The need for better management of patient phone calls following a surgical procedure or visit has increased over the past few decades. This is a resource intensive issue for a busy practice and requires extra staffing or physician time that takes him or her away from other patients. Postoperative patients are commonly discharged from a facility much earlier than they were only a few years ago, which may create confusion with their understanding of the importance of postoperative care. Patients may not recall instructions on how to manage common problems such as pain or side effects due to medications, causing them to call later with questions. Educating patients and families prior to surgery may reduce the number of calls a physician receives, but even the most attentive patient will only recall a fraction of what they have been told prior to surgery. Following surgery, the amount of information retained decreases substantially. Take-home patient education materials may help, but they need to be concise and easy to understand.

For an orthopedic surgeon, pain-related questions are the primary reason for post-discharge patient calls. These types of calls can be managed by developing practice management tools that utilize office staff to proactively follow up with the patient, pre-setting answers to FAQs for the triage nurses who handle the calls initially, setting expectations before surgery, and using advanced methods of pain control that minimize breakthrough pain. The top five methods used in our practice to reduce postoperative phone calls are discussed below.

1. **Set patient expectations.**
Patient education is conducted preoperatively in our group. Educating my patients is very important for myself and our team. Patients are made aware of the surgery they are having and what it entails prior to the surgery date. Ensuring that there are no open questions on the day of surgery will decrease the anxiety level of the patient. Caregivers are asked to come to a preoperative visit as well so that after surgery they can focus on just getting the patient home rather than on all the fine details of the nerve block, cryotherapy, and prescriptions.

I make sure the patient has an appropriate expectation for pain levels. I explain that the initial bolus from the day of surgery will wear off around thirteen to eighteen hours. When this wears off, it is important that the patient knows that they may go from 0/10 pain to a 2-3/10 and that is acceptable. Setting the patient up with goals of 0/10 pain the whole time is an unrealistic expectation. Patients can better handle a small amount of pain when they are prepared for it ahead of time.

2. **Use peripheral nerve indwelling catheters instead of single shot nerve blocks.**
No one can predict an individual’s response to pain after surgery. Single shots can give patients the misleading idea that they will stay that numb and have no pain. In reality, single shots can last eight to twelve hours depending on the patient. The placement of indwelling peripheral nerve catheters using ultrasound has increased my patient satisfaction and overall pain scores. This is a very effective method for reducing acute post op pain. When we provide the patient with a peripheral nerve indwelling catheter, the patients are able to get through the first two days with very low pain scores. If we are able to achieve acceptable pain scores throughout the first three days, the patients are able to go home, start productive physical therapy, and have a successful start on the road to recovery. Patients are educated on how to titrate their own local anesthetic via an ambulatory infusion pump.
for breakthrough pain and sent home with detailed discharge instructions. In my experience, patients have a more successful outcome if you are able to decrease the amount of pain from day one.

### 3 Prescribe extended release narcotics early.

I use extended release narcotics early in the post-operative setting. Prescribing an extended release narcotic allows the patient to have an easier time when the single bolus from surgery wears off. For me, having the little bit of long acting narcotic taken early when the patient is not experiencing pain really helps with patient compliance. The long acting narcotic allows us to have pain control on board to allow the patients to have a smoother transition when the continuous local anesthetic infusion is finished. Patients are only given enough medication for the first ten days after surgery.

### 4 Consider cryotherapy as a way to reduce pain and narcotic use after surgery.

There are many ways to utilize cryotherapy, ranging from the big cooling machines to a bag of ice. If insurance does not cover the cooling unit, we suggest an ice bag used on a regular schedule with a focus on keeping the dressing dry. This is an extremely effective, cheap, easy modality which may help reduce patients’ overall pain.

### 5 Implement a follow-up call process

Our practice provides follow-up phone calls to the patients post-op day one. Patients are given a lot of information in the PACU and caregivers are not always able to remember everything at discharge. When the patients are educated and know that a nurse is going to call them the next day, they save their basic questions for that phone call rather than relying on the surgeon for every little question. These follow-up calls make patients feel like someone is with them all the way through the process.

In this day and age, patients are looking at ways to be more in charge of their health care. In our practice, we allow patients to actively participate in their pain management. We combine enhanced communication techniques and a multimodal approach to pain management including a patient titratable continuous infusion of local anesthetic. These provide the patient with options that have resulted in better patient outcomes, higher satisfaction, and fewer postoperative phone calls.

Ron Hollis, MD has a consulting/speaking/financial relationship with Avanos Medical, Inc.

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