

Chronic Pain Policies: Providing Quality Care in the Community Health Clinic Setting

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Chronic pain is becoming an ever increasing chief complaint in the world of medicine. No matter what field of medicine a provider is in they likely will treat patients who suffer from chronic pain. And while chronic pain clinics are becoming more common and available; the low-income patient without insurance or access to transportation cannot always receive care from these facilities. This leaves the family practice provider with the burden of understanding and managing chronic pain on top of a commonly already over loaded schedule where visit times are short and limited. This patient can be managed properly, with standardized policies and protocols in place, the right screening tools and follow up templates chronic pain can be managed appropriately and in a reasonable amount of time.

In 2011 it was estimated that 100 million Americans suffered from chronic pain(1). This figure was larger than the estimated Americans with diabetes. Chronic pain affects many and it also disables individuals from being able to work or even perform daily tasks. In a survey done by the National Institute of Health it was said the four most common types of pain indicated by the survey were low back pain (27%), followed by severe headache or migraine pain (15%), neck pain (15%) and facial ache or pain (4%) (2). These are all common complaints seen in a Family Practice setting. During my year of clinic rotations for Physician Assistant school I have seen all of these complaints and helped treat many chronic pain patients in almost all of my rotations. It can often be a frustrating complaint for providers because of the confusion of the origin of the pain, the exasperation from the patient because they cannot find relief and the overwhelming amount of medications available and knowing when to use which one. All of these factors have lead me to study chronic pain more and after speaking with the staff at Central Mississippi Health Services Inc. I learned that they too see a large amount of chronic pain and have limited resources for referral.

Further investigation with the clinic revealed that a fellow GE-NMF PCLP scholar from last year helped the clinic develop Chronic Pain Protocols with screening assessments included but the clinic never put the protocols into place. We decided it would be a productive project to have me see the chronic pain patients

using the protocols developed last year and revise them as needed so they can be used on a daily basis by the clinic.

The scholar from last year, Kristy Goodman; had done thorough research on treating chronic pain and picking screening tools that had been validated with Evidence Based Medicine. She picked the following assessments to determine if opioid treatment should be used, if the patient had mental health issues, and to create a contract between provider and patient.

Screener and Opioid Assessment for Patients with Pain (SOAPP): Tool for clinicians to determine how much monitoring a patient on opioids will require. Helpful for determining which patients require more monitoring on opioids or which should be referred to a specialty clinic.

Consent for Chronic Opioid Therapy: A consent that informs the patient of risks of taking an opioid, possible addiction, development of tolerance and side effects expected specifically to men and women.

Long-term Controlled Substances Therapy for Chronic Pain: A consent going over the agreement and expectations between Provider and Patient for opioid use. These include maintaining the same provider, pharmacy, agreeing to urine drug tests, bringing prescriptions in original bottles to every visit, not sharing/selling prescriptions and the option for the provider to dismiss the patient from the practice for breaking any of the agreements.

Pain Assessment and Documentation Tool (PADT): Monitoring tool to use at follow up visits to assess how the patient's current medication regimen is helping control pain and allow for activities of daily living.

Current Opioid Misuse Measure (COMM): Similar to the SOAPP, this helps determine if patient's currently on opioids or who have recently used opioids have misused them. This helps guide what kind of monitoring the patient will require. A

score greater than nine indicates the patient is at increased risk for opioid misuse and should be monitored closely.

Depression Checklist: This helps determine if the patient is also struggling with depression as well as pain as this would change medication course and mental health referrals.

Anxiety Checklist: This helps determine if the patient is also struggling with anxiety as well as pain as this would change medication course and mental health referrals.

Along with these assessments she attached two articles: One on Practice Guidelines for Chronic Pain Management by Anesthesiology and an article from The Journal of Pain on Opioid Treatment Guidelines.

The Practice Guidelines for Chronic Pain Management go over evidence based medicine suggestions on how to treat chronic pain in a variety of ways prior to initiating opioids. These medication suggestions range from SSRIs to acupuncture.

The guidelines go into great detail on determining when to begin chronic opioid therapy, who should be started on this therapy, picking which opioid therapy to use, proper monitoring, when to discontinue therapy and many other pertinent guidelines and recommendations.

This binder created by Ms. Goodman is full of all the right stuff to help guide a community health center to best practices for chronic pain. But in the busy setting of Central Mississippi Health Services they never put any of these practices into place. Because of this I saw a great opportunity to test these policies, see what works and what needs to be tailored to the specific needs of the clinic and help them have a more substantial chronic pain guidelines in place.

The first item to be decided is who is a chronic pain patient. As decided by the clinic and outlined in Ms. Goodman's protocols; chronic pain is defined as pain persisting for more than three months. Any new patient fitting this definition or

patients who are being treated for chronic pain differently than the outlined guidelines in the binder would then be placed into the new policies and managed accordingly.

In order to do this I needed to select the proper screening tools to use at patient visits. The clinic had already selected three screening assessments that they felt were most important: the Depression, Anxiety and Current Opioid Misuse Measure. These assessments were to be given at the initial chronic pain visit. Along with these it is important to assess as best as possible, what is the source of the pain? Is it from an old injury? Car accident? Trauma? Foreign body (such as surgical screws)? If imaging and proper documentation of the source of pain has not been performed this will need to be done. Once the source of the pain is identified, or at least the process to identify it has been started we need to determine the characteristic of their pain so it can be categorized and treated effectively. Determining the origin of their symptoms will help select treatments. I have developed a method through mentorship that categorizes pain by recognizing symptoms that originate from certain organ systems in the body. Table 1 breaks these categories down:

Table 1: Categorizing Pain:

	Characteristics	Symptoms
Neurological	diabetic neuropathy, trauma, impingement	Burning, electric, radiating, shooting
Muscle	muscle tears, strains/sprains, rhabdomyolysis	aching, weakness, cramping
Inflammatory	infection, sprains/strains	tender to palpation, erythema
Bone	trauma, fracture, history of osteoporosis/osteopenia	deep pain, pain located in joints, joint stiffness, weight bearing pain
Central	stroke, trauma to brain/spinal cord	balance issues, strength/grip problems, numbness, paralysis

Psych/Emotional	history or symptoms of depression, anxiety, bipolar, ect.	sense of hopelessness, loss of interest, mood changes, feelings of doom
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An important side to chronic pain- and any patient visit in general is to have the patient be an active participant in their care. With chronic pain you can discuss what the patient's goals are for their pain management and make sure that realistic expectations are in place. It is most likely that a patient with chronic pain will never have complete resolution of their pain and setting goals that incorporate that reality is key. Goals for each patient could be vastly different and exploring this with patients can drastically change your treatment plan. Some patients may want to go back to work, others just want to be able to complete daily activities and some may want to find treatments that help eliminate the need for narcotics or other dependent and risky medications. Setting goals and reassessing at each visit will help tailor the visit and keep both provider and patient moving in the same direction together.

If narcotics are indicated for pain management it is suggested by guidelines to have a Pain Contract signed by both patient and provider. This contract goes over expectations of the patient to receive these medications. Every contract can be a little different but most include a minimum that the patient must only receive narcotic prescriptions from one provider, if another provider (such as an ER) prescribes narcotics the patient MUST inform their primary provider, patient agrees to pill counts and randomized drug screenings, early prescriptions will not be filled and the patient must use the same pharmacy. The previous PCLP scholar provided the suggestion of pain contracts and samples but I have not seen these contracts used at the clinic. This was one revision that I made this year- creating a contract with the clinic's information on it and having copies available for the staff so they are at hand whenever needed.

After deciding what was pertinent for a patient visit for managing chronic pain I came up with the following routine: for initial visits I gave the Depression, Anxiety Screenings and the COMM assessment. I spoke with the patient about the

origin of their pain, what tests had been done to confirm the origin, reviewed documents when available, discussed goals for pain management, what had been used in the past and came up with a temporary plan to try and control pain with usually a two week follow up. For follow up patients who had already filled out the screenings in the past I did a less intensive history taking and establish what their current regimen was, if it was helping obtain their goal and modified regimens as needed.

The following tables show my results from the screening assessments:

Table 2:

Depression Screening Results	
None or Minimal	1
Borderline	0
Mild	2
Moderate	3
Severe	2
Total	8

Table 3:

Anxiety Screening Results	
None or Minimal	0
Borderline	0
Mild	0
Moderate	2
Severe	3
Extreme or Panic	3
Total	8

Table 4:

Chronic Opioid Misuse Measurement	
Less than 9	2
Greater than 9	6
Total	8

While I only gave eight screening assessments I found it interesting that all but one patient had some degree of Depression, all had Anxiety and only two patients were considered 'without risk' by the opioid misuse screening. And while all of them had some degree of mental health issues I can only recall one patient being on medications for mental health and all but one patient was already being prescribed or had been prescribed narcotics. This was concerning for me because prescription narcotic overdoses have been on the rise for the last several years. Often I found patients would tell me that narcotics were the only medication that they found helpful and I could see how this developed a trap for the provider. Once you prescribe narcotics to a patient for pain relief it is hard to stop providing those prescriptions when the patient believes it is the only thing that works for them even though another medication would work a little less effectively but be far safer.

When discussing the origin of patient's pain I found it relatively common for patient's to have a traumatic origin to their pain. I probably worked with twenty chronic pain patients and several had pain from gunshot wounds, several more from work injuries involving heavy materials, car accidents and lastly surgery. I did not have one patient who was not aware of when or what had started their pain. This made documentation a little easier because I could be very specific but even with specifics there were not 'cures' available for these patients' pain. Even though the wounds had healed they were all experiencing lasting pain that more often than not had improved very little over the years.

Establishing goals for pain management proved to be somewhat difficult. Initially all the patients would list having their pain completely resolved as their main goal but once discussing the reality and expectations with chronic pain most would say they wanted to be able to do simple activities of daily living without the hindrance of pain. In some ways it seemed like an achievable goal to start with small steps like being able to cook three meals a day or do the laundry or play with the kids but when I would discuss ideas of achieving those goals such as walking around the block everyday, physical therapy, getting adequate sleep- patients would express a sense of defeat and state they did not think it was possible for them to be

able to work at their goal. Patients would tell me that they had been in pain for so long that they expected to be in pain forever and just wanted medications to help 'make it through the day'. With some encouragement patients would agree to try physical therapy or a small amount of exercise but often on follow up they had not followed through. It was hard to feel like I could convince patients that change was worthwhile or possibly beneficial when things have been done so differently in the clinic for so long. Unfortunately I did not feel like I was getting much support from the staff either. They appeared to understand what the best practices were for chronic pain but it seemed that when time was a factor they chose the path of least resistance so the visit could be kept short. This often meant a prescription for Lorcet, telling the patient they needed to be more active and to follow up in a month.

Where I felt I was able to make a difference was creating a template for the clinic's Electronic Medical Record. The staff at the clinic uses a generic template in the EMR for most patient visits and therefore important questions related to specific conditions are often missed. I spent about four days figuring out how the EMR worked, how I could create a template within the system and then creating a Chronic Pain template to be used at initial and follow up visits. The focus of this template was retrieving valuable History of Present Illness information and having useful tools in the 'Plan' portion of the visit for providers. Questions were inserted in the HPI that focused on the source of pain, what functional status the patient had, what limitations their pain created, what treatments they were trying, exactly what pain medications they were on and how much, how much and the quality of their sleep and I was able to insert Depression/Anxiety and the COMM assessments into template along with the ability to have scores calculated and recorded. In the Plan section I made sure all the useful tools were present from the other Plan template but added a Pain Management section. This section asked the provider to choose the origin of pain that was going to be treated that most likely was related to symptoms the patient was experiencing. The options were neurological, bone, inflammatory, muscle, central or psychological. The provider had the option to select multiple origins if needed. The purpose of this was to help the provider be specific on where the pain was coming from and help guide their choice for medications. There is also

a section for describing the patient's goal for pain management so this can help guide treatment and be reviewed at follow up and a section that requires the provider to indicate if the patient has signed a Pain Contract in order to be prescribed opioids. Several of the providers were excited about this new template because they felt it would help guide them through treating Chronic Pain just a little bit better.

My recommendations for further improvement of this project include an audit of a random selection of charts to help determine what tools are being used, if proper follow up is being done and to determine what further improvements and revisions the project needs to be efficient for the clinic. By determining what patients had signed a Pain Contract and if they were complying by the expectations of that contract it could help the provider determine what barriers the patient was having with their pain treatment and provide more specific and consistent care. A student could also check to see how often Depression and Anxiety screenings were being recorded in the EMR and if patients with a moderate to high score were being treated for their mental health illnesses. They could also look to see if providers were tracking the origin of pain in the Plan section and then if they were subsequently prescribing medications that targeted that type of pain. Once they have collected this data they could look for ways to overcome the barriers that were preventing the clinic from being able to achieve the level of care they desired for these patients. One very specific feature that I noticed was not being utilized was looking patients up in the state database to see if they were being prescribed opioids from other locations. They said they were all supposed to have access to this but it had not occurred yet. Assessing the barriers for this and helping the providers gain access to this resource could be very helpful.

This was an enlightening experience. I learned that even when providers are well prepared with the proper information and training that without the proper tools to execute proper care it becomes challenging to take care of patients. The providers understood the basics of treating chronic pain and had most of the resources they needed on hand but with limitations in their EMR and not being able to maintain consistency with care and follow ups it became difficult to maintain

organization and make progress with the patient care. I think with some follow up projects from other PCLP scholars we could help make their Chronic Pain Program a functional and effective program for not only them but their patients as well.

References:

- 1) Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research*. The National Academies Press, 2011. http://books.nap.edu/openbook.php?record_id=13172&page=1.
- 2) National Centers for Health Statistics, Chartbook on Trends in the Health of Americans 2006, Special Feature: Pain. <http://www.cdc.gov/nchs/data/hus/hus06.pdf>.