



# Opioid Stewardship Program (OSP) | Session 6

## A Good Discharge Plan for Pain Management With and Without Opioids

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Thursday, January 27, 2022

# 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 & Medicaid Services (CMS) is providing guidance on the scope of and payments for qualifying community-based mobile crisis intervention services under section 9813 of the American Rescue Plan Act of 2021 (ARP).

**Overview**

Section 9813 of the ARP amends section 1947. Section 1947 allows states to use federal financial assistance to pay for mobile crisis intervention services for the first 12 fiscal years beginning on April 1, 2022, and ending March 31, 2033. This authority is subject to the corresponding authority, section 1115 demonstration authority, or section 1115 demonstration authority. The percentage (FMAP) for expenditures for these services for the first 12 fiscal years is 75 percent, and thereafter 50 percent. This authority is subject to the conditions outlined in statute. The Act permits states to disregard Medicaid comparability at section 1903 of the Act as part of their submission to the provider agreement requirement into provider agreements with the 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** **Contact: HHS Press Office**  
**December 28, 2021** **202-690-6343**  
[media@hhs.gov](mailto: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 them 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

# 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
  - D. When discharging from a post acute setting

# Pain Management Discharge Plans

- Reflect an organization's opioid stewardship principles

**Opioid Stewardship Program (OSP) Implementation**  
**Acute Care Provider OSP Assessment**

Quality Improvement Organizations (HSAG) logo

Facility Name: \_\_\_\_\_ CCN: \_\_\_\_\_ Assessment Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

Work with your department leadership team to complete the following assessment. This OSP implementation 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
<b>A. Commitment</b>					
1. Your facility has an OSP leadership team in place with representatives from various departments and disciplines (e.g., administration, emergency, surgery, pharmacy, internal medicine, behavioral health).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your facility has a workflow that facilitates required Prescription Drug Monitoring Program (PDMP) review for discharging providers prescribers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your facility utilizes Enhanced Recovery After Surgery (ERAS) protocols in areas like perioperative, inflammatory, musculoskeletal settings. <sup>ii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your facility provides treatment for opioid withdrawal. <sup>iii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Action</b>					
5. Your facility has an established method to identify patients at risk for opioid use disorder (e.g., opioid risk tool, single screening question, COWS scale). <sup>v</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your facility refers for medication-assisted treatment (MAT) (e.g., buprenorphine or methadone in combination with counseling). <sup>vi</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Opioid Stewardship Program (OSP) Implementation**  
**Emergency Department OSP Assessment**

Quality Improvement Organizations (HSAG) logo

Facility Name: \_\_\_\_\_ CCN: \_\_\_\_\_ Assessment Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

Work with your department leadership team to complete the following assessment. This OSP implementation 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
<b>A. Commitment</b>					
1. The emergency department (ED) has presence within your organization's opioid stewardship initiatives. <sup>i</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The ED has a workflow that requires Prescription Drug Monitoring Program (PDMP) review prior to prescribing opioids. <sup>ii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The ED provides treatment for opioid withdrawal. <sup>iii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Action</b>					
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 for drug events [ADEs] related to opioids, naloxone prescription upon discharge). <sup>iv</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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-opioid analgesics, musculoskeletal pain, lower back pain, headache, fracture/dislocation). <sup>v</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The ED has an established method to identify patients who may require medication-assisted treatment (MAT) (e.g., opioid risk tool, single screening questions, Clinical Opioid Withdrawal [COW] scale). <sup>vi</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Pain Assessment & Management Program (PAMP) Implementation**  
**Skilled Nursing Facility (SNF) PAMP Assessment**

Quality Improvement Organizations (HSAG) logo

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
<b>A. Commitment</b>					
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. <sup>i</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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. <sup>ii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your facility uses screening tools to identify residents who are or may have been at risk for OUD. <sup>iii</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Action</b>					
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. <sup>iv</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.1 Your facility reassesses/responds to the resident's pain through the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Evaluation and documentation of response(s) to pain intervention(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Progress toward pain management goals including functional ability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Side effects of treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Risk factors for adverse events caused by the treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# 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.)



**Mary**

- Admitted to the hospital for diverticulitis
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- **She is opioid naïve**



**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**

# 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**



**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.

# Opioid Tolerant



**The prior 7 days of opioids are  $\geq 60$  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
- Initial 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

# ALTO Clinical Applications— Pain Pathways by Indication

## Headache/Migraine

### Immediate/First-Line of Therapy

1 L 0.9% NS + high-flow oxygen  
 Ketorolac 15 mg IV  
 Metoclopramide 10 mg IV  
 Dexamethasone 8 mg IV  
 Trigger-point injection with lidocaine 1



### Alternative Options

APAP 1000 mg PO + ibuprofen 600 mg PO  
 Sumatriptan 6 mg SC  
 Promethazine 12.5 mg IV OR prochlorperazine 10 mg IV  
 Haloperidol 5 mg IV  
 Magnesium 1 g IV  
 Valproic acid 500 mg IV  
 Propofol 10-20 mg IV bolus every 10 min



### If Tension Component

Cyclobenzaprine 5 mg OR diazepam 5 mg PO/IV  
 Lidoderm transdermal patch

## Renal Colic

### Immediate/First-Line of Therapy

APAP 1000mg PO  
 Ketorolac 15 mg IV  
 1 L 0.9% NS



### Second-Line IV Therapy

Lidocaine 1.5 mg/kg IV (max 200mg)



### Alternative Options

DDAVP 40 mcg IN

## Extremity Fracture/Joint Dislocation

### Immediate/First-Line of Therapy

APAP 1000mg PO  
 Ketamine 50 mg IN  
 Nitrous Oxide (titrate up to 70%)



### Ultrasound-Guided Regional Anesthesia

Lidocaine perineural infiltration (max 4mg/kg)

### Additional Pathways for:

- Musculoskeletal Pain
- Chronic Abdominal Pain

# 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

# Stopping Opioids After Surgery (SOS) Risk Stratification Tool

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



## 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

## ACS TRAUMA QUALITY PROGRAMS BEST PRACTICES GUIDELINES FOR ACUTE PAIN MANAGEMENT IN TRAUMA PATIENTS

### PAIN MANAGEMENT AT HOSPITAL DISCHARGE



### Pain: What to Expect and How to Manage at Home

Based upon your injury or illness, some pain will not disappear completely. Review the following information to better understand what to expect while dealing with pain.

- Due to injury or illness, you may continue to experience a varying level of pain.<sup>1,2</sup>
- Work to develop non-opioid and non-medical methods to self-manage pain.<sup>1,2</sup>
- If you are actively injured, pain will not disappear immediately.<sup>1,2</sup>
- Surgery does not guarantee a pain-free result. At times this can temporarily increase pain short-term.<sup>1,2</sup>
- There is a risk of complications with surgery and medications throughout the process.<sup>1,2</sup>
- Work with your provider to develop a pain plan for your post-operative time.<sup>1,2</sup>
- Make sure to have support from family and friends during recovery. If possible, include them in conversations with your medical team.<sup>1,2</sup>

### Comfort Menu

To support healing and management, use this Comfort Menu to help you explore various ways you can manage your pain at home.



### Managing Your Pain in the Hospital

#### What Is Pain?

Pain is your body's natural way of telling you that something may be wrong. You can experience pain as a result of an illness, injury, or a surgical procedure.

Pain can feel like burning, stabbing, throbbing, aching, or pinching. It can be steady or occasional. Pain can be emotional, the result of anxiety, or physical.

#### Fear of Pain

If you are sick, just had surgery, or are injured, you may be afraid of feeling discomfort or pain. The fear and anxiety can make your pain worse. It is important to remember that your healthcare team will provide medication and other ways to manage your pain.

#### Realistic Expectations of Pain Control

While you are sick in the hospital or after surgery, you can expect to

#### My Pain Goal Is:

(Acceptable Level of Pain)

#### Alternatives to Pain Medication

You may receive medications to help manage your pain.

But, there are other ways to manage your pain.

- Ice packs
- Heating pads
- Massage
- Repositioning with additional blankets and pillows
- Relaxation
- Music
- Physical therapy
- Deep breathing
- Meditation



Disabling: unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.

- Acute pain that does not improve
- Before discharge, assess for addiction risk

- assess & counsel patient/caregiver about falls, driving, work safety & medication interactions?

No? Repeat steps

Yes? Move to step 2

CME

## REVIEW

CMAJ

### Patients with opioid use disorder in the hospital

Ben R. Holt MD MS, Jeannette M. Tetrault MD

<https://doi.org/10.1503/cmajpodcasts/160290-view>

Opioid use disorder refers to a problematic pattern of opioid use leading to clinically

significant distress or impairment. How can patients with opioid use disorder be identified in hospital?

### Discharge Algorithm for Pain Related Complaints

**Step 2A:**  
For patients on home opioids or discharged with opioid prescriptions.

#### Treatment planning...

- utilize PDMP (E-FORCSE\*), opioid & substance abuse risk tools (SOAPP®, Opioid Risk Tool, CAGE-AID<sup>†</sup>)

- consider OTC & nonpharmacologic options

- discuss with patient if they can implement pain management plan (insurance coverage, transportation, appointments, etc.)

- consider a bowel regimen for opioid induced constipation (\*give & review information sheet)

- \*give & review opioid safety sheet, potential risks & adverse effects

**Step 2B:**  
Complete the Patient Risk Factors Assessment to determine factors that may impact the effectiveness of the patient's pain plan.

#### For Example:

- Depression & Mental illness
- \*Smoking
- \*Alcohol
- \*Diet
- \*Exercise
- \*Stress/relaxation
- \*Sleep
- \*Ergonomics/how work environment may impact pain

\*Refers to a handout provided in the pain management packets available to give to patients in the ED.

CHRONIC and ACUTE on CHRONIC PAIN

**Step 3:**  
Review 4 Flat Tires analogy



\*SOAPP®: <http://www.queensu.ca/healthservices/soapp-14.pdf>  
 CAGE: [http://www.painline.ca/assets/health.com/products/CAGE\\_Risk\\_Tool.pdf](http://www.painline.ca/assets/health.com/products/CAGE_Risk_Tool.pdf)  
 CAGE, and other Alcohol Screening Tools: [http://pubs.niaaa.nih.gov/publications/aa02b/aa02b\\_2\\_79-79280](http://pubs.niaaa.nih.gov/publications/aa02b/aa02b_2_79-79280)

For more information on PAM visit: <http://pam.ner.gov/ner.med.law.ufl.edu/>  
 Email: [nerresearch@jax.ufl.edu](mailto:nerresearch@jax.ufl.edu)  
 or scan the QR Code



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

# Opioid Stewardship Resource Site



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## Opioid Stewardship



### About Opioid Stewardship

The opioid epidemic continues to be a serious public health threat nationally. The primary evidence-based strategy to effectively address this crisis in our healthcare communities is having a robust opioid stewardship program (OSP). To support provider OSP implementation efforts, HSAG has developed this resource site to provide guidance and information from safe and appropriate prescribing of opioids to navigating the complex issues associated with opioid use disorder (OUD). The following resources are categorized by the elements of opioid stewardship they support and include gap assessments, links to guidelines, webinars, and vetted evidence-based literature and toolkits.

### Prescribing Guidelines

National

Arizona

California

### Commitment

### Opioid Stewardship Assessments

Download PDF versions:

- Emergency Department OSP Assessment
- Acute Care Provider OSP Assessment
- Skilled Nursing Facility (SNF) Pain Assessment and Management Program



Medicare Quality

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

PDMP Workflow

QIO Events

# 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

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

Register for the entire OSP “Quickinar” series today!  
[bit.ly/OpioidStewardshipProgramQuickinars](https://bit.ly/OpioidStewardshipProgramQuickinars)



# 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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