2019

Implementation of a Chronic Pain Functional Assessment Tool in Primary Care Practice

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Recommended Citation
Stevens, Jude Emerson, "Implementation of a Chronic Pain Functional Assessment Tool in Primary Care Practice" (2019). College of Nursing and Health Sciences Doctor of Nursing Practice (DNP) Project Publications. 28.
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Implementation of a Chronic Pain Functional Assessment Tool in Primary Care Practice

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Conflicts of Interest Statement

• There are no relationships, conditions, or circumstances that present a conflict of interest relevant to the content of this presentation.

• This project was not funded.
Introduction – Problem

• 20% of patients with non-cancer pain symptoms or pain-related diagnoses receive an opioid prescription (CDC, 2016)

• 46 people die every day from overdoses involving prescription opioids (Scholl et al., 2018)

• Number of opioid-related deaths involving a prescription opioid has remained relatively consistent since 2015 in VT (VDH, 2018)
Available Knowledge

• >50% of Americans who report chronic pain receive care in the primary care setting (Anderson et al., 2012)
• PCPs face significant barriers in managing chronic pain (Moore et al., 2016)
• Current guidelines advocate use of a functional assessment to improve the efficacy and safety of chronic pain management using opioids
Purpose and Aims

• Integrate functional assessments into patient care visits for chronic pain
• Optimize safe and effective prescribing
Context and Setting

• Appletree Bay Primary Care
  • Academically-affiliated Patient-Centered Medical Home (PCMH) primary care practice in Burlington, VT
  • High proportion of adult patients with complex co-morbidities and low socioeconomic status
Rationale

• NP identified as having large number of chronic pain patients
• Pain, Enjoyment of Life, and General Activity (PEG) scale is a brief, well-validated functional assessment tool
• Use of functional assessment
  • Assures compliance
  • Reaffirms commitment to improved analgesia and function
  • Useful information in short period of time
When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient.
- Evaluate risk of harm or misuse:
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (e.g., PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (e.g., PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (e.g., difficulty controlling use).
    - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME):
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤3 months).
**PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)**

1. **What number best describes your pain on average in the past week?**

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<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Pain as bad as you can imagine</td>
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2. **What number best describes how, during the past week, pain has interfered with your enjoyment of life?**

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<td></td>
<td>Does not interfere</td>
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<td>Completely interferes</td>
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3. **What number best describes how, during the past week, pain has interfered with your general activity?**

<table>
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<td>Completely interferes</td>
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</table>
ASSESS BENEFITS OF OPIOID THERAPY

Assess your patient’s pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item (PEG) Assessment Scale:

1. What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)

3. What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.
Methods

• Quality improvement project
• Baseline data on current functional assessment utilization and barriers amongst providers were collected
• PEG scale was administered from Nov 2018-Feb 2019 during routine chronic pain visits
• Post-visit descriptive statistics were computed
• Summative exit interview was completed with the NP
Interventions

• Administer PEG during patient visits
• NP completes post-visit survey
• Disseminate findings and recommendations to practice
Study of the Interventions

• Post-visit survey data
• Summative exit interview with NP
Baseline provider survey (n = 5)

Administer PEG (n = 16)

Project manager (n = 7)
NP (n = 9)

Post-visit survey (n = 16)

Summative exit interview

Disseminate findings and recommendations to practice
Measures

• Contribute to understanding of the patient’s level of pain and/or function?
• Influence plan of care?
• Other components of chronic opioid assessment (i.e. VPMS, naloxone, opioid contract renewal)?

• Score entry in EHR?
• Previous scores in EPIC?
  • Calculation and/or change?
• Facilitate conversation with patient?
• Opioid refill?
Analysis

• Descriptive statistics of post-survey data
• Qualitative analysis of summative exit interview
Results – baseline provider survey

- 80% clinic providers (n = 5) reported that functional assessments have value in managing chronic pain, 20% used them regularly
Results

• Post-visit surveys (n = 16)
  • Consistent documentation of PEG scores in the medical record (94%)
  • Increased conversations regarding chronic pain (56%)
  • Prompted completion of other components of evidence-based opioid management (44%)
  • Improved understanding of patient pain/function (38%)
  • Informed the plan of care (13%)
Results (continued)

• Summative exit interview
  • Benefits of PEG use
    • Quick and easy to use
    • Facilitated discussion about treatment and goals
    • Especially helpful when starting/altering meds
    • Helpful to document progress or lack thereof with therapy
    • “Absolutely” plans to use in future
  
• Barriers to PEG use
  • Difficult to find tool in EHR
  • Time constraints
  • No prompts in EHR for chronic pain visit components
  • Questionable utility with long-term opioid use
Interpretation

• What does it take to implement a new tool in primary care practice?
  • New systems
    • Morning huddle
    • Chart review
    • EHR flag/visit type
    • Reports
  • Teamwork
    • Involve RNs, MAs, NP students
Limitations

• Small sample size
• Single patient panel
• Lack of baseline data
• Sustainability
Conclusions

• PEG use in primary care
  • Limited impact on plan of care
  • May be valuable as a vehicle for broader discussions on chronic pain management and other components of evidence-based prescribing practices for non-cancer, non-palliative pain
  • Room for wider integration
Acknowledgement Statement

• My deepest appreciation goes to
  • Amy O’Meara, DrNP, APRN
  • Deborah Wachtel, DNP, APRN
  • Ellen Watson, MS, APRN
  • Ellen Long-Middleton, PhD, APRN
  • Jennifer Laurent, PhD, APRN
  • Richard Pinckney, MD, MPH
  • VT AHEC providers and staff
  • Appletree Bay providers, staff, and patients
  • DNP class of 2019
  • James Ciulla
References


