Step 7: Improving Transitions of Care for Patients with Pain

7.1 Elements of a "Quality" Discharge

Transitions are vulnerable times for all patients, and this is even more true for patients with pain and/or complicated pain management regimens. Patients frequently face challenges in getting prescriptions filled after discharge, or confusion about how to take their medications. This confusion leads to increased pain and return to emergency rooms and re-hospitalization. With careful planning, these negative outcomes can be avoided. Systematizing procedures that ensure consistent pain control after discharge is important, as opposed to relying on individual and busy providers to remember key steps.

Since most hospitalized patients with acute or chronic pain will likely continue to have pain at discharge, those responsible for the future outpatient management of pain should be informed of the treatment plan. Communication with patients, caregivers and outpatient medical professionals about expectations and strategies for pain control in the outpatient setting should be initiated early in the hospital stay. All patients should have careful medication reconciliation, timely completion of a discharge summary with confirmation of receipt by primary care provider, patient education on managing their pain and an appointment with their outpatient pain prescriber. An example checklist, which could be completed for all patients being discharged on opioids medication, is shown below in Table 6.

Table 6: Discharge Checklist for Patients Going Home with Long-term Opioid

- ❏ Identify outpatient provider who is willing to prescribe opioids
- ❏ Run a Prescription Drug Monitoring Program (PDMP) report to identify concerning fill patterns, e.g., multiple providers, multiple pharmacies
- ❏ Ensure that outpatient provider is comfortable with discharge regimen
- ❏ Check that an appointment is scheduled with outpatient pain provider
- ❏ Ensure that pain is stable on discharge regimen for at least 24 hours
- ❏ Ensure that insurance will cover any new medications
- ❏ Check with pharmacy where patient plans to fill prescription to ensure that it has sufficient supply to fill the discharge prescription
- ❏ Give the patient a follow-up number where patient or pharmacy can call the prescribing provider for any problems with the discharge prescription
- ❏ Use the teach-back method to ensure that patient understands how to take medications after discharge
- ❏ Give the patient a phone number to call for questions about how to take medications or increased pain

7.1.1 Transitioning to an Outpatient Pain Regimen

The outpatient prescriber of chronic medications should be identified early in the hospitalization. If possible, direct communication (phone, email) will help design a regimen that is appropriate and will be sustainable after discharge. If a treatment will be unavailable in the outpatient setting, then transition to alternatives must be made well before discharge, to ensure that the post-discharge regimen will be effective. For example, in only very rare cases, e.g., as malignant bowel obstruction, will parenteral opioids need to be provided at home. Thus, most patients must be transitioned to enteral preparations. Additionally, many insurances do not cover certain opioid preparations or adjuvant medications that are available in hospitals. Pharmacies may not stock certain opioid preparations or other medications. Before a new medication is started on the inpatient side, prescribers should verify that their insurance will cover it. Before discharge, a pharmacy should be identified to ensure that it carries the prescribed medications and has sufficient quantity to fill the planned prescription. Patients should be stable on the planned regimen for an extended period of time prior to discharge. Monitoring the response to therapy for at least 24 hours should provide evidence about the safety and durability of the plan.

7.1.2 Access to Specialists After Discharge When Appropriate

In some cases, the outpatient prescribing physician may be a pain or palliative care specialist, while in others specialists may be consulted for outpatient procedural interventions. If an ongoing consultation with specialists is recommended, the inpatient team should help patients arrange appointments and be explicit about the roles of the consultants in communication with the primary care provider. In the event that patients have access to inpatient consulting services that are not available after discharge, the consultants should be queried about outpatient management and their advice communicated to the primary care provider.

7.1.3 Cost Considerations in Outpatient Pain Regimens

Some medications, particularly newer or rarer brand-name formulations, may not be covered by patients' health insurance plans, and some may be covered only with specific prior authorization requirements. Furthermore, some insurers have responded to the rise in overdose and deaths involving prescription opioids by imposing dose ceilings and/or limitations on the number of pills or patches they will cover in a given period of time. In any case, the pain medication list should be checked for coverage prior to discharge, and any necessary pre-authorizations should be obtained. In different hospital settings, the best person for this role may vary between a pharmacist, social worker, discharge planning nurse or hospitalist.

7.1.4 Other Logistical Considerations When Discharging

Patients on Controlled Substances In most situations, a prescription for controlled substances must still be printed on tamper-resistant paper. The prescriber must have a license with the **Drug Enforcement Administration (DEA)** adequate to the schedule of the controlled

substance. Prescriptions should be checked for the correct formulation and appropriate directions for the amount of medication prescribed. The pharmacy where the patient will fill the prescription should be open at the time of discharge, and have an adequate supply. When in doubt about any of these issues, the discharging prescriber should contact the pharmacy directly and consider faxing a copy of the patient's prescription to the pharmacy to confirm that it will be able to fill the patient's prescribed medication. Finally, discharge prescriptions should include appropriate contact information for the prescribing physician in case of any mistakes or pharmacist's concerns.

7.1.5 Assess Risk for Failure of Outpatient Management and Misuse of Outpatient

Prescribed Opioids Outpatient management is more likely to fail (and risk of readmission increases) when patients do not obtain adequate benefit from their treatment plan or suffer adverse medication consequences. Patients or care providers may have unrealistic expectations for the performance of their medications when they are outside the hospital, but appropriate education throughout the hospitalization and at discharge may improve expectations. Patients and families should be educated about what constitutes a pain crisis and when to contact their physicians, in order to avoid emergency room visits. Assessment and clear communication to both patients and outpatient providers of any adverse effects of patient's' regimen at admission and during the hospitalization will also inform long-term outpatient management.

All patients discharged on opioids should have a documented discussion of the short- and long-term adverse effects of their medications. Additionally, hospitals or services may wish to create limits for the amount of opioids that will be prescribed on discharge, e.g., requiring that a patient have a follow-up appointment with a pain or primary care provider in one to two weeks, and providing only enough medications to get through to that appointment. Many patients admitted to the hospital with a painful condition have a history of opioid misuse or addiction, or are at high risk for these. Acute pain due to trauma, surgery, fracture or other conditions for which opioids are of benefit should always be treated.

Compared to an ambulatory setting, prescribing opioids is safer in the hospital, as doses are controlled by medical staff and patients are monitored. However, prescribers should be careful in setting expectations for chronic opioid therapy that might be continued outside the hospital. Once the cause of the acute pain is resolved, a plan should be made to taper the patient off opioids. If ongoing pain treatment is necessary after discharge, the patient's risk level for opioid misuse will inform discharge planning. Hospitalists will want to prescribe lower-risk medications and communicate expectations to the patient about follow-up and adherence to the regimen prescribed. Hospitalists should also be aware that the highest-risk patients, particularly those with active substance abuse, may have difficulty finding providers who are willing to prescribe ongoing opioid therapy.

Risk factors for opioid misuse and abuse include:

- ❏ Personal history of substance abuse, including alcohol as well as street drugs
- ❏ Family history of substance abuse, including alcohol
- ❏ Age between 16 and 45
- ❏ Psychological disease, including depression, bipolar disorder, anxiety and PTSD
- ❏ A personal history of sexual abuse
- ❏ Heavy smoking

There are several validated tools to assess risk for opioid misuse that are designed for use in the **ambulatory setting**.21
The opioid risk tool, a five-item questionnaire that risk-stratifies patients into low, medium and high risk, can be found at .

Strategies for prescribing in patients at higher risk for opioid misuse include:

- ❏ Avoiding intravenous of opioids when patients are able to take oral medication
- ❏ Setting clear expectations about how opioids will be taken – i.e., establishing a daily schedule for taking oral long-acting opioids, or “no more than X pills per day” for short-acting opioids
- ❏ Use of non-opioid therapies such as NSAIDS, tricyclic antidepressants, gabapentin, acetaminophen and SNRIs, as well as non-pharmacologic therapies and regional blocks
- ❏ Issuing opioid prescriptions at discharge with no more than a two-week supply

No model adequately predicts which patients will misuse or suffer complications from opioids, although the risks of complication do rise with increasing dose and active substance use disorder. Universal precautions for prescribing opioids at discharge include documentation of any aberrant behavior and screening for substance use disorder. Appropriate urine toxicology testing on admission may identify secondary drug use, although care is warranted in interpreting the results.

An algorithm for interpretation of urine drug testing is included in Appendix D. State-based **Prescription Drug Monitoring Programs (PDMPs)** are key tools for institutions and health professionals to use in screening for evidence of misuse or diversion of opioid medications. These programs track data from all prescriptions of controlled substances that have been filled and make the data available to health professionals who are registered. Almost all states within the U.S. have operational programs. Websites and contact information for each state can be found on the Prescription Drug Monitoring Program Training and Technical Assistance Center website: www.pdmpassist.org.

Accessing the state PDMP to review the patient’s pattern of refills can provide clues about recent patterns of use of prescribed controlled substances. Patients with evidence of any trouble with controlling their use of medication in the past may benefit from discharge plans that require

highly structured medication dispensing, if risk-benefit analysis still favors opioids for pain control. All patients on chronic opioids should identify someone close to them (family member, friend or paid caregiver) who can help assess response to treatment with opioids. In high-risk patients such a person is imperative for monitoring for adverse consequences and controlling the access to medications. Controlling access may require locking up the medication, dispensing limited supplies or use of bubble packs. Prescription of naloxone and education on its use to both patients and care providers should be provided for any high-risk patient.

7.2 Patient Education about Pain at Discharge

Patient education is an area of discharge planning that is often overlooked and is ripe for improvement. Enacting systems to ensure appropriate patient education is essential to improvement in this area. For example, **education could be completed as part of the discharge process by the bedside nurses, using educational materials**. A pharmacist or pain nurse could be asked to see all patients who are being discharged home on opioid medications. Patients on pain medication regimens must be educated about expected magnitude and timing of analgesia, side effects and drug-drug and drug-disease interactions that may affect the levels of pain control or side effects. Clinicians should provide this information in clear language and images.

A sample teaching brochure that can be used at the time of discharge is available in **Appendix E**. Checking for the patient's understanding using the "Teach Back" method is an effective way to identify any gaps in communication. "Teach Back" occurs after a patient education session when the clinician asks the patient to explain, in his/her own words, the lesson(s) imparted. Any discrepancies or gaps should prompt more education, and another round of Teach Back. Such an interaction gives the opportunity to provide a small amount of information, check for understanding and then reinforce or add to that information.

Teach Back is best understood as a test of the clinician's skill in presenting the information, and may also provide an indication of the durability of the discharge plan. To help patients begin to practice their own pain management, protocols can be implemented to help patients begin to manage their own pain a few days before discharge. Education materials can include areas to write out a patient's pain management regimen, so that they understand all of the medications that are being used to treat their pain, and which they take as needed and which they should take whether or not they are having pain. Patient education materials may enhance adherence to recommended treatments and improve pain control. In addition to standard discharge teaching and materials, pain-specific materials may be used.

Appendix C includes a Sample Opioid Medication Guide for Patients and Caregivers.

7.3 Post-discharge Resources

The time between discharge and follow-up with primary care provider has been identified as a period of high risk for hospital readmission, and many quality improvement interventions have focused on bridging this gap in the continuum of care. Improving the quality of pain management can take advantage of these existing processes. The patient's pain control and use of medication should be assessed during the discharge phone call and at home care visits, and effective problem solving may prevent unnecessary visits to the emergency room or urgent care setting. Some important questions to consider during post-discharge contact include:

1. Were you able to fill your pain medication prescriptions?
2. Are you keeping track of when you take your medications? Have you made any changes to the prescribed schedule?
3. Have you or has anyone else noted any side effects (e.g., constipation, sedation or sleepiness)?
4. Do you know when you have a follow-up appointment with your doctor?
5. Do you know when to call your doctor if your pain gets worse?

Completing a performance improvement project for pain management can be very rewarding. We wish you and your team the best of success.