Improving HCAHPS Pain Scores

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Objectives

Technicians
• Discuss payer for performance strategies
• Describe drugs used to treat pain
• Identify side effects of drugs used to treat pain

Pharmacists
• Describe drug therapy interventions to improve HCAHPS pain scores
• Identify key components to a thorough pain assessment
• Develop strategies to prevent side effects of pain meds and reduce LOS

Payer for Performance

• Established by National Quality Forum (NQF)
• Attempt to standardize quality measures/reporting
• Measure patients’ perspective
• Allow for public reporting
• Enhance public accountability

Patient Experience of Care

• Hospital Consumer Assessment of Healthcare Providers and Suppliers (HCAHPS)

• Consistency Score
  — Compares patient experience of care rate to that of all hospitals

• HCAHPS score + HCAHPS consistency score = Patient experience of care score

Incentive Payment OCT 2012

Funded from 1.5% of Diagnosis-Related Group payment

FY 2013: 1% withheld
FY 2015: 1.5% withheld
FY 2016: 1.75% FY
FY 2017 and thereafter: 2% withheld

May receive net increase or decrease in Medicare payment
Will depend on total performance score

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.
Hospital Value-Bases Purchasing Program

- Clinical Process of Care – 20%
- **Patient Experience of Care – 30%**
- Outcome – 30%
- Efficiency – 20%

Patient Experience of Care

- Nurse Communication
- Doctor Communication
- Hospital Staff Responsiveness
- **Pain Management**
- Medicine Communication
- Hospital Cleanliness and Quietness
- Discharge Information
- Overall Hospital Rating

HCAHPS Pain Scores

Pain Questions (2)
- Did everything help my pain
- My pain was well controlled

3 scores are generated
- Overall pain score
- Did everything to help my pain
- My pain was well controlled

Pharmacist Therapy Management

<table>
<thead>
<tr>
<th>% Hospitals Where Pharmacists Manage Specific Therapy</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Anticoagulation</td>
<td>69.2</td>
</tr>
<tr>
<td>Pain Management</td>
<td>11.6</td>
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<tr>
<td>Nutrition</td>
<td>43.2</td>
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<tr>
<td>Renally Dosed Antibiotics</td>
<td>79.7</td>
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<tr>
<td>Aminoglycosides</td>
<td>80</td>
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<tr>
<td>Vancomycin</td>
<td>89.4</td>
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<tr>
<td>Antibiotic Selection</td>
<td>21</td>
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</tbody>
</table>

N=413 hospitals (2013)

Role of the Pharmacist

Personal experience
Medication Therapy
- Protocols
- Eforcs®

Began reading and attending pain conferences
Experts in drug therapy monitoring
- Began seeing post NS/orthopedic patients
- Joined the health system Pain Team: educate
New Pain Service

Weaver 9

Neurosurgical Patients
- Multi-level fusions
- Hardware to bone
- Acute on chronic pain
Neurosurgery Scores
Sept 2013-August 2014

W9 - Pain Management

W9 - Pain Well Controlled

W9 - Staff Does Everything to Help With Pain

Patient Assessment is Critical
Case

66 YOF s/p spine surgery
Recommend and implement multimodal PO plan
Patient didn’t buy in
Refused the plan
Discussed plan with patient
Based on prior experiences she received IV opiates x 72 hours and didn’t want PO meds

Case

Patient hospitalized for non pain issue
Suffers from headaches routinely
Develops headache while in hospital hospital
Headache for 2 days
Seen by neurologists, IM
Pharmacist consulted
What do you want for your headache?
Ibuprofen, caffeine, lidocaine pach, feverfew
Takes these at home / they work

Case post op withdrawal

• 38 YOM s/p spine surgery
• Opiate use on med reconciliation form reported as: Percocet "prn" pain***
  – Ignored true baseline opiate use
  – Used our protocol:
    • Percocet 5 q 4 hours prn pain
    • May repeat x 1 tab in 1 hour if pain unrelieved
• Patient in 10/10 pain, thrashing, crying
• BP 180/120   HR 120 bpm
• Rx plan post op ?

Patient History

Patient smokes 1 PPD: Consider nicotine replacement unless Ci
Patient drinks 8 beers/day: ETOH w/d protocol
Patient smokes marijuana, cocaine, heroin* etc*
Good luck 😊
Patient takes SSRI/drugs associated with w/d at home: resume
Patient takes tramadol at home: We reduce dose by 50%
Patient drinks caffeine: reduce dose and taper

Case

• 62 YOM severe pain 10/10
• POD 4 spine surgery
• What do I need to know to manage his pain?
  – What hurts?
  – Large toe “I’m having a gout flare”
• Does this patient require opiates?

Case

• 82 YOF s/p complicated spine surgery
  – Dementia and communication issues
• Admitted to ICU
• POD 12 and c/o severe pain
• What do I need to know to assess pain?
• What hurts?
  – Chronic arthritis exacerbated by laying in bed
    • Received acetaminophen
    • Good pain control
Quantitative Assessment

Quantitative (Severity)
Cognitively Intact Communicative patient
1-10 pain scale score
Non Cognitively Intact
Wong Baker Faces Scale

FLACC score/Pain AD scale

Incorrect Assessment Tools

• 75 YOM spine surgery patient
• 12 hours surgery / anesthesia
• Post op non-communicate delirium patient
• RN asks patient “do you hurt”
  – Patient says NO or doesn’t answer
  – No pain medication x 6 hours post op
• New onset atrial fib with RVR
• Transferred to N-ICU
• Receives no pain medication

Pharmacy Consult

• CAM ICU +
• Unable to interact with environment
• Optimize environment
• Dexmetomidine gtt
• IM Olanzepine
• Fentanyl gtt
• IV Methocarbamol
• NO benzos
• NSAID

Objective Symptoms of Pain

Objective SIGNS May or May NOT be present
Tachycardia*
Blood Pressure*
Respiratory Rate*

PAD guidelines state do NOT use these parameters in delirium patient
We find value in the addicted patient not taking heart rate drugs

Case

• Delirium x 10 days
• 6 months later
  – Exhibits some degree of cognitive impairment at times
  – No recollection of time in hospital

Take Home Message

Pain Assessment Tool MUST be appropriate to patient*
Consider:
  Is this patient a good historian?
  Should this patient be having pain?
  12 hour surgery with hardware
  7 level surgical site
Qualitative Assessment
Baseline opiate use (EFORSCE)
Description, Location
Effective treatment modalities by history
Evaluation of substance withdrawal
Goal Setting

Anatomical Considerations

The Normal Pain Processing Pathway

Multi-Modal Pain Management
Rationale Polypharmacy

THERAPEUTIC OPTIONS
Neuropathic: Peripheral Central
Mix Pain: Neuropathic and nociceptive elements
Nociceptive: Visceral
- TCAs/SNRI
- Anticonvulsants
- Tramadol
- Opioids***
- Topicals
- Anticonvulsants
- Tramadol
- Opioids
- NSAID's
- Acetaminophen
- Tramadol
- Opioids
- Muscle relaxers/
Anti-spasmodics

Codd GE, Montoro FP, Molina L, Rogers KE, Stone Dj, Tallarida RJ. Pain 2006;114(3):234-64

Neuro-chemical Basis for Surgical Pain

Cell damage → PGs/Bradykinin → Peptide release → substance P → Vasodilation → Neurogenic edema → Histamine release → Serotonin release* → Nor-epinephrine → GABA

Cold for Acute Injury

- Including surgical sites

Opie Pain Plan

Patient verbalizes 10/10
Hydromorphone* 0.5mg IV x 1
hydromorphone/APAP 7.5 mg q 4 h prn
moderate/severe pain first dose NOW
May repeat in 30 minutes and increase to 2 tablets thereafter
Methocarbamol 750 mg po q 4 hours
Pregabalin 75 mg po bid
Celecoxib 400 mg po x 1 now then bid x 5 days

Application

- The role of IV opiates should be reserved for patients
  - Who cannot tolerate PO
  - Patients with severe pain
    - Who require quick relief (15 minutes or less)
- ORAL opiates should be used for ALL other patients

Predicting and Preventing Side Effects
Side Effects

- **Itching**: Cetirizine daily prn
- **Nausea/Vomiting**: Zofran first, Promethazine, Scopolamine patch**
- **Hypotension**: Fluid bolus*, Ephedrine IM*
- **Respiratory Depression**: Senna/Docusate routine, Miralax routine, Methylnatrexone SC PO day 2 if no prior BM

Our Practice PO Patients

If the gut works USE it: Optimize PO pain plan

**Lower IV doses**: Hydromorphone 0.5 mg IV q 2 h prn breakthrough pain unrelieved by PO medication AND PCA  
OR B-10/10 pain overlapped with PO

Use PCAs WITHOUT basal along with PO opiates  
0.2 mg Hydromorphone PCA q 6 minutes on demand only

Multimodal drug therapy  
IF patient becomes NPO scrap plan and use PCA  
With basal UNLESS OSA etc

Our Practice if NPO

- Use PCA  
- Opiate tolerant  
  use basal rate  
- Opiate naïve/OSA*  
  capnography  
  No basal rate  
- Treat cause of the NPO  
- N&V  
- Procedure: NPO except meds

**STOP-BANG Questionnaire**

1. **Snoring**: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?  
   Yes No
2. **Tired**: Do you often feel tired, fatigued, or sleepy during daytime?  
   Yes No
3. **Obstructed**: Has anyone observed you stop breathing during your sleep?  
   Yes No
4. **Blood pressure**: Are you now being or have you been treated for high blood pressure?  
   Yes No
5. **BMI**:  
   BMI more than 35 kg/m²?  
   Yes No
6. **Age**:  
   Age over 60 years old?  
   Yes No
7. **Neck circumference**:  
   Neck circumference greater than 40 cm?  
   Yes No
8. **Gender**:  
   Gender male?  
   Yes No

- Identify patients who are at RISK for respiratory depression and take precautions  
  Capnography  
  No long acting

Heavy multimodal with nvs known  
NOT to cause resp depression  
Limit combos know to cause resp dep.

Pharmacologic Dosing Curves After a Single Opioid Dose

The Peaks associated with IV opiates can cause respiratory depression and euphoria

Lower peaks with oral provide less side effects and less euphoria

IV bolus duration of action

**Interruption bolus vs. PCA**  
**Opioid tolerant**
Self-Assessment Question
The benefit of oral pain medications over IV pain medications is:

a) 30 minute onset of activity
b) Longer duration of effect
c) Equivalent doses of po yield equal efficacy
d) ALL of the above

d) ALL of the above

Long Acting Opiates
Avoid long term in opiate naïve patients
May be useful short term (1-4 doses)
Avoid in OSA patients/underdiagnosed OSA patients
Useful in opiate tolerant patients with short acting breakthrough medication

Long Acting Opiates

Medication Equivalent Dosing

Hydromorphone IV 2 mg
Hydromorphone PO 6 mg
Oxycodone/APAP* 30 mg
Hydrocodone/APAP* 30 mg
Lortab, Norco, Vicodin
Morphine PO 30 mg

Medication Equivalent Dosing

www.duragesic.com PI (use available tools)
Barriers to Pharmacist Pain Interventions

Pharmacist Barriers

Workload*

Assessment
Lack of understanding of anatomy
Lack of training*
Inappropriate assessment**

Patient factors
pain is subjective, addiction is rampant
patient fear/bias***
Undiagnosed OSA

Order Entry

• Are opiates optimized
  – Oxycodone 3 hour drug
  – Oxycodone with APAP 4 hour drug
  – Hydrocodone 4 hour drug
• Is itching a documented side effect of opiates
• Is the patient receiving bowel regimen
• Is the patient having N&V
• Is patient receiving morphine with poor renal function

Thank You!

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