Transcript of Cyberseminar

 Session Date: 03/03/2015

Series: Spotlight on Pain Management

Session: Admitted to the hospital and in and in chronic pain. What is the inpatient care team to do?

*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm or contact: hilary.mosher@va.gov*

Robin Masheb: This is Robin Masheb, Director of Education at the PRIME Center, and I will be hosting our monthly pain call entitled, “Spotlight on Pain Management.” Today’s session is “Admitted to the hospital…and in chronic pain. What is the inpatient care team to do?” I would like to introduce our presenter for today, Dr. Hilary Mosher. Hilary Mosher is a Hospitalist at the Iowa City VA Medical Center and at the University of Iowa Hospitals and Clinics. She’s also a Researcher with Comprehensive Access and Delivery Research and Evaluation at the Iowa City VA, and Clinical Assistant Professor at the University of Iowa Carver College of Medicine. She completed the VA Quality Scholar Fellowship in 2014. We will be holding questions for the end of the talk. At the end of the hour there will be feedback form to fill out immediately following today’s session. Please stick around for a minute or two to complete this short form, as it is critically important to help us provide you with great programming. Dr. Bob Kerns, Director of the PRIME Center, will be on our call today and he will be available to take any questions related to policy at the end of our session. And now I’m going to turn this over to our presenter.

Dr. Hilary Mosher: Hi. Thank you very much and thank you all for joining the seminar and to Robin and to Bob for this opportunity to present. As Robin said, I work about fifty percent of the time as a Hospitalist. From 2012 to 2014 I had a great opportunity to work in the VA Quality Scholar Fellowship Program to explore some of the clinical interests I had and the questions that grew out of my work as a Hospitalist. So currently I have about fifty percent of my time dedicated to research and quality improvement in the area that I’m going to talk about here. It’s really came out of my interests, not so much in pain directly, but my interest in pain grew out of an interest in functional outcomes of hospitalized veterans. And I really grew to realize how important pain and their pain management in the hospital was to the functional outcomes I was seeing. So the topic I want to talk about is the question of how to best treat chronic pain patients when we encounter them during medical hospitalization. It really grew out of clinical challenges that I face in the hospital in caring for patients with multiple medical comorbidities, many of which included chronic pain. I want to make a few disclaimers in that I really am not a pain specialist. I also have no particular expertise in prescribing opioids, although I clearly do prescribe them to many different types of patients in the hospital setting. I have only limited experience treating patients with chronic pain in the primary care clinic, and so I have no conflicts of interest.

I’ve told you where I lack expertise and you might be wondering why I’m speaking to this group. This slide is intended as a visual summary of that explanation. On the bottom right hand side of your screen is an image representing people in their community setting performing functions of their daily lives. As a Hospitalist one of my main goals is to get people back into that setting with maintained or improved health and function. On the upper left there’s a representation of a numeric pain rating scale, the type that is used just about universally during hospitalization to access patient pain. The arrows are a visual shortcut to symbolize that I’m working where these patients enter from their outpatient lives into the event of hospitalization. I think that during that hospitalization in what happened in the outpatient setting that led to them being admitted, and then what types of things do we do or not do in the inpatient setting that allow people to remain in the community outside of the hospital. So conceptually during hospitalization patients are removed from their community setting. I started to think, “I’m fairly well equipped in terms of their medical problems to manage and to treat and to be confident that I’m leaving people with a good chance of recovery and an ongoing recovery at discharge. I realized early in career that I felt ill equipped to address chronic pain, especially in these complex medical patients, and especially in cases where that was persistent or ill explained pain. So this is my journey to try to become better equipped to manage patients in this clinical setting.

In the next forty-five minutes or so I have three main intentions. The first is to quantify and characterize the challenge of chronic pain in the medical inpatient. The second is to present and to assess a proposed conceptual model for chronic pain in the medical inpatient. The third is to elaborate goals and strategies relevant to hospitalized veterans with chronic pain. Before we get started with all that, I wanted to take a brief moment to find out a bit more about my audience. I’m going to ask you to identify your main role. You can select more than one of these. The five categories that I’ve listed are inpatient care provider, so a provider of any type who cares for patients in an inpatient setting, an outpatient care provider, researcher, a pain specialist, and if you’re trained as a physician that’s another specialty. I’ll hand it over to Heather for the poll.

Heather: Great. Responses are coming in. We’ll give everyone just a few more moments and then I’ll read through those results. It looks like things have slowed down, so I’m going to go ahead and close that out. We are seeing thirty-five percent inpatient care provider, thirty-eight percent outpatient care provider, thirty-seven percent researcher, twenty-one percent pain specialist, and twelve percent physician. Thank you everyone for participating.

Dr. Hilary Mosher: Okay. Thank you. That makes me even more enthusiastic about what I hope to learn by the end of this presentation. I think there’s a lot of expertise out there and I feel like I’m fairly early in my career and really benefitting so much from the expertise that’s available. From everyone I’ve talked to about this so far, so I want to make sure that we have time at the end. I will start with a case that’s intention is to illustrate some of the challenges that I face with pain in the hospital. This is a case of a sixty-four year old veteran who was admitted with shortness of breath and left-sided chest pain. His pain is worse when he takes deep breaths and he has a past history of chronic obstructive pulmonary disease. He’s a current smoker, though he reports he’s trying to quit. He also has been diagnosed with obstructive sleep apnea, but he doesn’t use his CPAP machine to treat it. He says that the mask is uncomfortable and he doesn’t sleep well with it. He also has osteoarthritis with chronic knee and low back pain. This condition limits his activity level at home. He has been prescribed the following home medications and pharmacy records show that these are filled fairly regularly. Salmeterol inhaler for COPD, Simvastatin, and he takes a baby aspirin. Hydrocodone and Acetaminophen 5/325, and he takes one to two tables four times daily as needed. Then about a month ago he was prescribed Clonazepam, one milligram, at bedtime.

He has a chest x-ray and it shows he has concern for pneumonia, a right-sided parapneumonic effusion. He diagnosed with community-acquired pneumonia with a small parapneumonic effusion. And because he is not toxic in appearance and the effusion is free flowing and too small of a task, we don’t have any plans to do a thoracentesis to remove this fluid with a needle entry. A cardiac workup was negative for cardiac cause of his pain. He is requiring supplemental oxygen which will keep him in the hospital I would expect a few days. He’s short of breath and he has worsened pain when he breaths hard and when he is ambulating to the bathroom. Here again is a case where I’ve got medical plans that are fairly clear to us. We’ll treat with antibiotics and oxygen in the acute setting. But we’re faced with making a decision about treating his pain. His pain is assessed regularly by the attentive nursing staff. He reports that at times it’s a seven out of ten and it gets as high as nine out of ten when he is up and walking. So I want to take a moment and have you all act as his doctor and respond to this next poll question. I’m going to read the responses on this slide and then you’ll see shorter responses when you actually go to the poll question. There are five choices. A) We would stop the opioids. He shouldn’t be on these and they might make his respiratory issues worse. B) We would continue the opioids, but it’s nothing to do with the hospital problem, and it isn’t the inpatient physician’s role to change them. C) We could increase the opioids, because he has new pain and his pain is limiting his function. D) We could decrease the opioids. They aren’t really helping and they might be harming him. E) We could change to intravenous opioids while he’s in the hospital. He has an IV, and intravenous opioids would allow for more rapid onset and dose titration …

Heather: I’m sorry Hilary.

Dr. Hilary Mosher: That’s alright, are you going over to the poll?

Heather: I was just about to say that I think somebody has been muting all of us here. People may have missed the end of what we said there, so I’m going to put it up here now. I apologize for the delay in getting that up. My full audio cancelled out there for a moment.

Dr. Hilary Mosher: Okay. Do you want me to go back, or did I have sound coming through for the end of those?

Heather: You may have missed the very end of it, but responses are coming in here.

Dr. Hilary Mosher: Great.

Heather: You may want to read through the last one or two of them while we have people putting their responses in here.

Dr. Hilary Mosher: Okay. So the five choices would be that we would stop all opioids, continue oral opioids, increase the dose or oral opioids, decrease the dose, or change to intravenous opioids in the hospital.

Heather: I’ll give everyone just a few more moments before I close that out. It looks like we’ve slowed down. We are seeing seven percent saying to stop oral opioids, twenty-four percent saying to continue the oral opioids, twelve percent are saying to increase oral opioids, twenty-nine percent are saying to decrease oral opioids, and twenty-nine percent are saying to change to intravenous opioids in hospital. Thank you everyone.

Dr. Hilary Mosher: I don’t think that it’s easy to make predictions, especially about the future. But I have to say that those results were kind of spread out right like I thought that they would be. Now that I asked the question I have to give you the right answer, correct? And I would like the right answer too. This is where I was a couple of years ago when I would take care of patients just like this gentleman and not know exactly what the best thing was to do. And so I went looking for evidence at that time. Because what I thought of as I worked with patients, I was developing strong clinical opinions on the best answer. At the end of this I’ll get more into the way that I practice and what we’re doing to assess those types of practice. But there also just seems to be a great variation in practice and sensitivity around issues of pain and where this could possibly be a tense conversation with patients and really a lot of clinical uncertainty. Before getting back to the case I’ll summarize some of the things that I found as I started trying to read about pain in a particular patient setting and a patient population.

The first thing that I think we all are aware of or could think was fairly intuitive is that pain prevalence during hospitalization is very high. And in some studies we see it as high as ninety percent looking across all settings, surgical settings, oncological settings, interventional radiology, pediatrics, obstetrics. In a lot of those we’d have clearer sources of tissue damage sources of injury that would explain acute pain. In medical patients sometimes it’s a little less clearer, “Do they have a new acute pain condition?” Chronic pain is rarely considered in studies of inpatients both pain prevalent and in pain treatments. There are a few studies out there that when looking at prevalence will look at prior pain duration. They’ve shown that between twenty and forty percent of patients in the hospital reported pain duration greater than three months prior to the hospital setting. That pain duration is positively associated with pain severity in the hospital. What about pain treatment during the medical hospitalization? This is a fairly recent paper that many of you may be familiar with. Dr. Herzig and her colleagues looked at over one point one million medical hospitalizations in a non-VA setting and found that during those hospitalization events, over half of those patients received opioids. And over one third of the total patients received parenteral or IV opioids. And thirty percent of those exposed to opioids during the hospitalization had two or more different ones. There was a really wide range in terms of how often a hospital used opioids in the study. A lot of that was explained by the characteristics of the patient served in the hospital, but even after adjusting for those the opioid prescribing rates by the hospital ranged from thirty-three percent to sixty-four percent of medical inpatients receiving opioids during their hospital stay.

The study was done with inpatient pharmacy claims data and they were unable to say anything about, “Were patients on opioids prior to hospitalization or were they discharged with opioids?” All we know is what happened during the hospital setting. This slide helps to illustrate what I’ll describe about pain management from my experience in a hospital setting. Really it is largely opioid based. Evidence about the effectiveness of these treatments is extrapolated similar to how we’ve seen over the years with pain in the outpatients in an ambulatory setting. It’s extrapolated from the care of cancer patients and from post-surgical patients. It largely follows a biomedical model where the effectiveness at a point in time is on a numeric rating scale, and it assumes injury as the proximate cause of the pain. The other thing I was interesting and I think that’s changed in practice. I talked to my colleagues who did their training much longer than I did who would find it shocking to some degree of how readily we give opioids to hospitalized patients, especially to the elderly, because they think of the adverse effects of giving them more dangerous drugs.

But the environment I believe we’re practicing in now, we’re much more attuned to concerns about NSAIDs and Acetaminophen as analgesics in the hospital, because these are relatively contraindicated in patients with bleeding conditions, issues with bleeding, or potentially a planned procedure, kidney injury or a liver injury. So although we may have very reasonable concerns about falls and confusion, delirium, constipation, urinary tension, and over sedation that come with opioids, there’s been a cultural shift where these somehow are seen as more acceptable or maybe less dangerous or maybe less objectively measurable in some cases than some of the other alternatives. So I think we’ve seen this pendulum swing about opioid safety clearly and it’s well documented in the outpatient setting, I think if the pendulum is swinging it’s doing it more slowly or with sort of lag in the inpatient setting and we’re still operating it at least in my experience with the attitude that opioids are safe in these patients and safer than another alternative. There also is a sense in the hospital and I think based on the idea that we’re working with acute pain, is that we could have a pain free hospital. And that that might be a goal one would strive for. Pain management is a part of a quality measure. We have questions such as, “How well was your pain controlled in the hospital? How satisfied were you with your pain management?”

Providers are sensitive to wanting to make sure that their patients do have good pain control and are satisfied. However, we do know that pain levels and satisfaction show poor correlation in numerous settings across numerous studies. So we don’t really understand what a numeric scale means and what constitutes satisfaction with pain management. There have been recently more and more efforts to improve the quality of inpatient pain management with multi-disciplinary, very comprehensive programs to try to target pain assessment, the processes of getting medications to patients and different modalities. This has been one that I studied, and I know that explicitly that one of the challenges in looking at their outcomes was that they didn’t have a sense of what the pre-hospitalization pain or pain treatment was among their population of patients. So contextualizing the responses in the hospital with patients preexisting pain was difficult. The hospital systems are designed to ask, “How much pain,” by really not, “What kind of pain.” As a result we’re passably well equipped to address acute pain conditions and acute chronic pain conditions to a certain extent. And I think the talk last month about treating pain in those different scenarios that were presented points out that there are some good recommendations in handling those situations. But we’re really not well equipped to differentiate and identify and treat chronic pain conditions unrelated to the hospitalization, or to even know how important it is to differentiate these conditions and to treat chronic pain separate from acute pain when we’re in these settings.

So we have acute pain conditions in the hospital, acute superimposed on chronic pain, but then I really was struggling with chronic pain conditions that are unrelated to hospitalization. Is what I’m doing for those patients neutral, beneficial, or potentially harmful? So this is a perceived gap. I think for those of you who were on the call last month we have surgical patients with or without prior opioid use, cancer patients with new or intractable pain, with or without prior opioid use, and then the challenging population of inpatients with severe acute pain with a clearly known etiology and a background of addiction or drug abuse history. Those are patients that can be very, very difficult to treat and I think take up an inordinate amount for the mental and emotional space for many of us. But I don’t get the sense that they are the highest in terms of the proportion of patients who have had prior analgesic treatment with opioids or suffer from prior chronic pain. So I remain uncertain about this group here, the non-surgical patient with chronic non-malignant pain and/or chronic opioid use, in whom there is no apparent acute pain or diagnoses that clearly accounts for the pain symptoms. And yet during the hospital stay the pain is an important quality of life and a functional issue for the patient.

The first question that I asked was that to me in my daily practice this is a lot of patients, but how many patients get this characterization? One of the first studies we did with the great benefit of having wonderful VA data in which we could link inpatient and outpatient records, we looked at a hundred and twenty-two thousand veterans who were experiencing a medical hospitalization. These are patients that haven’t been hospitalized in the last three hundred and sixty-five days. So they actually also were relatively one might say a healthier hospitalized population than what we see on a day-to-day level with the many patients who have more than one hospitalization a year. Of these, over half have a documented chronic pain diagnosis in the year prior to admission. That was based on the ICD-9 codes. A quarter of them, just over one out of four, met a definition of chronic opioid therapy in the months prior to hospitalization. That was the answer to the first question, “How many patients nationally who are admitted for medical hospitalization have established opioid use prior to coming into the hospital?” So again falling into the category of wondering how best to treat them.

We wanted to do a little bit more about characterizing these patients. So we divided them into three groups based on their prior pre-hospitalization opioid use. We have a group that has no exposure to opioids that we could capture in the pharmacy records. We have those who had chronic opioid therapy, which was ninety days or more at some point in the last six months. And then we had this middle group who has in between one and eighty-nine days of therapy in the prior six months. A lot of those were close to the eighty-nine. So they were relatively high amounts of opioid exposure. And so we looked at a number of different prevalent diagnoses that would characterize a patient prior to admission or during hospitalization to help understand who was this patient population. So we did find that cancer and metastatic cancer diagnoses were higher in those who received the opioids. We also found a significantly higher burden of a mental health diagnosis in those patients admitted to the hospital who had received opioids before, and nearly one in five had a diagnosis of PTSD.

Interestingly, we did find out that only seventy-five percent of patients with long-term opioid therapy who were admitted to the hospital had documentation of a chronic pain condition at the time of hospitalization. We looked a little bit then about outcomes of hospitalization, but the most interesting thing in terms of knowing who are these patients that are treating cancer alone does not account for the burden of pain conditions in opioid use among a hospitalized patient. This is a fairly large proportion of patients that we encounter in the hospital. I want to break for just a few moments here and see if there are any questions that have come in before I switch gears just a little bit in the talk.

Robin Masheb: This is Robin and I don’t have any questions at this point.

Dr. Hilary Mosher: Okay. So this early research confirmed my clinical suspicion when I said that chronic pain was a significant issue. After spending some time reading and educating myself and trying to find studies which might have differentiated pain management between populations and looking at the evidence-based review that had been done earlier in Mark Helson’s group, I thought this really is an area that we need to generate more knowledge about. So I began focusing on understanding and figuring out, “What specific questions can we ask and answer and what interventions might be made?” What I’m presenting here is the conceptual model that we’ve put together to think about chronic pain in this setting. At the bottom of this slide is an adaptation of Doctor Kern’s diathesis-stress model of chronic pain acknowledging its pre-existing vulnerabilities and eliciting stimuli that lead to chronic pain experiences. The cognitive, affective, biological, and behavioral domains are involved in this development. Along this trajectory hospitalization can occur at any time. So hospitalization may be the initial eliciting stimuli that leads to chronic pain, and there’s a fairly good search for literature about predictors of chronic or persistent post-surgical pain, but hospitalization can also be just another event in the life span of a patient who has existing chronic pain. Hospitalization can occur for reasons related or unrelated to the pain-causing condition.

Within this event of hospitalization when we start thinking about the outcomes and the quality improvement-type effort that we might make, we can then better structure or process an outcome model within it in which we would look at hospital factors and provider factors that contribute to the pain management choices, and to the processes of inpatient pain management. And then we’re looking at both inpatient and outpatient outcomes of pain relief, satisfaction, distress, function and then post-hospitalization outcomes that might be more long-term and consistent with being interested in chronic pain outcomes, opioid use, following hospitalization. And then importantly to really consider the antecedents and to find a way to capture prior outpatient opioid use and then characteristics of patients that contribute to potential pain outcomes in a hospital setting and after discharge. Visually I hope that this model emphasizes that what I’m trying to do is to embed this idea of thinking about inpatient pain management within the broader trajectory of a patient’s life. And also to think about it as providing a framework in which we consider if and how our approach to inpatient pain management should make better or reinforce efforts in the ambulatory setting to improve pain treatment across \_\_\_\_\_ [00:30:38]. So coming out of this model I’m thinking about improving pain treatment with these five lines of inquiry to the study and improve pain care for this population. First, we need to measure and to characterize prior pain and pain treatment. Second and third, we need to access and understand our current local practice of pain treatment, and understanding important determinants in whether those are primarily a patient factors that are pushing how we manage, or is it more a hospital factor, a hospital culture resources that are available in the inpatient setting. Fourth, we need to assess patients’ attitudes and needs beyond basic satisfaction measures. So formalizing some of the discretions that I’ve had about, “What is it that patient’s want and expect and could potentially take from different approaches to pain treatment in the inpatient setting?” Finally, you need to identify and track meaningful inpatient and post-hospitalization outcome measures. That would be appropriate and potentially sensitive to quality improvement things that we might do.

Going back to our case as a way to reflect on the complexity of the attacks, you’ll recall that this is a sixty-four year old veteran with COPD and pneumonia, chronic knee and low back pain for which he takes opioids. In visiting with him we might discover that overall the goal of great value to him is to remain independent in his home for as long as possible. And in order to do that he needs to have a short-term \_\_\_\_\_ [00:32:20] his pneumonia and we need to forestall the worsening of his COPD and the hospital requiring physical deconditioning is well recognized. And so to these ends, two important aims would be to ambulate him aggressively and to support a successful smoking cessation. As you will recall, he is a smoker who is contemplating and actually making efforts to quit. So when we say something about the goal of pain treatment and the balance between, “Do we want him pain free, or do we want him up and ambulating?” With a pain medication you primarily have sedation, and as an effect along with analgesia I’ve had the experience where patients on opioids are somewhat left volitional in the hospital. When I take those off a little bit they’re up and about more. So balancing again analgesia versus some measure, “Is he participating with physical therapy? Is he actively ambulating? Would we consider the opioids are working?” Some other things that we might consider would be the concern about his untreated sleep apnea as a contributor to his respiratory issues, and the worry that any opioids both in hospital and long-term might worsen his obstructive sleep apnea if that’s to remain untreated.

So my \_\_\_\_\_ [00:33:57] would be to counsel this patient on alternatives to opioids, along with counseling smoke cessation and to explore, “Are the opioids working? Are they working in the outpatient setting? Would he potentially be receptive to trying some other things, especially trying those in the hospital and seeing how different modalities of pain management might work for him?” Going along with this, what would my goal be for his numeric pain rating scale being assessed in the hospital? That might be to have him at or below the pain levels he endorses at home. So I would ask him what is his baseline pain that he lives with. And if he’s one of these people that reports a high baseline level of pain, I might be comfortable just having that as the hospital goal to be at that number. But this may be uncomfortable for an inpatient team in a hospital culture saying that that patient really should be pain free. Any pain over two or four really is something that we need to pile on some treatment for. There are lots of different aspects of a discussion that might go into this, other than just, “I want him sleeping in the hospital. I want him not anxious. I want him to be without pain.” Along with this is this explanation of, “Should this benzodiazepine that was just started, why was that started? Are we treating his breathlessness and anxiety? Is this contributing or not contributing to the event of him now worsening independently of the pneumonia or not?” I’ve found that I’ve had a lot of these discussions with patients around pain and pain \_\_\_\_\_ [00:35:55] hospital. That noise you hear is my pager going off madly. I apologize for that. I started to think is there a way to formalize some of this into something that we can put together as a real quality improvement initiative?

It’s a really good argument in mind as to why it matters for patient safety, over medicalization in the hospital setting, patient satisfaction if we’re not adequately treating patients with high levels of pain, and then long-term outcomes. I think there’s a certain argument for understanding veteran expectations and the therapeutic relationship in the hospital setting. And for some of our more difficult chronic pain patients I worry sometimes that by using the power of the inpatient setting to demonstrate analgesia, we're giving high doses of opioids, we’re monitoring the respiratory status and offering some relief, that our patients who may benefit from non-opioid modalities in the outpatient setting and might be working with their providers to go in that direction such as the opioid safety initiative, that then in an inpatient setting they’re getting a different model or a different way of thinking or a different message about their pain that reinforces an expectation of pharmacologic tier that might not be something that is then portable into the outpatient setting. So that’s a little bit of where I get into the concern about the harm of inconsistency in the message from the medical community, and if that impacts the therapeutic relationship that a patient might have with their primary care provider.

The first approach that we’re taking right now is to do some qualitative work on interviewing medical inpatients to try to get out some of these questions of pain as we’re transitioning from the outpatient to the inpatient setting and how those inform each other. This is just another figure here where reinforcing that chronic pain antecedents influence inpatient pain experience. The inpatient pain experience may have positive or negative effects on some of these domains that maintain chronic pain. Changes in chronic pain outcomes of pain, distress, and disability may mediate need for subsequent hospitalization. That changes how a patient might do in an outpatient setting, things like their ability to do some of the physical, respiratory, or cardiac therapy that might be indicated for once they get out of the hospital. So we do have some ongoing investigations that’s unfunded work that’s preparatory for a grant resubmission and we’ve just completed a local satisfaction survey among our medical inpatients to get more detail about their perceptions of pain management and their uses of alternatives to pharmacologic therapy. Along with that we’ve assessed and collected their pre-admission, inpatient, and discharge medications. We’ve found with this to compare the satisfaction responses between patients with prior opioid use and with those without. I would love to think that I had preliminary data that was ready for presentation, but we are still doing the analysis on this. So unfortunately I can’t show results that we hope to get soon. As I mentioned, qualitative interviews with veterans with chronic pain who are admitted to the hospital to explore some of the issues of importance to them and the attitudes that the patients have and what the patient experience is.

We also are in the early quarters of a quality improvement initiative as funded through the VA Office of Rural Health, in which we are partnering with our pain clinic to look at what sorts of things that our pain clinic has had that’s been really successful in the outpatient setting and translating that to an inpatient setting. So we’re building a multidisciplinary inpatient team for the nurse coordinator, pain psychologist, and their hospitalist physician lead to identify leverage points for cultural change and then exploring veteran readiness to accept some non-pharmacological approaches. Some of this involves both the educating physicians looking at our nursing culture, the interactions between physicians, the physician attitudes about who owns pain and are they just seeing their role as, “I’m going to write the medication,” versus, “I’m going to do a more broad assessment of what’s driving the patients discomfort and suffering in the hospital.” Again, we’re just starting to collect these interviews now and haven’t gotten yet into the coding for those. But I’m very optimistic that we’ll find coming out of this some opportunities for inpatient intervention.

One of the things that we just found already in our early work is that pain is positively associated with hospital length of stay. Quite a few of our patients are in the hospital fairly briefly and one might ask, “How much can we really do to not just improve pain with pain treatment, but to do something meaningful about changing attitudes about pain treatment?” And I think for this group some of them may spend quite a bit of time in the hospital. We see fairly large improvement with physical therapy interventions that are ongoing when the patients are there, and we may have time also to introduce some potential therapies around pain. We’re looking at adopting aspects of the smoking ce4ssation model, looking at the hospitalization as an opportunity to tell us a little bit about smoking cessation, they also may be comfortable about pain treatment. We’re exploring some brief interventions for radical change using focused acceptance and commitment therapy. We’ll also introduce, educate about, and practice non-pharmacological approaches and perhaps demonstrate a benefit to individual patients with some of these alternatives.

I wanted to put this slide in, because this is a very nice protocol that Dr. Kerns is involved with. It’s an acute pain assessment and a describing protocol. Although it doesn’t really address inpatient management, I think being familiar with this and keeping it in the back of my mind as we think about them when we look at discharge transitions and for patients say who are short-term in the hospital, how we should think about prescribing to them as they transition to an outpatient setting and back to their primary care provider. I have referred to this as one of the nicest protocol in ways to articulate thinking about pain management. Within my work I also refer to this and they find this very valuable, alternate acute care clinics, continuity clinics, as well as when they think about discharge management. I want to leave enough time now for questions. I’ve gone a little over than what I wanted to do, but I want to start with asking four opinion questions. The first one is agreeing or disagreeing with a statement. Most patients with chronic non-malignant pain should be encouraged to try non-opioid approaches. You can strong disagree, disagree, neutral, agree, and strongly agree.

Heather: Responses are coming in. We’ll give everyone just a few more moment and then I’ll go through those on the line here. It looks like things are slowing down a little bit so I’m going to close it out. We are seeing four percent saying strongly disagree, zero saying disagree, four percent neutral, twenty-three percent agree, and sixty-eight percent strongly agree. Thank you.

Dr. Hilary Mosher: Great. The next statement is inpatient providers should initiate discussions of chronic non-malignant pain treatment with hospitalized patients. You can strongly disagree, disagree, neutral, agree, and strongly agree.

Heather: We’ll give everyone just a few more moments to fill that out and I will go through the responses on the line here. Okay, I’m going to close it out. We are seeing zero strongly disagree, two percent disagree, seven percent neutral, thirty-three percent agree, and fifty-eight percent strongly agree. Thank you everyone.

Dr. Hilary Mosher: Will I mess up if I skip this last question, because this is sort of asking that last question?

Heather: No, that’s totally fine.

Dr. Hilary Mosher: Okay. And then the last question is the biggest challenge to improving inpatient pain treatment is changing \_\_\_\_\_ [choose one answer). Fill in the blank with patient attitudes and beliefs, physician behavior and training, nurse behavior and training, inpatient pain treatment doesn’t need changing, and other (please type in comments). If you have a comment that would be the place to put those “other” answers.

Heather: I’ll give everyone just a few more moments to respond and I will close it out. It looks like things are slowing down. We are seeing thirty-nine percent patient attitudes and beliefs, forty-two percent physician behavior and training, eight percent nurse behavior and training, zero inpatient pain treatment doesn’t need changing, and eleven percent other. There we are seeing patient, physician, and nurse. Thank you everyone.

Dr. Hilary Mosher: There’s always a way to get out of that, huh? I have a lot of people to thank in supporting me in the work that I’m doing, primarily among them D. O. Welch and Charlotte Bailey who have been my mentors in pain in our pain clinic here. And they’ve just done some wonderful work in changing the outpatient pain culture and supporting our primary care providers. I work closely with Kendra Stewart here in our qualitative core that’s been helping me with the work we’re doing with interviewing patients. Before we go to questions I love this little joke as a take home message, “Doctor, will I be able to play the violin after the operation?” Well, “Yes, of course.” The patient responds, “Great! I never could before!” I think for me I’m always reminding myself that I need to understand where the patients are and where they want to be and how we can help them get there even when I’m only just in counseling with them during sometimes a brief hospital stay. So with that I’d like to open it for questions and comments and really anything people would like to talk about.

Robin Masheb: Thank you. We have some questions starting to come in. One question is, “Is the inpatient setting the right place for counseling or communicating the risks of opioid use?”

Dr. Hilary Mosher: Yeah, I think that’s a very good question. I’m not sure how to test the answer to that, how to know that I have the right answer. They’re still suffering from a lot of pain. They are having a lot of functional decline and I see that in the outpatient setting it looks like their pain medications have been titrated up without benefit. I’ll talk to them and just get a sense of if they think they’re getting benefit. Sometimes I’ll ask the question, “Is the medication helping with the pain, or is it just helping them deal with the pain?” Sometimes you can see a patient kind of switching in their mind how they’re thinking about something. And then I will talk to patients about the long-term medical adverse events or effects of the medications. My concern about how the opioid as a medication might be affecting their other comorbidities. One of the great luxuries of being a Hospitalist is I have time. We’re all very, very busy, but I don’t have another patient necessarily waiting outside in the clinic to come into a clinic appointment. And so I do have the luxury of finding time to come back during the day and sitting down with a patient and discussing and perhaps educating them. As time goes on and the outpatient initiative and the culture changes, I think more patients are learning about some of these. Some patients say, “No one has ever told me that.” When I see those types of responses I have the opportunity to say, “Let’s try decreasing your dose a little bit and seeing how you do while you’re in the hospital.” If they’re receptive to that and see that they do alright, then we do have some room to say, “Let’s look at other alternatives. Let’s stop increasing doses as a way to treat pain.” Those types of encounters and outcomes make me think that there might be a small but important proportion of patients for whom that type of interaction would be valuable. It’s a long-winded answer, but I think it’s trickier when we get into patients who I might suspect have more of an addicting kind of interaction with the drug. I don’t feel as if that’s my expertise with them to address that type of thing. It really is beyond the scope of my expertise. I just don’t practice any addiction medicine.

Robin Masheb: When you talk to patients and you’re talking about risks, do you talk to them or is there some sort of risk communication tools that are visual or graphic?

Dr. Hilary Mosher: That’s a good question. I haven’t found anything and I haven’t developed anything. I don’t have it off the top of my head right now, but I know there are studies out there about what are the rates of low testosterone in patients, so their endocrine dysfunction in patients on long-term opioids. But I think most of the patients that I work with the statistics are less important to their understanding than just the idea that your sleep apnea might be worse. We haven’t been shown that people’s physical function or their ability to go back to work is really improved by these things. I do have some concerns that some of your issues with low energy and low sexual function, low lobito, could potentially be related to the opioids. And just introducing the idea of the \_\_\_\_\_ [00:53:38] is more what I’m focusing on, rather than getting into percentages of risks or what are the specifics about risk versus benefit in terms of percentages and number.

Robin Masheb: Do you find that patients in the inpatient setting are receptive and willing to participate in non-pharmacological methods for treating their pain?

Dr. Hilary Mosher: Some of them are. Some of them are very resistant and very stuck in any discussion of it. That’s actually the real direction of what we’re trying to quantify, because I can’t give you a quantified answer to that now. It’s more of just my impressions, and I think there’s a lot of recall bias that I have with that. So one of the things that we’ve done is we’ve used the modified APS Satisfaction tool. Patients can mark non-pharmacological approaches that they’ve used. They also can make a note there if they were ever counseled on these things during the hospital stay. Maybe a third of patients will use non-pharmacological approaches already. We have very low rates just in the questions that I’ve looked at so far in counseling patients or non-pharmacological approaches. I think we’re looking at that as a potential target as we identify, “Would patients who aren’t using these approaches be receptive. What can we do within their community physician culture to use that as the first line approach to maybe decrease unnecessary pharmacologic?” I’ll have a better quantification of this receptivity over the next few months as we look at the results of the survey.

Robin Masheb: This is more of a comment than a question. How well a patient does with counseling for smoking cessation might give you a way of estimating how receptive people would be for pain counseling in the inpatient setting.

Dr. Hilary Mosher: Yeah. That’s a real challenge, because I think smoking cessation is really tough. Is changing opioid use going to be tougher or less tough? One thing I will say is I don’t find a lot of patients who say, “I use these cigarettes but they don’t really do much for me.” But I do find patients that say that about their opioids. And that might be the first group to target. Then when we get into patients who I think are much more reliant for whatever reason or have a stronger feeling about their opioid analgesia that that’s going to get more where we’re seeing challenges that we see with tobacco use.

Robin Masheb: Are there any objective tools to measure good quality pain control in the hospital?

Dr. Hilary Mosher: Please send them to me if someone has one that they really like. I haven’t thought on that yet. I like the APS tool. I think it’s going to give us useful information. I know there’s a much longer tool that was developed specific in the VA population. I haven’t worked with that one and I think it was a bit long for our purposes. I think pain is devilishly hard to measure. As I said when we started, I come at this from a true commitment to improve functional outcomes. And I think ultimately some of the really clinically meaningful outcomes for me will be to figure out how to get sensitive measures of functional outcome in our patients with pain and then to have their satisfaction with their pain levels or their opioid use be more secondary outcomes that show that we don’t make these things worse in our interventions that allow them to see improve functional outcomes. That’s kind of tipping the hand a little bit, but if I could have things exactly how I wanted them that’s where I would focus a lot on in my work.

Robin Masheb: We have one last question. What are the objective elements in the ICSI tool?

Dr. Hilary Mosher: I’m not sure I quite understand the question. The pieces of the ICSI that I think are really helpful and I feel like that gave me some sense if I hear something to kind of shoot for and be consistent with, is the idea that when we encounter these patients short-term as they are experiencing their long-term trajectory and having an established relationship with their primary care provider, it’s incumbent on us to assess not just if they have pain but is this acute or chronic pain and to really characterize that and have that guide our management. To be very knowledgeable, educate ourselves about their current treatment and to be as consistent as possible with it. And then to minimize the changes or the acceleration of opioid therapy at discharge and to limit the discharge medications that we give. Pretty much as a rule now, I do not discharge patients on opioids if they have a provider who’s prescribing. In the rare cases that I do because they are adamant that they need them and say that they don’t have them at home and they aren’t going to see their provider until Monday, I will follow the guideline of three days and I give them the message regardless of how insistent they are with me and say, “It’s very important that you have this relationship with your primary care provider and that I want to protect you from any perception that I’m getting in the way of that or that we’re providing you excess medications in a way that might get in the way of a trusting relationship with the provider.” I keep these guidelines in the back of my mind as a support and a way to help residents feel supported when they take that approach with some of the patients who are a bit more aggressive in feeling that they want more opioids at discharge.

Robin Masheb: I got a little bit more clarification on this question. Is there some sort of an objective assessment that’s a part of that tool as opposed to just a self-report in asking patients what their pain rating is?

Dr. Hilary Mosher: Yeah, I don’t know the answer to that. I’m not aware that there is an objective assessment. That might just be my own ignorance.

Robin Masheb: Thank you so much Dr. Mosher for preparing and presenting. We very much appreciate it.

Dr. Hilary Mosher: Thank you and thank you for all the questions.

Robin Masheb: The audience had some great questions. This is just a reminder to hold on for another minute or two for the feedback form. Our next Cyber Seminar will be on Tuesday, April 7th, by Dr. John Sellinger. It is entitled, “Interdisciplinary Assessment as a means to breaking the gap between primary and specialty care settings.” We will be sending registration information out to everyone around the 15th of the month. I want to thank everyone for joining us at this HSR&D Cyber Seminar, and we hope to see you at a future session.