Navigating Opioid Prescribing Through Four Different Health Care Environments

Outpatient, Inpatient, Long-Term Care, & Hospice

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Disclosures

In order to obtain contact hours you must:

- Watch the 60-minute webinar (live or recorded)
- Complete evaluation & reflective question(s)

Dr. Storm and other planners for this educational activity have NO relevant financial relationships with illegible companies to disclose. The expiration for this enduring material is 01/30/2026.

Continuing Education

In support of improving patient care, this activity has been planned and implemented by Quality Insights and CAMC Institute for Academic Medicine. CAMC Institute for Academic Medicine is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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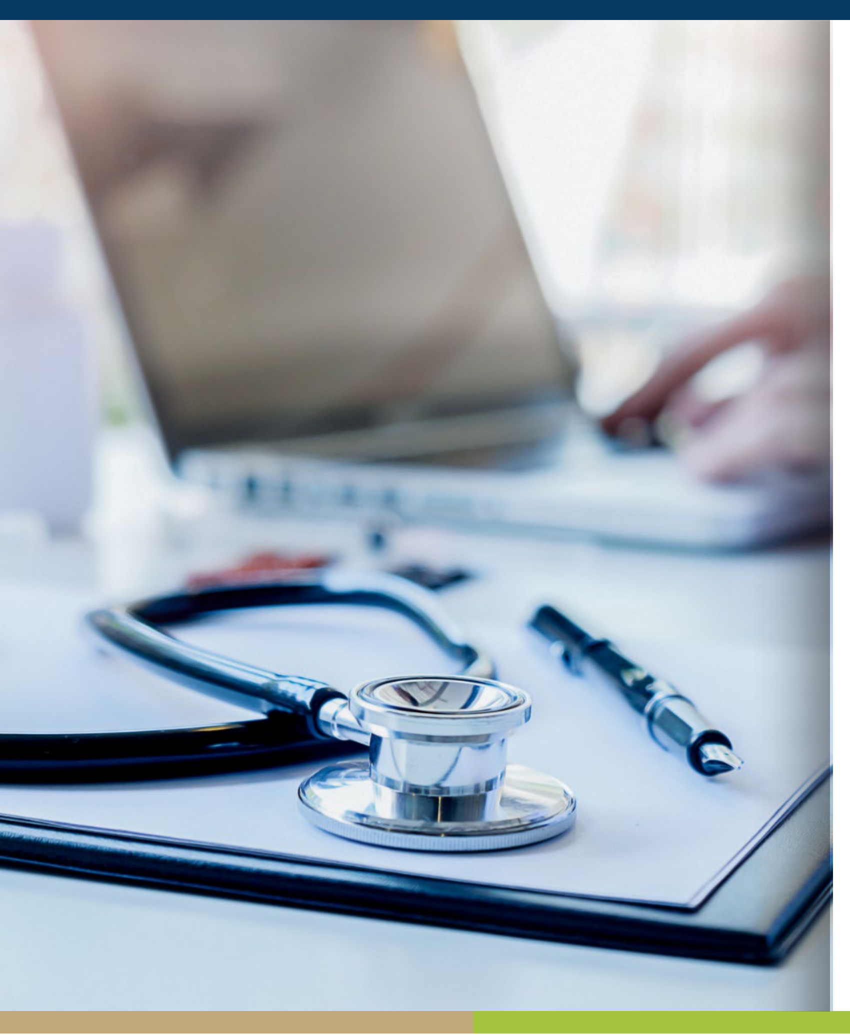
Today's Speaker

Jean Storm, DO, CMD

Medical Director
Quality Insights

Learning Outcomes



At the conclusion of the webinar attendees will:

- Understand why opioid prescribing needs to be approached differently depending on health care environment
- Understand which guidelines help providers decide when and how to prescribe opioids appropriately
- Understand why a pain assessment is an essential step in opioid prescribing
- Be able to explain the difference between acute, subacute and chronic pain and understand how they are treated differently

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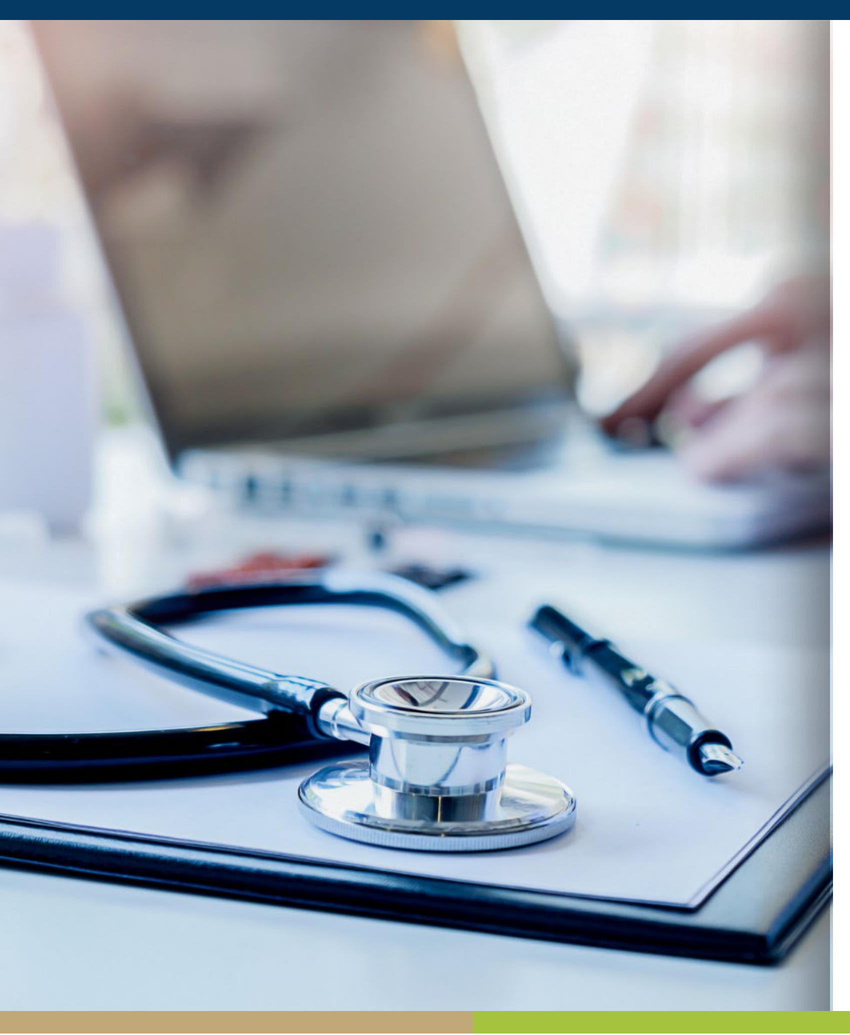
Learning Outcomes



At the conclusion of the webinar attendees will:

- Be able to explain and utilize the goals of the 2022 Centers for Disease Control & Prevention (CDC) Guideline for prescribing opioids
- Recognize why opioid prescribing needs to be approached differently in the inpatient setting and understand the importance of appropriate opioid prescribing at discharge from the hospital
- Understand the basic tenets of opioid prescribing in long term care as well as the challenges involved in opioid use in this setting
- Appreciate the importance of appropriate pain management in the hospice patient in improving quality and quantity of life

Where are we with opioid prescribing?

- The following is based on a text I received from a nurse recently when I was on call.
- I believe the information relayed in this text is very common in nursing homes across the country.
- We need to examine the current culture if we want to make change.

> Resident in 2201 has bad arthritis and has 1 50mg tramadol twice daily for pain. States will not take only one, residents wants 3 (150mg) in the morning and 2 (100mg) at night otherwise won't take it and wants the order changed to hydrocodone. What would you like me to do with the order? Resident just had left trans-metatarsal amputation.

Why is Opioid Prescribing So Challenging?

1. Pain is difficult to describe/quantify
2. Numeric pain ratings fail to explain pain
3. Pain is often self-reported
   – Patients over-report to enhance provider response
   – Patients under-report due to concerns surrounding other perceptions, finances, etc., etc.
4. Pain type/duration/quality directs opioid prescribing

THE FOUR ENVIRONMENTS

- Outpatient
- Inpatient
- Long-Term Care Facility / Skilled Nursing Facility (SNF)
- Hospice

Why Does Opioid Prescribing Need to be Tailored to Environment?

- Different patient goals
- Different levels of supervision
- Health care setting might change the type of pain
- Different resources available in each location
- Important to keep in mind that each patient needs to be approached individually in each health care setting

A basic framework

A basic framework is needed in each health care environment to guide:

1. When to initiate opioids
2. Which opioid to initiate
3. What dose to initiate
4. How long to continue opioids
5. When follow-up will be done
6. What will follow-up consist of?
7. What else is being done?

OUTPATIENT
Opioid Prescribing

OUTPATIENT

Patient Case

A 76-year-old female patient makes an appointment with you due to back pain which started 2 weeks ago after she picked up her grandchild. Pain is described as “sharp and constant.” She was seen in urgent care the day after the pain started and an X-ray was done, which revealed no fractures.

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2016 CDC Guideline for Opioid Prescribing

- Practices significantly changed after 2016 CDC Guideline for Opioid Prescribing
- The 2016 guideline described:
  1. When to initiate opioids and when to continue opioids for chronic pain
  2. Opioid selection, dosage, duration, follow-up, and discontinuation
  3. Assessing risk/addressing harm
- There was some concern of misapplication of the guideline following the release

OUTPATIENT

2016 CDC Guideline

MME per capita (POS)

Total Overdose Deaths (TOD)

Any Opioid Deaths (AOD)

Opiate Treatment Admissions in 1000s (OTA)

Opioid Rx Deaths (POD)

# of Overdose Deaths: 0, 10,000, 20,000, 30,000, 40,000, 50,000, 60,000, 70,000, 80,000

MME/capita & OTA in 1,000's: 350, 400, 450, 500, 550, 600, 650, 700, 750, 800, 850

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

FIGURE 2

2010–2019 update. The green line represents opioid prescribing (POS, MME/capita); the red lines are opioid deaths (POD, AOD, and TOD); the blue line represents opioid addiction (OTA). Over the past decade, as the green line (prescription opioids) declined by +50%, prescription opioid deaths remained flat while opioid addiction, any opioid and total overdose deaths continued increasing "exponentially (9)".

Source: Front. Pain Res., 04 August 2022. Sec. Pain Research Methods.
https://doi.org/10.3389/fpain.2022.884674

OUTPATIENT

2022 CDC Guideline for Opioid Prescribing

Added to the new guideline released in 2022:

- Explained that the guideline was meant as a clinical tool to enable communication between patient and provider
- Outlined:
    1. Acute pain: < 1 month
    2. Subacute pain: 1-3 months
    3. Chronic pain: > 3 months
- Intended to be flexible
- Expanded scope from primary care physicians (PCPs) to all providers prescribing opioids

OUTPUTPATIENT

2022 CDC Guideline for Opioid Prescribing

The guideline **IS NOT**:

- A replacement for clinical judgement
- A law
- To be applied inflexibly
- Intended for sickle cell, cancer, end-of-life/palliative-care patients
- Focused on opioids prescribed for opioid use disorder (OUD)

OUTPATIENT

Guiding Principles of 2022 Guideline

1. Acute, subacute, and chronic pain need to be approached differently
2. Recommendations are voluntary
3. A multimodal and multidisciplinary approach is stressed
4. The guideline is not meant to be applied beyond its scope
5. It is important to attend to health inequities to ensure access to all persons

OUTPATIENT

Highlights of 2022 CDC Opioid Prescribing Guideline

(4 areas)

OUTPATIENT

Determine Whether or Not to Initiate Opioids

- **Recommendation 1:** Non-opioid therapies are at least as effective as opioids.
- **Recommendation 2:** Non-opioid therapy is preferred for subacute and chronic pain.

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2.1 APPROACHES TO PAIN MANAGEMENT

Patient A

Patient B

Patient C

Patient D

Therapeutic alliance and shared decision-making

Diagnostic Evaluation: Biopsychosocial Approach

Pain Management Toolbox*

- NSAIDs, OTCs
- Medications
- TENS
- Yoga
- Epidural steroid injections
- Gabapentinoids
- Interventional procedures
- Specialty referral
- Massage
- Self-management
- Nerve blocks
- Behavioral health
- Neuromodulation
- Acupuncture
- Neuropathic Rx
- Physical therapy
- Short-term opioid

*This list is non-exhaustive nor in any particular order

Clinical Indication

Integrative Treatment Plan:

Multimodal, multidisciplinary, individualized

- NSAIDs
- Yoga
- Nerve blocks

- Short-term opioids
- Behavioral health
- Physical therapy

- Acupuncture
- Trigger point injection
- Self-management

- Gabapentinoids
- Tai chi
- Epidural steroid Injections

Figure 6: Individualized Patient Care Consists of Diagnostic Evaluation That Results in an Integrative Treatment Plan That Includes All Necessary Treatment Options

Source: U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html

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Select Opioid and Determine Dosage

- **Recommendation 3:** Start with immediate release formulations (discuss naloxone use).
- **Recommendation 4:** Start with lowest dose.
- **Recommendation 5:** If a patient is already on opioid, assess benefits vs. risks of continuing. (Do not discontinue abruptly or aggressively taper.)

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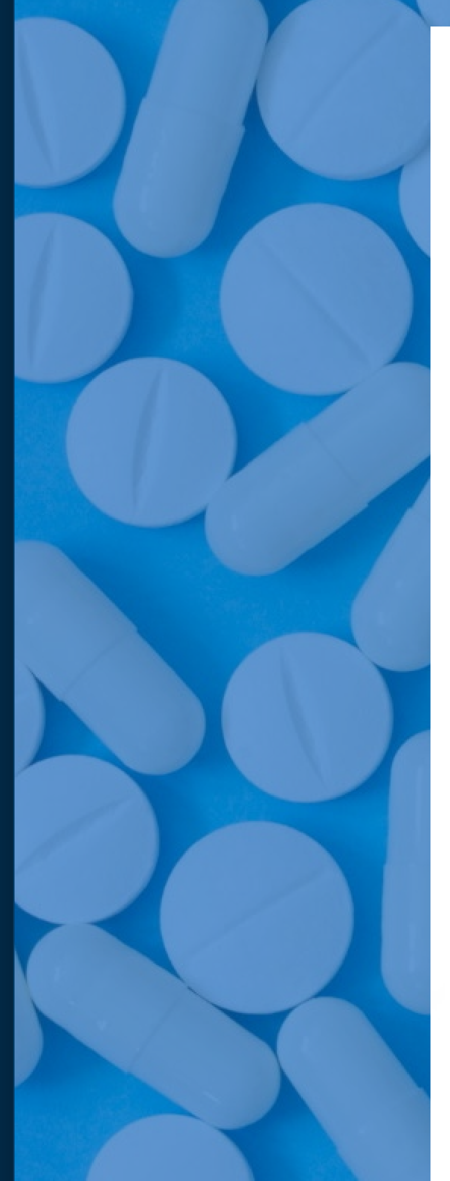
Short Acting Opioid Formulations

- Commonly prescribed oral, short-acting opioids include:

  Codeine, Hydrocodone, Hydromorphone, Methadone, Morphine, Oxycodone, Oxymorphone, Tramadol

- Use caution when prescribing doses above 50 morphine milligram equivalent (MME) daily dose and avoid prescribing doses above 90mg MME, as these doses are linked to higher levels of overdose and death

OUTPATIENT



Calculating morphine milligram equivalents (MME)

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

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

Source: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

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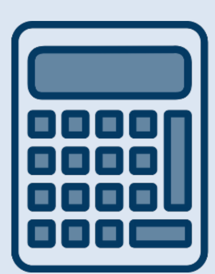
Calculating MME

A patient is taking oxycodone IR 10mg po q4h

- Total daily dose is 10mg x 6 = 60mg
- Conversion factor for oxycodone is 1.5
- MME is 60mg x 1.5 = 90 MME/day



Online MME calculator:

https://www.mdcalc.com/calc/10170/morphine-milligram-equivalents-mme-calculator

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Decide Duration of Opioid Prescription

- **Recommendation 6:** Do not prescribe an amount greater than needed for pain duration.
- **Recommendation 7:** Evaluate benefit within 1 to 4 weeks.

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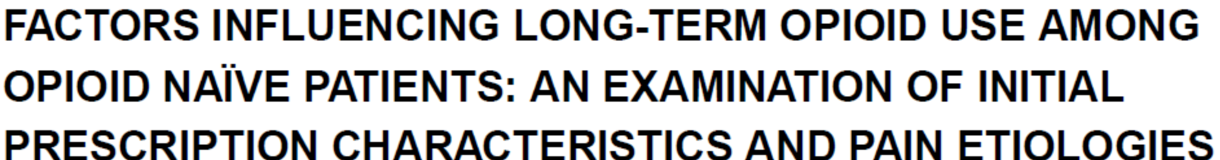

FACTORS INFLUENCING LONG-TERM OPIOID USE AMONG OPIOID NAÏVE PATIENTS: AN EXAMINATION OF INITIAL PRESCRIPTION CHARACTERISTICS AND PAIN ETIOLOGIES

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Abstract

The relationships of characteristics of the initial opioid prescription and pain etiology with the probability of opioid discontinuation were explored in this retrospective cohort study using health insurance claims data from a nationally representative database of commercially insured patients in the U.S. We identified 1,353,902 persons aged ≥14 with no history of cancer or substance abuse, with new opioid use episodes and categorized them into 11 mutually exclusive pain etiologies. Cox Proportional Hazards models were estimated to identify factors associated with time to opioid discontinuation. After accounting for losses to follow-up, the probability of continued opioid use at one year was 5.3% across all subjects. Patients with chronic pain had the highest probability for continued opioid use followed by patients with inpatient admissions. Patients prescribed doses above 90 morphine milligram equivalents (HR=0.91, CI: 0.91–0.92); initiated on tramadol (HR=0.90, CI: 0.89–0.91) or long-acting opioids (HR=0.78, CI: 0.75–0.80); were less likely to discontinue opioids. Increasing days' supply of the first prescription was consistently associated with a lower likelihood of opioid discontinuation (HRs, CIs: 3–4 days'

Source: *J Pain.* 2017 November: 18(11): 1374-1383. doi 10.1016/j.jpain.2017.03.010.

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Factors influencing long-term opioid use

- Days supply of first prescription in opioid naive patients is a major prognostic factor for continued opioid use after controlling for pain types, patient demographics, and mental disorders
- The days supply demonstrates a dose-response relationship with the likelihood of opioid discontinuation
- The more days supply that is given in the initial prescription, the more likely that individual will be taking the opioid a year later
- Persons prescribed 11-14 days initially are 3x more likely to continue the opioid compared to persons prescribed 2 days or less

OUTPATIENT

Assessing Risk and Addressing Harm

- **Recommendation 8:** Assess risk (drug and alcohol screening, OUD tools).
- **Recommendation 9:** Review Prescription Drug Monitoring Program (PDMP).
- **Recommendation 10:** Consider benefits vs. risks of toxicology screening.
- **Recommendation 11:** Avoid concomitant benzodiazepine and opioid prescribing.
- **Recommendation 12:** OUD should receive treatment! Detoxification should not be done without medication assistance.

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Patient Case

A 76-year-old female patient makes an appointment with you due to back pain, which started 2 weeks ago after she picked up her grandchild. Pain is described as "sharp and constant." She was seen in urgent care the day after the pain started and X-ray was done, which revealed no fractures. What type of pain does this patient describe?

A. Acute
B. Subacute
C. Chronic
D. Enduring
E. None of the above

INPATIENT
Opioid Prescribing

INPATIENT

Patient Case

A 76-year-old female patient is admitted to the hospital after she falls at home after picking up her grandchild. She is found to have a femur fracture in the emergency room and is admitted for surgical repair. Oxycodone IR 5mg po q6 prn is ordered post-operatively.

INPATIENT

Inpatient Opioid Prescribing

- Studies have demonstrated that almost half of all patients admitted to the hospital receive opioids for most of their stay
- Rarely is opioid prescribing patient-centered
- No formerly published guidelines

Source: Shoshana J. Herzig MD, MPH, Michael B. Rothberg MD, MPH, Michael Cheung MBA, Long H. Ngo PhD, Edward R. Marcantonio MD, SM. *Journal of Hospital Medicine*. Opioid utilization and opioid-related adverse events in nonsurgical patients in US hospitals. Journal of Hospital Medicine. Volume 9, Issue 2. February 2014, Pages 73-81. https://doi.org/10.1002/jhm.2102

INPATIENT

Best Approach

It is important to utilize a step-wise approach to pain management:

1. Non-pharmacologic approach first
2. Non-pharmacologic + non-opioid medication if #1 is ineffective
3. Non-pharmacologic + non-opioid medication + short term use of short acting opioid if #2 is ineffective

INPATIENT

Hospitalized Patients with Opioid Use Disorder (OUD)

The approach to hospitalized patients with OUD has changed in the last few years:

- Medications for opioid use disorder (MOUD) should be continued in the hospital
- Full agonist opioids (oxycodone, fentanyl, hydrocodone) can be used along with MOUD (medications for opioid use disorder)

Source: Watto MF, Chan CA, Cohen S, Syed F. “#366 Opioid Use disorder, Acute Pain in the Hospitalized Patient”. The Curbsiders Internal Medicine Podcast. https://thecurbsiders.com/episode-list Final publishing date November 14, 2022.

INPATIENT

Discharging with Opioids

- Utilize an algorithm to determine amount of opioid medication on discharge prescription based on inpatient use of opioids
- Describe FDA compliant disposal
- Ensure follow-up phone call is done

INPATIENT

Guidelines for Patient Centered Opioid Prescribing and Optimal FDA-Compliant Disposal of Excess Pills after Inpatient Surgery: A Prospective Clinical Trial

Intervention

1. Discharge Rx Guidelines

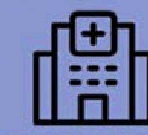
Opioid Usage Day Prior to Discharge*		Discharge Opioid Rx*
0	→	5
1-3	→	15
≥4	→	30

*Opioid usage in oxycodone 5mg pill equivalents. Rx prescription

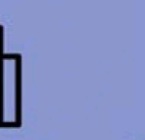
2. FDA-Compliant Disposal

1. Patient Education

2. Reminder Phone Call

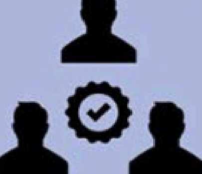


3. Dropbox at Hospital



4. Follow-up Questionnaire

Outcomes



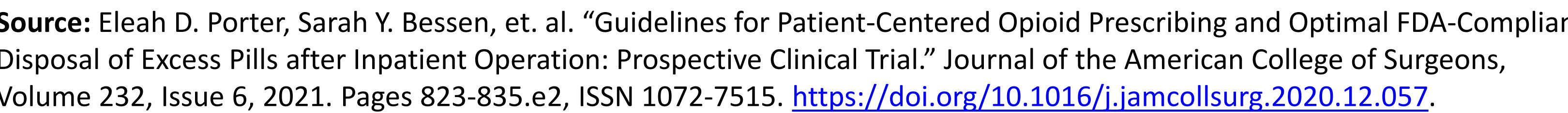
93% of patients' pain needs satisfied*

*No opioid Rx refill obtained

83% FDA-compliant disposal achieved

51% used hospital dropbox

Porter et al. J Am Coll Surg, June 2021



Source: Eleah D. Porter, Sarah Y. Bessen, et. al. "Guidelines for Patient-Centered Opioid Prescribing and Optimal FDA-Compliant Disposal of Excess Pills after Inpatient Operation: Prospective Clinical Trial." Journal of the American College of Surgeons, Volume 232, Issue 6, 2021. Pages 823-835.e2, ISSN 1072-7515. https://doi.org/10.1016/j.jamcollsurg.2020.12.057.

INPATIENT

Patient Case

A 76-year-old female patient is admitted to the hospital after she falls at home after picking up her grandchild. She is found to have a femur fracture in the emergency room and is admitted for surgical repair. Oxycodone IR 5mg po q6 prn is ordered post-operatively. She is taking 3 doses per day prior to discharge. How many oxycodone should be prescribed on discharge?

A. 9
B. 6
C. 15
D. 0
E. 3

LONG-TERM CARE/SNF

Opioid Prescribing

LONG-TERM CARE/SNF

Patient Case

A 76-year-old female is admitted to SNF following a hospitalization for femur fracture repair. Her discharge instructions include an order for oxycodone IR 5mg po q6 prn. She continues to complain of moderate to severe pain in her hip 5 weeks after admission to SNF.

LONG-TERM CARE/SNF

AMDA Clinical Practice Guideline for Pain Management

11 Basic Steps

1. Screen for pain periodically
2. Obtain and document details about pain
3. Identify causes of pain
4. Interpret findings and draw conclusions about a patient's pain
5. Implement a pertinent pain management plan
6. Manage specific pain situations
7. Select and implement specific pain situations
8. Prescribe and manage analgesics prudently
9. Obtain appropriate support for pain management as indicated
10. Monitor all patients being treated for pain
11. Review and revise pain treatments as indicated

Source: AMDA – The Society for Post-Acute and Long-Term Care Medicine. Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: AMDA 2021

Let's Look at This Patient Again

Resident in 2201 has bad arthritis and has 1 50mg tramadol twice daily for pain. States will not take only one, residents wants 3 (150mg) in the morning and 2 (100mg) at night otherwise won't take it and wants the order changed to hydrocodone. What would you like me to do with the order? Resident just had left trans-metatarsal amputation.

Some Questions to Help Devise a Plan

- Have the patient describe the pain and location. Arthritic pain? Pain from amputation?
- When was the surgery performed?
- What other medications is the patient receiving?
- What pain interventions is the patient receiving? (non-pharmacologic as well as pharmacologic)
- Why is the patient asking specifically for hydrocodone?

General Principles for Prescribing Opioids

1. Determine PRN vs standing order
   - Acute? Chronic? Mild? Severe?
   - Mild acute pain → PRN
   - Acute, severe, continuous → Standing
   - Chronic, mild → PRN
   - Chronic, severe, continuous → PRN + standing

LONG-TERM CARE/SNF

TABLE 21
Use of Standing vs PRN Doses in Different Pain Categories

Category	PRN or Standing Dose
Acute pain (mild to moderate, intermittent)	PRN dosing may suffice (+/- nonpharmacological interventions) ***Example:*** Acetaminophen 650 mg q6h PRN
Acute pain (moderate or more severe, continuous)	May require a standing dose +/- supplemental PRN doses (plus nonpharmacological interventions) ***Examples:*** • Acetaminophen 650 mg q12h standing dose + 325 mg q8h PRN in between standing doses • Diclofenac 25 mg q12h standing dose + acetaminophen 325 mg q8h PRN in between standing doses of diclofenac • Hydrocodone/acetaminophen 5/325 mg q6h PRN or standing
Chronic non-cancer–related pain (mild to moderate, intermittent)	PRN dosing alone may suffice (+/- nonpharmacological interventions) ***Example:*** Acetaminophen 650 mg q8h PRN or alternate with ibuprofen 200 mg q6h PRN
Chronic non-cancer–related pain (more severe, frequent, or continuous)	May require a standing dose +/- supplemental PRN doses (+ nonpharmacological interventions) ***Examples:*** • Acetaminophen 650 mg q12h standing dose + 325 mg q8h PRN in between standing doses • Diclofenac 50 mg q12h standing dose + acetaminophen 325 mg q8h PRN in between standing doses of diclofenac
Chronic cancer-related pain (mild to moderate, intermittent)	May require a standing dose +/- supplemental PRN doses (+ nonpharmacological interventions) ***Examples:*** • Morphine sulfate ER 15 mg q12h standing dose + acetaminophen 650 mg q8h PRN in between standing doses of morphine sulfate • Morphine sulfate IR 20 mg/cc; give 0.25 cc (5 mg) sublingually every 2 hours PRN for breakthrough pain
Chronic cancer-related pain (more severe, frequent, or continuous)	Standing dose of an opioid with frequent supplemental PRN opioid doses (+ nonpharmacological interventions) ***Examples:*** • Morphine sulfate ER 15 mg q12h standing dose + Morphine sulfate IR 20 mg/cc; give 0.25 cc (5 mg) sublingually every 2 hours PRN for breakthrough pain • Hydromorphone 4 mg q6h standing dose +/- ibuprofen 400 mg q8h PRN in between standing doses of hydromorphone
Chronic pain – neuropathic/ fibromyalgia	Standing dose of a SNRI/TCA/gabapentinoid (+ nonpharmacological interventions) ***Example:*** Duloxetine 30 mg q12h
End-of-life pain	Standing dose of an opioid with frequent supplemental PRN opioid doses ***Example:*** Morphine sulfate ER 15 mg q12h standing dose + morphine sulfate-IR 2 mg q2h PRN

Source: AMDA – The Society for Post-Acute and Long-Term Care Medicine. Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: AMDA 2021

LONG-TERM CARE/SNF

General Principles for Prescribing Opioids

2. Identify pain relief goal
3. Utilize a risk assessment tool as needed
4. Utilize the simplest schedule
5. Use the lowest possible dose
6. Reassess periodically

LONG-TERM CARE/SNF

Opioid Prescribing Options

1. **Morphine**
   - The standard to compare other opioids
   - Can cause neurotoxicity in renal impairment
2. **Hydromorphone**
   - Use with caution due to potency
3. **Hydrocodone**
   - Typically manufactured with acetaminophen
4. **Oxycodone**
   - Carries high risk of addiction
5. **Fentanyl**
   - Very potent, FDA has issued major warnings
6. **Methadone**
   - Complex medical interactions
7. **Tramadol**
   - Potentially problematic as the adverse effects vary among individuals

LONG-TERM CARE/SNF

Approach to Opioid Titration

1. When beginning opioid therapy, start with PRN immediate-release
2. During titration, select an appropriate schedule
   - Approximately 4-5 doses of a short-acting opioid will be needed to achieve steady state pain relief
3. Periodically evaluate PRN
   - Consider ordering scheduled analgesic if PRN is insufficient
4. Consider long acting opioids
   - Review PRN usage and calculate dose of long acting preparation

Challenges

1. Constipation
2. Psychiatric and behavioral issues
3. Respiratory depression
4. Dependence
5. Other: anorexia, weight loss, confusion, falls, urinary retention, etc.

LONG-TERM CARE/SNF

Constipation Impact on Pain

- A study of 126 community-dwelling older adults, respondents with chronic constipation had lower scores for physical functioning, mental health, general health perception, and bodily pain when compared to respondents without constipation
- Another study of 100 people over the age of 65 demonstrated a markedly higher prevalence of physical pain and a decrease in perception of health in constipated patients compared to healthy controls

Sources: O'Keefe EA, Talley NJ, Tangalos EG, Zinsmeister AR. A bowel symptom questionnaire for the elderly. J Gerontol. 1992;47:M116–21
Talley NJ. Definitions, epidemiology, and impact of chronic constipation. Rev Gastroenterol Disord. 2004;4 Suppl 2:S3–10.

LONG-TERM CARE/SNF

Important Considerations

What if there is inadequate relief despite escalating opioid doses?

1. Opioids are not indicated or they are not working.
2. Pain is undertreated.
3. Underlying cause has not been identified.
4. The situation requires a different approach.

LONG-TERM CARE/SNF

Patient Case

A 76-year-old female is admitted to SNF following a hospitalization for femur fracture repair. Her discharge instructions include an order for oxycodone IR 5mg po q6 prn. She continues to complain of moderate to severe pain in her hip 5 weeks after admission to SNF. What should be done first?

A. Increase oxycodone IR dose from 5mg q6 to 10mg q6 PRN
B. Discontinue oxycodone IR due to tolerance
C. Examine the patient's hip
D. Increase the amount of physical therapy she receives
E. Order diclofenac 1% gel applied to hip q8

HOSPICE
Opioid Prescribing

HOSPICE

Patient Case

A 76-year-old female patient currently residing in SNF is diagnosed with lung cancer metastatic to her spine. She is receiving oxycodone IR 5mg q6 prn without relief of her back pain. She has decided to pursue hospice care and will be discharged to home under hospice services.

HOSPICE

Hospice Pain Management

- Pain is common at end of life
- A proper assessment must be done to determine type, characteristic, and severity of pain
- Effective pain management at end of life increases quality of life and may actually prolong life

Source: Philip S. Whitecar MD, A. Patrick Jonas MD, Mark E. Clasen MD, PHD. “Managing Pain in the Dying Patient.” American Family Physician. 2000;61(3):755-764

HOSPICE

Principles of Pain Management in Hospice

1. Choice of medication should be based on type of pain.
2. Patients with chronic or frequently recurring pain should receive medication around the clock.
3. Episodic or breakthrough pain should be anticipated. Daily breakthrough should be equal to regularly scheduled dose.
4. Doses should be titrated promptly. Morphine and other opioids can be increased by 50% every 24 hours until adequate response.

HOSPICE

Barriers to Optimal Pain Management

1. Denial by patient and family
2. Fear that increasing pain means disease progression
3. Fear of addiction and abuse
4. Fear of diversion

HOSPICE

Patient Case

A 76-year-old female patient currently residing in SNF is diagnosed with lung cancer metastatic to her spine. She is receiving oxycodone IR 10mg q4 prn without relief of her back pain. She has decided to pursue hospice care and will be discharged to home under hospice services. How should you change her pain management plan?

A. Refer her to pain management
B. Add oxycodone ER 30mg q12 and continue oxycodone IR 10mg po q4 PRN
C. Discharge her with a referral to outpatient physical therapy
D. Reduce her dose of oxycodone IR to 5mg
E. Continue current plan

Take Home Points

- Environment specific guidelines help us decide when and how to prescribe opioids appropriately. Use them!
- Pain assessment is an essential step in opioid prescribing.
- Acute, subacute and chronic pain are approached treated differently.
- Appropriate opioid prescribing is essential at discharge from the hospital.
- It is important to utilize basic tenets of opioid prescribing in long-term care and to keep in mind challenges unique to this environment.
- Appropriate pain management is essential for the hospice patient in improving quality and quantity of life.

Questions?

Contact

People wanting CE Credits: ***Please remain for instructions for accessing post-webinar evaluation and questionnaire.***

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Evaluation

"How to Navigate Opioid Prescribing Through Four Different Health Care Environments: Outpatient, Inpatient, Long-Term Care, and Hospice"

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