


Opioid Stewardship Program (OSP) |Session 6

A Good Discharge Plan for Pain Management With and Without Opioids

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Jeff Francis, Quality Improvement Specialist

Thursday, January 27, 2022

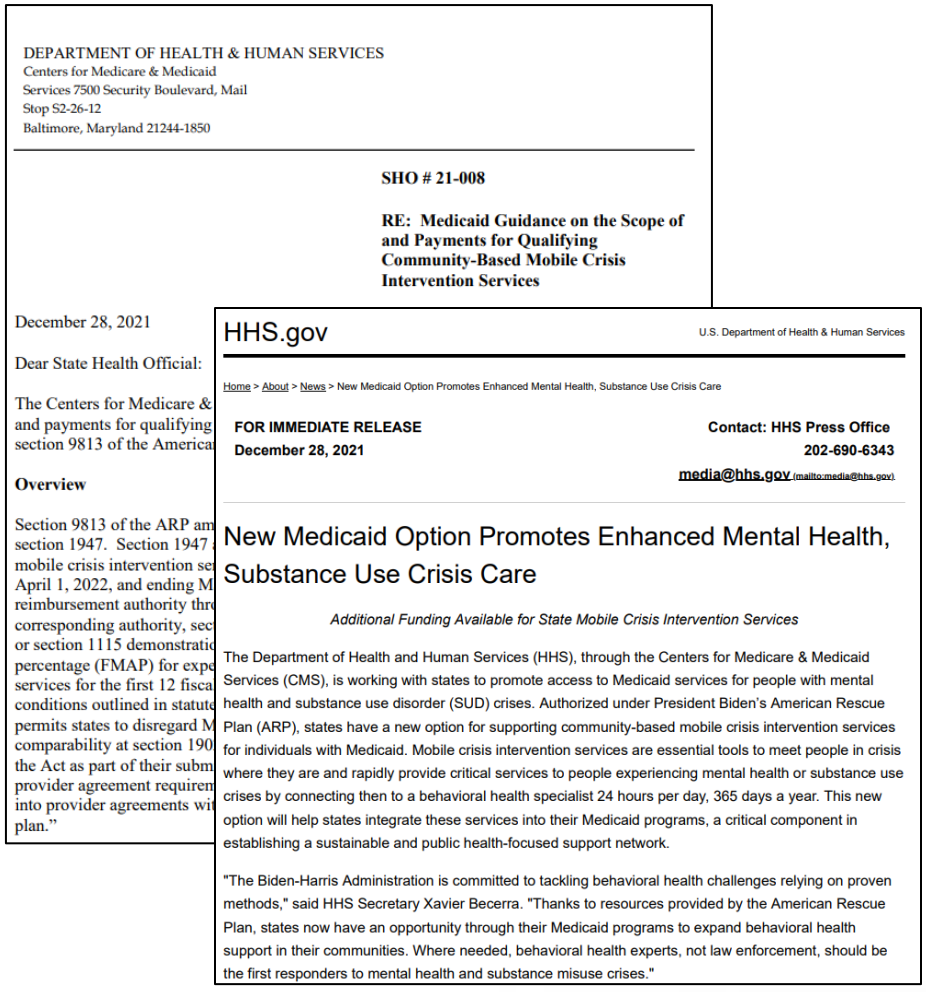
HSAG HEALTH SERVICES ADVISORY GROUP

Last Session's Action Items

1. Review and choose 2 screening/assessment tools for OUD (RODS, Opioid Risk Tool, COWS) best suited to your setting.

2. Trial the chosen tools with 5 patients.

Mental Health/SUD* Services—A CMS Priority



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO # 21-008

RE: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services

December 28, 2021

Dear State Health Official:

The Centers for Medicare & and payments for qualifying section 9813 of the America

Overview

Section 9813 of the ARP am section 1947. Section 1947 mobile crisis intervention se April 1, 2022, and ending M reimbursement authority thr corresponding authority, sec or section 1115 demonstrati percentage (FMAP) for expe services for the first 12 fisca conditions outlined in statut permits states to disregard M comparability at section 190 the Act as part of their subm provider agreement requiren into provider agreements wi plan."

HHS.gov

U.S. Department of Health & Human Services

Home > About > News > New Medicaid Option Promotes Enhanced Mental Health, Substance Use Crisis Care

FOR IMMEDIATE RELEASE
December 28, 2021

Contact: HHS Press Office
202-690-6343
media@hhs.gov (mailto:media@hhs.gov)

New Medicaid Option Promotes Enhanced Mental Health, Substance Use Crisis Care

Additional Funding Available for State Mobile Crisis Intervention Services

The Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), is working with states to promote access to Medicaid services for people with mental health and substance use disorder (SUD) crises. Authorized under President Biden's American Rescue Plan (ARP), states have a new option for supporting community-based mobile crisis intervention services for individuals with Medicaid. Mobile crisis intervention services are essential tools to meet people in crisis where they are and rapidly provide critical services to people experiencing mental health or substance use crises by connecting then to a behavioral health specialist 24 hours per day, 365 days a year. This new option will help states integrate these services into their Medicaid programs, a critical component in establishing a sustainable and public health-focused support network.

"The Biden-Harris Administration is committed to tackling behavioral health challenges relying on proven methods," said HHS Secretary Xavier Becerra. "Thanks to resources provided by the American Rescue Plan, states now have an opportunity through their Medicaid programs to expand behavioral health support in their communities. Where needed, behavioral health experts, not law enforcement, should be the first responders to mental health and substance misuse crises."

- $15 million in grants to 20 states for **mobile crisis intervention services**
  - A key to effective behavioral health crisis continuum of care.
- Provide rapid assessment/crisis resolution to those with a behavioral health and/or SUD condition ⟶ reduce psychiatric ED admissions
- July 2022: National Suicide Prevention Lifeline—Dial 988

*SUD=Substance use disorder

Knowledge Check

- When is the **optimal** time to initiate a pain management discharge plan?
  A. Upon admission to the hospital
  B. 24 hours prior to hospital discharge
  C. Prior to admission at each point within the continuum of care
  D. When discharging from a post acute setting

Knowledge Check

- When is the **optimal** time to initiate a pain management discharge plan?
  A. Upon admission to the hospital
  B. 24 hours prior to hospital discharge
  C. Prior to admission at each point within the continuum of care
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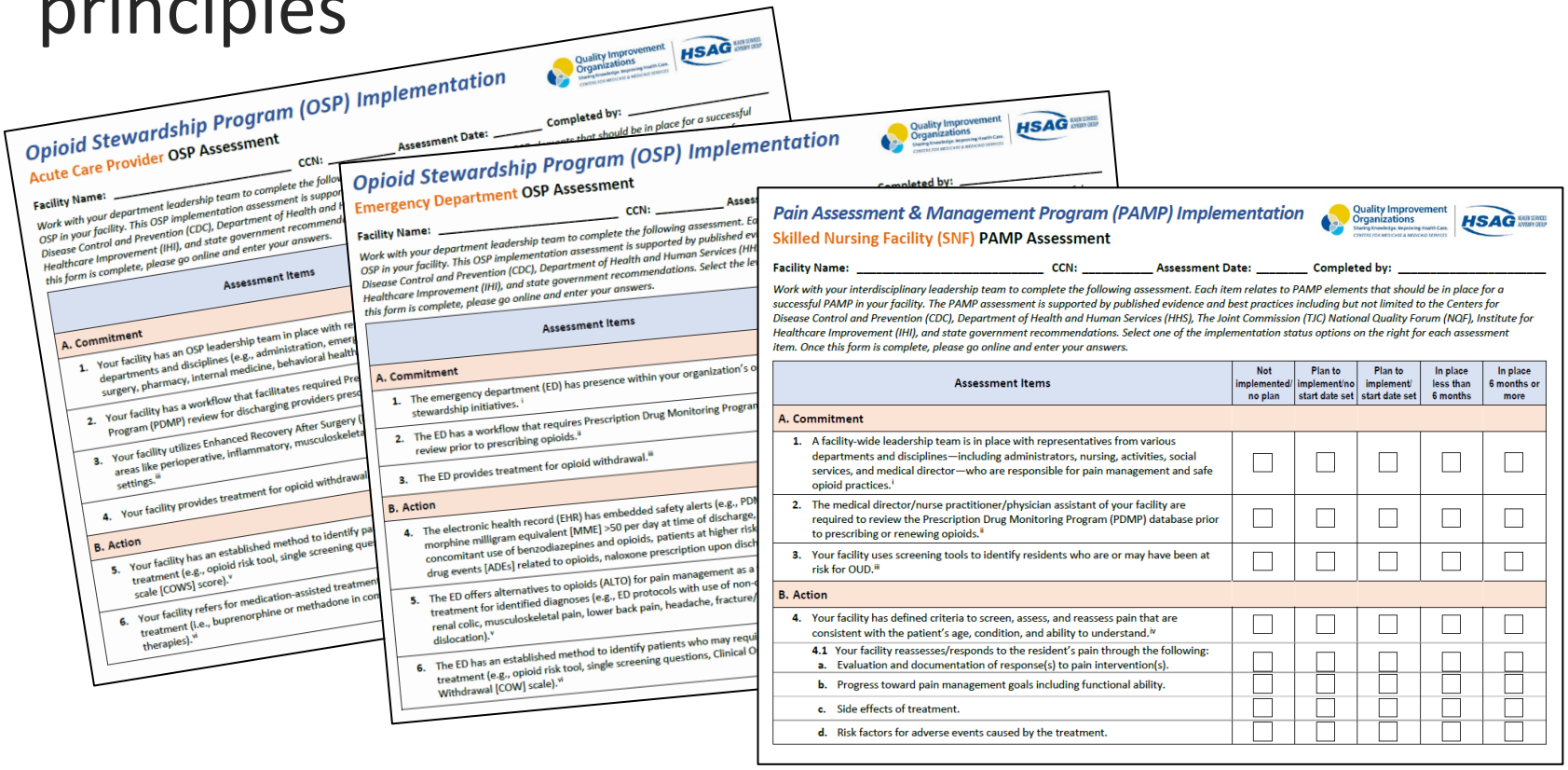
Pain Management Discharge Plans

- Reflect an organization's opioid stewardship principles



Opioid Stewardship Program (OSP) Implementation
Acute Care Provider OSP Assessment
Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____
Work with your department leadership team to complete the follow
OSP in your facility. This OSP implementation assessment is suppor
Disease Control and Prevention (CDC), Department of Health and
Healthcare Improvement (IHI), and state government recommend
this form is complete, please go online and enter your answers.

Assessment Items
A. Commitment
1. Your facility has an OSP leadership team in place with re departments and disciplines (e.g., administration, emerg surgery, pharmacy, internal medicine, behavioral health
2. Your facility has a workflow that facilitates required Pre Program (PDMP) review for discharging providers presc
3. Your facility utilizes Enhanced Recovery After Surgery (areas like perioperative, inflammatory, musculoskeleta settings.[iii]
4. Your facility provides treatment for opioid withdrawal
B. Action
5. Your facility has an established method to identify pa treatment (e.g., opioid risk tool, single screening que scale [COWS] score).[v]
6. Your facility refers for medication-assisted treatmen treatment (i.e., buprenorphine or methadone in com therapies).[vi]

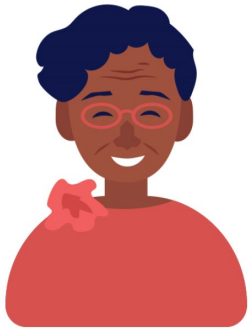
Opioid Stewardship Program (OSP) Implementation
Emergency Department OSP Assessment
Facility Name: _____ CCN: _____ Assess
Work with your department leadership team to complete the following assessment. Ea
OSP in your facility. This OSP implementation assessment is supported by published ev
Disease Control and Prevention (CDC), Department of Health and Human Services (HH
Healthcare Improvement (IHI), and state government recommendations. Select the le
this form is complete, please go online and enter your answers.

Assessment Items
A. Commitment
1. The emergency department (ED) has presence within your organization's o stewardship initiatives.[i]
2. The ED has a workflow that requires Prescription Drug Monitoring Progra review prior to prescribing opioids.[ii]
3. The ED provides treatment for opioid withdrawal.[iii]
B. Action
4. The electronic health record (EHR) has embedded safety alerts (e.g., PDM morphine milligram equivalent [MME] >50 per day at time of discharge, concomitant use of benzodiazepines and opioids, patients at higher risk drug events [ADEs] related to opioids, naloxone prescription upon disch
5. The ED offers alternatives to opioids (ALTO) for pain management as a treatment for identified diagnoses (e.g., ED protocols with use of non- renal colic, musculoskeletal pain, lower back pain, headache, fracture/ dislocation).[v]
6. The ED has an established method to identify patients who may requi treatment (e.g., opioid risk tool, single screening questions, Clinical O Withdrawal [COW] scale).[vi]

Pain Assessment & Management Program (PAMP) Implementation
Skilled Nursing Facility (SNF) PAMP Assessment
Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____
Work with your interdisciplinary leadership team to complete the following assessment. Each item relates to PAMP elements that should be in place for a successful PAMP in your facility. The PAMP assessment is supported by published evidence and best practices including but not limited to the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS), The Joint Commission (TJC) National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), and state government recommendations. Select one of the implementation status options on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Commitment					
1. A facility-wide leadership team is in place with representatives from various departments and disciplines—including administrators, nursing, activities, social services, and medical director—who are responsible for pain management and safe opioid practices.[i]	☐	☐	☐	☐	☐
2. The medical director/nurse practitioner/physician assistant of your facility are required to review the Prescription Drug Monitoring Program (PDMP) database prior to prescribing or renewing opioids.[ii]	☐	☐	☐	☐	☐
3. Your facility uses screening tools to identify residents who are or may have been at risk for OUD.[iii]	☐	☐	☐	☐	☐
B. Action					
4. Your facility has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.[iv]	☐	☐	☐	☐	☐
4.1 Your facility reassesses/responds to the resident's pain through the following: a. Evaluation and documentation of response(s) to pain intervention(s).	☐	☐	☐	☐	☐
b. Progress toward pain management goals including functional ability.	☐	☐	☐	☐	☐
c. Side effects of treatment.	☐	☐	☐	☐	☐
d. Risk factors for adverse events caused by the treatment.	☐	☐	☐	☐	☐

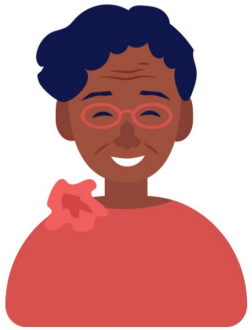
What are the pain management discharge plan needs of these patients?



Mary

- Admitted to the hospital for diverticulitis
- She has not taken an opioid pain reliever since post op from a hysterectomy in 1999
- **She is opioid naïve**

What are the pain management discharge plan needs of these patients? (cont.)



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Harry

- Post stroke. Will discharge from SNF soon
- He has taken oxycodone 5 mg 4 times daily for 5 years following a work-related back injury
- **He is opioid tolerant**

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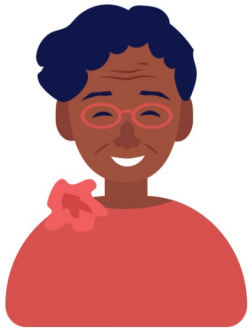

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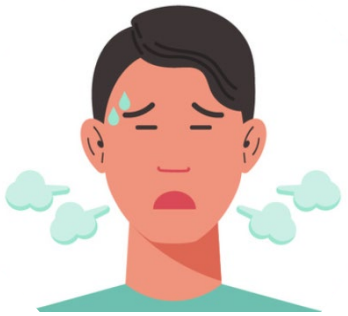
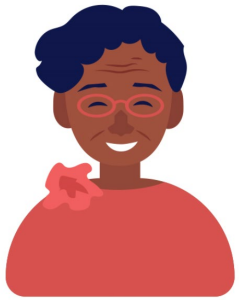


John

- 2 days post appendectomy reporting severe pain at surgical site
- Presents with diaphoresis, diarrhea, vomiting, and gooseflesh. Active opioid withdrawal.
- He scored a 6 on the RODS Tool.
- **He has untreated OUD**

Opioid Naïve



No opioids within the previous 90 days

- 1 in 5 opioid-naïve patients continue opioid use 3 months after surgery

- Set realistic pain management expectations
- Continuous, comprehensive patient education
- Discharge opioids should only be for the necessary amount of time (no more than 3–5 days)
- Smoking, depression, bipolar disorder, and pulmonary hypertension are risk factors associated with persistent opioid use.

American Society of Anesthesioloists. October 9, 2021. Available at: https://www.asahq.org/about-asa/newsroom/news-releases/2021/10/more-than-one-in-five-opioid-naive-patients-still-use-opioids-three-months-after-surgery

Opioid Tolerant

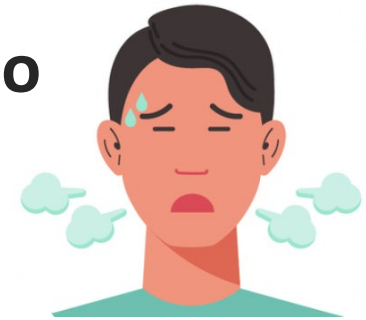
The prior 7 days of opioids are ≥ 60 MME/day

- Associated with chronic pain/acute on chronic pain

- *Careful* titration of acute pain doses avoids complications
- PRN dosing not usually associated
- Chronic pain implies scheduled dosing around the clock
- Smoking, depression, bipolar disorder, and pulmonary hypertension are risk factors associated with persistent opioid use.

OUD

A problematic pattern of opioid use that leads to serious impairment or distress



- Assess and Identify—the earlier the better
- Heightened tolerance to opioids, hyperalgesia could indicate OUD → Need to screen
- Initiate treatment with untreated OUD focuses on treating symptoms of opioid withdrawal **and** treating the acute pain.
- Initiate medication for OUD (MOUD) and coordinate outpatient treatment to prevent relapse

First Things First

- **Consider the patient's situation (*Assess*)**
  - Effect of pain on quality of life
  - Collaborate with the patient to evaluate current treatment
  - Express concern for health/safety and need for accurate history to decrease risk.
  - Be nonjudgmental
  - Take time to address patient/family concerns
- **Be aware of *your* perceptions and stigma**
  - **Your** attitude affects your patient's satisfaction

Key Points for Pain Management Discharge Plans

- **Type, amount, and duration of opioids** at discharge must balance the benefits against the risks
- **Post-discharge opioid use is best predicted** by usage the day before discharge
- **Discharge prescriptions—**Separate opioids and nonopioid analgesics to more easily taper opioid use.
- **Educate patients prior to discharge regarding:**
  - individualized risk factors associated with sustained prescription use,
  - an *individualized* analgesic plan, and
  - an anticipated timeline for weaning

OSP Pain Management Strategy: Multimodal Approach

Pharmaceutical Options

- Alternatives to Opioids (ALTO) first: Multimodal non-opioid approach
  - Goal: Utilize as first line of therapy and educate patients
  - Opioids are used as a rescue drug

Nonpharmaceutical Options

- Complimentary/Integrative/Alternative Therapies
  - Heat, ice, massage, aromatherapy, meditation, acupuncture, restorative yoga
- Rehabilitation
  - Assistive devices, Polar Care, electrotherapy
- Education for patient and family
  - Pre-procedure, pre-discharge
- Psychological Support
  - Behavioral Health consult
- Lifestyle Change
  - Exercise/weight loss
- Spiritual Support

ACPA - A Car with Four Flat Tires (YouTube): https://youtu.be/5RIii6OUK2A

ALTO Clinical Applications—Pain Pathways by Indication

Headache/Migraine

Immediate/First-Line of Therapy	Alternative Options	If Tension Component
1 L 0.9% NS + high-flow oxygen	APAP 1000 mg PO + ibuprofen 600 mg PO	Cyclobenzaprine 5 mg **OR** diazepam 5 mg PO/IV
Ketorolac 15 mg IV	Sumatriptan 6 mg SC	Lidoderm transdermal patch
Metoclopramide 10 mg IV	Promethazine 12.5 mg IV **OR** prochlorperazine 10 mg IV	
Dexamethasone 8 mg IV	Haloperidol 5 mg IV	
Trigger-point injection with lidocaine 1	Magnesium 1 g IV	
	Valproic acid 500 mg IV	
	Propofol 10-20 mg IV bolus every 10 min	

Renal Colic

Immediate/First-Line of Therapy	Second-Live IV Therapy	Alternative Options
APAP 1000mg PO	Lidocaine 1.5 mg/kg IV (max 200mg)	DDAVP 40 mcg IN
Ketorolac 15 mg IV		
1 L 0.9% NS		

Extremity Fracture/Joint Dislocation

Immediate/First-Line of Therapy	Ultrasound-Guided Regional Anesthesia
APAP 1000mg PO	Lidocaine perineural infiltration (max 4mg/kg)
Ketamine 50 mg IN	
Nitrous Oxide (titrate up to 70%)	

Additional Pathways for:

- Musculoskeletal Pain
- Chronic Abdominal Pain

https://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf

Enhanced Recovery After Surgery (ERAS)

Traditional Pain Management Pathway

- Pain assessment

- Opioid/non-opioid prescribing and discharge

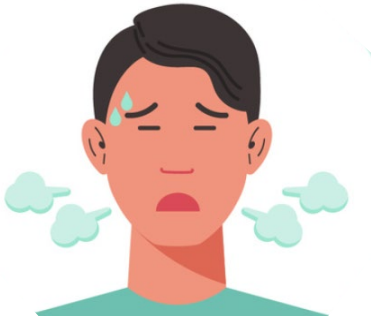
ERAS Pain Management Pathway

- **Preadmission:** Pt/family education; recovery/pain management planning
- **Preoperative:** minimize fasting to reduce anxiety, pain perception and improve diet recovery
- **Intraoperative:** administer analgesics and nerve blocks for pain and N/V
- **Postoperative:** Pt assessment, plan modification, and multimodal medication
- **Post-Discharge:** anesthesia recovery, surgical procedure and pain management education
- **Continued Quality Improvement:** Compliance and outcomes analysis

https://www.anesthesiafacts.com/wp-content/uploads/2020/04/infogr-aana-enhanced-recovery.pdf

Stopping Opioids After Surgery (SOS) Risk Stratification Tool

Characteristic	Scoring
Age	
18-24	0
25-34	3
35-44	4
45-54	4
55-64	4
Biologic Sex	
Male	0
Female	3
Discharge Status	
Home	0
Non-Home Discharge	11
Socioeconomic Status	
High	0
Low	5
Procedure Category	
Minor	0
Major	4
Length of Stay (Days)	
3 or less	0
4 or more	1
Past Medical History	
Depression	4
Anxiety	4
Any prior opioid use	17
Prior sustained opioid use	36
Total Score	



Risk of Sustained Prescription Opioid Use

- Circle the score for each category and add for total
- Scores <30: Low risk
- Scores 30–60: Intermediate Risk
- Scores >60: High risk

Caution—Mitigate Risks with OSP Discharges

- **Post-discharge opioid use is best predicted by usage the day before discharge**

Number of Pills Prior to Discharge	Mean Number of Pills Required Post-Discharge
0 pills	1.5 pills
1–3 pills	7.6 pills
More than 4 pills in the 24 hours prior to discharge	21.2 pills

- Leftover pills can lead to diversion
- Longer prescription duration predicted?
  - Consider outpatient pain management service for management of pain
- Co-prescribe naloxone for patients at high risk for opioid overdose
  - OUD, co-prescribed benzodiazepines with opioids, elderly with polypharmacy

Revisiting Key Points

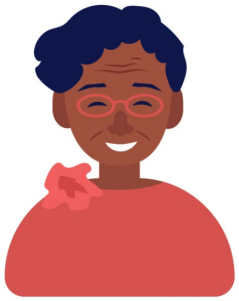
- ☑ **Type, amount, and duration of opioids** at discharge must balance the benefits against the risks
- ☑ **Post-discharge opioid use is best predicted** by usage the day before discharge
- ☑ **Discharge prescriptions—**Separate opioids and nonopioid analgesics to more easily taper opioid use.
- ☑ **Educate patients prior to discharge regarding:**
  - individualized risk factors associated with sustained prescription use,
  - an *individualized* analgesic plan, and
  - an anticipated timeline for weaning

Improving Transitions of Care with an Effective Pain Management Discharge Plan

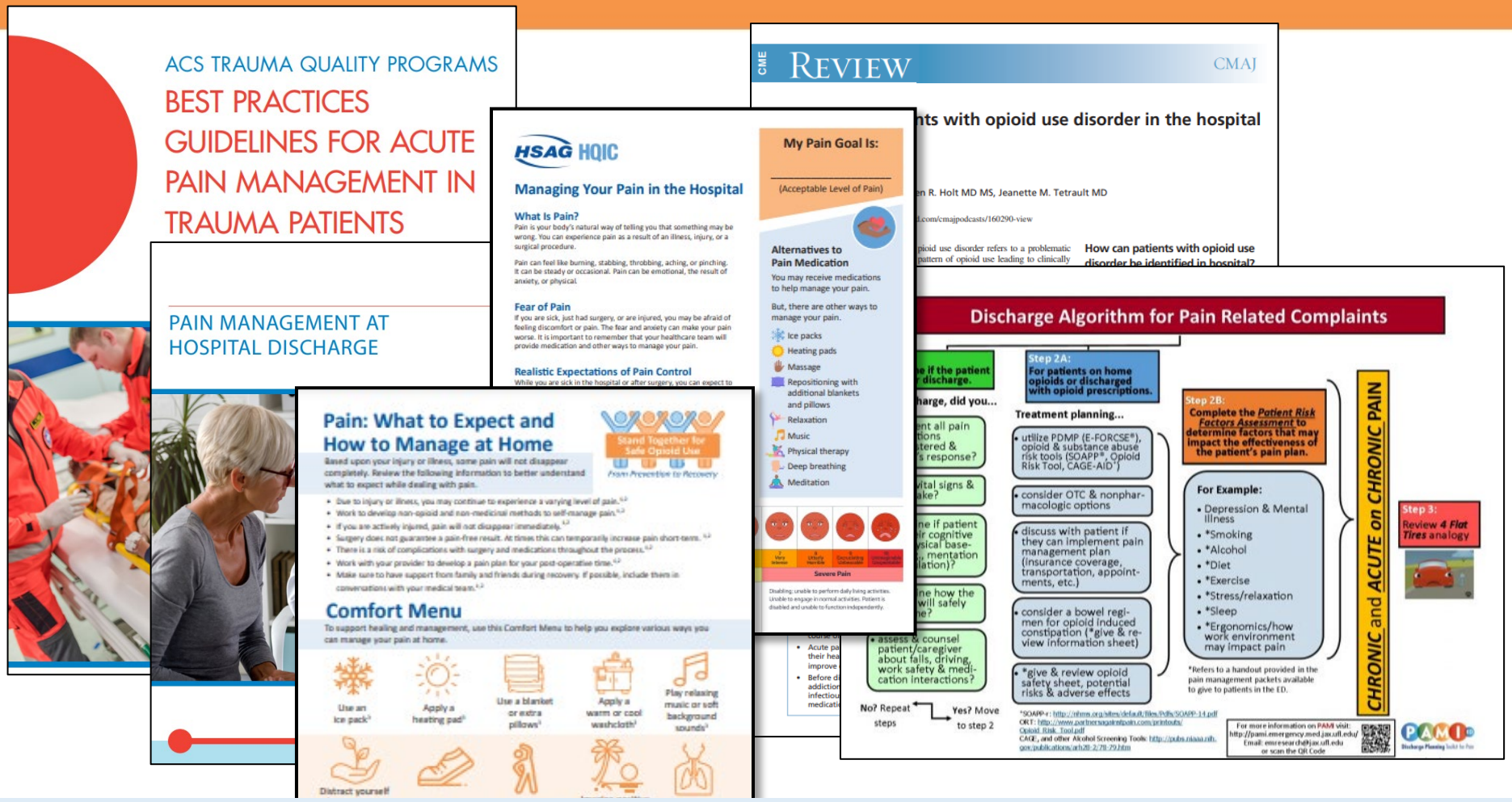
- Manage pain with lowest dose of opioid therapy necessary
- Include non-opioid therapy to help reduce opioid needs
- Ensure accurate medication reconciliation is completed
- Discharge instructions for patients in clear, age-appropriate language including follow-up appointments
- Discharge summary includes:
  - pain course of treatment
  - plans for ongoing post-discharge pain management
  - delivery to post-discharge providers in a timely manner
- Pain management plan is clearly communicated to post-acute teams along with a completed discharge summary
  - **Best Practice** is a doc-to-doc handoff, especially with more complex cases
- Ensure medications will be available for the patient

Questions To Ask When Evaluating Discharge Plans

- What pain management strategies are currently being used?
  - Are the strategies effective?
  - Are effective strategies continued once discharged?
- Is opioid reduction and risk mitigation incorporated into individual plans of care?
- How does a plan differ for a patient who is opioid naive as opposed to opioid exposed?
- What does a pain management discharge plan look like for someone with OUD?



Resources



https://www.hsag.com/osp-resources

Opioid Stewardship Resource Site

https://www.hsag.com/osp-resources

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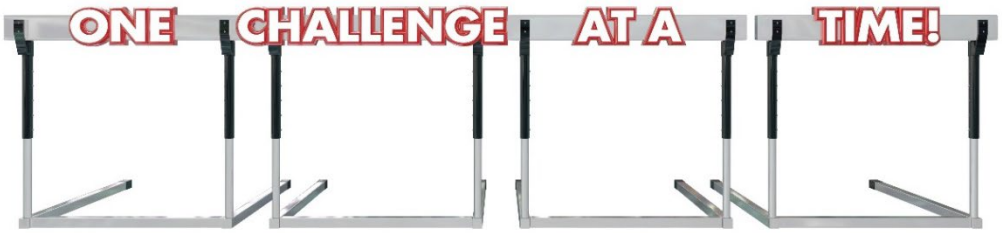
Action Items by Next Quickinar (2/10/2022)

1. Review two resources from today's session with your OSP team.

2. Identify/delineate opioid naïve, opioid tolerant, and OUD pathways in your organization's pain management policies.



OSP "Quickinar" Schedule: Mark Your Calendars

OSP Quickinar Kickoff: Introduction to Opioid Stewardship and Quickinar Format Thursday, October 21, 2021 | 10:30–11:00 a.m. PT ✓	**Partnering with Pharmacists for ongoing Medication Management** Thursday, February 10, 2022 | 10:30–11:00 a.m. PT
OSP Assessment Overview Thursday, October 28, 2021 | 10:30–11:00 a.m. PT ✓	**Double Trouble: Benzos and Opioids | Harm Reduction with Naloxone** Thursday, March 10, 2022 | 10:30–11:00 a.m. PT
Interpreting the OSP Assessment Results/Developing an Action Plan Thursday, November 18, 2021 | 10:30–11:00 a.m. PT ✓	**Medication for OUD (MOUD): Prescribing Buprenorphine** Thursday, April 14, 2022 | 10:30–11:00 a.m. PT
Developing a Dashboard Thursday, December 9, 2021 | 10:30–11:00 a.m. PT ✓	**Getting Patient Buy-in through Education** Thursday, May 12, 2022 | 10:30–11:00 a.m. PT
Screening Patients for OUD Risk and Opioid Withdrawal Thursday, January 13, 2022 | 10:30–11:00 a.m. PT ✓	**Reevaluating Your Program and Celebrating Success** Thursday, May 26, 2022 | 10:30–11:00 a.m. PT
A Good Discharge Plan for Pain Management with Opioids Thursday, January 27, 2022 | 10:30–11:00 a.m. PT ✓	

Register for the entire OSP "Quickinar" series today!

bit.ly/OpioidStewardshipProgramQuickinars

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Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing opioid stewardship practices.

Thank you!

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Jeff Francis: jfrancis@hsag.com




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