Opioid Stewardship Series, Season 1, Episode 5: Discharge Plan for Pain Management With and Without Opioids

Speaker 1 (00:03):

Hello and welcome. My name's Jeff and I'm a RN quality improvement specialist. I have over 10 years' experience as an RN in the acute care space from CNA to RN to a supervisory role, and as well as in a network level for nursing quality. So, that's my background. I'm going to give Claudia a quick second to give her background, and then we'll go ahead and proceed with the session.

Speaker 2 (00:27):

I'm also a quality improvement specialist with HSAG, and I've been an RN for 35 years. I think, at most of that in the acute, uh, care setting, um, in the emergency department and behavioral health. I'm certified in behavioral health, that, that was the majority of my career before I went into ED, and I've done clinical education and other, things as well. So, we're really looking forward to working with you on your opioid stewardship today and how that, how that plays into discharge planning with pain. So we're going to review a few examples of what you might typically see in patients requiring a pain management discharge plan. And we'll answer the questions of, you know, what are the pain management discharge plan needs of these patients, and how do their plan, their plans differ based on their needs and their opioid exposure, as well as what, what we should be looking for in assessing to plan for discharge from the first time we come in contact with them.

Speaker 2 (01:29):

So, first we have Mary, and, uh, Mary was admitted to the hospital for diverticulitis, and she's not taken an opioid reliever since post-op from a hysterectomy in 1999. So, she's considered opioid-naive, and that means she's had no opioids within the previous 90 days. All right, so, and we're going to get more detailed about those terms, um, in just a moment. Next, we have Harry, and Harry is two weeks post-stroke, and, um, he'll soon be discharged from the SNF where he's going to be rehabbing. And he's been taking oxycodone five milligrams four times daily, uh, for five years following a work-related back injury. And I'd like to talk to that doctor. And he's considered opioid-tolerant or opioid-exposed. Let's get to the last example. We'll use John. And finally, we have John, and he's two days post-appie (appendectomy), and he's reporting severe pain at his surgical site.

Speaker 2 (02:32):

And he's presenting with diaphoresis. He's sweating a lot, and he's got diarrhea, and vomiting, and goose flesh. So, chances are he's in active opioid withdrawal. And he's scored a six on that RODS tool that Dr. Springer showed us last session. So, he's considered to have an untreated opioid use disorder. So, we're going to refer to Mary, Harry, and John, as we apply quality discharge strategies for managed pain management with or without opioids. So, let's look at some key points to keep in mind with patients who are opioid-naive like Mary is. An opioid-naive patient is, once again, that hasn't taken opioids within the previous 90 days. And, uh, it also implies that the patient is not chronically receiving opioids on a daily basis. So, if prescribed opioids, it's assumed it's going to be for acute pain. And of note from Mary, since she's opioid-naive, you'll want to know about this American Society of Anesthesiologists report.

Speaker 2 (03:35):

So, they've found that one in five opioid-naive patients continue to use opioids three months after surgery. So, what's wrong with that picture? Is it? Well, if acute pain is defined as last lasting less than 90 days, why would surgery patients still be taking their opioids after 90 days? So, that's not acute pain anymore. <Laugh> So, that's something you keep in mind. We want to remember that starting a patient on opioids that, uh, that comes with a responsibility of setting realistic expectations of what pain management, uh, should be. So, zero pain is not realistic, and how it should be controlled and with the patient being continuously as well as comprehensively educated, um, and offered alternative pain management choices. So, that educational support is so, so important because it really helps facilitate that discharge plan. You got to educate from the very beginning to, because you want them to understand that those opioids are only taken for a necessary amount of time, no more than three to five days.

Speaker 2 (04:45):

In addition, that that same anesthesiologist report talked about what the top four modifiable risk factors are, um, that are associated with, um, persistent opioid use after surgery. And that is smoking, bipolar, depression, and pulmonary hypertension. So, what does that have to do with discharge planning? Well, um, you want to reduce the likelihood of ongoing opioid use. So, patients who smoke you should really be encouraging and educating them about tobacco cessation. Those with pulmonary hypertension, you want to make sure that they're following through with their doctor after discharge for managing their condition. And patients with bipolar and depression, they may need an adjustment for surgery with their medication, and ongoing behavioral health support, obviously after discharge. So, here's some points to keep in mind with patients who may be opioid-tolerant like Harry is. So, opioid tolerance is equated to a patient's, prior seven days of opioids being equal or greater than 60 morphine milligram equivalents a day.

Speaker 2 (05:57):

And that's per the FDA. So, it implies that patients are chronically receiving opioids on a daily basis, routinely, not on a PRN basis, but routinely for longer than, uh, one week or one week or longer. So, opioid tolerance is associated with chronic pain, as opposed to acute pain. Also, increasing doses can occur with acute pain, which has been termed acute-on-chronic pain. You'll, you'll see that often. So, with acute on chronic pain, careful titration, of acute pain doses can really help to prevent complications. And, and there are some excellent resources that we have on our resource page, OSP resource page for prescribing for acute-on-chronic pain. And again, just remember that those top four risk factors for persistent use are the same. All right. So, to provide quality discharge and patient care, recognition of and diagnosis of that OUD, that opioid use disorder is really vital for patients, especially with an untreated OUD.

Speaker 2 (07:05):

So, opioid use disorder is defined as a problematic pattern of opioid use that leads to serious impairment or distress. And it's diagnosed with a specific set of criteria from the DSM-5. So, clinically, if our patient, John here showed, a heightened tolerance to opioids that were being used for pain, or an extreme response to pain that seems kind of out of, just kind of out of the norm for most, it may indicate that he has an underlying OUD, but he would require further screening obviously, because you don't, don't want to assume just based on that. So, consider the RODS tool that Dr. Springer shared with us last session, or that opioid risk tool, or the SBIRT screen patients for risk of OUD. And all of these are on our OSP research page.

Speaker 2 (07:58):

So, in John's case, if OUD has been untreated, it's untreated and, and it's discovered, this is really what you're managing initially. You're going to be managing, you're focused on the symptoms of opioid withdrawal and treating the acute pain associated with his appendectomy. 'Cause this is what I've seen, <laugh> and some of this is stigma-related. They'll start addressing that opioid withdrawal, but then they're really not addressing his acute pain. So, we want to make sure that we're doing that as well. So, the an IV opioid and, and or a short-acting oral opioid are both suitable for treating acute pain as well as addressing the opioid, the initial opioid withdrawal. But then, fairly promptly you'd want to consider medication for OUD treatment, even in the early phases of hospitals. So, and this is called MOUD, you, you may know it as MAT. MOUD is really the more acceptable term now because we realize it's an ongoing condition.

Speaker 2 (08:58):

So, medications for opioid use disorders, we'll call MOUD. So, inpatient initiation of OUD treatment has been found to be very feasible, very effective. And it leads to better engagement for outpatient treatment, see is what I'm talking about during the hospitalization as well. Because that supports it all. And it helps to reduce ED admissions. And then your discharge plan for John obviously needs to include coordinating his outpatient treatment to prevent relapse. So, making sure that there's a facility that he's ready to bridge to, that he can bridge to. Is it accessible to him? Can he get to it? Does he have transportation for it? If he works, are there outpatient clinic hours compatible with, or if he's transferring to a SNF even, um, for any reason, can they accommodate his, um, MOUD regime?

Speaker 2 (09:53):

So, those are all good questions to ask. So, with all these patients, what does a quality discharge look like? Well, we know that the first thing we always have to do, first thing's first, you got to assess right? We nurses know that. With any plan, your assessment's really important. So, keeping in mind those, these overarching principles is really important for a pain management plan for discharge, whether the patient's pre-hospital, in the hospital getting transferred to a SNF, or going home. So, consider your patient's situation. You want to recognize what their current situation is and collaborate with them to evaluate how current pain and treatment is impacting their quality of life. And you want to understand that there are times when you talk about this that, um, they, a patient may feel like you're being very intrusive. So, they may not want to disclose everything about their health issues.

Speaker 2 (10:51):

Uh, they may feel like you don't need to know everything. So, you want to assure your patients that you're being non-judgmental and that you're really, um, coming from a place of concern and safety, and health for them. So, uh, and then take, you want to take time to address the patient family concerns from the get-go. 'Cause we know that it's really important to do that in the beginning with our interactions, and assessments because it saves time in the long run, right? And ounce of prevention is worth a pound of cure. So, be aware of your perceptions and stigma. This is really important because your attitude toward your patients who are dealing with chronic pain or pain of any kind can, and OUD, can really affect their outcomes. And at least once, these have shown that nurses who had really good knowledge and attitudes regarding pain and chronic pain, their

patients experienced more satisfaction. So, we know that with satisfaction that also will affect their pain. So, in a good way. So, those are important traits.

Speaker 1 (11:57):

So, what we want to leave you with, with these considerations, with these, uh, patients that we highlighted is considerations of questions to ask in regards to pain management discharge plans and for indications of sound opioid stewardship. What pain management strategies are currently being used for the patients? Are the strategies effective? Are effective strategies continued once discharged? How do you know that? You know, these are the things that you can kind of look at your discharge planning process and evaluate. Next, and importantly, is opioid reduction and risk mitigation incorporated into individual plans of care and supported by the discharge plan for follow-through. This is really where the rubber meets the road with individualized care management, or pain management care plans for these three individuals that we described. In Mary's case, for instance, if all are EROS, what strategies were used while hospitalized, um, and she's transitioning to a SNF not having had opioids in that entire stay, how does her pain management discharge plan support that?

Speaker 1 (13:06):

Secondly, for Harry, he had agreed to say, an opioid paper plan during the hospitalization and received a TENS unit at, while he was admitted at the facility to help with his chronic pain. How does this plan get communicated to post, post-acute facilities, where he's going to rehab? And lastly, if John was induced with buprenorphine protocol for his OUD treatment while in the hospital, what happens when he's cleared for discharge for following, following his appendectomy? Best practice is your organization partners with an opioid treatment program that provides a bridge service for him. He gets seen by a peer support navigator who accompanies him to opioid treatment center. So, third, how does pain management discharge plan in my organization differ for a patient who is opioid-naive and opposed in, as opposed to opioid-exposed? So, this would really, these are the considerations between Mary as and Harry's case focus, focusing on that individualized, uh, management plan like we considered. And lastly, for patient with OUD, how did you treat acute pain for John Wall, uh, with an opioid use disorder? Was this communicated properly in the outpatient, to the outpatient providers as well? So, these are some of the, the questions that really drive, um, process improvement for these discharge planning.

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