

# NewsLine

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September 2011

## No Pain, All Gain



**By Tracy Hines, AAS; Susan Lasker Hertz, RN, MSN, CHPN; and Christine Zanoni, BSBA**

**T**he renowned palliative care physician, Dr. Ira Byock, once said, “There is no such thing as uncontrollable pain, only pain that has yet to be controlled.”

These words served as the guiding force behind a Comfortable Dying Protocol which The Denver Hospice (TDH) unveiled in March 2010. The Protocol, which TDH had also adopted as one of its organizational pillar goals, was the result of a

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*Comfortable dying is at the heart of the hospice mission. It is now also one of CMS’s measures for hospice quality reporting per the Final FY2012 Wage Index.*

*In this article, The Denver Hospice discusses a recent performance improvement project—and new Comfortable Dying Protocol—that helped staff control pain in 94 percent of home patients within 48 hours of admission. Its work can serve as a timely example as members prepare for CMS’s quality reporting requirements.*

### Inside

#### **New Study on Dementia Patients**

A new study shows that bereaved family members of nursing home patients who died of dementia felt their loved ones had received better care because of hospice.

#### **2011 Circle of Life Awards**

Six of the seven programs honored this year are NHPCO members. See the photos from this prestigious event.

#### **Hospice in the Continuum**

Redmond-Sisters Hospice is a small, rural program in Central Oregon. Despite a limited budget for expansion, it introduced a Transitions program seven years ago. Executive Director Rebecca Bryan discusses the many benefits.

#### **The Voice of NCHPP**

Hospice By The Bay adopted a transdisciplinary team model in 2007. Laura Koehler, director of clinical services-south, shares the reasons for the change—and the many rewards.

### **Plus...**

- A Message From Don
- The 2011 Hospice Quilt
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14-month process improvement project (PIP) that was conducted between 2009 and 2010 to improve our staff's ability to manage a patient's pain within 48 hours of admission.

We began seeing positive outcomes from using the Protocol in early 2011 and, by April 2011, we had exceeded our project goal. In this article, we discuss the steps taken to develop the Protocol, as well as our results at key junctures along the way.

### Setting an Ambitious Goal

"Comfortable Dying" (i.e., was the patient's pain brought to a comfortable level within 48 hours of admission to your hospice) is one of three [End Result Outcome Measures](#) (EROM) that NHPCO established to help hospices assess the quality of their patient care. The NHPCO Comfortable Dying Measure includes a protocol that hospices may follow, along with several other tools to help hospices compile and submit their data to NHPCO. Then, each quarter and each year, NHPCO produces national-level summary reports so each hospice can compare its own performance with the national-level mean.

Prior to 2009, TDH had utilized the NHPCO Comfortable Dying

Measure, but had not given it sufficient attention. In 2009, however, we got serious about it. Knowing that CMS would be releasing quality reporting requirements within the near future, Comfortable Dying was adopted as a pillar goal, and we invested the necessary time and resources to fully address this aspect of care, including the appointment of a clinical quality specialist to collect and track the data, and monitor the program. We also set an ambitious goal of having 90 percent of patients who were admitted in pain to have their pain controlled within 48 hours.

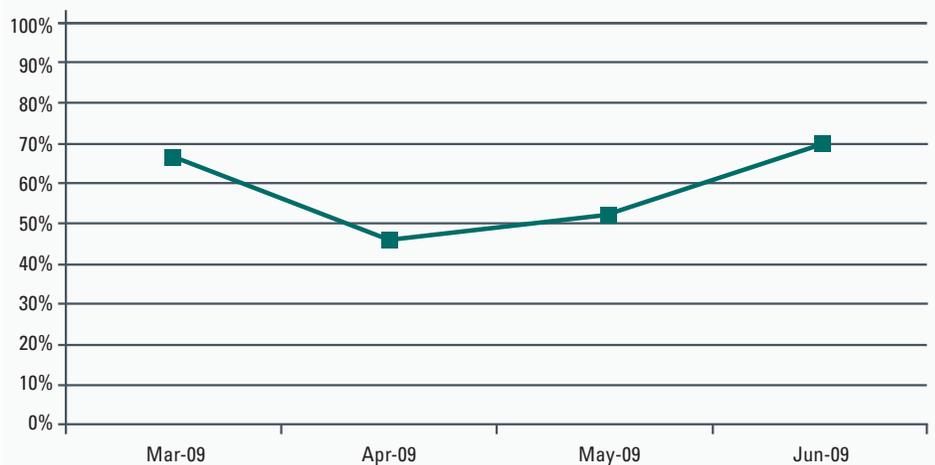
### The Project's Early Stages

Per the NHPCO Protocol, we began the project by simply asking at admission, "Are you uncomfortable because of pain?" If the patient was non-responsive, however, the admissions staff would ask the patient's caregiver. (This deviated from the NHPCO Protocol, but we decided it was an important element.) We expected the answers to be yes or no.

We also knew it was important to have consistency in both language and timing, but early on we found that the data-collection process was very manual and wasn't always consistent. After a four-month period (March-June

**Figure 1: The Project's Early Stages**

Percent of TDH patients whose pain was brought to a comfortable level within 48 hours of admission:



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2009), the results were below our expectations—just a 2 percent improvement as shown in Figure 1.

A disappointed staff then went through the four stages of acceptance:

1. “The data are wrong.”
2. “The data are right, but it is not a problem.”
3. “The data are right. There is a problem, but it is not my problem.”
4. And finally—“The data are right. There is a problem, and it is my problem!”

Then we all rolled up our sleeves and returned to the drawing board!

### **Identifying the Problems**

TDH put together a focus group comprised of representative members of the hospice team—medical directors, admissions and after-hours staff, clinical managers, primary-care nurses, clinical operations assistants, and our pharmacist. Together the group identified what was working and what wasn't working, as well as the wide variation in how the question

about pain was worded. The group also found that the staff's interpretations of the answers were also all across the board.

From that focus group and subsequent meetings of the Quality Management Committee, TDH developed a plan of action that included four primary steps.

#### **Step 1: Admission Notification**

Starting with admissions, staff asked patients the same question they had been asked during the project's early stages: “Are you uncomfortable because of pain?”



However, if the answer was yes, then a *very specific* standardized email was sent to the primary care team and the clinical manager to let them know that TDH was admitting a patient who is uncomfortable because of pain. Staff used a standardized email process and the IT department created a template that could be filled in. In order to assist in data collection, an acuity code was entered.

We also focused on a best practice we called, “key words at key times,” meaning that asking the question in a particular way at a particular time was an important part of ensuring that our values were being carried out. (This also followed the NHPCO Protocol.)

### **Step 2: After-hours Contact**

We also determined that if we were going to make an impact on improving comfort in just 48 hours, we needed to contact the patient and caregiver within four to six hours after the initial admission assessment.

We implemented proactive phone calls in which we asked whether the medications that were ordered had been received and if they were working. We then asked, “Has your pain been brought to a comfortable level?” If the medications had not improved

comfort, that triggered a visit by an after-hours nurse in addition to proactive follow-up phone calls before 9 p.m.

### **Step 3: Contact at 24 Hours**

Additionally, at 24 hours post-admission, the primary care nurse would telephone the patient regardless of what the “after-hours contact” had indicated. We aimed to make the calls in the early morning, so if pain was still a problem, the nurse could make an early-morning visit. If the patient or caregiver answered “no” to the question, a nurse visit was triggered.

### **Step 3: Contact at 48 Hours**

If the patient was continuing to experience pain at 48 hours post-admission, the nurse was required to make a visit and arrange for a consultation with a hospice medical director. At this juncture, three important factors were also considered: Is a change in medications needed? Is a change in the patient’s level of care needed? Does the patient need to be transported to our inpatient care center or go on continuous care?

A non-clinical administrative assistant also called the patient at 48 hours post-admission and asked: “Has your pain been brought to a comfortable level?” If

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the answer was yes, the response was entered into the system as a data collection end point. If the answer was no, the primary care nurse, clinical manager and our internal stakeholder group were notified, and clinical interventions and mobilization of resources took place to address the patient's pain. (Our internal stakeholder group was comprised of our medical director, director of performance improvement, clinical quality specialist, chief medical officer, chief clinical officer and director of home-hospice services.)

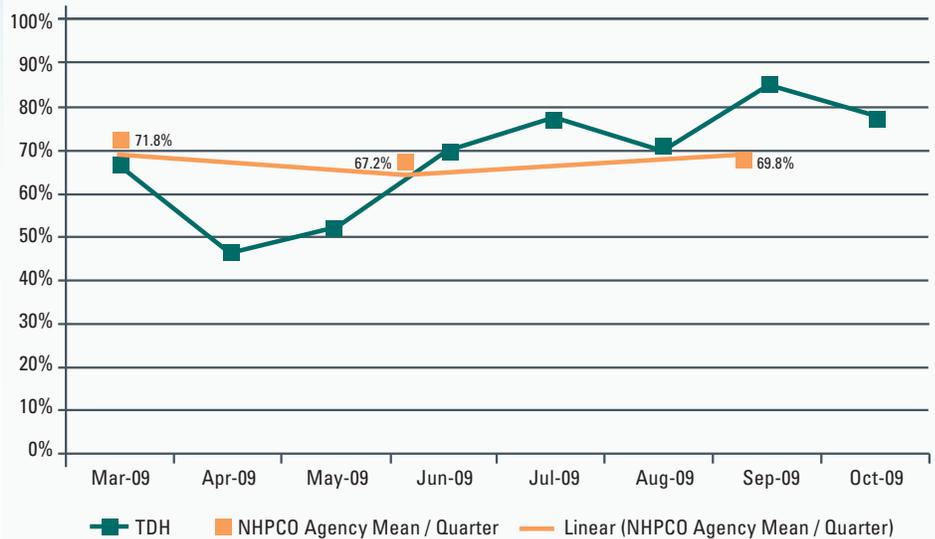
### Some Promising Results

In calculating results at month eight of the project (October 2009), we looked at the number of patients in pain at 48 hours and divided it by the total number of patients admitted in pain. We only tracked home patients and tracked the patient and caregiver responses separately, so we could see if there was a difference.

Our sample was small, with 25 percent of home patients reporting discomfort because of pain at admission. But we continued to track all four steps of our algorithm, including: Were the calls made? Did the visits take place? Were the right

**Figure 2: Promising Results by October 2009**

Percent of patients whose pain was brought to a comfortable level within 48 hours of admission:



people notified? Were clinical interventions made? And were these interventions appropriate?

We plotted the numbers on a line graph to see our progress (see Figure 2), and convened weekly meetings of our Quality Improvement Project Group which focused on the comfort-at-48-hours process and the outcomes. TDH board members who serve on the Quality Management Committee and normally attend these meetings on a quarterly basis, also volunteered to attend on a monthly basis to reinforce and

support our efforts. In addition, we explicitly emphasized to staff the importance of the comfort-at-48-hours quality measure to our specific hospice mission—“To encircle those facing advanced illness with unprecedented levels of comfort, compassion and expertise.” As one board member said, “If we meet monthly about financial performance, why not monthly about quality measures?”

### More Tweaks, More Improvement

We tweaked our Protocol to include a consultation with the attending physician at 24

hours post-admission when the patient indicated that he or she was uncomfortable because of pain. We also asked the TDH medical director to review the patient's clinical records to ensure appropriate interventions were in place early enough in the plan of care to have an impact on the patient's perceived comfort.

We also focused on competency to ensure our nursing staff had the skills to intervene effectively. Among other things, we required each nurse to take a four-hour inservice on "The Denver Hospice Way of Pain Management" and required each nurse to complete a 50-question competency exam. Our education department and pharmacy partner also conducted

education sessions as part of the training blitz.

Each nurse—both our clinical managers and our after-hours and care center RNs and LPNs—had to pass the competency exam (by 100 percent) within a specified time frame. If they did not, counseling and disciplinary action were taken. The competency exam is now given annually.

The process itself also helped us to understand why some patients decline interventions or forego medications. For the clinical staff, it was really about respecting patients' choices.

By February 2010, we began to see that results from our new Protocol had become more stable, hovering

### Helpful Training Tool

The authors presented on this topic at the NHPCO 26th Management and Leadership Conference in April 2011—and the session is now available on CD or as an MP3 file for just \$10.

To review or purchase the tool, visit [www.dcpvideronline.com/nhpco](http://www.dcpvideronline.com/nhpco), and enter "11C" in the Keyword Search. Then scroll to the session listing, "Comfortable Dying: No Pain, All Gain."

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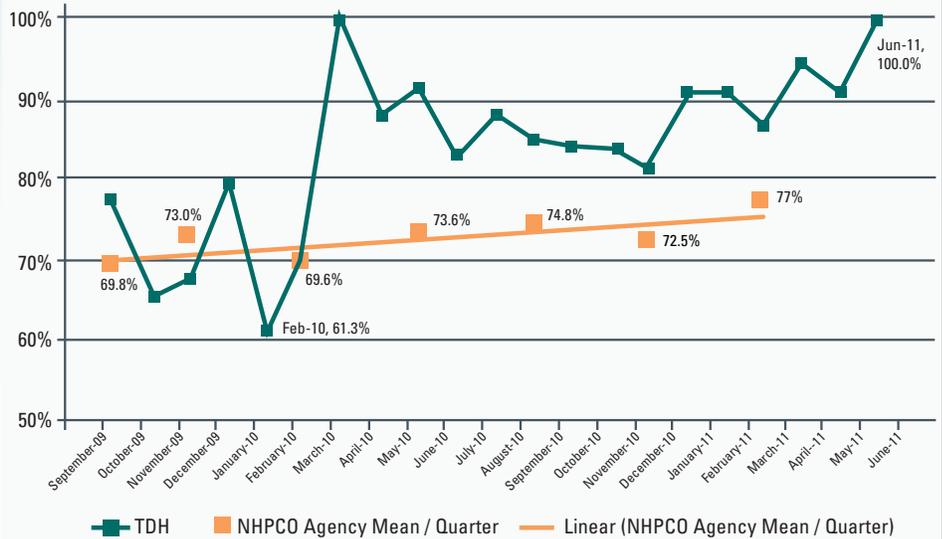
around 90 percent. In April 2011, results reached 94 percent—and we had exceeded our initial goal. (See Figure 3.)

By establishing a formal Comfortable Dying Protocol, TDH is now able to effectively respond to those patients in pain at admission—with documented outcomes to prove it.

*Tracy Hines is a clinical quality specialist at The Denver Hospice, while Susan Lasker Hertz is director of home-hospice services and Christine Zaroni is the former director of performance improvement.*

**Figure 3: Comfort at 48 Hours**

Percent of patients whose pain was brought to a comfortable level within 48 hours of admission:



## Free Performance Measure Tools

NHPCO offers a range of tested performance measure tools—available to members free of charge. Each tool yields meaningful and actionable data that can help inform your hospice’s performance improvement projects:

- End Result Outcome Measures (EROM)
- Family Evaluation of Hospice Care (FEHC)
- Family Evaluation of Bereavement Services (FEBS)
- Family Evaluation of Palliative Care (FEPC)
- National Data Set (NDS)
- Survey of Team Attitudes and Relationships (STAR)

Visit the Research page of the [NHPCO website](#) for a helpful two-page Overview of Performance Measures, along with details about each tool.

