# Palliative Care
# Reference Guide | 2025

UPMC PALLIATIVE AND SUPPORTIVE INSTITUTE

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# Assessment of Pain

## **For Patients Who Can Communicate:** Consider the acronym: "PQRSTUV":

| | |
|---|---|
| **P: Precipitating** (and Alleviating) **Factors** | "What makes the pain better/worse?" |
| **Q: Quality** | "How would you describe the pain?" |
| **R: Region or Radiating** | "Where is the pain? Does it go anywhere?" |
| **S: Severity** | "What is the pain (on a scale of 0 -> 10) – now/at best/at worse/on average?"<br>*Must ask: "What level of pain is acceptable or tolerable?"* |
| **T: Time and Temporal** | "When did the pain start? How does it change throughout the day?" |
| **U: *previous* Utilization** | "What have you used previously?" |
| **V: Values** | "How is this pain inhibiting your daily life?" "How is your pain inhibiting your activities?" |

## **For Patients Who Are Cognitively Impaired, or Cannot Communicate:**

e.g.: Pain Assessment in Advanced Dementia (PAIN-AD) Scale:

| Parameter: | 0 Points | 1 Point | 2 Points |
|---|---|---|---|
| **Breathing**<br>Independent of Vocalization | Normal | Occasional labored breathing. Short period of hyperventilation | Noisy, labored breathing. Long period of hyperventilation. Cheyne-stokes respirations |
| **Negative Vocalization** | None | Occasional moan or groan. Low level speech with negative or disapproving quality | Repeated troubled calling out. Loud moaning or groaning. Crying |
| **Facial Expression** | Smiling or inexpressive | Sad, frightened or frowning | Facial grimacing |
| **Body Language** | Relaxed | Tense, distressed pacing, or fidgeting | Rigid. Fists clenched, knees pulled up. Pulling or pushing away. Striking out |
| **Consolable** | No need to console | Distracted or reassured by voice or touch | Unable to console, distract, or reassure |
| | | **TOTAL:** | *Provides Approx. Severity Score:*<br>0-3: Mild Pain; 4-7: Moderate Pain; 8-10: Severe Pain |



References: Chalkley AJ, Mulhall DJ. The PQRSTUV: The Personal Questionnaire Rapid Scaling Technique. Br J Clin Psychol. 1991 May;30 ( Pt 2):181-3.
Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc. 2003 Jan-Feb;4(1):9-15.

# Adjuvant and Non-Opioid Agents for Pain

## Based on Perceived Etiology of Pain:

| | Class or Drug | Starting Dose/Route | Maximum Daily Dose (MDD) and Duration | Comments |
|---|---|---|---|---|
| Nociceptive Pain | **APAP** Acetaminophen | 650mg PO/PR q4h<br>1000mg IV q6h | • MDD: 3-4,000mg; 2,000mg/day for those with hepatic impairment<br>• IV Duration: ≤2 doses per UPMC policy | • Lacks anti-inflammatory effects of NSAIDs<br>• Avoid in severe hepatic disease |
| | **Common NSAIDs** | **Ibuprofen** 400mg PO q8h | • MDD: 3,200mg | Caution in patients with gastric disease, renal impairment, decompensated heart failure, liver impairment or at risk for bleeding. Use not recommended in CrCl < 30 |
| | | **Naproxen** 250mg PO q12h | • MDD: 1,250mg | |
| | | **Ketorolac** 15-30mg IM/IV/PO q6h | • MDD: 120mg. Elderly, renally impaired, and/or weight <50kg/dose = 10-15mg IM/IV<br>• Max Therapeutic Duration: 3-5 days | |
| | | **COX-2 Selective** | | |
| | | **Celecoxib** 100-200mg PO BID | • MDD: 400mg/day | Caution in patients with renal impairment, decompensated heart failure, or at risk for bleeding; Use not recommended in CrCl < 30 |
| | | **Meloxicam** 7.5-15mg PO daily | • MDD: 15mg/day | |
| | **Common Steroids*** | **Dexamethasone** 4-8mg/day | • MDD: 8mg/day. Short courses are advised (< 2 weeks) | Use with caution in patients with heart failure, risk of bleeding, or on immunotherapy. Use in close coordination with primary teams. |
| | **Common Topicals** | **Lidocaine 4 or 5% Patch** 1-3 patches topically daily | • MDD: 3 patches/day | Typically removed after 12 hours of administration to avoid toxicity. Do not use heating pad on patch to avoid skin reactions. |
| | | **Diclofenac 1% Gel** 2-4g topically to painful area | • MDD: 32g/day | Dosage card for patients included in packaging. 2g for upper extremities, 4g for lower extremities. Minimal systemic absorption. |



*limited to most used in the palliative care setting

References: UPMC Policy and Procedure Manual: Pain Management Policy (HS-NA0408). Available on UPMC infonet.

# Adjuvant and Non-Opioid Agents for Pain (cont.)

## Based on Perceived Etiology of Pain:

| | Class or Drug | Starting Dose/Route | Maximum Daily Dose (MDD) and Duration | Comments |
|---|---|---|---|---|
| Neuropathic Pain | **Anti-epileptics** | **Gabapentin** 300mg PO at bedtime | • MDD: 3,600mg<br>• No additional benefit seen >1800mg/day | • Reduce dose in renal insufficiency (CrCl <60mL/min)<br>• Post-dialysis supplementation dose recommended |
| | | **Pregabalin** 75-150mg/day in 2-3 divided doses | • MDD: 450mg-600mg/day depending on indication | • Reduce in renal insufficiency (CrCl < 60mL/min). Use with caution in patients with congestive heart failure |
| | **SNRIs** | **Venlafaxine** 37.5mg XR PO once daily | • MDD: 300mg/day<br>• No additional benefit seen >150mg/day | • Reduce dose in mild and moderate renal insufficiency<br>• Avoid in severe renal and hepatic insufficiency |
| | | **Duloxetine** 30mg PO once daily | • MDD: 90mg/day<br>• No additional benefit seen > 60mg/day | • Avoid in severe renal insufficiency<br>• Contraindicated in hepatic insufficiency |
| | **Common TCAs** | **Amitriptyline** 10mg-25mg PO daily | • MDD: 75-150mg/day depending on indication | • High anticholinergic burden; caution for use for older adults. QTc prolongation risk<br>• Reduce dose in severe hepatic impairment |
| | | **Nortriptyline** 10-25mg PO daily | • MDD: 150mg/day | • Anticholinergic side effects; QTc prolongation risk<br>• Reduce dose in severe hepatic impairment |
| | **Common Topicals** | **Capsaicin** 0.075%-0.1% cream | • MDD: 4 patches in one application, Cream can be used up to 4x/day | • Do not apply on damaged or broken skin; do not use with external heat source (e.g. heating pad)<br>• Minimal systemic absorption |



References: UPMC Policy and Procedure Manual: Pain Management Policy (HS-NA0408). Available on UPMC infonet.
Product Information: NEURONTIN(R), gabapentin. Pfizer, Inc. (per FDA), NY, NY, 10/2017.; Product Information: LYRICA(R), pregabalin. Pfizer, Inc. (per FDA), NY, NY, 6/2011.

# Principles of Opioid Therapy

## Initiating Opioids:

| | |
|---|---|
| **Appropriate?** | Are opioids appropriate for the patient's specific pain(s)? *Some types of pains do not respond well to opioids*<br><br>Always screen patients for risk factors for opioid misuse upon initiation of opioid therapy. *Must check PA PDMP** Can also consider utilizing the Opioid Risk Tool (ORT) |
| **Adjuvants?** | Adjuvants should always be considered for pain. *See page 3 for more information* |

## Throughout Opioid Therapy: Monitor for the 4As

| | |
|---|---|
| **Analgesia** | Has the current medication regimen improved the patient's pain scores? |
| **Activity** | What is the patient's specific goal? *This may not be just a reduction in severity. Consider functional goals as well* |
| **ADRs** | Is the patient experiencing any opioid-induced effects? *Must ask the patient about each potential effect individually* |
| **Abuse** | Screen for abuse:<br>• Personal or family history of alcohol, tobacco or substance abuse<br>• Younger age (less than 35 years of age)<br>• Psychiatric disease such as anxiety, bipolar disorder, PTSD; particularly if uncontrolled<br>Red flags suggesting opioid misuse:<br>• Asking for specific opioid medication/formulation/brand, or for early refills or early prescriptions; inability to control use; inappropriate urine drug screen results (negative for prescribed substances or positive for non-prescribed substances)<br>• Receiving prescriptions from different providers* Must check PA-PDMP prior to every opioid prescription<br>* Pennsylvania PDMP website: https://pdmp.health.pa.gov/cas/login |



References: Katz NP, Adams EH, Benneyan JC, et al. Foundations of opioid risk management. Clin J Pain. 2007 Feb;23(2):103-18.
Passik SD. Issues in long-term opioid therapy: Unmet needs, risks and solutions. Mayo Clin Proc. 2009 Jul; 84(7): 593–601.

# Principles of Opioid Therapy (cont.)

**Initiating Opioids:**

1. Determine **drug**:
   - Morphine is considered first-line therapy. Consider for all patients (except for renal failure and true allergy)
2. Determine **dose**:
   - Start low and go slow
   - Be aware of commercially available oral formulations
3. Determine **route**:
   - PO route is preferred. IM route is not recommended
4. Determine **frequency**:
   - Never use long-acting opioids to control acute pain
   - For opioid naïve patients, only prescribe short-acting agents as needed (PRN)

**Titrating Opioids:**

- Titrate no faster than every 24 hours
  - First, calculate previous 24 hour OME total
  - If response is inadequate consider increasing 25-50% for moderate pain and 50-100% for severe pain
  - If adding a long-acting agent: Give ~2/3 of total OME as long-acting. Give 10-15% of total daily long-acting agent OME as short acting breakthrough agent (PRN). Recommended interval for breakthrough dose is 3-4hours.

**Rotating Opioids:**

Primary reasons to rotate opioids are: presence of intolerable adverse drug reaction or drug allergy and/or renal failure, and insurance coverage and/or cost issues

**Converting Opioids:**

1. Assess patient
2. Determine total daily dose of opioid
3. Decide new opioid and route; consult equianalgesic table and calculate new opioid dose

$$\frac{\text{mg of } \textbf{current} \text{ opioid (\& route)}}{\text{equivalent mg } \textbf{current} \text{ opioid (\& route)}} = \frac{\text{“X” mg of } \textbf{new} \text{ opioid (\& route)}}{\text{equivalent mg } \textbf{new} \text{ opioid (\& route)}}$$



   - Consider cross-tolerance when rotating to a different opioid (reduce new dose by 25-50%)
4. Individualize based on assessment and monitor

**Tapering Opioids:**

- Reduce opioid dose by 5-20% each week or month
- Once at the lowest commercially available formulation, either increase the interval between doses or reduce the dose every 2-5 days

OME = oral morphine equivalent

References: Berna C, Kulich RJ, Rathmell JP. Tapering long-term opioid therapy in chronic noncancer pain: Evidence and recommendations for everyday practice. Mayo Clin Proc. 2015 Jun;90(6):828-42.
Dowell D, Compton WM, Giroir BP. Patient-centered reduction or discontinuation of long-term opioid analgesics: The HHS Guide for Clinicians. JAMA. 2019 Nov19;322(19):1855-1856.

# Select Opioid Products

## COMMONLY AVAILABLE OPIOID FORMULATIONS*

*Not all inclusive, does not include intravenous. Check with pharmacy for availability and patient's insurance for coverage. **Prior authorizations may be required for opioid prescriptions**.

| Opioid | Short Acting (mg) | Long Acting (mg) |
|---|---|---|
| Morphine | Tabs (15, 30)<br>**MSIR®** Oral Solution (10mg/5mL, 20mg/5mL, 20mg/mL) § | **MSContin®** Tabs (15, 30, 60, 100, 200) |
| Oxycodone | **Roxicodone®**, Tabs (5,10,15,20,30)<br>**Roxicodone®** Oral Solution (5mg/5mL)<br>**RoxyBond®** Tabs (15, 30)<br>**OxyFAST®**, **Oxydose®**, **Roxicodone® Intensol** Oral Concentrate (20mg/mL) §<br>**Endocet®, Percocet®** Tabs (oxycodone/APAP) (2.5/325, 5/325, 7.5/325, 10/325) | **OxyContin®** Tabs (10, 15, 20, 30, 40, 60, 80)<br>**Xtampza ER®** Caps (9, 13.5, 18, 27, 36) |
| Hydromorphone | **Dilaudid®** Tabs (2, 4, 8)<br>**Dilaudid®** Oral Solution (1mg/mL) § | **Exalgo®** Tabs (8, 12, 16, 32) |
| Oxymorphone | Oxymorphone IR Tabs (5, 10) | Oxymorphone ER Tabs (5, 7.5, 10, 15, 20, 30, 40) |
| Fentanyl | ⊘ | **Duragesic®** Transdermal Patch (12, 25, 37.5, 50, 75, 100mcg/hr) |
| Buprenorphine | ⊘ | **Butrans®** Transdermal Patch (5, 7.5, 10, 15, 20mcg/hr)<br>**Belbuca®** Buccal Film (75, 150, 300, 450, 600, 750, 900 mcg) |
| Codeine | Tabs (15,30) | |
| Tramadol | Tramadol Tabs (50,100) | **Ultram ER®** Tabs (100, 200, 300) |
| Hydrocodone | **Vicodin®, Lortab®** Tabs (hydrocodone/APAP) (5/325, 7.5/325, 10/325) | **Hysingla ER®** Tabs (20, 30, 40, 60, 80, 100, 120)<br>Hydrocodone ER 12-hour Tabs (10, 15, 20, 30, 40, 50) |

**Brand Name**; Generic Name – most opioid preparations have generic formulations

§: orders for oral solutions must include drug name and strength (in mg/mL) to avoid confusion

# Opioid Equianalgesic Chart*

All opioids are compared to morphine via oral morphine equivalents (OMEs).

| Opioid Agonist | Oral (mg) | Parenteral (mg) | Comments |
|---|---|---|---|
| **Morphine** | 30 | 10 | Not recommended for patients with renal dysfunction (CrCl <30 mL/min), as metabolites can be neurotoxic<br>Use with caution in patients with hepatic dysfunction |
| **Hydrocodone** | 30 | | Reduce dose in patients with severe renal and hepatic dysfunction |
| **Oxycodone†** | 20 | | Reduce dose in patients with hepatic dysfunction |
| **Hydromorphone** | 7.5 | 1.5 | Use with caution in patients with hepatic dysfunction |
| **Oxymorphone** | 10 | | Reduce dose in patients with renal dysfunction (CrCl <50 mL/min)<br>Contraindicated in patients with moderate or severe hepatic impairment. Reduce dose with mild hepatic impairment |
| **Fentanyl** | | 0.1** (100mcg) | Safe in renal dysfunction<br>Consider major interactions with CYP 3A4 inhibitors or inducers<br>For patch conversion, see box below; Note: IV fentanyl dose/hr = transdermal fentanyl dose |
| **Tramadol** | 120 | | Maximum daily dose: 300mg; Reduce dose in patients with severe organ dysfunction<br>Risk of serotonin syndrome and seizures |

**Notes on Fentanyl Patches:**

- THE 24-HOUR OME DIVIDED BY 2 IS EQUAL TO FENTANYL DOSE IN MCG/HR. Example: 50mg PO OME = 25mcg/hr fentanyl patch
- Patch takes ~24 hours to achieve full effect. When removing a patch, remember the analgesic effect can still last up to 24 hours
- Patch is typically changed every 72 hours

*These are rough estimates; individual patients may vary
**Equivalency for a one-time dose of IV fentanyl only
†Xtampza ER 9mg = Oxycontin (Oxycodone ER) 10mg

References: McPherson ML. Demystifying Opioid Conversion Calculations: A Guide For Effective Dosing. Amer Soc of Health-Systems Pharm, Bethesda, MD, 2010. Copyright ASHP.

# Patient Controlled Analgesia (PCA)

The following are suggestions for PCA orders for adults.
Like all opioid orders, doses must be individualized.

**EDUCATE FAMILIES TO NOT PRESS THE PCA BUTTON!**

| **Opioid Agonist** | Opioid Status, Age | **Loading Dose(s) (optional)** | **Starting Patient Administered Dose (mg)** | **Lockout Interval (min)** | **Starting RN Bolus Dose (mg)** | **Continuous Infusion Rate (mg/hr)** |
|---|---|---|---|---|---|---|
| **Morphine** | *Opioid Naïve* | 2-4mg q15 min | 1 | 10-20 | 1 | When indicated, calculate based on intermittent PCA use or previous opioid requirements |
| | *Elderly (>70 years old)* | 2mg q20 min | 0.5 | 10-20 | 0.5 | |
| **Hydromorphone** | *Opioid Naïve* | 0.2-0.3mg q15 mins | 0.2 | 10-20 | 0.2 | |
| | *Elderly (>70 years old)* | 0.2mg q20 mins | 0.1 | 10-20 | 0.1 | |

- Morphine is the opioid of choice (except for true drug allergy and renal failure)
- Capnography ($EtCO_2$) monitoring is mandatory for all patients receiving PCA therapy, except those on mechanical ventilation, who are comfort measures only (CMO) or end-of-life. See PCA policy for more information. In patients with RR <6 breaths/min for 1-2 minutes, PCA will alarm and pause from administering medication



References: UPMC Policy and Procedure Manual: UPMC PCA Monitoring and Managing Guidelines. Available on UPMC infonet.

# Buprenorphine for Pain

## Select FDA-Approved Buprenorphine Products for Pain*

| Brand Name | Starting dose | Recommended Maximum Daily Dose (MDD) | Comments |
|---|---|---|---|
| **Butrans®** (Transdermal patch) | Not currently receiving opioids: 5mcg/h transdermal Q7days<br><br>Dosing recommendations to avoid precipitated withdrawal when converting from other opioids to Butrans**:<br>Previous OME per day:<br>< 30mg: 5mcg/h Q7days<br>30-80mg: 10mcg/h Q7days<br>> 80mg: consider alternate analgesic | • MDD: 20mcg/h given risk of QTc prolongation with higher doses | • Dosing frequency every 7 days<br>• Use with caution in severe hepatic impairment given limited ability to alter the dose of transdermal formulation in this setting<br>• Patch takes ~24 hours (up to 48 hours) to reach full effect<br>• Consider drug interactions with CYP3A4 inhibitors or inducers<br>• Buprenorphine 20mcg patch is approximately equivalent to 60mg OME per day |
| **Belbuca®** (Buccal film) | Not currently receiving opioids: 75mcg once daily or Q12H<br><br>Conversion from other opioids to Belbuca**:<br>Previous OME per day:<br>< 30mg: 75mcg once daily-Q12H<br>30mg-89mg: 150mcg Q12H<br>90mg-160mg: 300mcg Q12H<br>>160mg: consider alternate analgesic | • MDD: 1800mcg/day (900mcg Q12H) given risk of QTc prolongation with higher doses | • Dose reduce in severe hepatic impairment<br>• Consider drug interactions with CYP3A4 inhibitors or inducers |

- Buprenorphine is a partial mu-agonist (ceiling for side effects)
- It is possible to utilize simultaneous short-acting full opioid agonists for breakthrough pain while on buprenorphine.

*This is not meant to be a comprehensive review of buprenorphine or guide for initiation for opioid use disorder.

**If patient on full opioid agonists (e.g. oxycodone, morphine), package insert recommends tapering off current opioids prior to starting buprenorphine products to avoid withdrawal. This is not typically clinically possible prior to starting buprenorphine product for pain. In these instances, may utilize package insert starting dosing (above) to avoid precipitated withdrawal upon initiation and increase to effect. These starting doses do not accurately reflect “direct” OME conversions.

References: Product Information: BUTRANS(R), buprenorphine. Purdue Pharma LP. (per FDA), Stamford, CT, 10/2019.; Product Information: :BELBUCA(R), buprenorphine. Collegium Pharmaceutical, Inc. (per FDA), Stoughton, MA, 6/2022.

# Opioid-Induced Constipation (OIC)

All patients on opioid therapy should be prescribed a bowel regimen.

| Medication | Site and Mechanism of Action | Usual Starting Dose | Onset of Action | Maximum Daily Dose |
|---|---|---|---|---|
| **Stimulant Laxatives** | | | | |
| Bisacodyl | Colon; stimulates peristalsis | PO: 5-15mg x1 dose<br>PR: 10mg x1 dose | PO: 6-10 hours<br>PR: 15 min–1 hour | 30mg |
| Senna | Colon; stimulates myenteric plexus, alters water and electrolyte secretion | 2 tabs (8.6mg/each) at bedtime | 6-10 hours | 68.8mg |
| **Osmotic Laxatives** | | | | |
| Polyethylene Glycol | GI tract; osmotic effect | 17g (1 capful) q24 hours in 8 ounces of water | 48-96 hours | As tolerated by patient |
| Lactulose | Colon, osmotic effect | 15-30mL q12-24 hours | 24-48 hours | 60mL (or 40g) |
| Sorbitol | Colon; delivers osmotically active molecules to the colon | 15-30mL q12-24 hours | 24-48 hours | 27-40g |
| **Saline Laxative** | | | | |
| Magnesium Citrate ∞ | Small and large bowel; attracts and retains water in the bowel lumen | 6.5-10 ounces once daily | 30 min–3 hours | 6.5-10 ounces |
| Magnesium Hydroxide (MoM) ∞ | Colon; osmotic effect & increased peristalsis | 30mL q12-24 hours | 30 min–3 hours | 60mL |

- Goal is for patient to have a bowel movement every 2-3 days. If no bowel movement after 3 or more days, consider enema or high colonic tap water enema.
- Other medications that can exacerbate constipation: ondansetron (Zofran®), anticholinergics (tricyclic antidepressants, scopolamine, oxybutynin, promethazine, diphenhydramine), lithium, verapamil, bismuth, iron, aluminum, calcium salts. Constipation can occur with even 1 dose of IV morphine, and patient will never become tolerant to this adverse reaction
- Oral docusate capsules (alone) will not increase frequency of bowel movements
- ∞: Avoid use of MoM and related products in patients with renal dysfunction because of risk of electrolyte imbalances

# Agents for Refractory Opioid Induced Constipation

**Opioid Induced Constipation (OIC) Definition: those receiving opioids, with less than 3 spontaneous bowel movements per week despite treatment with maximum doses of two first-line laxatives** *(found on page 10)*

Preferred, Formulary Agent: **1st line: Naloxegol (PO)**

| ***Dosing:*** | **Administration:** |
|---|---|
| Initial dose: 25mg once daily<br>*Reduce in patients with CrCl <60 mL/min to 12.5mg once daily*<br>*Avoid in severe hepatic impairment*<br>*Use with strong CYP3A4 inhibitors is contraindicated; avoid if possible with moderate CYP3A4 inhibitors* | All other laxatives should be held for at least 3 days at initiation of naloxegol therapy. Other laxatives can be initiated after 3 days if inadequate results with naloxegol alone<br><br>Naloxegol should be taken on an empty stomach |

Formulary-Restricted Agent (Restricted to: Pain Service, Oncology, Critical Care, GI Services, Palliative Care):
**Methylnaltrexone (oral and subcutaneous)**

**Methylnaltrexone PO Dosing:**
450mg once daily (150mg if CrCl <60mL/min)
**Methylnaltrexone SC Dosing:**

| Patient Weight | | Dose (Administer once daily or every other day) |
|---|---|---|
| Pounds | Kilograms | |
| <84 | <38 | 0.15mg/kg |
| 84-136 | 38-62 | 8mg |
| 136-251 | 62-114 | 12mg |
| >251 | >114 | 0.15mg/kg |

*In patients with renal impairment (CrCl <60 mL/min), reduce dose by ½

**Administration:**

Not recommended for the following:
- Use >4 months
- Treatment of post-operative ileus
- Patients with known or suspected mechanical gastrointestinal obstruction

Discontinue all maintenance laxatives before starting, may resume if suboptimal response after 3 days

Methylnaltrexone administration recommendations:
PO: take 30 minutes before first meal of day
SC: inject into upper arm, abdomen, or thigh



References: Product Information: RELISTOR(R) subcutaneous injection, methylnaltrexone bromide subcutaneous injection. Salix Pharmaceuticals, Inc. (per FDA), Raleigh, NC, 2014. 9/2015. Product Information: MOVANTIK(TM) oral tablets, naloxegol oral tablets. AstraZeneca Pharmaceuticals. Wilmington, DE. 1/2015. Product Information: SYMPROIC(R) oral tablets, naldemedine oral tablets, BioDelivery Sciences International. Raleigh, NC. 5/2020.

# Prescribing of Take-Home Intranasal Naloxone Kits

**Patients who should be considered for take-home intranasal naloxone kits at discharge (any of the following):**

- Currently prescribed >50mg OME/day
- Currently prescribed long-acting or extended-release opioids (especially new start and/or methadone)
- Concurrently prescribed sedating medications (especially benzodiazepines and gabapentin)
- Known history of opioid use disorder or history of overdose
- Prescribed opioids and carries a diagnosis of pulmonary disease (e.g. OSA, COPD, etc.)

| | **Narcan® Nasal Spray** |
|---|---|
| **Dosing** | Administer a single spray/dose into one nostril. May repeat dose q2-3 minutes until patient is responsive or EMS arrives. |
| **Notes** | FDA approved formulation. Kit contains 2 doses |



In 2015, Pennsylvania issued a **state-wide standing order** for naloxone kits such that any Pennsylvania resident can obtain these kits from participating pharmacies without a prescription from a prescriber.

**To find a local pharmacy that carries intranasal naloxone visit:** https://www.overdosefreepa.org/find-local-resources/find-naloxone/

In 2023, the FDA approved the first over-the-counter (OTC) naloxone nasal spray which does not require a prescription from a prescriber. Patients pay out of pocket for OTCs, so it may still be more cost-effective for the patient to receive via prescription order through insurance (if applicable).

References: Zedler B, Xie L, Wang L, Joyce A, et al. Development of a risk index for serious prescription opioid-induced respiratory depression or overdose in Veterans' Health Administration patients. Pain Med. 2015 Aug;16(8):1566-1579.

# Interventional Pain Management

Interventions that minimize systemic opioids and help with pain relief in a targeted fashion can be considered for a wide spectrum of patients. At UPMC, the chronic pain and palliative care services collaborate to identify patients who are most likely to benefit from such interventions.

Examples of available interventions which are best supported by evidence are listed below:

| Common Nerve Blocks | |
|---|---|
| **Block Type:** | **Indications:** |
| **Erector Spinae Plane** | High: chest wall pain; Low: abdominal pain not amenable to Celiac block |
| **Celiac Plexus Block** | Abdominal visceral pain from: pancreatic cancer and other upper abdominal tumors |
| **Superior Hypogastric Block** | Pelvic visceral pain from gynecological, colorectal or GU cancers |
| **Lumbar Sympathetic Block** | Intractable LE pain from PVD or Chronic Regional Pain Syndrome |
| **Pudendal Nerve Block** | Vaginal pain, penile/scrotal pain, perineal pain |
| **Sphenopalatine/Trigeminal Nerve Block** | Facial pain |
| **Epidural Steroid Injection** | Low back pain – often for non-malignant pain |
| **Centrally Implanted Pumps** | |
| **Hardware Type:** | **Indications:** |
| **Intrathecal Pump** | Pain refractory to systemic opioids with a prognosis of >3 months |
| **Tunneled Epidural Catheter** | Pain refractory to systemic opioids with a prognosis of <3 months |
| **Spinal Cord Stimulator** | Most helpful in refractory neuropathic limb pain (especially ischemic limb) |

| **Exclude patients who are:** | | |
|---|---|---|
| | • Neutropenic/Septic<br>• Infection in the region of the proposed procedure | • Coagulopathic (INR >1.4 or platelets <100K)<br>• On anticoagulants/antiplatelet agents that are not safe to hold or reverse |

# Medical Cannabinoids

Medical cannabinoids include: 1. Single molecular compounds (e.g. dronabinol – *contains tetrahydrocannabinol* (*THC) only*); 2. Liquid extracts (e.g. nabiximols - *not yet approved in the US*); and 3. Botanicals (i.e. medical marijuana).

**FAQs: Medical Cannabis**

1. **What medical cannabis formulations are approved in PA?** Pill, oil, topical forms, tinctures and liquids, and dry leaf formulations for vaporization or nebulization only. No smoking or plant forms are allowed.
2. **How can patients obtain medical cannabis?** There is a 4 step process. 1. Patient registers for program through medical cannabis registry; 2. State-approved physician certifies patient suffers from a medical condition that qualifies for medical cannabis (copay usually included); 3. Patient pays for medical cannabis card (up to $50); 4. Patient gets medical cannabis from approved dispensary.
3. **What serious medical conditions qualify a patient for medical cannabis?** The list is constantly updated. *Some* of the approved conditions are: ALS, autism, cancer, Crohn's disease, epilepsy, glaucoma, HIV/AIDS, Huntington's disease, IBS, MS, Parkinson's Disease, PTSD, severe chronic or intractable pain, anxiety disorder, and sickle cell anemia.
4. **How much does medical cannabis cost?** Varies. A month supply can cost anywhere from $30-200 depending on formulation and route. Costs are determined by individual dispensaries. Insurances do not cover medical cannabis. The hospice benefit does not cover medical cannabis.
5. **Can the patient use medical cannabis in the hospital?** No. Per UPMC policy, medical cannabis cannot be administered or used while patient is in the hospital. Clinical staff will not under any circumstances handle medical cannabis, including obtaining, storing or administering.



To learn more, visit the PA medical marijuana website: https://www.pa.gov/guides/pennsylvania-medical-marijuana-program/

References: Medical Marijuana During Hospitalization at UPMC Presbyterian-Shadyside: Systemwide policy: HS-PH2026 Medical Marijuana

# Assessment of Dyspnea

**For Patients Who Can Communicate:** Ask about Severity (cannot rely on RR or $pO_2$ alone):

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

No Shortness of Breath — Worst Shortness of Breath Imaginable

**For Patients Who Cannot Communicate:** e.g.: Respiratory Distress Observation Scale (RDOS):

| | 0 Points | 1 Point | 2 Points |
|---|---|---|---|
| Heart Rate | <90 bpm | 90-109 bpm | ≥110 bpm |
| Respiratory Rate | ≤18 breaths/min | 19-30 breaths/min | >30 breaths/min |
| Restlessness (non purposeful movements) | None | Occasional, slight movements | Frequent movements |
| Paradoxical Breathing Pattern (abdomen moves on inspiration) | None | | Present |
| Accessory Respiratory Muscle Use (rise in clavicle during inspiration) | None | Slight rise | Pronounced rise |
| Grunting at End-Expiration (guttural sound) | None | | Present |
| Nasal Flaring (involuntary movements in nares) | None | | Present |
| Look of Fear | None | | Eyes wide open, muscle tense, etc. |
| | | **TOTAL:** | |

**A score of 3 or more (indicating moderate) should prompt the administration of medication for dyspnea. A score of 7 (indicating severe) or higher should prompt a call to primary provider or palliative and supportive care team.**



References: Campbell ML, Templin T, Walch J. A Respiratory Distress Observation Scale for patients unable to self-report dyspnea. J Palliat Med. 2010 Mar;13(3):285-90.

# Treatment of Dyspnea

- Address potential underlying etiologies: respiratory disease (e.g. COPD), cardiovascular diseases (e.g. CHF), infection, anemia, chronic kidney disease (CKD)
- Treat utilizing both nonpharmacological interventions and medications

**Nonpharmacological Interventions:** Handheld fan, pulmonary rehab, oxygen (with input from pulmonologist)

**Medications:** First line therapy: low-dose opioids. Include PRN reason: dyspnea for low-dose opioid orders to be used for dyspnea and NOT for pain or NOT only for pain).
- Consider benzodiazepines (BZDs), only if anxiety component exists. BZDs will not improve dyspnea alone

| | Starting Doses | Other Dosing Considerations |
|---|---|---|
| **Opioid Naïve** | • For Non End of Life Patients: Consider oxycodone 2.5-5mg PO q4h PRN or morphine 2mg IV q3h PRN<br>• For End of Life Patients: Morphine 3-5mg IV q2h PRN<br>• Opioid doses exceeding 30mg OME/day are not recommended in opioid naïve patients | • If distress not relieved in 15 minutes after starting dose, give bolus equal to the loading dose increased by 50%. If severe distress persists repeat the dose every 15 minutes until comfortable<br>• For increased pain/distress give extra bolus dose(s) equal to the last given bolus dose every 30 minutes as needed<br>• If using more than 2 bolus doses over a 6-hour period, consider starting a continuous infusion |
| **Opioid Tolerant** | • Calculate the equianalgesic parenteral dose of morphine for the last 24 hours *(see slides 6 for more information)*, and consider dosing strategies as listed<br>• Increase PRN dose by 50%<br>• Opioid doses should not exceed more than a 25% increase in opioid tolerant patients | • Divide the total 24 hour IV morphine dose by 24 to determine initial hourly infusion rate (mg/hour). Start continuous infusion at this rate<br>• If patient pain/distress use loading dose = hourly infusion rate<br>• If distress not relieved in 15 minutes after initial loading dose or the patient is in increased pain/distress, administer the loading dose increased by 50% and repeat every 15 minutes until comfortable<br>• If using more than two bolus doses over 6-hour period, determine new continuous infusion rate by recalculating total dose given over last 6 hours and dividing it by 6 |



References: Kamal AH, Maguire JM, Wheeler JL, Currow DC, et al. Dyspnea review for the palliative care professional: assessment, burdens, and etiologies. J Palliat Med. 2011 Oct;14(10):1167-72.

# Nausea and Vomiting Treatment

Medications should be selected based on perceived etiology and pathophysiology.

| | Drug | Starting Dose/Route | MDD | Comments |
|---|---|---|---|---|
| First Line Therapies | **Metoclopramide*** | 5-20mg PO/SC/IV AC and HS | 60mg | *Dopamine antagonist*<br>Contraindicated in bowel obstruction<br>Risk of EPS with prolonged use (>12 weeks) |
| | **Haloperidol** | 0.5-4mg PO/SC/IV q6h | 5mg | *Dopamine antagonist*<br>IV has higher risk of EPS and QTc prolongation than PO. Risk may not be significant with lower doses for emesis |
| | **Olanzapine** | 2.5-5mg PO once daily | 20mg | *Dopamine, histamine, serotonin, alpha-1 and acetylcholine antagonist*<br>Risk of QTc prolongation although may not be significant with lower doses used for nausea; Common ADRs: sedation, dry mouth, headache, dizziness, increased appetite |
| Second Line Therapies or Compelling Indications | **Prochlorperazine** | 5-10mg PO/IV q6h or 25mg PR q6h | 40mg | *Dopamine and histamine antagonist*<br>Risk of EPS; Common ADR: sedation |
| | **Ondansetron** | 4-8mg PO/IV q4-8h | 32mg | *Serotonin antagonist*<br>Risk of QTc prolongation<br>Helpful for chemotherapy induced nausea only<br>Common ADRs: headache, fatigue and constipation |
| | **Dexamethasone** | 4-8mg PO/IV qAM or BID | 8-16mg | Helpful for nausea due to raised ICP<br>Common ADRs: agitation, insomnia, and hyperglycemia |
| | **Scopolamine** | 1.5mg patch q72h | 1 patch q72h | *Acetylcholine antagonist*<br>Common ADRs: dry mouth, blurred vision, ileus, urinary retention.<br>Considered a higher cost agent |

*Metoclopramide is considered first line for empiric therapy; MDD: maximum daily dose (for nausea); ICP: intracranial pressure

References: Glare P, Miller J, Nikolova T, Tickoo R. Treating nausea and vomiting in palliative care: a review. Clin Interv Aging. 2011;6:243-59.
Wood GJ, Shega JW, Lynch B, Von Roenn JH. Management of intractable nausea and vomiting in patients at the end of life: "I was feeling nauseous all of the time . . . nothing was working". JAMA. 2007 Sep 12;298(10):1196-207.

# Diagnosis of Delirium

- Delirium is conceptualized as a reversible illness, except in the last 24-48 hours of life
- Delirium occurs in at least 25-50% of hospitalized cancer patients, and in a higher percentage of patients who are terminally ill
- Delirium increases the risk of in-hospital and six month mortality

**Potential Etiologies:**

| | |
|---|---|
| **D:** Drugs | Opioids, anticholinergics, sedatives, benzodiazepines, steroids, chemo - and immunotherapies, some antibiotics |
| **E:** Eyes and Ears | Poor vision, hearing, isolation |
| **L:** Low flow states | Hypoxia, MI, CHF, COPD, shock |
| **I:** Infections | |
| **R:** Retention (of urine or stool) | |
| **I:** Intracranial | CNS metastases, seizures, CVA, hypertensive encephalopathy |
| **U:** Under hydration/nutrition/sleep/pain | |
| **M:** Metabolic disorders | Sodium, glucose, thyroid, hepatic, deficiencies of Vitamin B12, folate, niacin, and thiamine and toxic levels of lead, manganese, mercury, alcohol |



**DSM-V Criteria for delirium includes five components:**

**A**. A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment)

**B.** The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day

**C.** An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception)

**D.** The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma

**E.** There is evidence from the history, physical examination or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, or exposure to a toxin, or is due to multiple etiologies

References: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

# Diagnosis of Delirium

**3D CAM** (Confusion Assessment Method)

Diagnosis is positive with presence of: 1 AND 2; and either 3 OR 4

| Feature | Questions Asked | Observations at Bedside | Positive Answers |
|---|---|---|---|
| **1. Acute Onset or Fluctuation** | • During the past day have you felt confused?<br>• During the past day did you think you were not really in the hospital?<br>• During the past day did you see things that were not really there? | ○ Fluctuation in level of consciousness<br>○ Fluctuation in attention during interview<br>○ Fluctuation in speech or thinking | Any answer other than 'no' is positive<br><br>Any positive observation is a yes |
| - AND - | | | |
| **2. Inattention** | • Can you tell me the days of the week backwards, starting with Saturday?<br>• Can you tell me the months of the year backwards, starting with December? | ○ Did the patient have trouble keeping track of what was being said during the interview?<br>○ Did the patient appear inappropriately distracted by environmental stimuli? | Anything other than 'correct' is coded as positive<br><br>Either observation is positive |
| - AND EITHER - | | | |
| **3. Disorganized Thinking** | • Can you tell me the year we are in right now?<br>• Can you tell me the day of the week?<br>• Can you tell me what type of place this is? | ○ Was the patient's flow of ideas unclear or illogical, for example: did the patient tell a story unrelated to the interview (tangential)?<br>○ Was the patient's conversation rambling, for example did he/she give inappropriately verbose and off target responses?<br>○ Was the patient's speech unusually limited or sparse? (i.e. yes/no answers)? | Any answer other than 'correct' is coded as positive<br><br>Answer is 'yes' |
| - OR- | | | |
| **4. Altered Level of Consciousness** | | Was the patient's speech unusually limited or sparse? (i.e. yes/no answers) | Either observation is positive |



References: Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Medicine. 1990;113:941-8.

# Treatment of Delirium

- **Always consider nonpharmacological interventions**
- **Always look for and treatment underlying causes of delirium** (see Page 18)
- Benzodiazepines are NOT effective in treating delirium not associated with alcohol withdrawal, may worsen delirium, and should be used cautiously
- **Although evidence is mixed, neuroleptics can be considered for the treatment of agitated delirium⍉. Haloperidol is considered first line agent**

| Medication | Starting Dose | MDD | Adverse Drug Reactions | | | |
|---|---|---|---|---|---|---|
| | | | EPS | Anti-cholinergic | Sedation | QTc Prolongation |
| **Haloperidol** | 0.5-1mg BID to q8h | 20mg | PO: ++<br>IV: +++ | + | 0/- | PO: +<br>IV: ++ |
| **Risperidone** | 0.25-1mg BID, up to q6h | 6mg | ++ | + | ++ | ++ |
| **Olanzapine** | 2.5-10mg daily | 20mg | + | ++ | +++ | + |
| **Quetiapine** | 12.5-50mg BID or TID | 800mg | + | ++ | +++ | ++ |
| **Aripiprazole** | 5-15mg qAM | 30mg | ++ | + | ++ | 0/- |
| **Thioridazine** | 50-100mg TID | 800mg | + | +++ | +++ | + |

MDD: maximum daily dose

⍉The FDA has determined that the use of antipsychotic medications in the treatment of behavioral disorders in elderly patients with dementia is associated with increased mortality. This risk appears to be highest during the first two weeks of use.



References: Grassi L, Caraceni A, Mitchell AJ, Nanni MG. Management of delirium in palliative care: a review. Curr Psychiatry Rep. 2015 Mar;17(3):550.

# Treatment of Depression and Anxiety

**Commonly prescribed antidepressants:**

| Category | Medication | Starting Dose | Target Daily Dose | Adverse Drug Reactions | | |
|---|---|---|---|---|---|---|
| | | | | Anti-cholinergic | Insomnia | GI Distress |
| SSRIs | **Citalopram** | 10-20mg daily | 10-40mg | + | + | ++ |
| | **Escitalopram** | 5-10mg daily | 10-20mg | + | +++ | ++ |
| | **Sertraline** | 25-50mg daily | 50-200mg | - | + | +++ |
| | **Fluoxetine** | 10mg daily | 40mg | - | + | + |
| | **Paroxetine** | 10mg daily | 40mg | ++ | + | + |
| SNRIs | **Venlafaxine (IR and XR)*** | 75mg/day (either qAM (XR) or divided TID (IR) | 150-375mg | + | ++++ | ++ |
| | **Duloxetineʁ** | 20mg BID | 30-60mg | + | ++ | ++ |
| Stimulants | **Methylphenidate†** | 2.5-5mg BID (at 08:00/12:00) | 5-40mg | -- | ++++ | + |
| Other | **Mirtazapine** | 7.5-15mg daily | 30-45mg | + | - | + |

* Dual serotonin/norepinephrine action at doses of 150-225mg which is effective in neuropathic pain and is mildly activating. On switching from the venlafaxine XR to venlafaxine, the shorter half life of venlafaxine requires frequent dosing to reach the same dose of venlafaxine XR. Use with caution in patients with hypertension

ʁ Do not use in patients with liver dysfunction

†Energizing, will see effect of medication after first or second dose

- Tricyclic antidepressants (TCAs) are not recommended first-line for treatment of depression or anxiety; for more information on this class utilize drug information resources like Micromedex®



References: Rodin G, Katz M, Lloyd N, Green E, et al. Treatment of depression in cancer patients. Curr Oncol. 2007 Oct; 14(5): 180–188.

# Treatment of Oral Secretions at the End of Life

- As the level of consciousness decreases in the dying process, patients lose their ability to swallow and clear oral secretions. As air moves over the secretions, the resulting turbulence produces noisy ventilation with each breath, described as gurgling or rattling noises
- These sounds are good predictors of near death; one study indicated the median time from the onset of increased upper respiratory sounds to death was 16 hours[1]
- Families may feel distress when hearing sounds produced by secretions at the end of life. It is important to discuss this with them and talk about how certain therapies can be helpful
- It may be helpful to discuss the role of oral and pharyngeal suctioning with family and nursing staff. While suctioning can help clear secretions initially, ongoing suctioning can cause discomfort at the end of life

**Nonpharmacological Interventions:** Position the patient on their side or in a semi-prone position (30-45° angle) to facilitate postural drainage

**Medications:** Standard of care are muscarinic receptor blockers (anticholinergic drugs). Note these agents will only address future secretions - will not dry up present secretions



| Medication (Route) | Starting Dose | Onset of Action | Maximum Daily Dose |
|---|---|---|---|
| **Glycopyrrolate** (PO)* | 1mg q4-6h PRN | 30 min | 8mg |
| **Glycopyrrolate** (SC/IV)* | 0.2mg q4-6h PRN | 1 min | 8mg |
| **Atropine** (IV) | 0.1mg q4-6h PRN | 1 min | 2mg |
| **Atropine**⌂ (SL drops) | 1gtt (1%) q4-6h PRN | 30 min | 48gtts |
| **Hyoscyamine** (Tabs, and SL Tabs) | 0.125mg TID-QID PRN | 30 min | 1.5mg |
| **Scopolamine** (Transdermal Patch) | 1mg patch q72h | **12 hrs** | 1 patch q72 hrs |

* Glycopyrrolate will not cross the blood-brain-barrier, reducing the risk of CNS toxicity (sedation, delirium)
⌂ Use atropine ophthalmic drops

References: 1. Bickel K, Arnold RM. Death rattle and oral secretions--second edition #109. J Palliat Med. 2008 Sep;11(7):1040-1.

# Communication Techniques: Responding to Emotion (NURSE)

A common/expected response to serious news is emotion. By responding to emotion, we create a moment of connection and space for the patient to feel and possibly share more. We are not trying to "fix" or resolve the emotion.

| Framework | Example |
|---|---|
| **N**aming | "This is overwhelming" |
| **U**nderstanding | “I can't imagine how hard this must be" |
| **R**espect | "I am so impressed with..." |
| **S**upport | "We will be with you every step" |
| **E**xplore | "Could you tell me more." |



Reference: VitalTalk™ https://www.vitaltalk.org/guides/responding-to-emotion-respecting/

# Communication Techniques: Addressing Goals of Care (REMAP)

This framework serves as an outline to guide a patient/family member through a goals of care conversation to ensure all important aspects are addressed. Expect emotion throughout the conversation.

| Step | What you say or do |
|---|---|
| **R**eframe why the status quo isn't working | ASK what their understanding is: "What have the doctors told you about...?"<br>ASK permission: "Is it OK if I talk about...?"<br>TELL: Give a big picture headline with information and meaning (e.g.):<br>"The scans show your cancer has spread and that means that it is no longer curable." |
| **E**xpect emotion & empathize | Use your NURSE statements (page 23) |
| **M**ap the future | "Given this situation, what's most important to you?"<br>"As you think towards the future, what concerns you?"<br>"What conversations have you had about if your health were to get worse?" |
| **A**lign with the patient's values | "As I listen to you, it sounds the most important things are [x,y,z]" |
| **P**lan medical treatments that match patient values | "Here's what I can do now that will help you do those important things. What do you think about it?" |



Reference: Childers JW, Back AL, Tulsky JA, Arnold RM. REMAP: A Framework for Goals of Care Conversations. J Oncol Pract. 2017 Oct;13(10):e844-e850.

# Communication Techniques: Addressing Code Status

In talking with patients or families about code status outside goals of care conversations, i.e. on hospital admission, consider utilizing this framework.

| Framework | Notes |
|---|---|
| **C**: Check for prior code status discussion/documents (POLST, GOC notes, advance directives) | *Ask permission before each step*<br>*Respond to emotion throughout* |
| **P**: Provide CPR-related prognosis and assess preferences | |
| **R**: Recommendation around CPR/intubation | |



**Tips for Code Status Discussions**

1. Focus on the outcome (surviving to leave the hospital, function after resuscitation...), not the intervention
2. Respond to emotion
3. Simple language – breathing machine, CPR (NOT ventilator, resuscitation, code status)
4. Emphasize what you WILL do before you talk about what you won't do
5. Compare expected outcome of CPR with what you know is important to the patient (goals/values which often comes with a larger GOC conversation)- especially important if talking with surrogate.
6. Document key components of your discussion in a centralized GOC form for future encounters

References:
1.Calculate prognosis after CPR using GO FAR calculator: GO-FAR (Good Outcome Following Attempted Resuscitation) Score
2.Okubo M, Komukai S, Andersen LW, et al. Duration of cardiopulmonary resuscitation and outcomes for adults with in-hospital cardiac arrest: retrospective cohort study. BMJ 2024 Feb 7; 384:e076019.

# Spirituality Overview and Tips

**Spirituality** is a collection of beliefs and practices that reflect how people understand themselves and the world around them. Spirituality is often a response to the vulnerability we experience as humans, facing what we cannot control. Even a person who is not affiliated with an organized religion will still have a spiritual aspect to how they understand and cope with a life-limiting or serious illness. Within palliative care, spirituality can be essential in the process of healing, even when there is no cure.

**Incorporating Spirituality into Patient Care**

- Patients and their families will often share aspects of their spirituality when faced with difficult medical news and hard decisions. It can be helpful for clinicians to consider spirituality as part of a patient's broader support network and coping strategies, and engage with the information accordingly. If you wish to inquire more specifically about a patient's spirituality, the HOPE map below is a helpful guide:



| | |
|---|---|
| **H: Hope** | Sources of hope, strength, comfort, meaning, peace, love and connection |
| **O: Organized Religion** | Role of organized religion in the patient's life |
| **P: Personal** | Personal spiritual practices |
| **E: Effects** | Effects of patient's spiritual and/or religious values on care |

**Hospital chaplains are trained to support a wide range of patient and family spirituality.**
**When asking a patient about a chaplain visit, consider referral by inclusion when possible:**

Referral by Inclusion: "Our treatment team consists of a variety of professionals to assist you during this stressful time. In addition to your physicians and nurses, you may meet social workers, chaplains and others. We all work together on your behalf."

Referral by Exclusion: "Would it be helpful for a chaplain to see you?

Reference: *Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment*. Am Fam Physician. *2001;63(1):86–87*.

# UPMC Palliative Care and Pain Treatment Resources

| Inpatient Supportive and Palliative Care Services | |
|---|---|
| UPMC PUH/MUH Supportive & Palliative Care Service | 412-647-7243; pager: 8511 |
| UPMC Shadyside Supportive & Palliative Care Service | 412-647-7243; pager: 8513 |
| UPMC Magee Womens Hospital of UPMC Supportive & Palliative Care Service | 412-647-7243; pager: 8510 |
| UPMC Children's Hospital of Pittsburgh of UPMC Supportive Care Program | 412-692-3234 |
| VA Palliative Care Program Outpatient and Oncology | 412-360-1293 |
| UPMC Altoona Supportive & Palliative Care Service (Altoona Family Practice) | 814-889-2701 |
| UPMC East Supportive & Palliative Care Service | 412-858-9565 |
| UPMC Hamot Supportive & Palliative Care Service | 814-877-2565 |
| UPMC Mercy Supportive & Palliative Care Service | 412-232-7549 |
| UPMC Northwest Supportive & Palliative Care Service | 814-677-7440 |
| UPMC Passavant Supportive & Palliative Care Service | 412-748-5790 |
| UPMC St Margaret Supportive & Palliative Care Service | 412-784-5484 |
| UPMC Washington Supportive & Palliative Care Service | |
| **Inpatient Medical Ethics Services** | |
| PUH/MUH Medical Ethics | 412-647-2345 (call operator, ask for Medical Ethics) |
| Shadyside Medical Ethics | 412-623-2121 (call operator, ask for Medical Ethics) |
| **Inpatient Pain Treatment Services** | |
| PUH/MUH Chronic Pain Service | 412-692-2234 |
| Shadyside Chronic Pain Service (Center Commons) | 412-665-8030; after hours call: 412-665-8031 |
| PUH/MUH Acute Interventional Perioperative Pain Service (AIPPS) | 412-647-7243; pager: 7246 (PAIN) |
| Shadyside Acute Interventional Perioperative Pain Service (AIPPS) | 412-692-2333 |

# UPMC Palliative Care and Pain Treatment Resources

| Outpatient Services | |
|---|---|
| Palliative Care at Benedum Geriatric Center | 412-692-4200 |
| Palliative Care at Hillman Cancer Center | 412-692-4724 |
| Palliative Care at Presbyterian Heart Failure Clinic | 412-647-7061 |
| Palliative Care at the Kidney Clinic | 412-802-3043 |
| Palliative Care at Magee in the GynOnc Clinic | 412-641-5411 |
| Palliative Care at St. Margaret Clinic | 412-784-5050 |
| Palliative Care at Passavant Clinic | 412-748-5790 |
| Palliative Care at Mercy Oncology Clinic | 412-232-7328 |
| Palliative Care at East Clinic | 412-357-3604 |
| Family Hospice | Administration: 412-572-8800<br>Info/Referrals: 1-800-513-2148 |
| Palliative Recovery Engagement Program | 412-232-6275 |
| St Margaret Pain Medicine | 412-784-5119 |
| Pain Management at Falk Medical Building (Presbyterian) | 412-692-2234 |

# UPMC Spiritual Care Resources

| Inpatient Hospital Spiritual or Pastoral Care Offices | |
|---|---|
| UPMC Magee-Women's Hospital | 412-641-4525 |
| UPMC Presbyterian/Montefiore | 412-647-7560 |
| UPMC Shadyside | 412-623-1692 |
| UPMC St. Margaret | Protestant Chaplain Office: 412-784-4080<br>Catholic Priest Office: 412-784-4082 |
| UPMC Mercy | 412-232-8198 |
| UPMC McKeesport | 412-664-2057 |
| UPMC East | 412-357-3151 |
| UPMC Passavant | 412-748-6516 |
| Children's Hospital of Pittsburgh | 412-692-5349 |
| VA Hospital Oakland campus | 412-822-1551 |

# Notes

## Indications for Palliative Care Referral:

- Pain in patients with life-limiting illness
- Management of other symptoms such as nausea, vomiting, shortness of breath, delirium
- Negotiating goals of treatment or end-of-life decision making
- Family support for a patient with a life-limiting illness
- Psychological or spiritual counseling for patients and their families
- Discharge planning and interface with local hospices
- Bereavement services in the event of death
- Outpatient palliative care follow up



Questions or comments regarding this information, contact Jane Schell, MD (schelljo@upmc.edu). This information provided by the UPMC Supportive and Palliative Care Programs are merely in the form of recommendations and do not replace the service of a provider.
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