



BASELINE DATA FROM THE PRACTICE CHANGE PROGRAMS: ROOM FOR IMPROVEMENT

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Introduction

The Practice Change Programs are part of an ongoing effort to improve pain management practices in health care facilities in the US. The programs combine facility assessments, pain management education, team building, on-site consultation, provision of tools and templates, and action plans targeted to improve system practices and patient outcomes.

In 2001 and 2002, the American Alliance of Cancer Pain Initiatives (AACPI) recruited seven State Cancer Pain Initiatives to implement the programs and to participate in data collection. An eighth state also implemented a program but collected a separate data set that is not included in this report.

This report provides a summary "snapshot" of the baseline practices of the 49 long term care facilities and 40 home health agencies that participated in the programs

Methods Recruitment

The AACPI awarded contracts to State Cancer Pain Initiatives to partially support the implementation of the programs. Qualified Initiatives were required to:

- identify and hire a coordinator, site visitor, and assistant for the 10-month program
- form collaborative relationships with the state agency that surveys long-term care facilities and home health agencies for licensure
- identify and recruit 15-25 health care facilities to participate in the program
- raise \$10,000 in local funds to supplement the program costs

The unit of recruitment was the health care facility. To be accepted into the program, the administrator and director of nursing were required to:

- identify a team of 2-3 staff members who would directly participate in the program's site visit and conferences, and who would be responsible for implementing an action plan to improve pain management practices
- support the activities of their team in terms of time, resources, and data collection

Each health care organization paid \$500 to participate in the program. This both helped to support the program costs, and to reinforce the facility's commitment to and perceived value of the program.

Figure 1: Program Implementation

Month	Activity	Data Collection
1-3	Site visits to each participating health care facility	The site visitor <ul style="list-style-type: none"> • instructed the facility teams to survey 10 randomly selected patients • worked with the facility teams to collect baseline assessments of the facilities' pain management system practices
4	1 st educational conference (2-day) <ul style="list-style-type: none"> • Consequences of unrelieved pain • Pain assessment in the cognitively intact and impaired • Pharmacologic management • Communication • Complementary therapies • Requirements for facility licensure • Action plan development 	<ul style="list-style-type: none"> • Each facility team submitted the results of patient surveys • Each conference participant took a pre-test (23-item survey of knowledge and attitudes)
5-8	Monthly calls to the facilities' teams to support and encourage the implementation of the action plans	Month 8: 2 surveys of 10 randomly selected patients
9	2 nd educational conference (1-day) <ul style="list-style-type: none"> • Management of neuropathic pain • Poster presentations by the facility teams • Other content as determined by the local team 	<ul style="list-style-type: none"> • Submission of second patient survey results • Post-program assessment of facility pain management system practices (completed by the facility teams) • Post-test of knowledge and attitudes
10	Final data submission from the Cancer Pain initiative to the AACPI	

Figure 2: Participating States

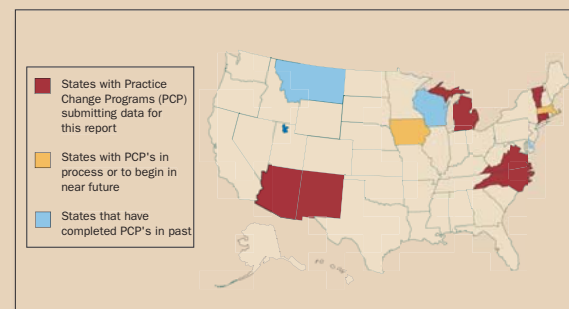


Figure 3: Participating Organizations

Long-term care facilities and home health agencies from seven states (CT, MI, NC, MN, VA, AZ and VT) submitted patient surveys and facility assessments.

	Long-term Care Facilities (n=49)	Home Health Agencies (n=40)
average # of patients (range)	143 (30-540)	400 (45-2337)
areas served*	Urban (65%); Rural (37%)	Urban (60%); Rural (55%)
Not-for profit incorporation	53%	90%
JCAHO accreditation	41%	82%

*Some organizations served patients from both urban and rural settings.

Results

Figure 4: Patient Survey Results

Each facility and agency was instructed to submit the results of surveys of 10 randomly selected patients before the 1st educational conference. Forty-three long-term care facilities provided data from surveys of 429 patients; 36 home health agencies provided data from surveys of 374 patients

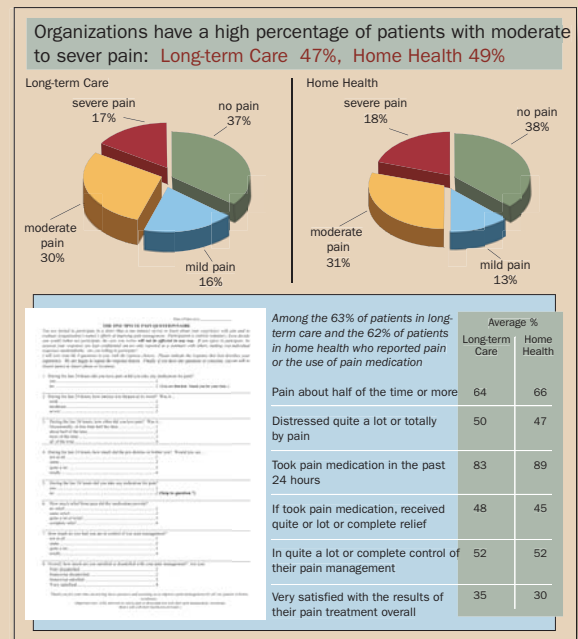


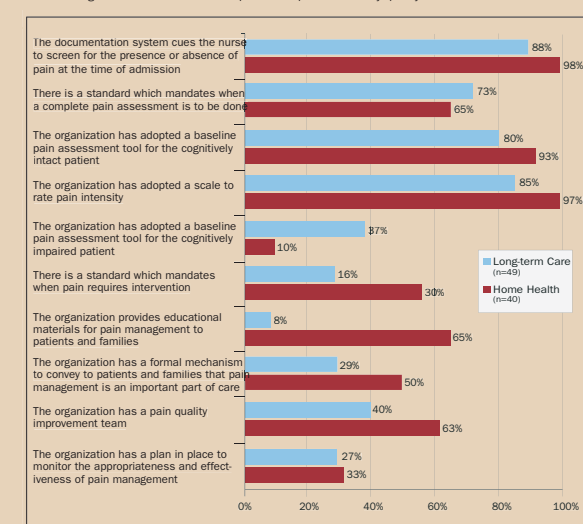
Figure 5: Results of Knowledge & Attitudes Survey

Those who attended the 1st educational conference took a 23-item knowledge and attitude pre-test. The differences between the percentage of correct responses from participants from long-term care (67%) and home health (69%) staff were small.

Encouraging Results		
HH n=88	LTC n=94	Knowledge & Attitudes Survey Items
92	99	Elderly patients cannot tolerate strong medications (such as morphine) for pain. (F)
92	96	Opioid analgesics are best ordered on a "prn" basis to encourage minimal dosing and reduce the risk of addiction. (F)
97	94	If patients take 10-15 extra strength Tylenol tablets each day they are at risk of liver damage. (T)
88	82	NSAIDs may diminish kidney function in the elderly. (T)
Discouraging Results		
71	59	Respiratory depression rarely occurs in patients who have been receiving opioids for several weeks. (T)
71	70	A placebo can be used to determine if pain is real. (F)
49	50	Prolonged administration of meperidine (Demerol) may result in seizures. (T)
74	75	Addiction occurs in 30-40% of persons treated with opioid analgesics for chronic pain. (F)

Figure 6: Facility Assessment

Percent of agencies and facilities that reported the presence of key quality indicators at baseline.



Conclusion

Baseline data from Practice Change Programs implemented in seven states provided a snapshot of pain management practices in long-term care facilities and home health agencies in the US. Pain was common in the patient population served: 49% of patients in home health and 47% of patients in long-term care reported having moderate to severe pain in the previous 24 hours. Long-term care facilities tended to have fewer system practices in place to support effective pain management than did home health agencies. Many facilities and agencies had policies and procedures in place to assure that pain was assessed, but few had set standards for intervention and follow-up, or systems to insure communication with patients and families about the importance and implementation of pain management. There was little evidence that they had instituted pain quality improvement efforts. The majority did not have systems in place to assess pain in the cognitively impaired, although long-term care facilities were more likely to have them than were home health agencies.

A knowledge and attitudes survey of facility staff that participated in the programs revealed substantial knowledge deficits. There was little difference in overall knowledge between long-term care and home health staff. In general, the baseline data demonstrated a critical need for improvement in pain management practices.