PAIN MANAGEMENT ESSENTIAL COMMUNICATION ELEMENTS FOR TRANSITIONS OF CARE GUIDE

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QIN–QIO Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving pain medication. Additionally, it can be used to evaluate your facility practices regarding communication of requisite pain-related elements to subsequent providers and identify opportunities for system improvements.

Pain Essential Communication Elements	Guidance
Pain diagnosis	Expectation is that pain is clearly indicated as a medical condition, regardless of whether it is a primary purpose for receiving services from the index (i.e., "upstream") provider. Diagnosis NOT to be deduced by evaluation of drug regimen.
Pain category(s) or classification	Pain characterized according to recognized category(s) including but not limited to: acute (e.g., post-operative), subacute, chronic (e.g., cancer and persistent non-cancer), nociceptive, neuropathic, inflammatory, central, or mixed.
Temporal characteristics	Expectation is that duration of pain is communicated to some degree (acute vs. chronic; new diagnosis vs. pre-existing condition [> 30 days]).
Pain severity, recent	Subsequent providers are to receive documentation of recent pain symptoms and response to therapy over previous 7 days (longer period preferred, describe full length of stay at index provider if LOS < 7 days). Include overview of severity of pain in recent days as well as frequency and responsiveness to interventions (pharmacological and other).
Pain severity, current	Most recent objective assessment of pain severity is documented and communicated to subsequent providers, including details of date and time of last two assessments and date and time the next assessment is due. Prefer accepted/validated pain scoring method.
Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen	Subsequent providers should receive at the time of transition between care settings, detailed characteristics of all drugs, including opioids prescribed to control pain symptoms, including drug names, dosages, routes, and frequencies. Communication should also include date and time last doses given AND date and times next scheduled doses are due. The location of transdermal patches and the date time of last placement and subsequent removal should be communicated.

Pain Essential Communication Elements	Guidance
Opioid doses administered within the last two 24 hour periods	Subsequent providers should receive a medication administration record of the last two 24-hour periods of opioid dosing including routine around-the-clock and as needed opioids. This can be beneficial in identifying pain management trends. If the drug choice is changed post-transition (e.g., due to availability issues), it is recommended that the receiving provider convert to oral morphine equivalents using a conversion calculator to determine appropriate dosing.
Identification of opioid naïveté in patients starting on an opioid.	Documentation of patient experience with opioid medications through questioning and consultation of the PMP (Prescription Monitoring Program) should be provided to subsequent providers. Long-acting or extended-release opioid formulations should be avoided in opioid naïve patients. Increased education and monitoring should be provided for opioid naïve patients. Standard definitions for opioid tolerance should be used. "Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid" *Source: NIH U.S. National Library of Medicine; DailyMed. Duragesic (Fentanyl Patch) under section 'Indications and Usage' accessible at* https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d7aade83-9e69-4cd5-8dab-dbf1d7b89bb4.
Presence, frequency, and degree of use of respiratory depressants (benzodiazepines, cough syrup containing alcohol, etc.)	Clinical documentation should clearly characterize presence of medications and/or substances that can cause respiratory depression. A risk vs benefit evaluation should be performed when concomitant use of opioids and respiratory depressants is present.
History of opioid overdose with date(s).	Details of episodes of opioid overdose and whether intentional or unintentional should be communicated to subsequent providers including causative agents if applicable, classification and current stability.
Contact information provided for the subsequent pain management prescriber/ physician.	The name and contact information of the receiving pain management prescriber should be verified and provided to the patient.

Pain Essential Communication Elements	Guidance
Alcohol and/or substance abuse and/or dependence history	Clinical documentation should clearly characterize any current use or history of alcohol and/or substance abuse or dependence, including the frequency and degree of use. If no alcohol and/or substance abuse or dependence exist, clinical documentation should clearly state that the patient has no history.
Behavioral health/mental health history and status	Subsequent providers should receive details of previous and/or ongoing behavioral health concerns/mental health disorders, if known, and their treatment, as well as a detailed characterization of mental status at the time of transition to subsequent providers, if applicable and/or available. Treatment may have implications for pain management or impact patient self-management of pain. If present, all diagnoses, current clinical status, and details of treatment regimens (drug and non-drug) should be described in detail, if possible. If no behavioral health issue or psychiatric illness exists or was previously diagnosed, clinical documentation should clearly state that patient has no known history.
Respiratory status	Clinical documentation should clearly characterize presence of any acute or chronic respiratory disease and status of treatment regimen, if applicable. If no respiratory disease is present, clinical documentation should clearly state that respiratory status is normal.
Date of last bowel movement	Clinical documentation should indicate when the last bowel movement occurred.
Bowel regimen ordered	Clinical documentation should clearly characterize what medication(s) the patient is on to prevent opioid-induced constipation and the clinical status and current treatment regimens must be described in detail.
Presence of potential barriers to safe medication use (e.g., cognitive impairment, mental health disorders, dementia, visual impairment, etc.)	Clinical documentation should clearly characterize the potential barriers to safe medication use. If present, current clinical status, details of treatment regimens (drug and non-drug), and impact on safe pain self-management or caregiver management should be described in detail.
Fall assessment and history	Frail, elderly patients may experience more catastrophic consequences of falls than younger, healthier patients (e.g., hip fractures). Some objective evaluation of falls risk/frailty may be helpful to subsequent providers, particularly in instances in which they have not yet seen personally (e.g., evening admission to nursing home).

Pain Essential Communication Elements	Guidance
Assessment of patient ability to self-administer current pain regimen	Clinical documentation characterizes in some manner (objectively or in subjective narrative) patient ability to administer and manage all agents prescribed for pain management.
Patient/caregiver/ family member capacity for identifying signs/ symptoms of overdose	Clinical documentation characterizes in some manner (objectively or in subjective narrative) patient/caregiver/family member ability to identify signs/symptoms of an overdose (e.g., respiratory distress, over-sedation, unresponsiveness, pinpoint pupils).
Caregiver/family member capacity for administering a reversal agent for overdose if reversal agent is available	Clinical documentation characterizes in some manner (objectively or in subjective narrative) caregiver/family member training/ability to administer reversal agent, if available, in the case of opioid overdose.
Instruction to follow safe usage, storage and disposal procedures for the prescribed medication for patients being discharged to home	Patient education is a key component for medication management and safety, especially in regard to controlled substances. Documentation of patient education in regard to medication usage and storage should be shared with providers.
Documentation of provision of educational materials to patient/ caregiver	Patient/caregiver education is a key component of quality pain management and an integral part of discharge counseling, particularly as patient's transition between care settings and experience changes in medical status, environment, and medications. Documentation of the provision of educational materials should be shared with subsequent providers. Details of the content of such materials is recommended, but not required.
Assessment of patient/ caregiver understanding of the education documented	Clinical documentation should characterize patient comprehension of their pain-related care plan, including monitoring and symptom recognition, medication administration and adherence, and communication with healthcare providers.

For more information: https://qi.ipro.org/

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