Best Practices for Pain Management and Prevention of Re-admissions

Angela Trahan, Mennonite Home
Kris J. Modl, Dove Healthcare
Jordan Emley, Grandview Heights Rehab and Healthcare

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To Reduce Resident's Pain Using Non-Medicine Treatments

Angela Trahan, RN
Director of Nursing Services
Mennonite Village
Albany, Oregon

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About Us

- Mennonite Village is a not-for-profit, Continuing Care Retirement Community in Albany, Oregon.
- Mennonite Village began as a 24-room nursing home in 1947.
- Mennonite Home is a skilled nursing facility (SNF)/intermediate care facility (ICF) combined facility with a general census of approximately 75.

MENNONITE VILLAGE

Problem

We were not scoring as well as we would have liked to in our quality measures for pain.

PIP Team Members

- Tanya Boyd, RCM
- Lacy King, RCM
- Barb Jones, CMA
- Sage Forson, CNA
- Casey Tessen, LPN

Goals

1. Improve quality measures
2. Reduce resident opioid use
3. To reduce resident pain

- Additionally, using an interdisciplinary team (IDT) approach, it aimed to help improve residents that suffer from pain that is chronic in nature and difficult to control.

Intervention

- Conducted **routine IDT meetings** to formulate project, develop interventions, and continue to adjust as needed
- Identified **barriers** to pain reduction
- Modified current pain **assessment tools**
- Discussed **case studies** on residents suffering from chronic pain or pain difficult to control
- Developed **non-pharmacologic pain program** that included a variety of pain interventions that **can be offered by CNAs and CMAs**
- **Monitoring** of non-pharmacologic pain intervention effectiveness on the treatment record

Pilot

- We started with residents on our short term rehab unit.
- After evaluating, transitioned to the other units.

Measures/Indicators

- Pain scores are being monitored through MDS, Section J to evaluate pain scores as reported by resident.
- 20 rehab residents were tracked using the MDS to determine if non medicine interventions were successful in reducing pain.
- Tracking began in March 2017 and ended in June 2017.
- 15 of the 20 residents had a decrease in pain reflected on the MDS.

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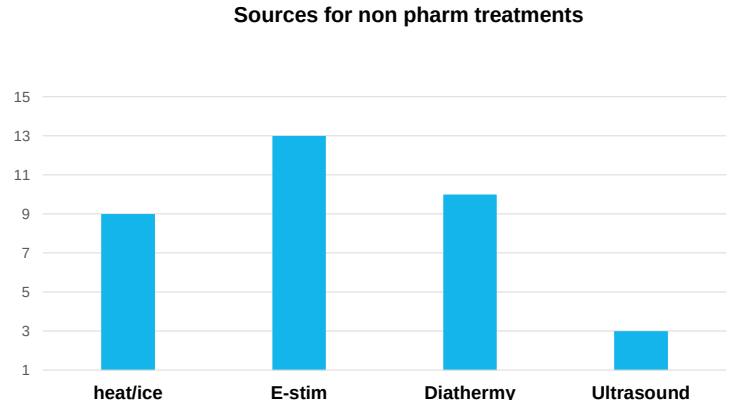
Measures/Indicators

Primary sources were therapy modalities and ice and heat packs.



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Results

- In February our quality measure (QM) for pain was 26.9 percent and the national was 15.8 percent
- In July our QM reduced to 20.4 percent and the national was 14.6 percent.

Lessons Learned

- Underutilizing non-pharmacologic pain interventions already available
  —included therapy modalities
- Underutilizing available staff
  —We now use CNAs and CMAs to assist with non-pharmacological pain interventions.

Next Steps

- Continuing monthly IDT meetings with case studies to further identify residents that could benefit.
- Transition to our long term care units.
- Continue to explore alternative pain interventions.

Resources

- Keilman, Linda (2015). Compendium of Evidence-Based Nonpharmacologic Interventions for Pain in Older Adults. Copyright 2015 by LJ Keilman, East Lansing: Michigan State University, College of Nursing
- Yurdanur Demir (2012). Non-Pharmacological Therapies in Pain Management, Pain Management - CurrentIssues and Opinions, Dr. Gabor Racz (Ed.), ISBN: 978-953-307-813-7, InTech, Available from: http://www.intechopen.com/books/pain-management-current-issues-and-opinions/non-pharmacologicaltherapies-in-pain-management

Contact Information

- Tanya Boyd, RCM
  tanyab@mennonitevillage.org
- Lacy King, RCM
  lacyk@mennonitevillage.org
- Angela Trahan, DNS
  angelat@mennonitevillage.org

Hospital Readmission Prevention – Chippewa Valley Continuum of Care Coalition

Kris J. Modl, ACBSW
Director of Social Services/Admissions
Dove Healthcare
South and West Eau Claire, Wisconsin

About Us

- The Chippewa Valley Continuum of Care Coalition formed out of a strategic planning process in 2010
- The coalition was initially comprised of two hospitals, five SNFs and a Family Care Organization

Dove Healthcare

Chippewa Valley Continuum of Care Coalition

About Us

- Our focus was to improve the continuum of care process as patients transitioned from the acute care setting to SNF in a time sensitive manner

About Us

The initial plan was to:

- Develop strategies to minimize the number of transitions and to ensure that all transitions were seamless
- Improve the well-being of our community by a collaborative process that promotes optimal patient care and services

About Us

- Today our coalition has grown to include three hospitals, hospice and home care agencies, medical clinics, Family Care, community based residential facilities (CBRFs) and multiple SNF's

About Us

With a purpose:

- To build and sustain a community coalition with a focus on improving transitions of care
- To encourage person-centered and person-directed models of care
- To collaborate and encourage efforts of organizations with shared visions
- To advance policies that further that vision
- To reduce the number of re-hospitalization/ patient care transitions

Coalition Participation

- Participation in the Chippewa Valley Continuation of Care Coalition (CVCCC) is open to organizations and individuals interested in fostering the vision by actively engaging in the planning and work of the Coalition

Coalition Participation

Charter members join in a commitment to:

- Share best practices and knowledge related to care transitions
- Mentor partners and providers
- Share data and support analyses related to care transitions
- Promote implementation of evidence-based interventions

Identified Gaps

Some of our initial work identified gaps that impact transitioning patients between levels of care.

Examples include:

- Patients being discharged to the SNF with higher acuity needs – care needs that not all SNFs are prepared to meet
- Regulatory differences between acute care and SNF care i.e. use of restraints and medications to manage patient behaviors in acute setting but not allowed in SNF resulting in an incomplete picture of patients current state for the SNF

Identified Gaps

- Root cause analysis of patients that are experiencing number of transitions – what pieces are missing?
  - Patients with behavioral health issues are the most difficult to transition
- Inconsistent, incomplete information shared by the acute care facilities, impacting the ability of the receiving facility to make a timely decision

Identified Gaps

- Lack of education earlier education of patients and families on long term care planning

Improvement Processes

Performance Improvement Opportunities included:

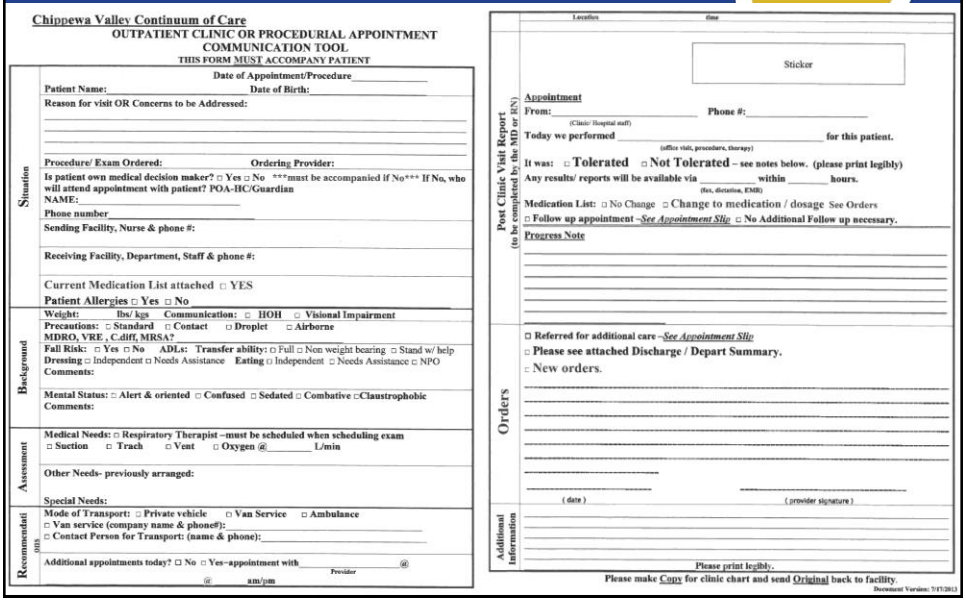
- Standardized acute care referral summary information
- Standardized acute care discharge information
- Standardized physician's plan of care (PPOC) information
  - i.e. MD signed, free of communicable disease statement, etc.
- Timelier receipt of Discharge Summaries
- Accompaniment to appointments, tests, etc.

Improvement Processes

Performance Improvement Opportunities include:

- Transfer / Communication tool from
  SNF ⇄ Clinic
- Facility capabilities
- RN to RN handover

Communication Tool



Chippewa Valley Continuum of Care
OUTPATIENT CLINIC OR PROCEDURIAL APPOINTMENT COMMUNICATION TOOL
THIS FORM MUST ACCOMPANY PATIENT

Situation
Date of Appointment/Procedure_____
Patient Name:_____ Date of Birth:_____
Reason for visit OR Concerns to be Addressed:
Procedure/ Exam Ordered: Ordering Provider:
Is patient own medical decision maker? □ Yes □ No ***must be accompanied if No*** If No, who will attend appointment with patient? POA-HC/Guardian
NAME:
Phone number
Sending Facility, Nurse & phone #:
Receiving Facility, Department, Staff & phone #:
Current Medication List attached □ YES
Patient Allergies □ Yes □ No

Background
Weight: lbs/ kgs Communication: □ HOH □ Visional Impairment
Precautions: □ Standard □ Contact □ Droplet □ Airborne
MDRO, VRE , C.diff, MRSA?
Fall Risk: □ Yes □ No ADLs: Transfer ability: □ Full □ Non weight bearing □ Stand w/ help
Dressing □ Independent □ Needs Assistance Eating □ Independent □ Needs Assistance □ NPO
Comments:
Mental Status: □ Alert & oriented □ Confused □ Sedated □ Combative □Claustrophobic
Comments:

Assessment
Medical Needs: □ Respiratory Therapist –must be scheduled when scheduling exam
□ Suction □ Trach □ Vent □ Oxygen @_____ L/min
Other Needs- previously arranged:
Special Needs:

Recommendation
Mode of Transport: □ Private vehicle □ Van Service □ Ambulance
□ Van service (company name & phone#):
□ Contact Person for Transport: (name & phone):
Additional appointments today? □ No □ Yes–appointment with_____ Provider @_____ am/pm

Post Clinic Visit Report (to be completed by the MD or RN)
Location time
Sticker
Appointment
From:_____ Phone #:_____ (Clinic/ Hospital staff)
Today we performed _____ for this patient. (office visit, procedure, therapy)
It was: □ Tolerated □ Not Tolerated – see notes below. (please print legibly)
Any results/ reports will be available via _____ within _____ hours. (fax, dictation, EMR)
Medication List: □ No Change □ Change to medication / dosage See Orders
□ Follow up appointment –*See Appointment Slip* □ No Additional Follow up necessary.
Progress Note

Orders
□ Referred for additional care –*See Appointment Slip*
□ Please see attached Discharge / Depart Summary.
□ New orders.
(date) (provider signature)

Additional Information
Please print legibly.
Please make Copy for clinic chart and send Original back to facility.
Document Version: 7/17/2013

EHR Paper Communication Form Example

RN to RN HANDOFF	SITUATION and BACKGROUND	ASSESSMENT	ASSESSMENT
Name of Hospital:	Hospital Admission Date:	Hospital Code Status:	Weakness:
Lakeview Hospital Rice Lake	Admitting Diagnosis:	NO CODE	Yes
MCHS- Bloomer	Health History (Secondary Dx):	FULL CODE	No
MCHS-Eau Claire	Procedures/Tests in Hospital:	Allergies:	Neglect:
MCHS-Methodist Rochester, MN		Neuro:	Yes
MCHS-Osseo		A & O x 3	No
MCHS-St. Mary's Rochester, MN		A & O x 2	
Oakleaf Surgical Hospital		A & O x 1	
Sacred Heart Hospital		Sleepy, arousable	
St. Joseph's-Chippewa Falls		Pupils:	
Other:		Equal	
Hospital RN:		Round	
Phone # of Reporting RN:		Reactive to Light	
goto Resp Therapy			

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EHR Paper Communication Form Example

CARDIAC	CARDIAC		PAIN	RESPIRATORY	RESPIRATORY	
Cardiac:	**Pedal Pulses:**		**Pain:**	**Respirations:**	**Lung Sounds:**	
Apical	Positive	Right	None	Non-Labored	Left	Clear
Radial	Negative	Left	Level of Pain on 0-10 Scale	Labored	Right	Abnormal
Regular		Bilateral	Location of Pain:	Irregular	All Lobes	Congested
Irregular	**Vitals:**		Name of Pain Med(s):	Wheezing	Bilateral	Crackles
Regularly Irregular	Temperature:		Time Last Pain Med Given:	**Cough:**	Upper	T/O
Pacemaker:	Pulse:		Next Pain Med Due:	None	Lower	SOB
Yes	Blood Pressure:			Productive	Other	
No				Non-Productive	**Treatment:**	
Edema:				Dry	None	
Yes				Other	Nebulizer	Bipap / Cpap
No				**Sputum:**	Inhaler	Compliant
				Yes	Oxygen	Non-Compliant
				No	Oxygen Saturations	

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EHR Paper Communication Form Example

GI		GI	GI	GI	GU	GU
Diet:		**Appetite:**	**Abdominal C/O's:**	**Last Bowel Movement:**	**Bladder Function:**	**Catheter:**
Fluid Restrictions:		Poor	None	**Bowel Function:**	Continent / Independent	None / Date D/C'd at Hospital
Yes		Fair	Nausea	Continent / Independent	Continent / with Assistance	Chronic
No		Good	Vomiting	Continent / with Assistance	Incontinent at Times	Catheter on Admission
Dentition:		Excellent	Diarrhea	Incontinent at Times	Incontinent	Foley Size
Dentures:	Upper	**Swallowing Difficulties:**	Gas / Bloating	Incontinent	**Appliances:**	Suprapubic Catheter
Partials:	Lower	Yes	Other	**Bowel Sounds:**	Pads	Date Catheter Last Changed
Own Teeth		No	**Ostomy:**	Present	Toilet	
			Ileostomy	All Quadrants	Commode	
			Colostomy	Hyperactive	Urinal	
			Stoma Location	Hypoactive	Bedpan	
			Peristomal Skin Condition	Passing Gas	Urostomy:	

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EHR Paper Communication Form Example

SKIN	ACTIVITY	RECOMMENDATION	RECOMMENDATION	RECOMMENDATION	COMMENTS
Skin Open Areas:	Transfers:	Isolation Precautions:	Coumadin:	Antibiotics:	Comments / Notes:
None	Independent	Yes	N/A	Yes	Other Restrictions:
	1-Assist	No	Last INR:	No	
Location #1	2-Assist	Blood Sugars:	Dose:	Dx for AB Use:	
Treatment	EZ Stand	N/A	Who Manages:	Free text	
	Mech Lift	Range or Last Reading:	INR Due Date:	Infusion Access:	
Location #2	Slide Board	Frequency of Monitoring:		IV	
Treatment	NA / Bedridden	Time Insulin Last Dosed:		PICC	
	Restrictions:	Type of Insulin:		CVC	
Location #3	Safety:	Pending Labs / Cultures:		Port	
Treatment	Fall Risk	Yes		Readmit Risk in Next 30 Days:	Ask RN about readmit risk
	Impulsive	No		Yes	
Add'l Skin Concerns:	Other:			No	
Free text					

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Coalition Subcommittees

Subcommittee Development

1. Provider and Community Education
2. Transitions of Care
3. Transportation

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Coalition Subcommittees

1. Provider and Community Education

- Identify knowledge gaps within our community related to the types of care transitions along with opportunities to improve communication and quality of care with those transitions
- Provide education to healthcare providers as well as the community at large regarding healthcare resources and support along the continuum of care

Coalition Subcommittees

2. Transitions of Care

- Monitors the transitions of care both from the hospital to the next level of care and vice versa
- Focus is on improving the continuum of care process as patients transitioned

Coalition Subcommittees

3. Transportation

- To compile transportation resources in one place so are accessible to all organizations in need
- Collaboration at the local and State level to ensure transportation services are available no matter the payer source or need

Next Steps

- Sponsoring a medical provider event to educate providers on current community data related to healthcare resource utilization, how to identify and treat our community based on patient centered goals of care from medical through end of life care, along with current resources in our community to support those patient goals of care.
- Sponsoring a community event to educate on need for Advance Directives and having goals of care discussions.

Next Steps

- Implementing multi-directional flow of information
  - i.e. to/from Hospital, SNF, Clinic, Home Care, etc.
- Educating receivers of this information as to what to do with it
  - i.e. medication reconciliation, etc.

Next Steps

- Ongoing collaboration with MetaStar – to reduce all cause admission and readmission rates

Contact Information

Kris J. Modl

Co-Chair CVCCC Transitions Subcommittee

kmodl@dovehealthcare.com

Performance Improvement Project on Pain Management

Jordan Emley, RN
Director of Nursing
Grandview Heights Rehab and Healthcare
Marshalltown, Iowa

About Us

- Grandview Heights Rehab and Healthcare is a family owned and operated facility
- Started in 1975
- 109 Dually Certified beds
- Average Daily Census is 95
- We pride ourselves on bringing people in from the community, providing skilled rehab, and returning them to their homes

Grandview Heights
Rehab and Healthcare

Problem

Our pain score for long stay residents reporting moderate to severe pain was well above both state and national averages

PIP Team Members

- Jordan Emley, RN/DON
- Carol Hazen, LPN/MDS Nurse
- Tammy Veldhouse, RN/QA Nurse
- Sue Tharp, Director of Rehab
- Kayla Perry, CNA
- Heather Melendrez, CNA
- Kelli Walsh, RN

Aim

To reduce the percentage of long stay residents reporting moderate to severe pain.

Intervention

- Pain assessment done two weeks prior to assessment period
- Different modalities to alleviate pain
- Education provided to residents regarding the comparative pain scale
- CNA education regarding pain assessment in residents with dementia

Measures/Indicators

- We primarily use our CASPER Report to collect and analyze our data regarding pain.
- When we began:
  - Our state percentage was 6.7 percent
  - Our national percentage was 5.6 percent
  - Our facility percentage was 12.2 percent
- Latest numbers show:
  - State: 7.6 percent
  - National: 6.3 percent
  - Facility: 3.7 percent

Results

- The results were quick and much better than what we had expected. Our goal was to decrease our percentage from 12.2 percent to 8.0 percent.
- After initiating our program, our number dropped to 5.3 percent and has continued to hover right around the 3.7 percent mark.

Lessons Learned

One key lesson we learned was that people do not accurately report their level of pain. As nurses, we learn that pain is what the person tells us it is, but we all have experience with people who present in a manner contrary to the number they're reporting. Education was key and that's where the comparative pain scale came in to play. After we would provide the description that correlated with the number the resident gave us, they typically changed their rating.

The second key was our focus was not on pharmacological interventions, but instead on therapy and education.

Next Steps

We now include the comparative pain scale in our everyday pain assessments with those residents who are able to use it. I feel this is what has continued to keep our numbers down.

Resources

- Comparative Pain Scale
- Pain Assessment in Advanced Dementia

Contact Information

Jordan Emley
Grandview Heights Rehab and Healthcare
Phone: (641) 752-4581
Email: jemley@gvhrehab.com

Discussion

- Questions?


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