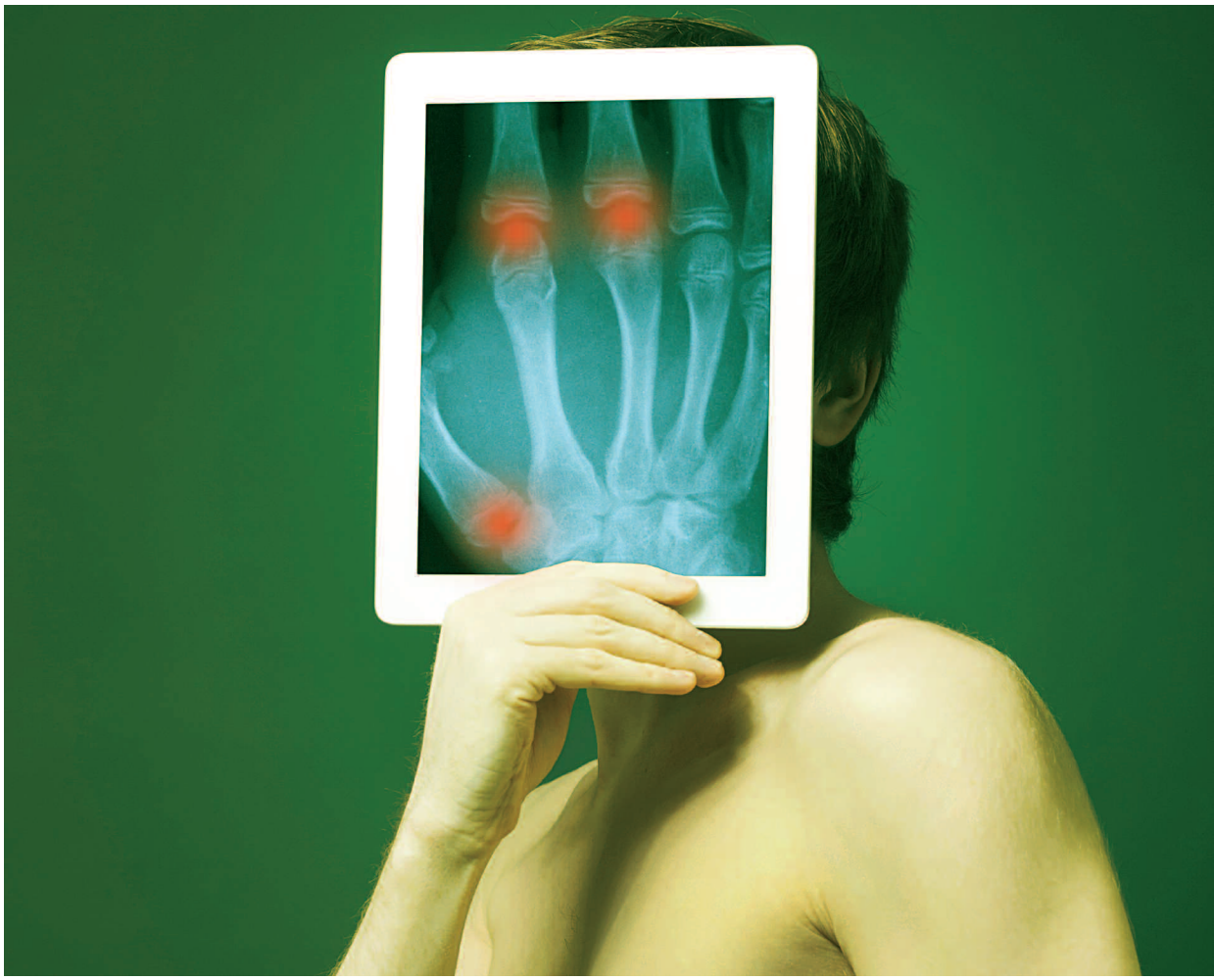


**FRAMING THE ISSUE:**

- Reimbursement issues related to HCAHPS and a general desire to improve patient satisfaction are prompting hospitals to focus attention on managing patients' pain.
- Patient data ranging from demographics to medication use to diagnoses provides a clearer picture of pain issues.
- Clinicians must be properly trained and kept up to date in the latest pain control techniques.

# Smart Pain Management Makes Good Business Sense

It's now a key factor in HCAHPS scores — and therefore, reimbursement. Hospitals are stepping up to the plate.

**BY GERI ASTON**

As ironic as it sounds, hospital procedures often cause pain. Each year hospitals perform about 10 million inpatient surgeries and 17 million outpatient surgeries, virtually all of which require some form of pain management.

If the sheer volume of procedures requiring pain control doesn't focus hospital executives' attention on the quality of pain management in their facilities, the push toward tying reimbursement to patient satisfaction should.

Hospital Consumer Assessment of Healthcare Providers and Systems — more commonly called HCAHPS — scores are among the measures the federal government is directed to use to calculate incentive payments under the Medicare Hospital Value-Based Purchasing program slated to begin this fall. Satisfaction with pain management happens to be one of the core



Photograph by iStockphoto

questions in the HCAHPS survey.

"Hospital CEOs need to make sure that they have somebody who is accountable for helping to develop the policies and processes for addressing pain in patients postoperatively," says Steven Gottlieb, M.D., CEO of TeamHealth Anesthesia, an anesthesia and pain management service company, Knoxville, Tenn. "Hospitals need a dedicated team of professionals that develop specific protocols to allow for continuity of care, consistency of care, and dependable outcomes with a low complication rate."

The Joint Commission's introduction in 2001 of a hospital accreditation standard that requires monitoring of patients' pain levels as a "fifth vital sign" spurred hospitals to make sure they measured patients' pain. When the Centers for Medicare & Medicaid Services began publicly reporting HCAHPS results in 2006, its action reinforced that message.

While hospitals responded by developing processes to identify and measure pain, those steps aren't the same as treating pain, and that's where many hospitals continue to fall short.

"It's surprising how many hospitals don't yet have a formal pain management program and how many hospitals lack a truly coordinated, interdisciplinary effort for inpatient pain control," Gottlieb says. "Interdisciplinary means [anesthesiologists] working together with nursing, physical therapy, pharmacy, surgery and psychiatry so there are the resources to call on to work together to improve patient care."

The pending reimbursement implications of HCAHPS survey results and the overall desire to improve patient satisfaction is beginning to change the landscape, Gottlieb says. "More and more hospitals are leveraging their anesthesia groups to develop protocols and processes and be accountable for optimal postoperative pain management."

## On a scale of zero to 10...

Newly updated practice guidelines for acute pain management recommend that anesthesiologists providing inpatient services do so within the framework of an acute pain service. The guidelines, developed by the American Society of Anesthesiologists, call on anesthesiologists to participate in developing standardized institutional policies and procedures, and to use an integrated approach to pain management.

At Barnes–Jewish Hospital in St. Louis, Michael M. Bottros, M.D., is in the process of developing just such a pain management service. The new program will focus not only on acute perioperative pain management, but also on chronic pain and cancer pain among inpatients.

Currently, patients who have pain after surgery typically are managed by the surgical service unless the surgeons have difficulty getting the pain under control, in which case they call for a consult from the pain team, explains Bottros, recently named director of the acute pain management service. The initiative will move pain management from a consult service to a more formal program with care pathways.

Because patients experience and deal with pain so differ-

Johns Hopkins Hospital

Johns Hopkins Hospital

## Treating the Whole Person

While more hospitals are adding chronic pain outpatient units, dedicated inpatient units are rare. Johns Hopkins is among the few hospitals featuring one. The multidisciplinary unit, created in the early 1970s, was among the first of its kind, if not the first, says Michael R. Clark, M.D., director of Hopkins' pain treatment program.

The eight-bed unit handles the most difficult cases of chronic, nonmalignant pain, he says. The average patient is in his or her mid-40s, has been in pain for more than 10 years, has had at least three related surgeries, is likely on formal disability, and has been treated with multiple medications.

Some of the most common conditions treated include lower back pain, fibromyalgia, chronic daily headaches and peripheral neuropathy. Care is directed by a team of four psychiatrists. Also staffing the unit are nurses, social workers, nurse practitioners and physical therapists. The psychiatrists call in other specialists for consultations. Hopkins also has a chronic-pain day hospital to help patients transition from the inpatient setting to the outpatient setting.

Anesthesiology usually comes to mind in pain treatment, but the Hopkins inpatient program uses psychiatrists "because our unit treats the whole person, and chronic pain typically affects every aspect of a person's life," Clark says. Patients are likely to have a psychiatric comorbidity. Plus, many of the medicines used to treat neuropathic pain syndrome also are used to treat psychiatric disorders, so the psychiatrists are familiar with the drugs.

The majority of the unit's patients are referred from Johns Hopkins' outpatient consultation clinic for pain treatment. "We also get patients from around the United States and around the globe who are looking for a program that will take the sickest of the sick, or they've been to other programs at other institutions and failed those."

CLARK

Johns Hopkins Hospital

Insurance coverage varies. Medicaid typically won't cover the admission, but Medicare usually will. Private mental health carve-out plans often won't cover the stay because it's in a psychiatric unit and they consider chronic pain a physical condition. Some private insurers have embraced the program because the patients are high-cost health care users and successful inpatient treatment can result in long-term savings. "If patients go through our program and do well, their health care utilization is going to drop by probably a factor of 10 because these are typically folks who are seeing multiple people on a weekly basis," Clark says.

A chronic-pain inpatient unit might not make sense for most hospitals, but many could benefit from adding psychiatry to their inpatient pain service, Clark says. "If a community hospital has an anesthesiology-based pain service or if they have a rehab center, if they would add a psychiatrist to the mix and create more of a multidisciplinary team, what they would find is they would have better outcomes and they would be able to retain that patient in their system." — GERI ASTON

ently from one another, fitting them into evidence-based treatment protocols and care pathways can be difficult. So the goal is to develop a "protocol-based individual approach," Bottros says. "You'd have an outline that says: 'You're going to have this type of surgery, so this is how we're going to try to approach your pain management. If it doesn't work, then we're going to go this route.'"

The subjective nature of pain makes the zero to 10 patient pain rating scale less valid than originally thought. For that reason, pain management teams have to know their patients and their pain baselines first. If a patient with chronic pain usually is at a seven on the scale, a postsurgical goal of getting the pain down to zero may not be feasible and could lead to an overdose, Bottros explains.

Developing the pain management pathways has to be a multidisciplinary effort that includes input from everyone from nurses to subspecialists, Bottros says. "It's not just having

## Grounding the 'Frequent Fliers'

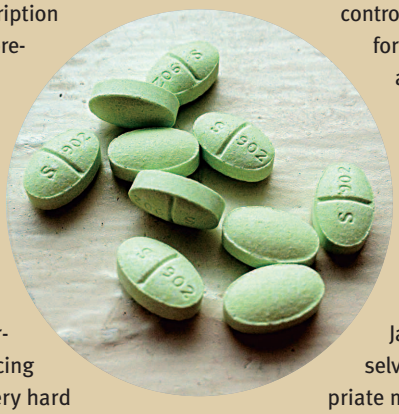
Efforts in some states to crack down on opioid abuse have renewed emergency departments' attention to narcotic prescribing policies and in some cases have provided emergency physicians with tools they can use to identify abusers.

At least 13 states either are considering or have passed narcotic prescribing laws in the 2011/2012 legislative season, according to National Conference of State Legislatures data.

In Washington, a law passed in April includes a statewide, real-time data feed to track ED visits; a state prescription drug monitoring program; and adoption of opioid prescribing guidelines for emergency physicians.

The law, which aims to discourage unnecessary ED visits among Medicaid patients, is a compromise forged between the state and hospital and medical associations. It replaced a proposal that would have allowed the state to deny Medicaid coverage for ED visits based on final diagnosis codes.

The ED-visit tracking system will help emergency physicians to see if a patient has been bouncing from hospital to hospital to get narcotics. "It's very hard when you have a patient who's never been to your emergency department, who's got excruciating abdominal pain, not to do an evaluation, and then to treat their pain because you have no indication that they're not there for a legitimate reason," says Nathan Schlicher, M.D., associate medical director at St. Joseph Medical Center in Tacoma. "But with the system in place, you could see they've been to 50 EDs in the state, all for abdominal pain and they've gotten 45 prescriptions for narcotics. Then you can have an honest conversation."



The Washington Chapter of the American College of Emergency Physicians already had adopted the ED opioid prescribing guidelines called for in the law. Included in the set of 17 provisions are recommendations against providing replacement controlled-substance prescriptions in the ED, against prescribing long-acting or controlled-release opioids in the ED, and for screening for substance abuse before prescribing opioids for acute pain.

In Florida, tougher laws designed to reduce the number of pain clinics and limit narcotic prescribing led to more ED visits for pain killers. To help emergency physicians cope with the influx of pain patients, officials at Florida Hospital and Orlando Health created a chronic pain management plan, announced in January. "Both hospital teams met and asked ourselves, 'What can we do to continue to ensure appropriate medical care for those in need, offer assistance to those in need?'" says David Goldman, D.O., a Florida Hospital emergency physician. The new plan includes guidelines for clinicians to ensure appropriate care, encourages doctors and patients to discuss pain care, and features referral options for pain care.

— GERI ASTON



Top Photograph from the Smithsonian Archives; bottom photograph from Tumblr

care paths or protocols, but it's also having buy-in from the surgical perspective, because if surgeons don't necessarily want a particular intervention, it's not going to happen."

## HCAHPS pain

Mount Sinai Medical Center in New York City has an interdisciplinary pain management committee with more than 25 members. A few years ago, the hospital discovered from its HCAHPS survey results that patient satisfaction with pain management was below the national average, so a team was assembled to dig deeper, says David L. Reich, M.D., professor and chair of anesthesiology at Mount Sinai School of Medicine. A look at patients' pain severity ratings and HCAHPS showed the two were related.

Next, the team looked at patient information, such as demographics and medication use, and characterizations of the hospitalization, such as the principal diagnosis, to see if patterns emerged. They did. The team could see, for example, which departments and patient characteristics were associated with high pain levels. The results then drove pain management improvement efforts, Reich says.

All hospitals should dissect their HCAHPS data and/or patient-reported pain severity ratings whether it be by department, by nursing unit, diagnosis, or classes of patients to see where pain management should be improved.

To prevent any patients from falling through the cracks, Mount Sinai empowered nurses to review daily pain severity on their units and to advocate for pain management team consults for patients whose assigned pain control wasn't working, Reich says. The hospital also developed a quality dashboard for physicians that includes metrics on their patients' pain severity.

## The right person, the right skills

Another growing area of interest among hospitals is persistent postoperative pain. Estimates of the incidence of such pain, defined as discomfort that usually lasts three to six months, range from 10 to 50 percent, depending on the type of surgery, according a 2011 Institute of Medicine report.

The medical community is trying to determine which patients are most at risk and how to prevent the problem.

Some predictive factors have been identified, according to a January 2011 article published by the International Association for the Study of Pain. For example, patients who have pain before the surgery, women, people on workers' compensation and patients with preoperative anxiety are more at risk. Patients having surgery that holds the risk of nerve damage also are more likely to experience persistent post-op pain. In these cases, minimally invasive and nerve-sparing techniques, if available, are superior, the article states.

As hospitals develop acute pain management programs, they should make sure physicians on the service have the proper background and education, and are using up-to-date techniques and approaches.

"There are a lot of people who take up the challenge of pain control, but they might not necessarily have the right training and the right skills," Bottros says. "While it's important and it's a noble effort, sometimes it can lead down a road of more problems." He and the other anesthesiologists on the Barnes–Jewish pain management team are certified in pain management.

## Communicate, communicate, communicate

Although the overriding goal of inpatient pain services is making sure patients get the best treatment possible, the pressure of the HCAHPS survey means communication with patients has to be part of the program.

TeamHealth Anesthesia has folded patient communication into its physician training. "You can use key words and phrases to get patients to understand what you're trying to accomplish and better respond on the HCAHPS survey," Gottlieb says.

Findings from a Johns Hopkins study support the importance of communication. The study, published online Feb. 16 by the *American Journal of Medical Quality*, examined the relationship between patients' perception of pain control during their hospitalization and their overall satisfaction. The results showed that patients were more likely to rate their overall experience high if they perceived that their care providers did everything they could to control pain, rather than the pain actually being well-controlled.

Providing good pain management not only helps boost patient satisfaction, but also improves patient safety scores, gets patients mobile more quickly, speeds their recovery and

## {STATS}

**100 million**
or so U.S. adults have common chronic pain conditions.

**26%**
of Americans report lower back pain lasting at least a day in the last three months.

**80%**
of surgical patients experience postoperative pain. Less than half report adequate pain relief.

**2.1 million**
visits are made annually to U.S. emergency departments for acute headaches.

**5%**
of American women ages 18 to 65 experience headaches 15 or more days per month.

**60%**
of ED patients with acute painful conditions receive analgesics.

**74%**
of ED patients are discharged in moderate to severe pain.

Source: "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," Institute of Medicine, 2011

## Persistent pain after surgery

| Type of surgery | Incidence of persistent pain | Incidence of severe/ disabling persistent pain |
|---|---|---|
| AMPUTATION | 30–50% | 5–10% |
| CORONARY BYPASS | 30–50% | 5–10% |
| THORACOTOMY | 30–40% | 10% |
| BREAST SURGERY | 20–30% | 5–10% |
| C-SECTION | 10% | 4% |
| INGUINAL HERNIA | 10% | 2–4% |
| OVERALL INCIDENCE | 10–50% | 2–10% |

Source: "Persistent postsurgical pain: risk factors and prevention," *Lancet,* May 13, 2006

shortens their hospital stay, Bottros says.

"It's going to be imperative that hospital executives begin looking at robust in-hospital pain services, whether it's for acute pain, like a dedicated acute pain service, or whether it's a more comprehensive acute and chronic pain service," Bottros says. "Something needs to be done because it's going to affect not just the satisfaction scores, which impact the hospital's reputation, but it's going to affect your reimbursement."

### Chronic pain centers

The prevalence of chronic pain has spurred some hospitals to create outpatient centers to serve this population. About 100 million adults have chronic pain, the IOM reports.

Barnes–Jewish Hospital was ahead of the game. The Washington University Pain Management Center at Barnes–Jewish was created in the early 1990s. Common problems that bring patients to the center include back, nerve, cancer and post-op pain. Care is typically outpatient, although the center's physicians can admit patients.

Care features a multidisciplinary approach to chronic pain. Physicians work closely with physical therapists and a psychologist.

"As physicians, we're trained in an old-school method where we think pain is a symptom of an underlying disease process," Bottros says. "We're finding out more and more that some people have continued pain even after the offending problem is removed." The care team looks at pain as a disease entity and addresses not only patients' anatomical and physiological problems, but also any psychosocial issues, Bottros says.

The center offers an eight-week program, Supportive Training and Education for People with Pain, that includes instruction patients in pain management techniques, safe exercise and coping with the psychological repercussions of chronic pain, such as depression.

Medical services include a wide range of procedures, from botox injections to radiofrequency ablation and minimally invasive lumbar spine decompression.

The number of patients and procedures, and the types of interventions are tracked, Bottros says. Patient demand and procedure volumes are growing. Within the next year, the center will move to a larger space.

Chronic pain treatment centers are becoming more common, Gottlieb says. "Hospitals have learned that these centers are a great avenue to acquire new patients and that they integrate nicely when caring for patients with cancer, work-related injuries, sports injuries."

The centers can generate hospital income, both directly from procedures performed there and indirectly from ancillary services and from inpatient surgeries, Gottlieb notes. Hospitals should track both to determine the complete revenue impact.

Done well, these centers bolster the hospital's reputation and build loyalty among successfully treated pain patients, Gottlieb adds.

"If a patient is in pain, they're going to try to find a place to get rid of their pain," he says. "If your hospital can't provide that, they're going to go to another hospital." — *Geri Aston is a contributing editor to* H&HN.

**HAVE A COMMENT?** *H&HN* welcomes your thoughts on this article. You can sound off at **hhnmag@healthforum.com.**

## EXECUTIVE CORNER

Several trends in pain management are occurring that hospital executives should keep in mind.

### Chronic pain on the rise

Pain prevalence is high and only going to get higher. Already about 100 million Americans are in chronic pain, and each year tens of millions of Americans undergo surgeries that require pain management. Those numbers will grow as the U.S. population ages.

### Reimbursement concerns

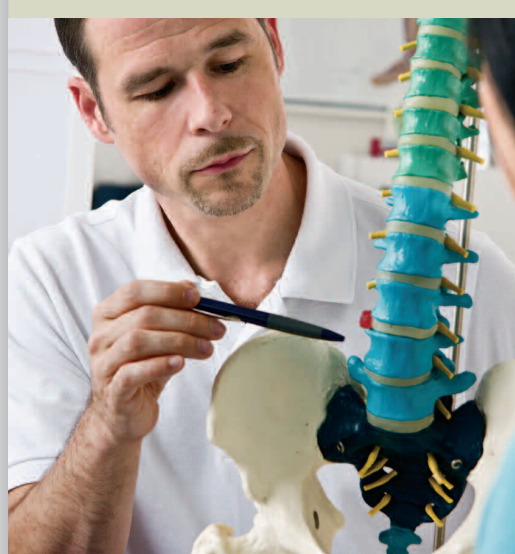
Patient satisfaction soon will affect reimbursement. HCAHPS survey scores, pain management among them, are one of the measures the federal government will use to calculate incentive payments under the Medicare Hospital Value-Based Purchasing program.

### Develop a formal program

More hospitals are developing formal inpatient pain management programs. The aim is to improve care, boost patient satisfaction and avoid revenue loss. Programs should be multidisciplinary and utilize evidence-based care protocols and pathways where appropriate.

### Continued outpatient growth

The number of outpatient chronic pain management centers is growing. These hospital-based centers can attract new patients and bring in direct and indirect revenue.



Photograph by iStockphoto