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

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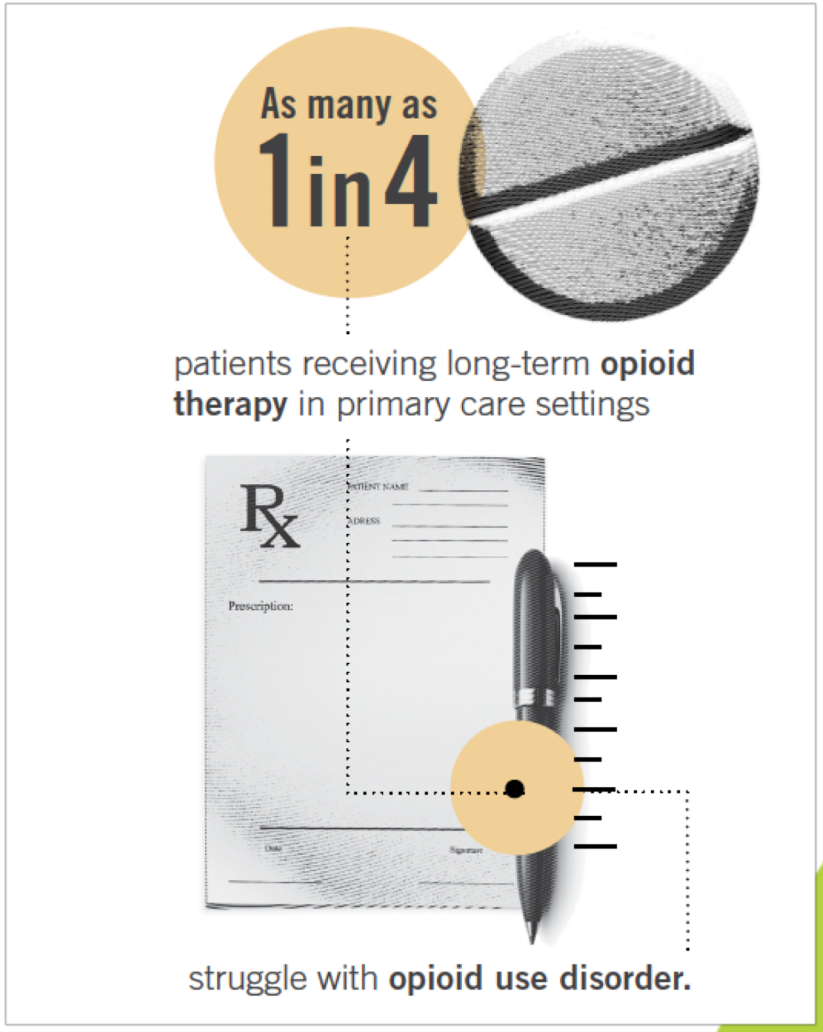
Conflict of Interest Statement

- 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)



CDC, 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

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, 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 (eg, 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 (eg, 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 (eg, 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?

0	1	2	3	4	5	6	7	8	9	10
No Pain										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?

0	1	2	3	4	5	6	7	8	9	10
	Does not interfere									Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
	Does not interfere									Completely interferes

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.

CDC, 2016

Methods

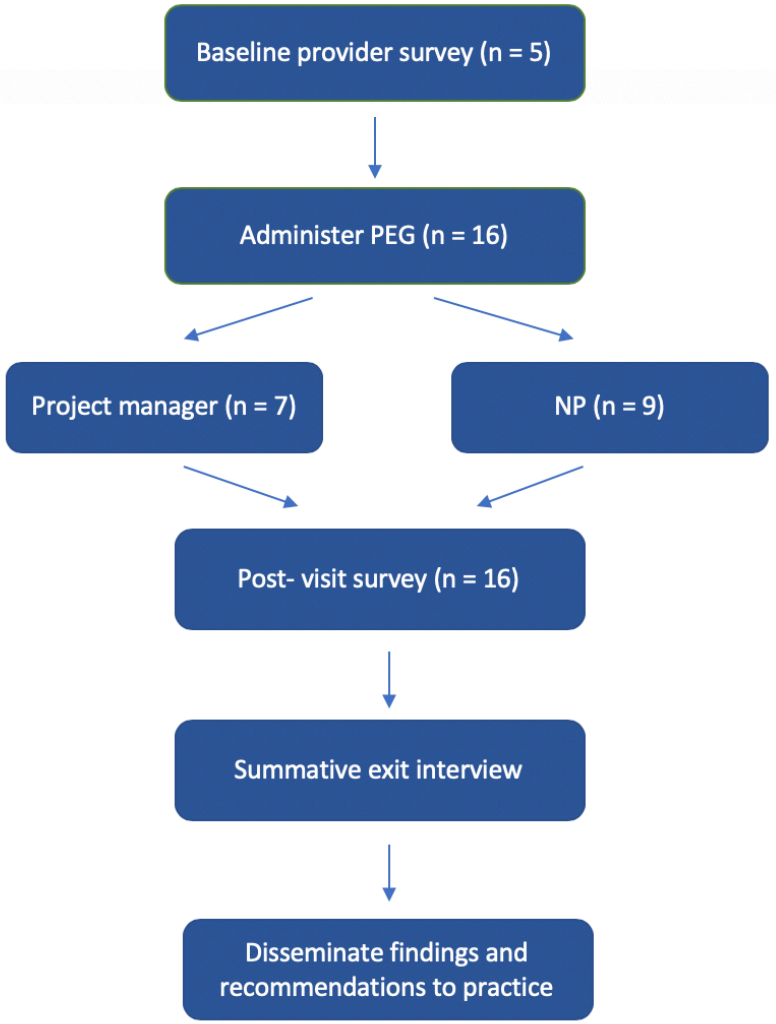
- Quality improvement project
- Baseline data on current functional assessment utilization and barriers amongst providers were collected
- PEG scale was administered from Nov 2018-Feb 2019 during routine chronic pain visits
- Post-visit descriptive statistics were computed
- Summative exit interview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

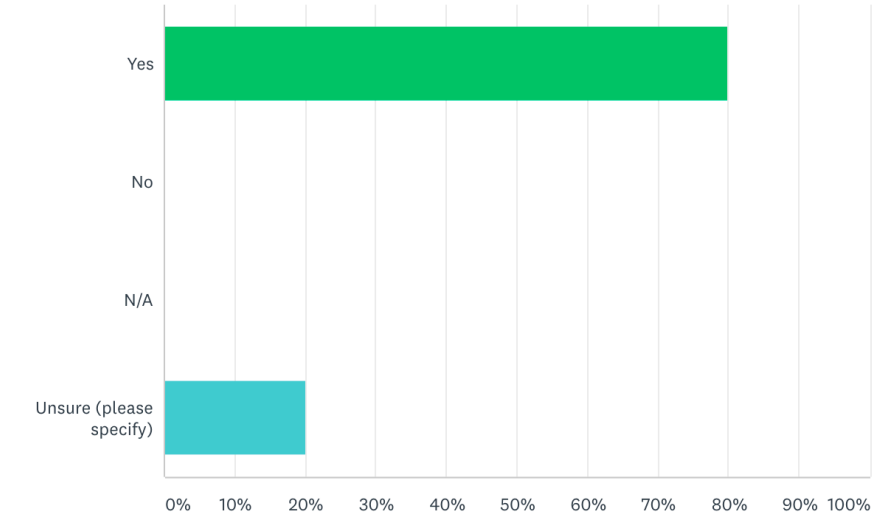
Analysis

- Descriptive statistics of post-survey data
- Qualitative analysis of summative exit interview

Results – baseline provider survey

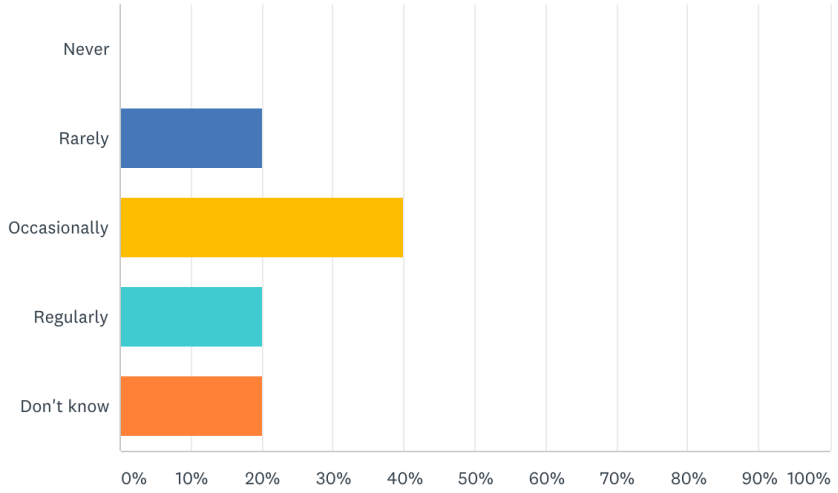
Do you believe functional assessments have value in treating patients with chronic pain?

Answered: 5 Skipped: 0



How often do you use functional assessments with your chronic pain patients?

Answered: 5 Skipped: 0



- 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

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