Title

(O-K4) Two-year Results from a New Model Pain Coach Educator Program and Integrative Discharge Toolkit for Pain Management in an Urban US Teaching Hospital and Emergency Department During COVID-19 Pandemic

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 25(1.1)

ISSN

1936-900X

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Publication Date

2024

DOI

10.5811/westjem.63024

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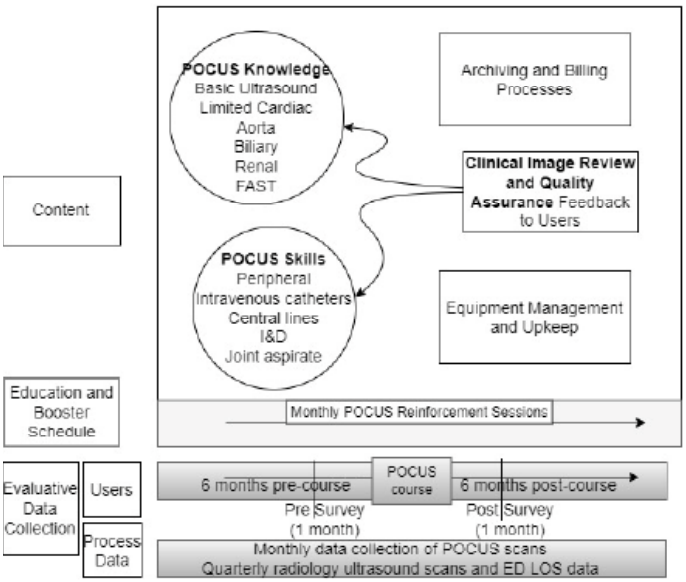

Figure 1.VA POCUS implementation plan-study timeline

Table 1. Identified themes and codes and respective barriers and facilitators as stratified by the Consolidated Framework for Implementation Research (CFIR)

CFIR construct: Individuals (number of participants)
Themes: Convenience and efficiency, opinions on clinical POCUS use, opinions on POCUS education
• **Barriers:**
• **Time constraints based on clinical volume (14/14)**
• **Comfort level with background POCUS knowledge and skills (14/14)**
• **Eliminating unnecessary and cumbersome steps for image acquisition and documentation/storage (11/14)**
• **Facilitators:**
• **Excellent image quality and ease of US machine use (14/14)**
• **Producing differentials and diagnoses; answering pointed clinical questions or progression of specific diseases (11/14)**
• **Provider clinical improvements and useful POCUS exams (10/14)**
• **Ensuring patient safety (7/14)**
• **Clinical standard of care (10/14)**
• **Patient-centered care improvements with increased efficiency and satisfaction (8/14)**
• **Hands-on POCUS group training rather than didactic learning (14/14)**
• **Both:**
• **US machine usability and familiarity (14/14)**
• **Ease of documentation (Barrier 4/14; Facilitator 8/14)**
• **Desire for more practice and repetition (13/14)**
• **Individuals' comfort with POCUS image acquisition and interpretation (Barrier 8/14; Facilitator 5/14)**
• **Different teaching and learning styles for POCUS education: preferred hands-on, small group training over classroom didactics (14/14); human models (5/14); simulation (6/14)**
CFIR constructs Inner setting (Themes: ED environment and peer influences/feedback/teaching)
• **Barriers:**
• **Availability of alternative radiology imaging modalities (11/14)**
• **Location and cleanliness at other sites (but not a problem at the Durham VA) (12/14)**
• **Facilitators:**
• **Availability of US machines and resources, cleanliness, and maintenance (14/14)**
• **US learners and resident teaching (14/14)**
• **POCUS use for ED procedures (14/14)**
• **Existence of a POCUS archiving system and faculty credentialing system (12/14; 14/14)**

Table 2. Durham VA Healthcare System Emergency Department POCUS scans, pre/post-course

	Pre-course POCUS scans (6 months)		Post-course POCUS scans (6 months)	
	Q4 (November 1, 2021 - January 31, 2022)	Q1 (February 1, 2022 - April 30, 2022)	Q3 (May 1, 2022 - July 31, 2022)	Q4 (August 1, 2022 - October 31, 2022)
Types of ED POCUS scans performed	0 cardiac	14 cardiac	25 cardiac	39 cardiac
	2 DVT	0 DVT	10 DVT	14 DVT
	0 renal	1 renal	2 renal	14 renal
	2 bladder volume	1 bladder volume	9 bladder volume	14 bladder volume
	2 biliary	4 biliary	9 biliary	12 biliary
	1 IVCFT	0 IVCFT	2 IVCFT	8 IVCFT
	9 lung	0 lung	9 lung	21 lung
	2 soft tissue	1 soft tissue	9 soft tissue	22 soft tissue
	0 aorta	1 aorta	2 aorta	4 aorta
	0 RUSH	0 RUSH (4 tandem)	0 RUSH	13 RUSH
	1 cardiac-concomitant	1 cardiac-concomitant	9 cardiac	2 cardiac
	0 ob/gyn	1 ob/gyn	2 ob/gyn	3 ob/gyn
	2 ocular	1 ocular	1 ocular	3 ocular
	0 liver	1 liver	9 abdomen (GBC)	1 liver
	1 vascular?	1 vascular/femoral artery		1 fistula
Monthly ED POCUS scans performed	0 US - November 2021		41 US - May 2022	
	0 US - December 2021		11 US - June 2022	
	10 US - January 2022		29 US - July 2022	
	3 US - February 2022		20 US - August 2022	
	91 US - March 2022		85 US - Sept 2022	
	10 US - April 2022		69 US - Oct 2022	
Total ED POCUS scans performed	72 total POCUS scans in 6 months pre-course (Nov 1, 2021 to April 30, 2022)		267 total POCUS scans in 6 months post-course (May 1, 2022 to Oct 31, 2022)	

9 (O-K4) Two-year Results from a New Model Pain Coach Educator Program and Integrative Discharge Toolkit for Pain Management in an Urban US Teaching Hospital and Emergency Department During COVID-19 Pandemic

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Oral Presenter: Phyllis L. Hendry, MD

Objectives: To describe the two-year implementation pilot and descriptive analysis of a novel emergency department (ED) pain coach educator program including a customized integrative patient pain toolkit for use at home, including patient demographics, pain characteristics, coaching and toolkit topics, implementation challenges, and one-month patient feedback and toolkit utilization survey.

Background: Pain is the most common presenting ED complaint, yet most emergency care professionals receive minimal education about nonpharmacologic, integrative pain management options. It is faster to administer or prescribe medications than to provide patient education and nonpharmacologic, nonopioid modalities. The US and other countries are dealing with opioid epidemics resulting in a renewed focus on pain education and integrative alternatives. The COVID-19 pandemic escalated pain management challenges. To address this, we developed a novel ED pain coach educator program providing individual, customized education sessions and integrative pain management toolkits for acute and chronic pain, followed by a one-month feedback and utilization survey.

Methods: The project was implemented in an urban US safety-net, not-for-profit hospital system and registered with the affiliated university's Quality Improvement Project Registry. Data collection occurred from January 1, 2021–December 31, 2022 with enrollment initially starting in EDs

and trauma center followed by expansion to select inpatient services. Study inclusion criteria included patients ≥14 years with acute or chronic pain with preference given to high-risk or high-utilization patients. Patients were excluded if in extreme pain prior to initial assessment and treatment, incarcerated, violent, suicidal, or critically ill. A training program and curriculum was developed for inaugural pain educators. Toolkits were customized based on type of pain and interest with a choice of 7 integrative options and 17 educational brochures. Patients were identified through electronic health record (EHR) tracking systems, paging, rounding, shared service patient lists, or by healthcare professional verbal request. All data was stored and managed in REDCap. Beginning in November 2021, patients completed a 30-day post-session phone survey that included questions about frequency of home toolkit use and session feedback. Descriptive statistics, Area Deprivation Index (ADI), medical and pain diagnoses, education and toolkit items provided, challenges, and follow-up survey data were collected and analyzed.

Results: There were 1,492 sessions conducted over two years with 1,295 unique patients receiving pain coach education sessions and discharge toolkits. The average age was 47.8 years (SD 17.2). The majority were female (63.6%), Black (53.7%), and non-Hispanic/Latino (96.6%). Most (43.6%) had a high level of socioeconomic disadvantage (ADI score >85, range 2-100). Sessions occurred in the ED (63.5%), in-patient (28.8%), out-patient (4.6%), and other (2.6%). Pain was reported as acute (55.3%), acute on chronic (28.1%), and chronic (16.6%), with patients often having multiple pain diagnoses (musculoskeletal, 73.4%; abdominal/pelvic pain, 13.8%; and low back pain, 12.8%). During customized educational sessions 89.7% of patients received a "4 flat tires analogy" stress ball, 87.9% hot/cold therapy, 86.9% aromatherapy inhaler/education, 56.6% pain journal with guided questions, 48.7%, virtual reality viewer, 33.4% therapeutic coloring, and 16.5% acupressure device. The top three challenges in conducting pain coaching sessions included medical condition such as nausea or lethargy, 14.5%; time constraints, 7.9%; or too much pain, 6.8% with 65.1% of sessions reporting no challenges. Of the 185 survey respondents, 169 remembered the session and were using toolkit items at home with 147 (86.9%) rating the session as helpful or very helpful and 135 (79.9%) using toolkit items daily or weekly.

Conclusion: Results from this novel ED-based pain coach education/toolkit program provide valuable insights and benefits for development of an international pain coach model. Most patients ranked the program as very helpful/helpful with continued use of integrative toolkit items at one month and qualitative statements of patient satisfaction and improved functionality. Appropriate timing of approach was a key issue. Multidisciplinary project champions and recognition were important to project success along with rounding. All program materials including an implementation guide are available online. Future plans include assessing program outcomes such as readmission and return ED rates, decrease in opioid use, cost effectiveness, and functionality.

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10 (P78) Evaluation of Emergency Room Reattendance and Re-hospitalisation Reductions with Our Hospital-to-Home Programme

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Poster Presenter: Jean MH Lee, MD, FRCSAE

Objectives: Many patients get readmitted post hospital discharge due to multiple factors. Home visits through hospital-to-home (H2H) programs are targeted at these at-risk patients with complex co-morbidities and high social care needs. We aimed to review the outcome of a H2H program with regard to reducing emergency department (ED) visits and readmissions.

Background: Upon discharge from inpatient wards, patients with high risk of re-hospitalisation are followed up by a heath care team at home visits, with the purpose to identify patient care needs which range from medical to social needs, and they intervene to prevent an avoidable readmission back to the ED or hospital. We also aimed to optimise the well-being of the patient with our multi-disciplinary team approach.

Methods: A retrospective review of patients cared for under the program in a tertiary hospital in Singapore from September 2020–August 2021 was conducted. We studied the demographics of patients three months prior to enrolment into the H2H program and followed up with them for the period of enrolment. The enrolment consisted of two home visits