓ Facilities may use their own form or the DOH-5003 MOLST form.	✓ Patient, health care agent, or surrogate may give written or verbal consent to a Non-Hospital DNR order. ✓ If the DNR Order is given before discharge, verbal consent may be given to the attending doctor or two adult witnesses, one of whom must be a doctor in the facility where the patient is admitted. ✓ If the patient is at home, it is sufficient to give verbal consent to the attending doctor. ✓ If consent if given in writing, it must be signed by two adult witnesses. ✓ Consideration of patient transfer to a long-term ventilator facility. ✓ Written or verbal consent must be recorded on the New York State Form DOH-3474 and signed by the doctor.

<u>8-Step MOLST Protocols: Bomba (2011)</u>

MOLST is a clinical process that results in completion of the MOLST form. The MOLST form, then, becomes a set of medical orders that reflect the patient's preference for life-sustaining treatment they wish to receive and/or avoid. The MOLST process emphasizes discussion of personal values and beliefs, the goals for the patient's care and shared medical decision-making. Clinicians are guided in the MOLST process by use of a standardized "8-Step MOLST Protocol" to guide a thoughtful discussion and process, as well as incorporate the ethical framework and legal requirements for making decisions to withhold or withdraw life-sustaining treatment in NYS.

The 8-Step MOLST protocols is summarized as follows:

1) Prepare for discussion – Understand patient's health status, prognosis, ability to consent – Retrieve any completed Advance Directives – Determine decision-maker and NYS public health law legal requirements;
2) Determine what the patient and family know re: condition, prognosis;
3) Explore goals, hopes and expectations;
4) Suggest realistic goals;
5) Respond with empathy;
6) Use MOLST to guide choices and finalize patient wishes – Shared and informed medical decision-making – Conflict resolution;
7) Complete and sign MOLST;
8) Review and revise periodically.

Bomba, 2005; Revised 2011 to comply with Family Health Care Decisions Act, effective June 1, 2010

Review the most recent version of the MOLST 8-Step Protocol here: http://www.compassionandsupport.org/pdfs/homepage/MOLST_8_Step_Protocol._revised_032911_.pdf

Visit the following site to review the Compassion and Support at the End of Life web site/training/documents: https://www.compassionandsupport.org

View the following page to review the State of New York Department of Health Medical Orders for Life-Sustaining Treatment (MOLST) Form: https://www.health.ny.gov/forms/doh-5003.pdf

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New York State Mandatory Prescriber Education Guidance

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to the e-leaRN web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

Note: Contact hours/CEUs will be awarded for this online course until June 20, 2020.

1. Which type of patient is most at risk for opioid overdose death?

    a. Mary, a 62-year-old Latina female with history of sexual abuse.
    b. Allen, a 25-year-old white male with a past medical history of depression.
    c. Rebecca, 35-year-old white female with a medical history of spinal stenosis.
    d. Michael, a 40-year-old African American male with diabetic neuropathy.

2. What is **NOT** a response to decrease opioid related overdoses?

    a. Implementation of the NYS I-STOP Prescription Monitoring Program.
    b. Mandating insurance coverage for needed inpatient treatment services.
    c. Emergency department providers prescribing 10 days of opioid analgesics for a toothache.
    d. Limit initial opioid prescriptions from 30-day supplies to 7-day supplies for acute, non-cancer pain.

3. When considering prescribing opioid analgesics for acute pain it is important for the primary care provider to do which of the following first?

    a. Complete a thorough history and physical exam.
    b. Call a prescription in to the pharmacy.
    c. Obtain a urine drug screen.
    d. Send patient to the emergency department for evaluation.

4. In NYS, what is the maximum amount of days a health care providers can prescribe controlled substance analgesics for?

    a. 3
    b. 5
    c. 7
    d. 10

5. Which of the following prescribers are **NOT** exempt from the duty to consult I-STOP?

    a. Veterinarians
    b. A practitioner working in a methadone program.
    c. A practitioner prescribing a controlled substance to a patient under the care of a hospice.
    d. A practitioner prescribing a controlled substance to a patient in an urgent care.

6. Who is responsible for providing patients with information and counseling for palliative care?

    a. Primary care provider
    b. Emergency department providers
    c. Nursing homes
    d. All of the above
    e. None of the above

7. Which of the following is an accountable medical order that addresses Do Not Resuscitate, feeding tubes and antibiotics?

    a. Power of attorney
    b. Health care proxy
    c. Non-hospital Do Not Resuscitate Forms
    d. Medical Orders for Life-Sustaining Treatment

8. The prescriber is going to treat a patient with acute pain, what is the best first line analgesic(s) to consider?

    a. Hydrocodone
    b. Hydromorphone
    c. Acetaminophen
    d. NSAIDs with acetaminophen

9. Prescribers must keep patient records when they prescribe for a patient. What should the prescriber document in the patient record?

    a. Patient identification data
    b. Physical examination results
    c. Diagnosis
    d. All of the above
    e. None of the above

10. Which statement in regard to prescribing controlled substances is true?

    a. Controlled Substances may be prescribed prior to examination of the patient.
    b. Prescribers can write prescriptions for family member and not create a patient record.
    c. All prescriptions for controlled substances must be filled within 30 days of the date of the prescription written by the prescriber.
    d. Health care providers only need a NYS license to prescribe controlled substances in NYS.