Improving Patient Satisfaction With Pain Management
Anthony Pazanese, Pharm.D.
Clinical Pharmacy Specialist
Pain Management and Palliative Care
Lakeland Regional Medical Center
1324 Lakeland Hills Blvd
Lakeland, FL 33805
anthony.pazanese@lrmc.com

Objectives
• Upon completion of this activity, the participant should be able to:
  – Describe available tools for measuring patient satisfaction
  – Discuss the impact of poor pain control on overall patient satisfaction
  – Develop strategies for improving patient satisfaction with pain management

Disclosure
• I do not have a vested interest in or affiliation with any corporate organization offering financial support or grant monies for this continuing education activity, or any affiliation with an organization whose philosophy could potentially bias my presentation

What Is Pain
• An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
  – Always Subjective
  – May have pain with inability to verbally communicate pain

JCAHO Pain Management Standards
• 2001 – Pain Management named national patient safety initiative
• Individualized patient pain control plans
• Assessment and frequent reassessment
• Use of pharmacologic and non-pharmacologic strategies
• Establishments of formalized approach

Pain Assessment Tools
• Numeric Rating Scale/Visual Analog Scale
  – Utility in chronic pain
• Non-Verbal Assessments
• Questionnaires


Effects of Uncontrolled Pain


APS-POQ

• Slightly more extensive than HCAHPS
  – 12 Question form
• Asks many of the same questions related to pain control and communication
• Most questions answered on 11 point rating scale (0 – 10 or 0% to 100%)
• Not standardized, and no incentive for hospital use

### APS-POQ Questions
- Pain relief percent in the first 24 hours
- How often were you allowed to participate in decisions
- Overall patient satisfaction with pain treatment
- How helpful was information about treatment options (if received)
- Which non-medicine methods were used, and how often were they suggested (if used)

---

### HCAHPS
- The first national, standardized, publicly reported survey of patients’ perspectives of hospital care.
- Scores driven by patient satisfaction.
- 27-item survey instrument and data collection methodology

---

### History of HCAHPS
- 2002 – CMS partnership with Agency for Healthcare Research and Quality (AHRQ) to develop and test HCAHPS survey
- 2005 – Survey endorsed by National Quality Forum and was approved by the federal Office of Management and Budget
- 2006 – HCAHPS Survey Implemented
- 2008 – First public reporting of results

---

### Hospital Incentive
- 2006 – Fully voluntary
- 2007 – included in pay for reporting for IPPS hospitals
  - 2% of annual payment update at risk
- 2010 – included in hospital value based purchasing (VBP) pay for performance for IPPS hospitals beginning with discharges in Oct 12
  - Per Affordable Care Act

---

### Goals of HCAHPS
- Ability to perform meaningful comparisons among hospitals
- Increased hospital accounting and incentives for quality improvement
- Pay-for-performance (Hospital Value-Based Purchasing) for IPPS hospitals
- Enhanced public accountability

---

### HCAHPS Process
- Survey administered to random sample of adult inpatients
- 48 hours to six weeks following discharge
- May be performed by survey vendor or collected by the hospital
- Mail, telephone, mail with telephone follow-up, or active interactive voice recognition
- Goal at least 300 surveys per year
Eligible Patients

- At least 18 years old
- Medical, surgical, or maternity
- Overnight stay or longer
- Alive at discharge
- Excludes hospice or SNF discharge, prisoners, foreign addresses, and “no-publicity” patients
- Includes 80-85% of patients


HCAHPS Composites

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Discharge information
- Cleanliness and Quietness
- Overall rating


Pain Survey Questions

- During this hospital stay, did you need medicine for pain?
  - Yes or No
- During this hospital stay, how often was your pain well controlled?
  - Never, Sometimes, Usually, or Always
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
  - Never, Sometimes, Usually, or Always


HCAHPS Pain Management

- High correlation with communication
  - Patients more likely to report satisfaction with good communication despite uncontrolled pain
- Significant differences between states
  - Cultural differences?
- Modification of survey may help identify the reason for this
  - Acute, Chronic, or Acute on Chronic pain
  - Use of multimodal therapy
  - Inpatient Pain Service availability


How are we doing?

<table>
<thead>
<tr>
<th>State</th>
<th>Percent of patients with well controlled pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alabama</td>
<td>77.4 +/- 9.734</td>
</tr>
<tr>
<td>2. Louisiana</td>
<td>73.6 +/- 6.843</td>
</tr>
<tr>
<td>3. Oklahoma</td>
<td>71.9 +/- 8.634</td>
</tr>
<tr>
<td>4. Maine</td>
<td>72.2 +/- 3.974</td>
</tr>
<tr>
<td>5. New Hampshire</td>
<td>71.4 +/- 3.693</td>
</tr>
<tr>
<td>46. New York</td>
<td>65.0 +/- 5.747</td>
</tr>
<tr>
<td>47. Florida</td>
<td>62.2 +/- 6.983</td>
</tr>
<tr>
<td>48. District of Columbia</td>
<td>63.3 +/- 2.081</td>
</tr>
<tr>
<td>49. Nevada</td>
<td>59.1 +/- 7.394</td>
</tr>
<tr>
<td>50. Hawaii</td>
<td>58.4 +/- 9.193</td>
</tr>
</tbody>
</table>


Introducing DL

- DL is a 46 y/o WF, presenting with acute exacerbation of COPD with pleuritic chest pain. She was given 2mg IV hydromorphone in the ED with relief of her pain, and requests this on the medical floor as well. She has a history of frequent ED visits for chronic back pain, requesting IV hydromorphone.
• Other significant PMH includes chronic pain secondary to fibromyalgia, depression, HTN, dyslipidemia, Type 2 DM, and morbid obesity
• Allergies:
  – Ketorolac (GI Upset)
  – Triptans (Panic Attacks)
  – Morphine (Nausea/Vomiting)
  – Tramadol (Hallucinations)

• Current pertinent home medications:
  – Gabapentin 300mg TID
  – Alprazolam 1mg TID PRN anxiety
  – Carisoprodol 350mg TID
  – Oxycodone/APAP 10/325 q4h PRN pain
• UDS on Admission
  – Positive for Benzodiazepines, Barbiturates
  – Otherwise negative
• SH: Tobacco; 2 PPD x 34 years

Potential hospital stay
• DL perceived as a “drug-seeker”
• Decreased quality of care by nurses
• Lack of physician communication
• Patient dissatisfaction

Improving Patient Satisfaction
Removing Barriers to Effective Pain Management

Improving Satisfaction
• Inverse Relationship Between Pain and Satisfaction
• Patient Communication and Counseling
• Staff Education
• Efficiency of Administrative Processes

Patient Communication
• Eliminate barriers that may lead to uncontrolled pain
  – Reluctance to report pain
    • Cultural barriers
    • Sign of a more severe illness
  – Reluctance to take medications
    • Fear of addiction
    • Worry about side effects
    • Waiting until pain is more severe


Patient Communication
• Establish reasonable goals of care
  — Post surgical pain is expected
• Attitude that staff is doing everything possible to help with pain
• Counseling on medications
• Counseling on effects of pain

Physician Education
• Eliminate barriers that may lead to uncontrolled pain
  — Fear of “drug seekers”
  — Inappropriate order sets or orders
  — Use of IV opioids as a panacea
  — Lack of adjuvant therapy
• Encourage appropriate follow-up
  — Affected by insurance status
  — Social Worker involvement?

Nursing Education
• How to assess pain
• Fear of “drug seekers”
• Incorrect assumptions about medications
  — NSAIDs given concomitantly with opioids
• Patient interaction should reinforce staff “doing everything they can”
• Pain: the 5th vital sign
  — Quick assessments performed with vitals

Nursing Education
• Why are medications being refused
• Identifying when medications are not working
  — Call physician
  — Suggest other methods (i.e. PCA postop)
• When to call physician
• Medication availability on whiteboard

Process Efficiency
• Value of Six Sigma
  — Identifying root causes of “pain points”
  — Reduce performance variation
  — Increase stability of processes
• Value of Lean
  — Match process flow to demand
  — Remove waste from operation process
  — Eliminate unnecessary steps

DL’s Potential Hospital Stay
• DL perceived as a “drug-seeker”
• Decreased quality of care by nurses
• Lack of physician communication
• Patient dissatisfaction

How was DL’s Care Perceived?

- Requesting IV Hydromorphone
- Frequent ED visits
- History includes fibromyalgia
- Allergies to Tramadol, Ketorolac, Triptans, and Morphine
- Taking Alprazolam, Carisoprodol, Oxycodone
- UDS results negative for opiates, positive for barbiturates

Proper Transitions of Care

- Chronic pain medications adjusted
  - Gabapentin titrated and Duloxetine started
- Patient educated on acute pain
  - Educated on ketorolac ADRs, and started on this
  - Home opioids acutely increased to q4h PRN
- Referral to Rheumatologist for management of chronic pain
- Staff education on UDS results

Expected Outcomes

- Better inpatient and outpatient pain control
- Improved staff-patient communication
- Improved staff-staff relationships
- Decreased readmission rate
- Decrease in frequency of ED visits
- Increased patient satisfaction

Summary

- Patient satisfaction is not the only or best measure to determine a “good” hospital, but is the method most patients will use, along with word of mouth
- Pain management is a significant factor in overall patient satisfaction, and is highly correlated with staff communication with the patient
- Numerous opportunities for interventions exist, especially in these areas

Questions?

Anthony Pazanese, Pharm.D.
Clinical Pharmacy Specialist
Pain Management and Palliative Care
Lakeland Regional Medical Center
1324 Lakeland Hills Blvd
Lakeland, FL 33805
anthony.pazanese@lrmc.com