The Pain is Back to Baseline and Now I Have to Discharge Them!

Transitioning Chronic Pain Patients Out of the Hospital

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Safer Pain Control for Opioid–Habituated Patients with Chronic Pain: The Hospitalist Perspective
Patients rate baseline chronic pain between 4/10 – 8/10 on clinic surveys.

- This fact should fundamentally affect pain control goals in the hospital.
Chronic pain inevitably flares

- Flares should NEVER be treated with escalated opioids
PAIN FLARE and MEDICATION VICTIOUS CYCLE

Baseline chronic pain

Misinterpretation as successful medication adjustment

Resolution

Pain flare

Misinterpretation as disease progression or tolerance to opioid

Medication increase
Emotional pain, physical pain and opioid withdrawal can feel (and look) identical.

- Hospitalists must broaden their differential diagnosis when assessing these patients.
- ASK patients about emotional distress.
Opioid-tolerant patients lose the ability to discern their bodies’ signals

Pain

- PHYSICAL PAIN
- EMOTIONAL PAIN
- INTENSE PAIN, CRAVING AND DYSPHORIA

Anxiety
Withdrawal
Disorganized pain control practices among ED providers and hospitalists leads to poor care

- Chronic pain patients don’t know what regimen to expect
- Patient prepares for a fight
- Provider can fight or order what is demanded (neither is good care)
PAIN


I don’t have time to fight over pain medications.

Stabbing? Sharp? Dull?

What makes it better?
What makes it worse?

Aching or burning?

Radiating or not?

Why didn’t the ED send you home?

How many more patients do I have to see today?
What ARE our inpatient goals?

- Pain score of 0?
- A default IV opioid regimen? The patient is sick enough to need the hospital, right?
- Patient satisfaction with our pain control? Not being fired?
- Not having to argue about opioids?
- Patient agrees to be discharged?
Case #1

- A middle-aged woman with Crohn’s disease treated with immunosuppression and many bowel surgeries, malnutrition from short-gut syndrome, prior fungal pneumonia and recurrent bacterial sepsis is frequently admitted for abdominal pain crises requiring IV opioids
  
  - Many hospitalists and residents teams care for her
  - She is often diagnosed with acute infections, including UTI, PNA, PICC-line sepsis (TPN) and others
  - She is chronically on PO opioids for pain, but during hospitalizations her regimen is always escalated
Case #1

- Over time, her pain is no longer controllable with PO medications in between hospitalizations
  - PCP authorizes central access for home IV Dilaudid infusion
    - She has a 3-month window without a readmission
  - She is readmitted, very agitated, after a young PCA in her home is found dead. She reports 10/10 abdominal pain in the hospital despite > 70 mg of IV Dilaudid per day.
  - Her daughter develops pain requiring frequent visits to the ED and is prescribed increasing doses of opioids

- The patient is found dead in her home 6–7 months later
Inpatient opioid prescribing has consequences
- IV formulations are very behaviorally reinforcing
- Withdrawal can trigger ED visits and readmissions
- Poor provider coordination leads to bad outcomes

Know the outpatient context
- Coordinate inpatient prescribing with outpatient plan of care

A well-defined diagnosis is essential to safe and effective inpatient pain control
For the opioid–habituated with acute–on–chronic pain, MAKE A DIAGNOSIS

- Chronic pain flare?
- Chronic pain with new acute illness?
  - Is the pain related to the acute illness?
- Emotional pain (depression/anxiety)?
- Opioid withdrawal?
- Addiction?
- Opioid–induced hyperalgesia?
- Diversion?
Case #2

- 44 year-old man has elective foot surgery. He denied PTA illnesses or medications. On POD #1 he reported 10/10 pain despite oxycodone 120 mg, OxyContin 70 mg and IV Dilaudid 6 mg. A Dilaudid PCA is started. He receives Ativan and hydroxyzine for comfort. At 0230 he is “sleeping”. At 0425 he is found unresponsive with agonal breathing and emergently intubated. He develops severe ARDS from aspiration requiring Flolan, proning and prolonged mechanical ventilation. He survives.

- He had a history of abusing pain medicines, often in combination with alcohol, and had been in CD treatment at least 3 times. This information was not obtained prior to surgery.
Prescribing inpatient opioids is HIGH-STAKES

- Adverse inpatient events
- Addiction
- Readmissions
- Diversion
- High cost of care
- Accidental overdose deaths
What happens in the ED, on hospital admission and at discharge must be fundamentally linked to the outpatient plan of care.

- Query pmp.pharmacy.state.mn.us to understand a patient’s prior opioid exposure.
Standardizing care allows providers to set consistent expectations for chronic pain patients

- PCP controls (fills) the chronic medications
- ED and hospitalists assess for and treat new, acute disease
- In the absence of a new painful illness, the hospital regimen should be the HOME regimen
WHAT ARE YOU TREATING?

- A chronic pain flare?
  - Provide time and emotional support, set expectations, continue home regimen

- Emotional pain (depression/anxiety)?
  - Provide support, continue home regimen

- Chronic pain with acute illness or injury?
  - Is the pain related to the new illness or injury?
  - Escalate opioids very carefully, consider involving a pain specialist
WHAT ARE YOU TREATING?

- Opioid withdrawal?
  - Resume home regimen, get help

- Addiction?
  - Recognize “the chaotic life in pursuit of a drug”
  - Recognize the high risk of death
  - Resume home regimen to prevent withdrawal
  - Get help

- Opioid–induced hyperalgesia?
  - The patient needs to slowly taper off opioids

- Diversion?
Control Discharge Prescriptions

- CDC recommends no more than 2–3 days of PO opioids for ACUTE PAINFUL ILLNESS
  - Addiction risk increases the longer patients are exposed to these medications
  - Uncontrolled psychiatric illness, prior drug or alcohol abuse all increase the risk of addiction

- For chronic pain patients on opioids, refills of chronic medicines is the PCP’s responsibility
44 year-old man with DM I complicated by neuropathy and painful gastroparesis has recurrent DKA. This is his 7th admission in 4 months. He takes OxyContin 10 mg BID and oxycodone 20 mg 5 times daily PRN for chronic pain. Parents found him minimally responsive at home and called 911. His oxycodone bottle is empty (due for refill in 10 days).

Labs in the ED confirm florid DKA, similar to all previous admissions.
Case #3

- After IVF and IV insulin, mental status normalizes
- Patient requests IV Dilaudid for 20/10 abdominal pain, saying he is nauseated with intermittent vomiting and cannot take pills
- During prior admissions, he usually receives IV Dilaudid until ready to discharge
Addiction...

...the chaotic life in pursuit of a drug
Addiction

- The patient in case #3 is at very high risk for death
- If we don’t see beyond the DKA, we are missing an opportunity to prevent death
- Opioid overdose and withdrawal often play a role in presenting symptoms
- Addicts are at highest risk for overdose death in the window after tapering off opioids
National Epidemic

- CDC: deaths from prescription painkillers climbed 18% yearly from 1999 – 2006
  - The rise has slowed, but 46 people are still dying from overdoses every day

- Prescription opioid abuse is fueling heroin addiction
  - Deaths from heroin doubled between 2010 – 2012
    - 74% who used heroin after 2000 started with prescription opioids
Over 70% who abuse these medications get them from friends and family.

The number of overdose deaths is directly related to the number of prescriptions written.
For every 1 death there are...

- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users
Standardizing Care at Regions

- ED/Inpatient care plans define priorities for pain control in opioid-habituated high-utilizers
  - Orange EPIC banner alerts providers

- Care plans CONTROL PREScribers and STANDARDIZE OPIOID PREscribing

- Time previously spent arguing over medications can now be spent listening and providing emotional support to patients

- Care plan work led to Hospital Admission Order Set changes which cue providers to differentiate acute pain from chronic pain
Patient Satisfaction

- Patients with chronic pain do better when they know what to expect

- Patients with chronic pain appreciate providers taking time to show compassion and learn WHO THEY ARE
  - A standardized treatment plan helps patients not feel judged when meeting a new provider

- Involve nurses and social workers at the bedside whenever possible
Patient Satisfaction

• 10/2012 Johns Hopkins study of 4349 surgical patients identified factors linked to higher patient satisfaction with pain control
  • Nurses always courteous and respectful: 5.69 adjusted OR
  • Perception care providers are doing everything they can to help: 3.63
  • Pain well-controlled: 1.5
Prescribing opioids in the hospital is very high-stakes.

Standardizing care across outpatient, ED and inpatient prescribers is the SAFEST way to care for patients with opioid-habituated chronic pain.

- Do your homework on admission
- Contact primary care providers, query the pmp
- Stop escalating opioids without a diagnosis
- Stop refilling chronic pain medications
Summary

- DEFINE your diagnosis
  - Continue home regimen unless you have a very good reason not to

- Chronic pain inevitably flares

- Opioid-habituated patients cannot tell the difference between emotional pain, physical pain and opioid withdrawal

- Addicted patients are often at high risk of death
And now, a moment of silence...