Pain and patient experience: A business partnership

Managing patients’ pain is no longer just a clinical goal—it’s a business necessity. The Centers for Medicare and Medicaid Services (CMS) has started incorporating value-based purchasing (VBP) scores, which include customer satisfaction, into hospital reimbursement payments.

Of the total VBP score, 30% comes from results from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which includes patient satisfaction questions related to pain management.

Surgical patients’ perceptions of pain control and the staff’s efforts to control pain do affect overall HCAHPS scores, a study in the American Journal of Quality confirms. According to the study, “The odds of a patient being satisfied were 4.86 times greater if pain was controlled and 9.92 times greater if the staff performance was appropriate.” In other words, how the staff reacted was even more important than if the pain was actually controlled.

The increasing attention on pain management highlights the deficiencies in acute surgical pain management and can lead to innovative approaches.

Challenges of pain management

“We are still not doing a good enough job of managing pain,” says Tong (T. J.) Gan, MD, MHS, FRCA, professor and vice chair of clinical research in the department of anesthesiology at Duke University Medical Center, Durham, North Carolina. Dr Gan also served on the American Society of Anesthesiologists (ASA) Task Force on Acute Pain Management when it updated its guidelines, “Practice Guidelines for Acute Pain Management in the Perioperative Setting,” in 2012.

Studies indicate how far clinicians need to go. A 1989 study found that half of patients said their pain was moderate, and 30% said it was severe or extreme—and a 2012 study found similar results.

“We [anesthesiologists] know what to do for pain management, but the implementation could be improved,” he says. Part of the difficulty is the lack of options for treating pain. “Opioids are still the gold standard,” he notes.

In many respects, opioids are “good drugs” because there is no ceiling effect, he notes. The downside is the side-effects ranging from mild (nausea, vomiting, constipation) to severe (respiratory depression and death). “You’re constantly balancing between managing side-effects and managing pain.”

Challenge of chronic pain

Another challenge is the number of patients with chronic pain, according to Barbara Godden, MHS, RN, CPAN, CAPA, clinical coordinator in the postanesthesia care unit (PACU) at Sky Ridge Medical Center, Lone Tree, Colorado. “An increasing number of patients routinely take drugs like Percocet, Oxycontin, and Vicodin at home; medical marijuana is legal in Colorado. It’s often hard to get the pain under control [in these patients].”

A third challenge is that “expectations are not realistic,” says Donna Curtis Kent, MS, RN, CNOR, an educator at AnMed Health, Anderson, South Carolina, which has 19 ORs. “Patients need to know they aren’t going to be pain free,” she says. It’s im-
important for the staff to work with patients to manage expectations, starting before surgery.

Setting expectations
These are strategies for managing patients’ pain control expectations that these experts recommend.

Patient assessment, teaching
In the preoperative setting, Godden says, nurses can assess patients for pain. They should ask about chronic pain and bring potential problems to the attention of the anesthesiologist.

“We do a tremendous amount of teaching,” she says. Nurses tell patients, ‘You aren’t going to be pain free, but we are going to get you to a level where you are comfortable.’”

Kent agrees patient teaching is crucial: “We are trying to set realistic expectations and pain goals with patients so they understand what controlled pain means—pain controlled well enough that they can function and participate in recovery. They need to know that nurses will try to control the pain.”

Establishing pain goals
Kent says the staff work with patients to establish pain goals. One of the most important is to ensure pain is sufficiently controlled so they can complete physical therapy and participate in recovery by, for example, using incentive spirometry.

Explaining pain options
Dr Gan recommends explaining pain control options to patients, including nonopioid medications, peripheral nerve blocks, and epidurals.

“That will increase their awareness so patients have fewer side-effects, resume food and liquids orally sooner, and recover faster.”

Using bedside handoffs
Another strategy Kent suggests is using bedside handoff reporting on surgical units. Both nurses are at the patient’s bedside for change of shift so they can engage the patient in a 3-way conversation on how effectively pain is being managed.

Nurses are encouraged to use sentences that reflect aspects of HCAHPS’s pain-related questions and address pain control goals. Examples:
• “We want to do everything in our ability to control your pain.”
• “What has worked to control your pain in the past?”
• “Make sure you call me if you need pain medication.”
• “What is the pain score that you can tolerate to participate in [a particular activity, such as walking in the hall]?”

Nurses need to explain that peripheral nerve blocks will wear off suddenly, Godden adds, so it’s important for patients to take pain medication ahead of that time. Postop calls also provide the opportunity to check on patients and encourage them to contact their physicians if pain control is not sufficient.

**Recommendations on multimodal therapy from the ASA guidelines**

The American Society of Anesthesiologists recommends that “whenever possible,” anesthesiologists should use multimodal pain management therapy. Other recommendations include:
• Central regional blockade with local anesthetics should be considered.
• Unless contraindicated, patients should receive an around-the-clock regimen of COX-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs), nonselective NSAIDs, or acetaminophen.
• Dosing regimens should be administered to optimize efficacy while minimizing the risk of adverse events.

The guidelines also state anesthesiologists should use options such as epidural or intrathecal opioids, systemic opioid patient-controlled anesthesia, and regional techniques based on risks and benefits for the patient, and that these modalities are preferred over intramuscular opioids ordered “as needed.”

Multimodal approach eases the pain of joint replacement

Greenwich Hospital, a 206-bed hospital in Greenwich, Connecticut, put a multimodal pain management approach in place for patients undergoing hip or knee joint replacement.

“Joint replacement surgeries have become the most common surgeries, and they are the most painful,” says anesthesiologist Mark Chrostowski, MD, who spearheaded the program, which significantly reduced opioid use and improved patient satisfaction. The program received the 2012 Connecticut Hospital Association’s John D. Thompson Award for Excellence in the Delivery of Healthcare Through the Use of Data.

Pain management approach
Pain management begins preoperatively when patients attend an education session about what they can expect before, during, and after surgery. Tori Kroll, RN, who coordinates the program, notifies the surgeon or Dr Chrostowski if a patient has chronic pain so the surgeon, anesthesiologist, and patient’s pain management physician can collaborate in establishing an effective pain control plan.

Before surgery, patients take nonopioid medications to control pain and inflammation. The anesthesiologist gives a local anesthetic via a nerve block to numb the surgical area; total knee patients receive a single injection, and total hip patients receive the anesthetic through a peripheral catheter placed under ultrasound visualization. Injections are given in a dedicated procedure area near the OR.

After surgery, patients continue the nonopioid medication and, if a peripheral catheter was placed to give the local anesthetic, it is connected to a patient-controlled analgesia (PCA) pump.

Kroll visits patients twice daily in the hospital to assess their progress, including how well pain is controlled, and follows up several months after surgery.

Medication protocol
Dr Chrostowski developed this protocol, but he says specific medications may vary, and it’s important to use other tactics such as patient education. Physicians can simply choose an order set to order the protocol.

Preoperative medications
- Acetaminophen 975 mg by mouth (PO) once
- Celecoxib 200 mg PO once
- Gabapentin 900 mg PO once
- Local anesthetic through a peripheral nerve block injection or a catheter.

Intraoperative medication
- Decadron 4 mg IV (as requested by certain surgeons).

Postoperative medications
- Acetaminophen 975 mg PO 3 times daily
- Celecoxib 200 mg PO 2 times daily
- Opioid pain medications as needed.

The bottom line
Analysis of 1-year data for 424 patients showed that those who received the protocol:
- used an average of 40% less opioids during the hospital stay
- decreased use of PCA by 47%.

In fact, many surgeons have stopped ordering PCA pumps because patients haven’t needed them. Other advantages included fewer side-effects from opioids and better adherence to physical therapy.

With the program, Dr Chrostowski says, “We have noticed a marked improvement in patient satisfaction.” Compared to 854 other hospitals, Greenwich Hospital is in the 95th percentile of patient satisfaction, according to Press Ganey data.

Creating a successful program
Dr Chrostowski says that to increase the likelihood of success, it’s important to take time to plan and launch the program. Kroll and Dr Chrostowski spent 6 months reviewing the evidence, developing the protocol, and talking to every anesthesiologist and surgeon who performs total joint procedures. Implementing the protocol took 2 to 3 months. They also educated nurses and physical therapists. Thereafter, the protocol was fine-tuned every month based on observations and feedback from nurses and physicians.

Dr Chrostowski cites data collection as another reason for the program’s success. “We started to see how well patients were doing and shared that with the surgeons. The data really helped us get everyone onboard.”

A change in mindset has also given the program a boost.

“Instead of just reacting to pain, we’re being proactive, treating pain before it starts,” he says.
Setting expectations for staff
OR staff “think they don’t have something to contribute to pain management, but they really do,” says Godden. She is working with nurses from the OR and PACU to improve hand-off communication, including how the patient was positioned, whether a local anesthetic was given, and whether the patient has chronic pain.

Kent recommends that nurses tap into others’ expertise by calling for a pain consultation for general advice or advocating that the physician order a pain consultation for patients with special needs such as chronic pain.

Godden, who is also the editor of ASPAN Breathline and immediate past director for clinical practice at the American Society of PeriAnesthesia Nurses (ASPAN), says the association’s clinical practice guidelines for postoperative pain management are being revised. She is working on competencies related to multimodal pain management.

Expanding the options
A multimodal approach, recommended in the ASA guidelines, involves using multiple options to control pain (sidebar). These range from medications given by various routes, including epidural or peripheral nerve blocks, to holistic interventions such as preoperative massages or local application of ice to the postoperative site.

Dr Gan says the multimodal approach uses “a number of different pain medications working by different mechanisms to increase the efficacy of each drug while reducing the side effects of medication.” Using drugs from 2 or more classes leads to lower doses and fewer side-effects compared to using each drug separately.

The multimodal approach can reduce the use of opioids by as much as 40%, he notes.

Part of a multimodal approach is preemptive pain medicine. For example, says Kent, patients having total knee replacement “receive an opioid, NSAID, gabapentin, and acetaminophen plus a nerve block prior to surgery, so that pain is not so severe after surgery.”

Perioperative pain management
The ASA guidelines recommend options such as epidural or intrathecal opioids, systemic opioid patient-controlled analgesia, and regional techniques based on risks and benefits for patients.

Though peripheral nerve and epidural blocks have their place, Dr Gan says, “one has to consider the patient’s wishes; they often don’t want an additional needle.” Many procedures on the limbs and shoulders are amenable to a peripheral nerve block, he notes. Long-acting local anesthetics and paravertebral and transversus abdominis plane blocks are being used for patients having abdominal procedures.

Regional anesthesia is growing in popularity, Kent notes. Some patients are discharged with pain pumps in place for 1 to 2 days. Other innovations are intrathecal and epidural preservative-free morphine.

Better pain control needed
More education, better pain control options, and “the need to focus on doing a better job” are the factors contributing to more effective pain management, Dr Gan says.

• Anesthesiologists should become more involved in postop pain management.
• Better pain control options include more use of nonopioid medications and taking an opioid-sparing and, whenever possible, opioid-free approach.

“We are still not there. There are a lot of things we can do to improve,” he says. ♦

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.
References
