

COVID-19 Dramatizes the Value of Rediscovering the Power of House Calls



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I work with a practice called Housecall Doctors P.C. in Highland, IN, which has treated more than 6,500 homebound patients over the last decade. We're an interdisciplinary care team that goes beyond primary care to ensure access to specialty treatments. As a team, we deliver care where it is often unavailable, and the results have been remarkable. Within a 12-month period ending last August, we treated more than 1,000 patients, reduced emergency department usage by 77%, and cut hospital readmissions by 50%. Moreover, patient satisfaction scores increased from 17% to 84% after implementation of the program.

COVID-19 has caused some physicians, insurance companies, and even the federal government to take special notice of the power of care models that reach out to patients. CMS issued new rules at the onset of the pandemic to allow home health agencies (HHAs) to provide services to Medicare beneficiaries through telehealth and to treat patients in their homes who are suspected of contracting COVID-19 or who have a condition that makes them more susceptible to the virus. They also allow for more flexibility on who is eligible to receive home healthcare and which clinicians are allowed to deliver care.

This crisis could have a silver lining if it prompts us to create a smarter model: while hospitals treat the most acute cases, more sick patients could be treated in their homes, where they recover better and quicker. With buy-in from CMS and a growing number of insurance companies, I am optimistic that more practices like ours will open. My hope is that with the new CMS rules, and the innovation being spurred by this pandemic, more physicians will take up this powerful model of care in their own areas.

All it takes is a team of clinicians working together to get it started in your community. COVID-19 will undoubtedly change how we deliver care. I hope that we can take this as an opportunity to form new partnerships, cross specialty lines, and, in a sense, rediscover our roots in bringing care into people's homes. ■



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Reducing Unnecessary Opioids After Total Hip Arthroplasty



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“There has been very little practical guidance on how to consistently implement reductions in prescribed doses, how to safely taper opioids after surgery, and how to personalize opioid prescribing to ensure that patients continue to receive effective pain management,” states Edward R. Mariano, MD, MAS. In line with national efforts by the American Society of Anesthesiologists and National Academy of Medicine, Dr. Mariano and colleagues tackled the problem of opioid overprescribing at the local level by developing a tool that could be rapidly implemented.

Testing an Opioid Prescribing & Tapering Protocol

For a retrospective cohort study, published in *Pain Medicine*, the team tested the hypothesis that implementing a multidisciplinary, patient-specific discharge protocol for prescribing and tapering opioids after total hip arthroplasty (THA) would decrease the morphine milligram equivalent (MME) dose of opioids prescribed. “At our hospital, patients who undergo lower extremity joint replacement surgery receive their care in a collaborative perioperative surgical home (PSH) model of care,” explains Dr. Mariano. “The PSH model facilitates regular communication between members of the healthcare team

and promotes continuous process improvement. We chose to design a protocol that could be variable and patient-specific.”

The study team created a tool that calculates each patient's total number of oxycodone tablets to be prescribed at discharge based on opioid consumption in the prior 24 hours, along with explicit instructions on how to taper the dosage and when (Table). “We avoided analgesics that combine an opioid with acetaminophen so patients could continue to take the maximum allowable daily dose of acetaminophen as part of their multimodal analgesic regimen,” notes Dr. Mariano. “We avoided prodrugs since the analgesia and side effects vary between individuals based on metabolism. We also attempted to keep the tool as simple as possible by using the prior 24-hour opioid consumption as the highest allowable dose and setting the taper downward from there every 2 days. Patients were given instructions to monitor for signs of withdrawal as well as recommendations for safe opioid storage and disposal. Patients who have received no opioid in the prior 24 hours should be given the option of going home without opioids rather than prescribing them unnecessarily.” Dr. Mariano and colleagues analyzed the PSH database and prescription data for all patients who underwent primary total hip arthroplasty 3 months before and 3 months after implementation of the new protocol.

“A Huge Difference”

The total median MME for 6 weeks postoperatively was 900—ranging from 57 to 2,082—

during the 3 months prior to the intervention, compared with 295—ranging from 69 to 741—during the 3 months after. While refill rates did not differ, median initial discharge prescriptions in MME were 675—ranging from 57 to 1,035—prior to the intervention and 180—ranging from 18 to 534—after. “No aspect of our inpatient perioperative pain management protocol changed,” notes Dr. Mariano. “All patients received multimodal analgesia, and there were no differences in patients' inpatient opioid usage, postoperative adverse events, or recovery trajectory that could account for the difference in prescribed opioid amount seen in our results. This emphasizes that discharge opioid prescribing prior to implementing our patient-specific protocol was arbitrary and that applying our new tool made a huge difference.”

Expanded Application

With these results showing it is feasible to develop a simple tool to guide discharge opioid prescribing and tapering for THA patients, according to Dr. Mariano, the researchers have applied the tool for all major orthopedic and spine surgery patients. “Not all physician practices may be able to use our tool in its current form since we have a PSH model of care and unique patient population,” he notes. “However, every practice can implement multimodal analgesia protocols, assess their patients' opioid use, and develop a similar tool that accounts for their patients' inpatient opioid consumption when determining how much opioid to prescribe at discharge with tapering instructions.” ■

Table Discharge Opioid Protocol

The below table shows a discharge opioid prescribing and tapering protocol based on each patient's prior 24-hour oral opioid use.

Prior 24-hour Oxycodone	Tapering Instructions (Prescribed As-Needed)						Total Oxycodone 5 mg Tablets Prescribed
	Days 1-2	Days 3-4	Days 5-6	Days 7-8	Days 9-10	Days 11-12	
10 mg	5 mg twice daily						4
20 mg	5 mg four times daily	5 mg twice daily					12
30 mg	5 mg six times daily	5 mg four times daily	5 mg twice daily				24
40 mg	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily			40
50 mg	10 mg five times daily	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily		60
60 mg	10 mg six times daily	10 mg five times daily	10 mg four times daily	10 mg three times daily	5 mg four times daily	5 mg twice daily	84

Source: Adapted from: Tamboli M, et al. *Pain Med.* 2020;21(7):1474-1481.

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Be an Upstander, Not a Bystander

By Aasna Shaukat, MD, MPH

I am a female immigrant gastroenterologist from Pakistan, practicing in Minneapolis. Having lived in this country for 22 years and married to a white man, I generally feel that I fit in pretty well. A couple weeks ago at work, I walked into a procedure room and introduced myself to a 66-year-old white male on whom I was about to perform a procedure. There were three other people in the room—a nurse and two techs. I explained the procedure in my usual cheerful voice and asked, “Do you have any questions?” like I always do at the consent process.

The patient said, “Yes, I do. Where's your burqa?” I was quite taken aback and wondered if I misheard.

Me: “I'm sorry. What did you say?”

Patient: “I said, where's your burqa?”

Me, confused: “Sir, why would I have a burqa?”

Patient: “Don't women like you wear one to cover themselves?”

Me (more confused): “What do you mean women like me?”

Patient: “Well, aren't you from Pakistan or Afghanistan? Aren't you Muslim?” I was at a loss for words and desperately wanted to end the conversation.”

Me: “Let's not talk about me but about your procedure. Any questions about the procedure?”

The patient replied, “no,” and we went ahead with the procedure and the rest of the day.

The incident bothered me all day and the following many days. I couldn't quite put a finger on what it was and brushed it aside and stopped thinking about it. In the wake of recent events, it dawned upon me that it wasn't the patient's comments that bothered me. It was the fact that no one standing in the room witnessing the conversation stepped in. Not during the conversation, and not after. Considering I've worked with my colleagues every day and in the same place for the last 12 years, I felt strangely betrayed.

Stories like this happen every day and are sadly more common than we realize. There will always be racist, insensitive, inappropriate comments by people across life. It's how we react to them that will shape our lives. Most individuals have asked how they can help. Well, start by being an upstander and not a bystander. That will mean the world to us people of color and immigrants.

And let's start teaching and training students in medical school, nursing, and technical schools how to identify and stand up to inappropriate comments. It may take us a few generations to make seismic changes, but we must start now.

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Therapeutic Ultrasound for Chronic Neck & Low Back Pain



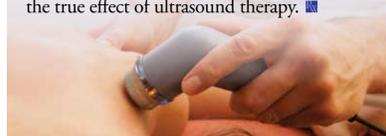
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A multimodal approach is most often necessary to adequately manage chronic nonspecific neck pain and low back pain (LBP). The treatment plan may include medications with differing sites of action, physiotherapy, psychosocial interventions, minimally invasive interventional techniques, and in some cases, surgery. Unfortunately, many of these options are not without risk. For instance, long-term use of NSAIDs is associated with cardiovascular, renal, and gastrointestinal adverse effects, and opioid analgesics come with the risk of tolerance, dependence, and addiction. Therapeutic ultrasound is a commonly utilized noninvasive modality that has shown effectiveness in the management of common musculoskeletal disorders, including myofascial pain syndrome, pelvic pain, and knee osteoarthritis. However, its effectiveness in LBP and neck pain has not been confirmed.

For a systematic review published in *Pain Medicine*, my colleagues and I sought to evaluate whether monotherapy with continuous ultrasound provides better pain control than standard therapy or no therapy in adults with chronic nonspecific neck pain and LBP. The therapeutic effects of ultrasound are mainly derived from thermal and nonthermal effects as mechanical ultrasound energy is absorbed by tissues, enhancing tissue healing and repair. We identified and reviewed 10 randomized control trials that evaluated therapeutic ultrasound in chronic LBP and neck pain.

The overall findings suggest that ultrasound is more effective than placebo. Three studies focusing on chronic neck pain found significant relief when ultrasound was combined with other treatments. However, only one study demonstrated that ultrasound was the cause of improvement. A significant benefit of ultrasound therapy is its excellent safety profile and ease of use, which is ideal given that many of the options in our current armamentarium are associated with side effect profiles that are often intolerable or preclude their use in patients with contraindications.

Due to a lack of well-designed trials, the effectiveness of therapeutic ultrasound was not determined and there is insufficient evidence to recommend its routine use in the treatment of these conditions. While reasonable evidence indicates that low-intensity ultrasound therapy in conjunction with exercise treatments may improve pain scores immediately after treatment for chronic LBP, evidence of long-term benefits is lacking. In both pain syndromes, blinded trials with adequate follow-up are needed to define the true effect of ultrasound therapy. ■



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