



Stony Brook Medicine

Pain Management at Stony Brook Medicine

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- To review pain assessment.
- To review pain management options.
- To review TJC Patient preference standard, CMS Core Measure 506, NYS Annual Opioid Antagonist prescription Requirement, PMP
- To review resources available at Stony Brook.

- All patients must have effective pain management.
- Patient self-report of pain must be source of assessment whenever possible.
- Patient's acceptable level of pain must guide treatment.
- Pain is assessed using a population-specific standardized assessment scale.



- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

International Association for the Study of Pain (Merskey, 1979)

- Pain is always subjective.
- The patient’s self-report of pain is the single most reliable indicator of pain.



- If the patient is unable to self-report, appropriate behavioral pain assessment tools should be utilized:
 - N-PASS: NICU
 - FLACC : pediatrics, Newborn nursery
 - CPOT: intubated/sedated patients and TBI
 - PAIN-AD: Geriatrics with dementia



DETERMINANTS OF PAIN

- The tools look at:
 - Observable behaviors (facial expressions, body movements, crying)
 - physiological measures (heart rate and blood pressure).



- Initial Pain Assessment should include:
 - Location(s) , Intensity , Sensory quality , Alleviating and aggravating factors
- Any new onset of pain requires a new comprehensive pain assessment.
- Assume Pain is Present (APP):

Term used to document anticipated pain in a patient who cannot self-report pain when the patient is undergoing a procedure which would normally cause pain if patient was aware and able to self-report.



Pain Re-assessment:

- Every shift minimally-pain score, sedation score, and respiratory rate/assessment.
- IV: within 15-30 minutes of administration of dose.
- PO/IM/SC: within 1 hour of administration of dose



- Acute pain presents most often with a **clear cause, relatively brief in duration and subsides as healing takes place.**
- Acute pain is often accompanied by **observable, objective signs of pain:**
 - increased pulse rate
 - increased blood pressure
 - Non-verbal signs and symptoms such as facial expressions and tense muscles.



- Acute Postoperative Pain
- Pain due to trauma
- Sickle cell painful crisis
- Acute pancreatitis
- Acute on top of chronic like exacerbation of chronic back pain



- Pain that is **persistent and recurrent**.
- When pain persists, it serves no useful purpose and may dramatically decrease the quality of life and function.
- Chronic pain rarely has any observable or behavioral signs, although persons may appear anxious or depressed.



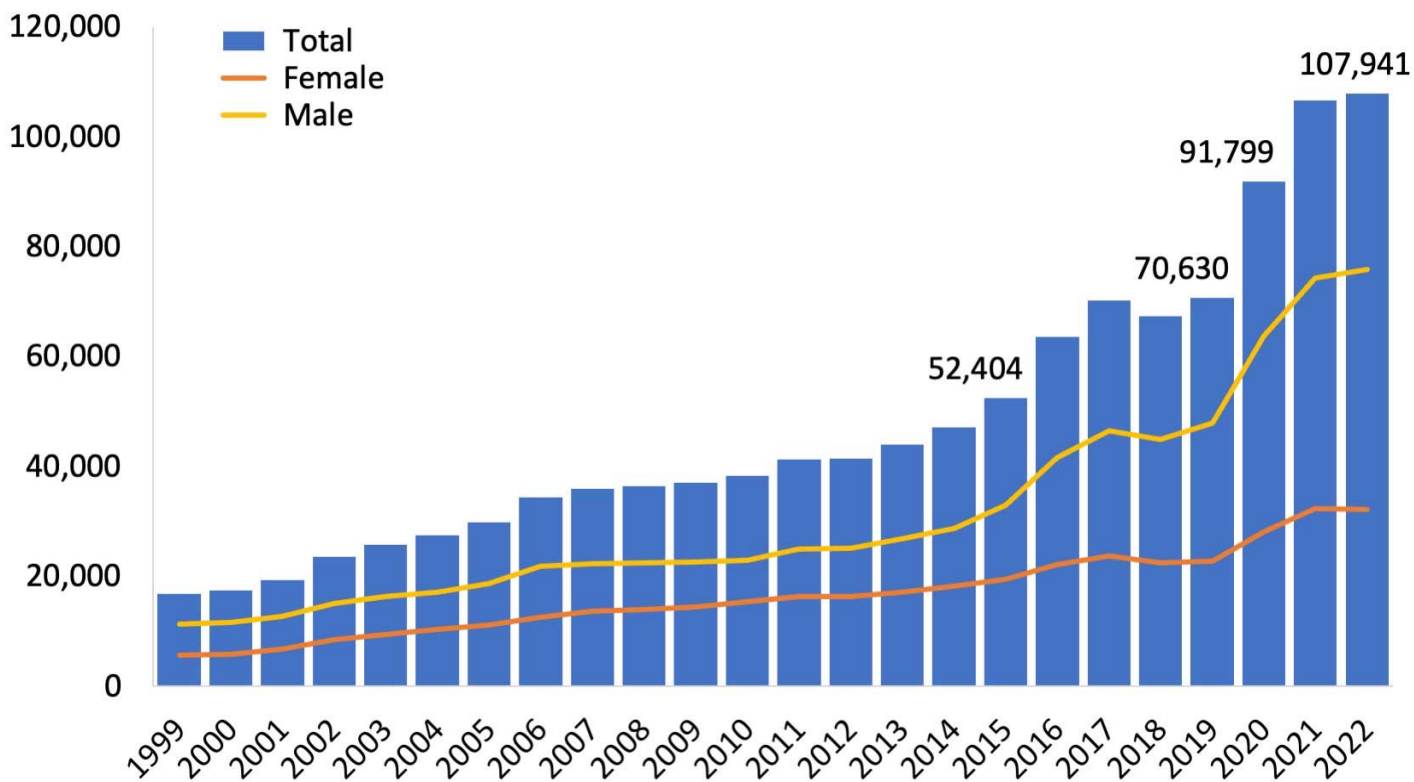
- Pain that is associated with cancer or cancer treatment.
- May be attributed to:
 - Tumor location
 - Chemotherapy
 - Radiation therapy
 - Surgical treatment



- There is a national epidemic occurring involving the misuse, abuse, and diversion of prescription opioids.
- Prescription opioid abuse constitutes about 20% of the causes for the problem.
- Prescribers must be aware that their opioid prescription could potentially end up being used for reasons not prescribed (sold, snorted, traded).



Figure 1. U.S. Overdose Deaths* by Sex, 1999-2022



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.



- The US government declared the opioid epidemic a public health emergency in 2017.
- In 2023, 108,000 died from an opioid overdose.
- About 20% of deaths are from prescription drug abuse.
- CMS has identified **an increased risk of overdose when patients are discharged with two opioids or an opioid and a benzodiazepine** and subsequently are monitoring discharge orders for two opioids or an opioid and a benzodiazepine. (Exception cancer/palliative patients) CMS Core Measure 50666



- The measure assesses the number of inpatient hospitalizations for patients age 18 and older who have been administered an opioid medication and are subsequently administered an opioid antagonist within 12 hours, an indication of an opioid-related adverse event.
- 'Opioids are often the foundation for sedation and pain relief. Opioid-based analgesia continues to be the most commonly used treatment in postoperative pain management, with more than 95% of surgical patients receiving opioids during their hospitalization (Baker et al., 2020). However, use of opioids can also lead to serious adverse events, including constipation, over sedation, delirium, and respiratory depression (Urman, 2022). Opioid-related adverse events (ORADE) have both patient-level and financial implications. The presence of an ORADE was associated with a 55% longer postoperative length of stay, 29% lower odds of discharge home, and 2.9 times the odds of death (Urman, 2021). Most opioid-related adverse events are preventable. Each year, adverse drug events (ADE) account for nearly 700,000 emergency department visits and 100,000 hospitalizations. Nearly 5% of hospitalized patients experience an ADE, making them one of the most common types of inpatient errors ' **CMS May 13, 2026**
- **CMS recommends improved monitoring and response**
- **Safe use of opioids and other sedating medications**
- **Prevent constipation with use of a bowel regimen while the patient is on opioids**



- Should be interdisciplinary and multimodal.
- Care is individualized
- **GOAL OF PAIN MANAGEMENT:
MANAGING PATIENT EXPECTATIONS**
 1. Maintain patient safety
 2. Optimize patient function
 3. Decrease pain score



RISK FACTORS FOR OPIOID USE

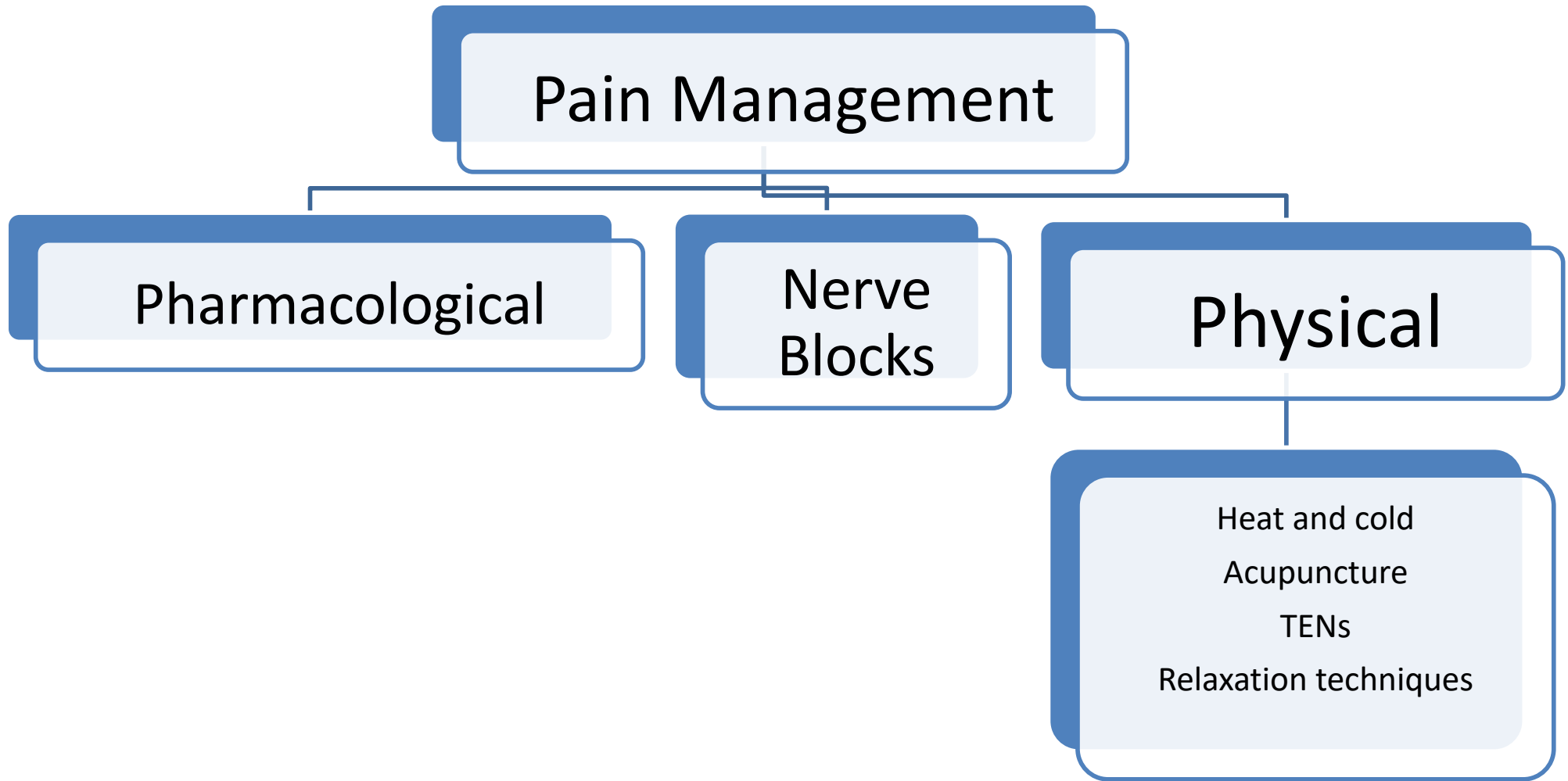
- Age > 60
- Respiratory disorders: Sleep apnea and COPD
- Cardiac disease, especially chronic heart failure.
- Opioid Naïve patients.
- Concurrent use of sedatives, opioids or other sedating medications (gabapentin, muscle relaxants).
- Thoracic or surgical incisions may impair breathing



MULTIMODAL ANALGESIA

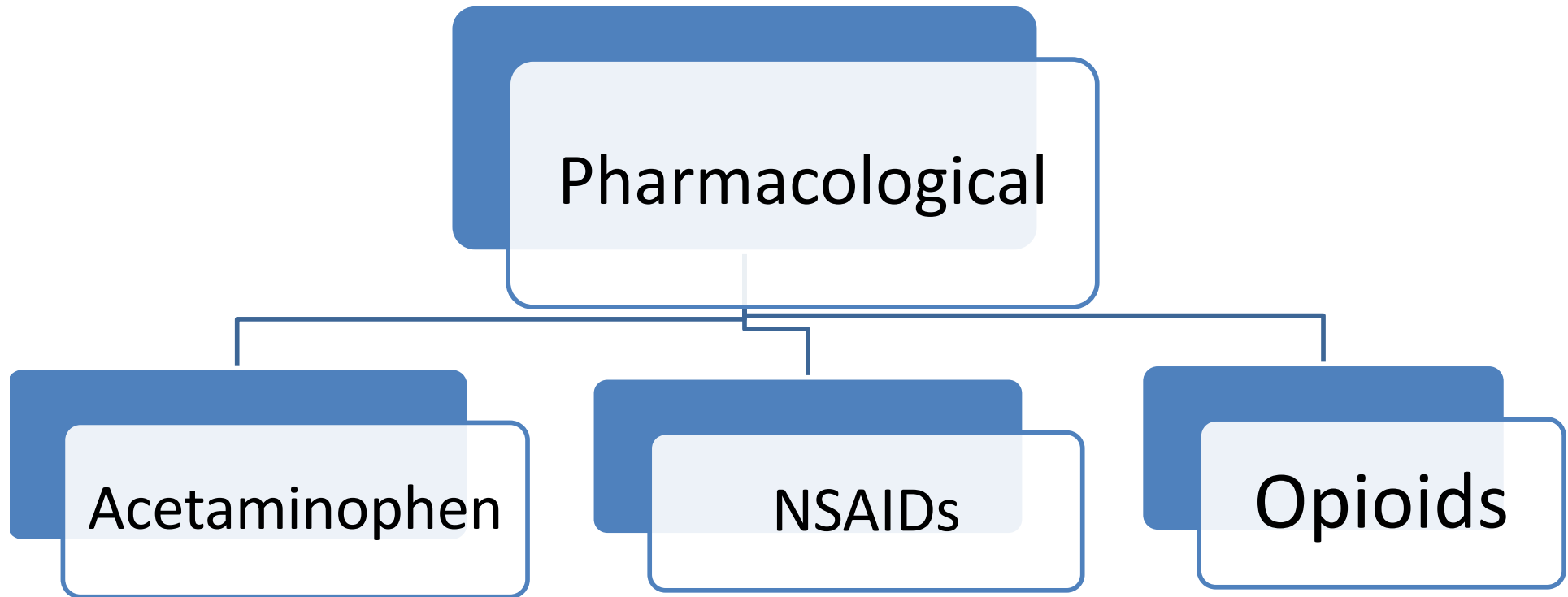
- This term describes the use of multiple modalities to provide pain relief with various parts of the pain pathway targeted.
- Decreased dependence on single modality agents decrease the risk of side effects.

Treatment options:





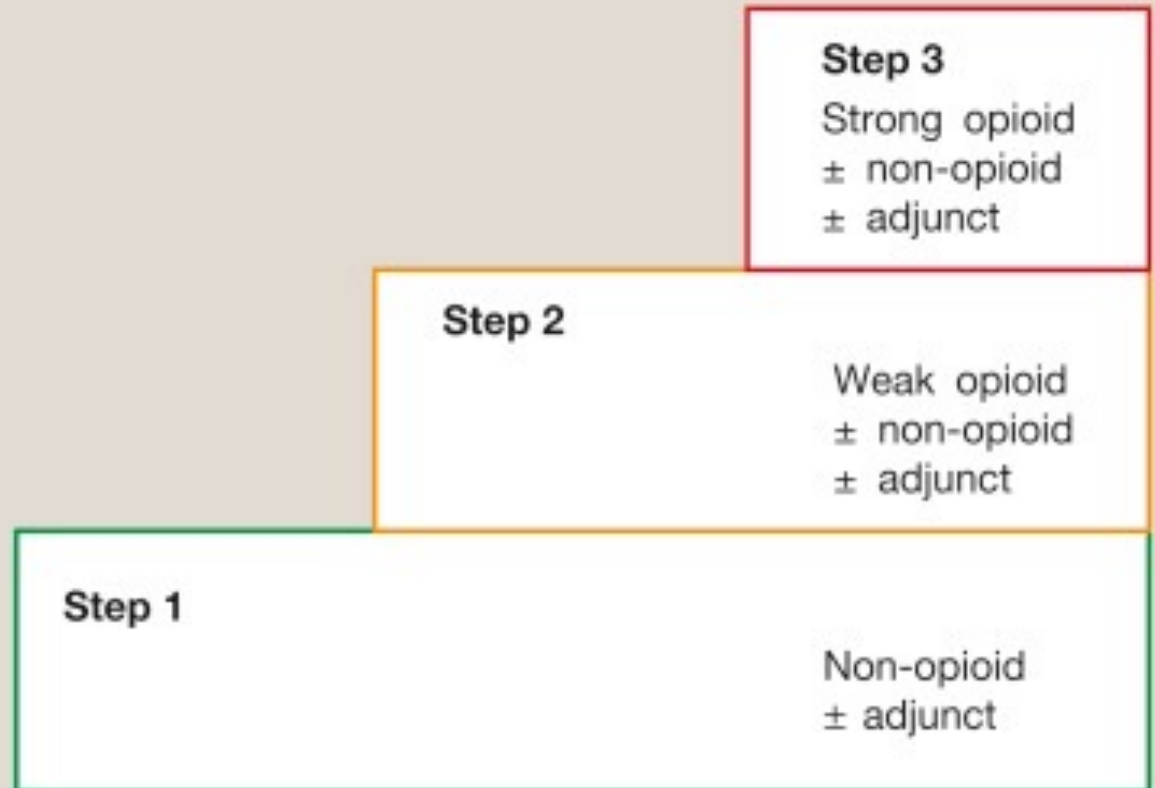
Pharmacological:





- Principles of the WHO pain management:
 - By the clock
 - By the mouth
 - By the ladder

WHO pain management stepladder

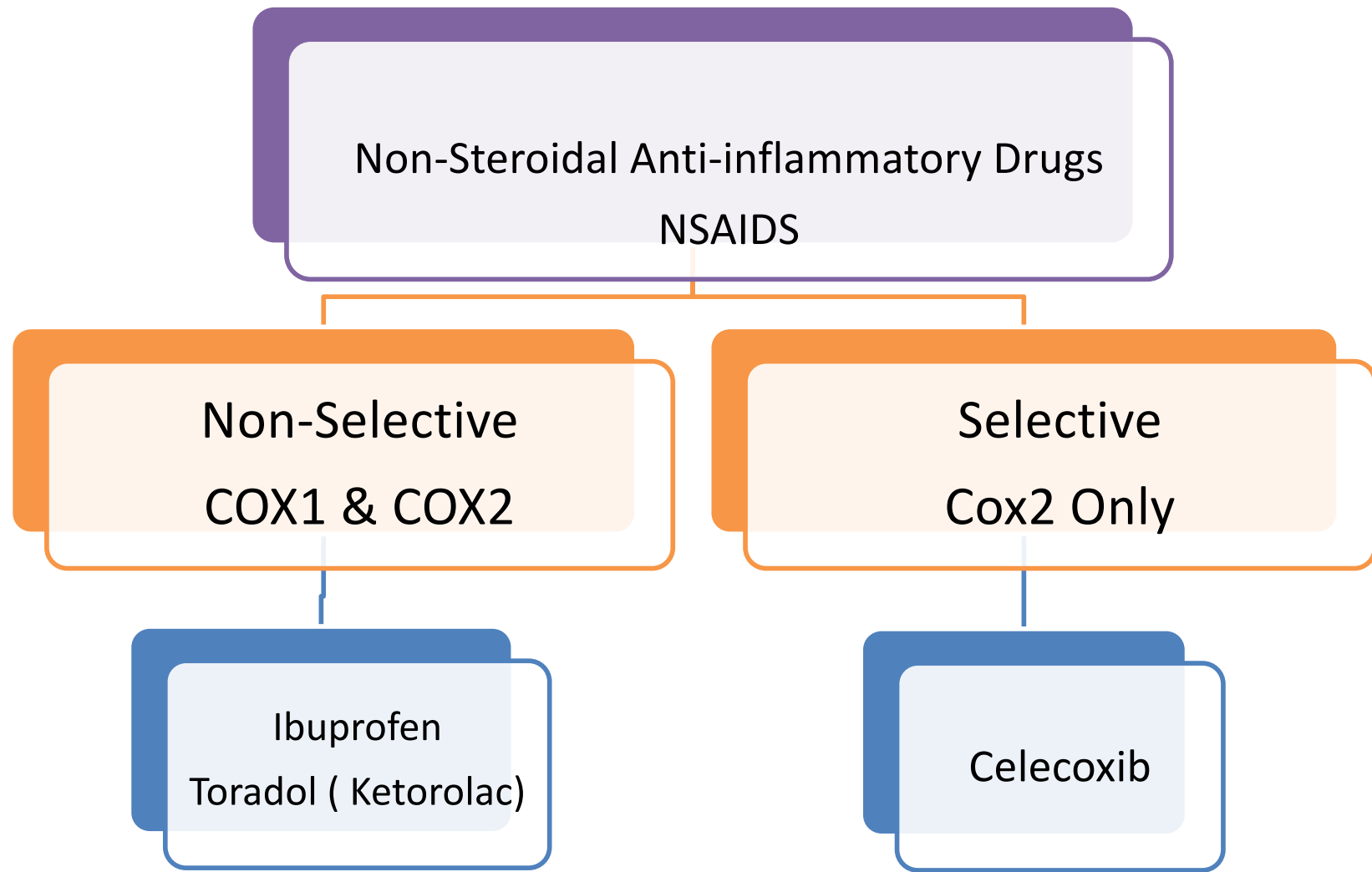


Nonopioid medications (Acetaminophen and NSAIDs) should be:

- Prescribed first unless contraindicated
- Around the clock.
- Opioids are prescribed as needed and only if the pain is severe.



NSAIDS:





Nonsteroidal Anti-inflammatory drugs can have significant opioid-sparing effects that can be close to 50%.

Contraindications:

- History of peptic ulcers and gastrointestinal bleeding, celecoxib may be used with caution.
- Renal impairment
- Pregnancy
- Severe coronary heart disease : use with caution, especially with celecoxib.

- Acetaminophen is available in the oral and IV form (Ofirmev).
- NSAIDS are mostly oral.
- Intravenous NSAIDs : Ketorolac (Toradol) and Ibuprofen (Caldolor).

- Medications were initially developed for a primary indication other than pain.
- Secondary effects of analgesia, e.g.
 - Antidepressants : e.g., Amitriptyline, Duloxetine
 - Anticonvulsants: Gabapentin
 - Steroids
 - Muscle relaxants



TJC Standard: Patient Preference

The patient can choose a lower dose, lower potency (Tylenol instead of an opioid), or a less invasive route of medication for pain.

In order to meet the standard:

- 1-The prescriber must have a “patient preference order” prescribed. It is listed under the medication orders. The patient preference order can be used whenever there are pain medications ordered for different levels of pain. **The order must be renewed q30 days.**
- 2-The **RN needs to document on the MAR** under comments that the medication of lower dose, potency or less invasive route was given due to patient preference.
- 3-**This standard does not allow for patient choice in higher doses or more invasive route of medication for pain.**





- These blocks are mainly used for acute postoperative pain or pain due to trauma.
- Have a substantial opioid sparing effect.
- The acute pain service anesthesiologist provides them.
- They can be placed in almost any region of the body.
- Nerve catheters can be placed to prolong the nerve block and analgesia if the patient stays in the hospital.



TJC requires patient education on:

- Pain Management plan for discharge
- Safe use of opioids
 - Taking medications as prescribed,
 - No sharing of medications
 - Avoid driving or activities requiring attention when taking opioids
 - Store preferably in a lock box.
 - Proper disposal of fentanyl patches and take back program to dispose of unused opioids.
 - Educate on the use of naloxone if discharging home with it



- Doctor Shopping: Using more than one doctor to obtain opioids
 - Prevent by checking databases
 1. External medication history on EMR
 2. New York State Prescription Drug Monitoring System
 - NYS requires all providers who prescribe opioids to check the PMP prior to ordering opioids.
- » Link found on The Pulse, under Resources : I-STOP NYSPMP (Prescription Monitoring Program / Registry)
- » To sign up for NYS PMP:
<https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/home>
1-866-529-1890 (M-F 8-4:45pm)



- NYS Public Health Law section 3309(7) requires prescribers to **prescribe an opioid antagonist with the first opioid prescription each year** in patients:
 - » History of substance use disorder
 - » High dose, cumulative prescriptions of 90 morphine equivalents or higher per day
 - » Concurrent use of opioids and benzodiazepine or sedative hypnotics
 - » **Example: Intranasal naloxone**



- Provides 24/7 services .
- Services:
- Consults for complex pain situations.
- Manages IV PCA, epidural catheters, nerve block catheters, and ketamine infusions for pain.
- Page Acute Pain Beeper(Pain PCA) for assistance.



- **The Acute Pain Service must be notified for:**
 - » Patients who report an indwelling device for pain management (e.g. , intrathecal pain pump or spinal cord stimulator).
 - » Any pre-surgical patient who is followed by an outpatient pain clinic.
 - » Any pre-surgical patient who is opioid tolerant: receiving long-acting/controlled-release narcotics
 - » Any pre-surgical patient who reports or tests positive for illicit drug use.
 - » Any patient who is on Buprenorphine.



- The Chronic Pain Center is located in the “Center for Pain Management” at Smithhaven Mall
- Call **638–PAIN** to make an appointment for an outpatient consultation
- **Treatments offered:**
 - Chronic non-urgent cases, e.g., chronic back pain, phantom pain, chronic persistent pain.
 - Treatment is mainly interventional. Epidural steroids, facet injection, stellate ganglion block.
 - Refill of intrathecal pumps, follow-up of spinal cord stimulators.



- Call 4-3408 for a consult.
- Contact for assistance:
 - With opioid withdrawal (IVDA, methadone)
 - Medication-Assisted Treatment (MAT): suboxone and methadone.
 - Social work can assist with setting up referrals to outside methadone clinics or suboxone providers.
 - Assist in anxiety or depression management, which impacts pain control.



- PC 0039 Pain Management Policy
- Joint Commission. National Performance Goals™ Effective January 2026 for the Hospital Program: Goal 6 The hospital prioritizes pain management and safe prescribing practices.
- NYS Annual opioid antagonist Prescription Requirement- Effective June 2022
- CMS Core Measure 506: Safe Use of Opioids
- CMS Core Measure HH-ORAE (Hospital harm-opioid related adverse events)