Q: Paul, are hospitalized patients and providers covered by some exemption of any of these standards & guidelines discussed? Are they expected to meet the same practice standards?

A: No, the standards are less stringent for inpatients.

Q: Do you have any advice to promote safe usage at a hospice that almost exclusively uses methadone for pain management?
A: Methadone poses unique safety problems. Make sure you have a good list of drugs that can interact with methadone and be cautious when adding drugs (e.g. Ketoconazole). The greatest risk for respiratory depression is ~7 days after it is first started. It is a very good drug, and like any opioid, you need to protect from others gaining access to it. So consider the security of the drug in the home … balanced with ease of access to use. The other issue with methadone is that its onset of action and duration of action of a single dose is not that great, so often times in out palliative care patients we often use a different opioid medication for breakthrough pain.

Q: I have been trying to engage our addictionologists in pain management. They say they are not often involved in that area. Do you have addictionologists on your pain team?
A: Yes, we have a Psychologist specializing in addictionology that sees all patients prescribed opioids on the outpatient basis.

Q: Is there a high probability of misrepresentation on the ORT questionnaire?
A: I haven't seen that. As I mentioned, we use more than one tool and don't use that as the only source of "truth" as it is not a lie detector. When asked in a respectful way and assuring patients their pain will be treated regardless of what their truthful responses are, I find most patients are up-front about their drug use patterns. Those who misuse substances or have an addiction disorder can sense when they are being disrespected and labeled and that's when the untruthfulness "misrepresentation" most often occurs.

Q: Recommended frequency of follow-up appts with chronic opioid pts?
A: As a general rule, first visit in 1-2 weeks, second visit based on risks (screening tools, Urine tests, etc.) Low risk – 1 month; medium risk 2 weeks, high risk 1 week with expected follow-up during the week.

Q: How effective is helping patients establish a pain goal during therapy?
A: Very important, with no goal you are certain to attain it. When you have a goal, if you don't achieve it, at least you learn along the way some things about the patient. Is it sub-optimal therapy? … An unrealistic goal?, … A lack of motivation or self-control?

Q: Do you see ineffective treatment of acute on chronic pain in hospitals? For example, physicians not ordering baseline opioid dosages during hospitalization?
A: Every day. It is a constant battle to advocate for what patients need and to find the best combination to help patients think feel and do as well as possible.

Q: What inpatient processes have you observed when treating patients who have a history of chronic pain? I am an acute pain nurse, but we do not have a process in place for treating patients with chronic pain... Very difficult to coordinate with the chronic pain providers in the inpatient settings.
A: Hospitals are not the best settings to manage a chronic condition; so we work on treating them as well as possible in the hospital and align the resources they need across the continuum of care …. This is a work in progress I hope to be researching shortly.