ORGANIZE AROUND PATIENTS’ NEEDS

Dr. Wanner’s Case Study | By Mari Ransco, MA, Chrissy Daniels, MS, Nathan Wanner, MD

THE PROBLEM

Historically, healthcare is something that happens to patients, not necessarily with them. In order to strengthen our connection to patients, organizations must identify and measure outcomes that matter to patients, organize teams around those efforts, and most importantly, improve. This introduces the real work of a healthcare buzzword: patient-centeredness. Being patient-centered is more than just individual behavior. A patient-centered organization designs processes and systems around what is important to the patient. The hard work of patient-centeredness is laser focus—the right people on the team, measure what matters, organize around it, audit, and flexibly re-design when necessary.

Learn about the “5 Elements” on page 5.

BIG IDEA: The following University of Utah case study explores how listening to patients and becoming process-oriented are key competencies to successfully organize around the patient. With the right team and the right process, this pain management initiative has spread to nearly all acute care units in one year, ensuring a better experience for all patients and the teams that care for them.

Background

After spending months developing a plan with his physician colleagues, Dr. Nate Wanner attends a nursing staff meeting to present the initiative’s linchpin: a pain management brochure designed to engage patients and providers. The entire team has an important role in the new initiative - tracking and discussing pain with patients every day.

In a few short months, he discovered that this simple work was not happening. While everyone wanted to reduce patient pain, implementing a team-based process was easier said than done. What started as an initiative to relieve pain began to feel like a burden.

Dr. Nate Wanner started thinking about pain management during his tenure as the director of the University of Utah’s hospitalist and palliative care service. Wanner noticed that patients often said their pain was not controlled and that staff didn’t always do everything possible to help with pain.

First, Wanner wanted to understand how the staff approached pain. He suspected that poor pain management scores partially reflected the clinical staffs’ deep-seated cultural attitudes toward pain and substance abuse amongst patients.
He conducted a qualitative survey of nurses, residents and hospitalists and the results were surprising. His analysis revealed that pain is a complex and frustrating subject that greatly contributes to professional burnout.

Staff felt that the unit lacked well-defined strategies and protocols for dealing with pain. One hospitalist commented, “I think front line physicians feel that they are stuck dealing with extremely challenging (and often very frustrating) pain patients without a great deal of support. Non-pharmacological options are limited, expertise and skill is sometimes lacking, protocols and standardization is non-existent, and specialist referral options are limited.”

The survey feedback was helpful. Wanner could see what patients were experiencing: conflicting messages from various staff members, few options outside of specific pain meds, at times an antagonistic relationship between caregivers and patients, and a periodic unwillingness to prescribe additional pain medications.

Learn how we indirectly inflict “suffering” on our patients, page 5.

THE SOLUTION

Step 1: The Initial Plan

Wanner knew he could take a few simple actions to make a big difference. He established consultation expectations with the Acute Pain Service and the Palliative Care Service and taught residents and hospitalists when to consult them. Wanner wrote a new patient brochure titled “My Pain Management Guide,” that included answers to frequently asked questions and alternatives to medications, such as hot and cold packs, comfort items and positioning. Most importantly, the guide featured a log for nurses to track a patient’s daily pain.

Ready to move forward, Wanner set out to pilot the brochure on the Acute Internal Medicine-A unit.

Step 2: Expanding the team to organize around patients’ needs

Excitement had quickly fizzled. While individual nurses began handing out the pain guide, the entire team needed a new process and workflow to include the pain guide into their daily tasks. The nursing team also needed to understand how the pain management guide would improve their busy daily workloads.

Andrew Davies, acute care nurse manager, convened a working group that represented each role on the nursing care team – a nurse, a nursing aide, a unit clerk, a nurse educator, and the assistant nursing manager. They knew the staff cared about reducing pain, but could they all perform the same process? At first, the new list of tasks felt just that – a task list of yet more things that had to be done every day with every patient without any more allotted time or resources. The working group knew they needed to approach the pain brochure differently.
The working group decided to involve bedside nurses in the project design and asked for feedback. The working group gave each person who participated a $5 Starbucks card for their feedback, no matter the content of the feedback.

The responses proved invaluable and uncovered many unintended consequences of the project and brochure design. For example, the care team revealed the importance of the nursing aide in pain management—a role overlooked by the physicians. The new process enabled the aides to offer a list of non-medication alternatives. The effect was gratifying—the aides felt empowered and more involved in the healing of the patient.

Step 3: Sustain and Spread

Similar pain management issues plagued acute care units throughout the hospital. Wanner and nursing leadership decided to pilot the changes on AIM-A in the other units. Wanner applied what had been learned on AIM-A and focused on a few key steps implemented by each unit:

1. Faculty engagement
2. Establishment of consulting services
3. Patient education brochure (Offering non-pharmacological options and patient education)
4. Staff engagement and assessment
5. Escalation process with unit MD leadership

Wanner led ongoing faculty engagement. The continuing physician education challenges norms, grounds physicians in patient feedback and encourages discussion of what is possible.

Three more units adopted pain management techniques. These units are home to a wide range of patients, including patients with cystic fibrosis, stroke, and patients recovering from transplant, bariatric and neurosurgery. Each unit found new ways to make pain management more patient centric and specific to their unit’s population.

The Reflection

All healthcare workers want to be patient-centered, but changing entrenched practices carried out by thousands of workers is hard. Changing attitudes is even harder. After nearly a year of continual work on pain management, a few conclusions stand out about patient-centered projects.

First, piloting an idea in one area proved extremely important. Wanner had an idea, but it only became a team-based solution when it was tested by the team. Getting quick wins was important in spreading the idea to other units.
Second, the team was critical to success. Wanner planned for physician, pharmacist and nursing collaboration, but social work and nurses’ aides were boons to the project. Their work made the difference for patients.

Third, a physician champion was necessary. Wanner began the project with the idea that more could be done for patients if we only listened. His leadership with the hospitalist group and other specialties was invaluable. Physicians needed to hear from someone within their own group in order to consider a change.

Lastly, spread of the improvement has been completed thoughtfully with verification of the new process from stakeholders at each step of the way. This implementation has struck a balance between one-size-fits-all and unit-specific solutions. Wanner’s approach has been to incorporate feedback and allow each unit to develop their own specific processes. All of these changes have contributed to a better workplace for staff. When re-surveyed, nurses, physicians and residents said they felt more supported in managing patient pain.

<table>
<thead>
<tr>
<th>University of Utah HCAHPS – “Staff do everything to help with pain improvement”</th>
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<td>% of patients reporting always</td>
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University of Utah Health Care HCAHPS percent of patients reporting always in Acute Internal Medicine-A (AIM-A), Acute Internal Medicine-B (AIM-B), Neuro Acute Care (NAC), and Surgical Specialty Transplant Units (SSTU). Surveys received from January 1, 2012 through August 25, 2015.
About the “5 Elements”

In analyzing what makes a truly exceptional experience, we have found five elements that differentiate a great experience from a good one. These elements are: caring, listening, information, efficiency and teamwork. A good experience will have one or more of these elements; a great one has all five. Creating exceptional experiences requires interpersonal, process and system interventions.

<table>
<thead>
<tr>
<th>Element</th>
<th>Alignment with Pain Case Example</th>
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<tr>
<td>Caring</td>
<td>The pain management guide makes caring visible to every patient at least once a day. Carving out reserved time to just discuss a patient’s pain level, how well they are sleeping, and how able they are to move around reinforces that the staff is concerned for the patient.</td>
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<tr>
<td>Listening</td>
<td>Watching the nurse write down what you say is powerful for patients. Nurses track patients’ pain every day in a log. This action communicates to patients that the team is listening and responding to their concerns.</td>
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<tr>
<td>Information</td>
<td>Frequently asked questions about pain are answered in the pain management guide. Physicians continue to answer these questions during their rounds, but it improves patient learning to receive the same information in a number of different formats. Additionally, the guide helps patients identify the non-pharmaceutical interventions that can help reduce suffering.</td>
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<tr>
<td>Efficiency</td>
<td>Better communication between the nursing teams and physician teams often leads to patients getting their pain medication faster and more effectively. Nursing also offered non-pharmacological methods in a more systematic way, and discovered that these tools offered surprising efficacy for patients.</td>
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<tr>
<td>Team</td>
<td>Thirty people often will care for one patient during an Inpatient stay. When the members of the team (nursing aide, nurse, physician, pharmacist) refer to the pain management guide, it feels like each of the thirty people have spoken to each other about each patient's care.</td>
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On Suffering

“…the word ‘suffering’ makes us feel bad. It reminds us we are powerless against so many of our patients' problems. And it makes us feel guilty. Suffering demands empathy and response at a level beyond that required by ‘anxiety,’ ‘confusion,’ or even ‘pain.’ None of us see ourselves as people who would stand by while someone is suffering. None of us can imagine ourselves as parts of organizations that tolerate or even inflict suffering in systematic ways…To make alleviation of suffering our job for all our patients feels like trying to fill a bottomless pit…If good organizations have ambitious goals, great organizations are effective in pursuing them. They close the gap between their mission statements and their operations. They find ways to measure what matters and organize themselves to improve their performance. They track and manage their progress toward those goals with the same discipline that they apply to their financial performance.”

What is Pain?
Pain is physical discomfort usually caused by illness or injury. There are two different parts of pain:

1. The physical sensation of pain
2. The emotions and fears pain causes

It is normal to have emotional stress in the hospital, but stress - along with lack of sleep, boredom & being inactive - can make pain worse. Part of our plan for managing your pain will be working on these issues with your help.

There are two kinds of pain:

Acute Pain
- Usually only lasts a short time
- Caused by something recent such as surgery, injury, or illness

Chronic Pain
- Lasts a longer period of time (3 months+)
- The cause sometimes cannot be found or healed
- It is often something that the person learns to function and “live with”
- Pain relief methods other than medications are often helpful for chronic pain since medications alone do not usually take away all of the pain.

Oral vs. IV Medication
Two common types of medications are oral and IV. Oral medication is pills or liquid you take by mouth.

Why don’t we always use IV pain medication?
Oral medication is just as strong as IV medicine, controls pain better, lasts longer and can be used at home. We will change IV medication to oral as soon as we can. This way we can make the best pain control plan in the hospital and when you leave the hospital.

My Pain Management Guide

Our team will discuss your pain management options with you regularly in the hospital. While we might not be able to make your pain disappear, we will do our best to manage it with your help.

Please ask your doctor or nurse if you have any questions about your pain plan.
# Managing Your Pain

## Pain Medication
For severe pain, using more than one kind of medication often works best.

## Positioning, Stretching, and Activity
Often changes in position can help with pain. Use pillows to support arms, legs and back. Try walking or sitting in a chair. A shower or bath may help as well.

## Music Therapy
Music can help you release tension and relax. Tune to Channel 90 on your TV.

## Touch and Light Massage
Friends or family may be able to help provide the healing power of touch.

## Social Work Visit
Social workers can offer mindless or relaxation techniques or help with coping skills.

## Chaplain Visit
Our chaplain can pray with you or work with you using guided imagery.

## Pet Therapy
Talk to the nurse about pet therapy to help with pain, anxiety and stress.

## Heat and Cold Therapies
Talk to your nurse about using hot and cold packs.

## Personal Care Needs
- Toothbrush
- Toothpaste
- Denture cleaner
- Lip balm
- Hair tie
- Shampoo
- Conditioner
- Deodorant
- Nail file
- Pajamas

## Comfort Items
- Warm blanket
- Extra pillows
- Humidification of oxygen tubes
- Ear pads for oxygen tubes
- Mouth swabs
- Saline nose spray

## Relaxation Options
- Ear plugs
- Door/drapes closed
- Personal headphones
- Quiet uninterrupted time

## Boredom Busters
- Books/magazines
- Crosswords
- Sudoku
- Deck of cards
- Word search
- DVDs
- Board Games

<table>
<thead>
<tr>
<th>Date</th>
<th>Comfort</th>
<th>Change</th>
<th>Pain Control</th>
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<tr>
<td></td>
<td>Little or no pain</td>
<td>Uncomfortable but manageable</td>
<td>Can’t handle</td>
</tr>
<tr>
<td></td>
<td>Some Pain</td>
<td>Getting better</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Uncomfortable but manageable</td>
<td>Getting worse</td>
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## Notes
- Normal sleep
- Awake with occasional pain
- Awake with pain most of the night