

Pain Speaking, Plain Speaking

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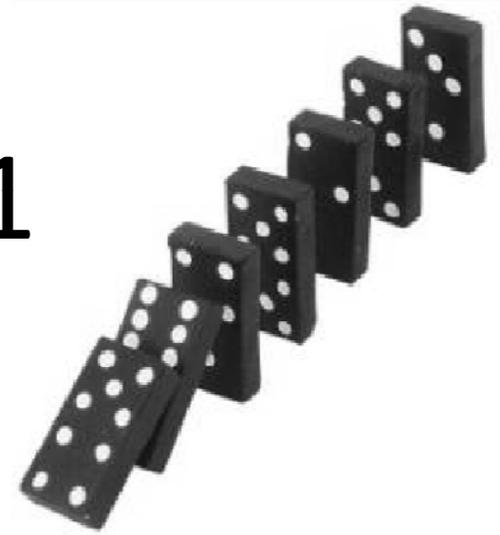
VA Greater Los Angeles, UCLA, Rand
Health

Overview

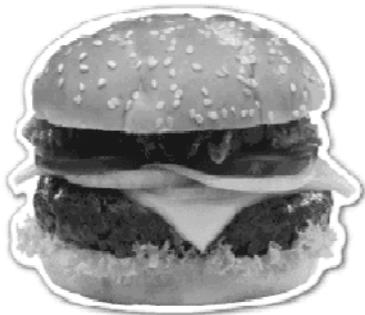
- Considerations and research in clinician and patient-reported pain screening,
- Current science of evaluating pain quality
- Implications for VA pain and symptoms research.



Food for Thought 1



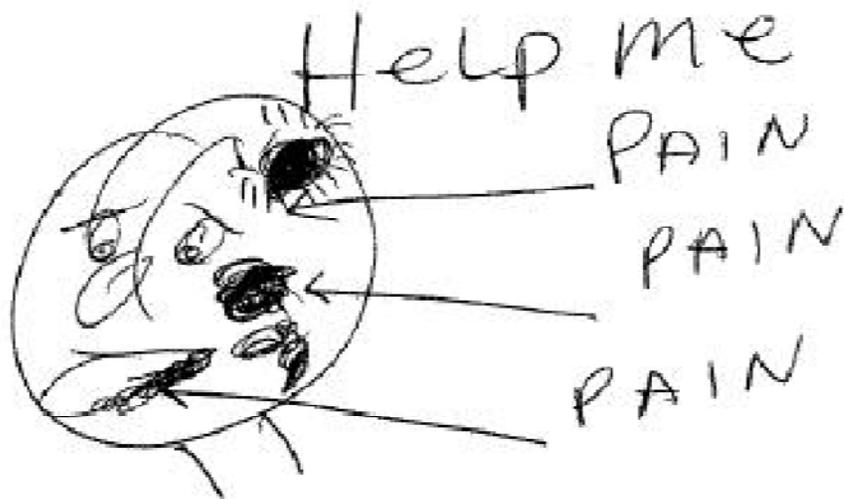
What are 'missed opportunities' in pain management? and how should we characterize them?



Undertreatment...?

I HAVE A TUMOR IN MY
HEAD OR DID YOU FORGET?

DOCTOR —



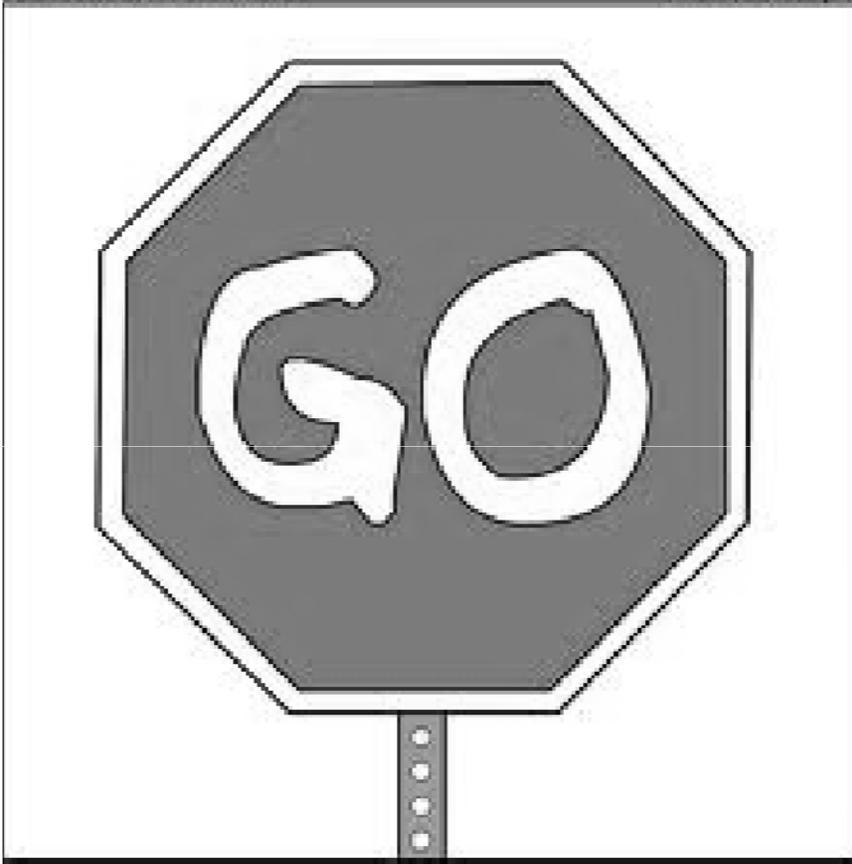
GODDAMN IT — I'M IN INTENSE
PAIN — I WANT IT TO STOP

Overtreatment...?



Wrong Treatment?





QUERI Step 1: Who (Why), Where, What?

Patient



Setting



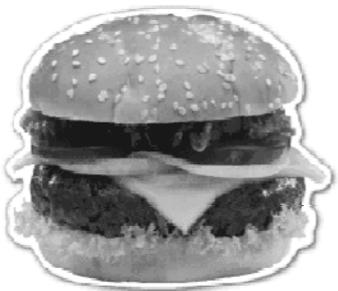
Tx Evidence



- Should we vary the interval of screening?
- Should we screen for pain ‘and’(e.g., substance misuse risk)?
- Cancer, long term care, and surgical (including outpatient) settings?

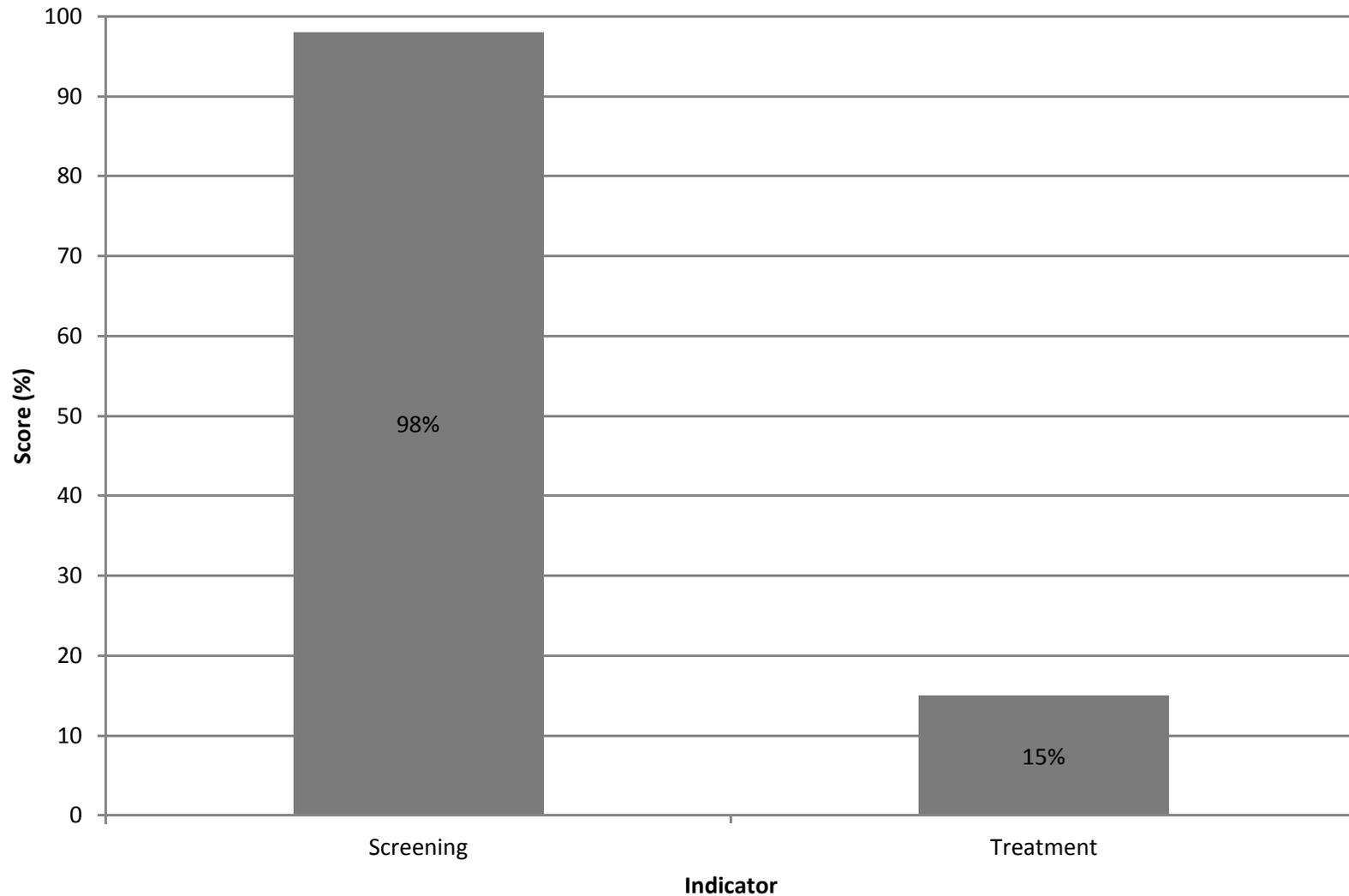
Food for Thought 2

How much variance in pain outcomes is related to its assessment?



Screening and Treatment Gap Measured by Chart Documentation in Primary Care

HELP Vet Pain Indicators

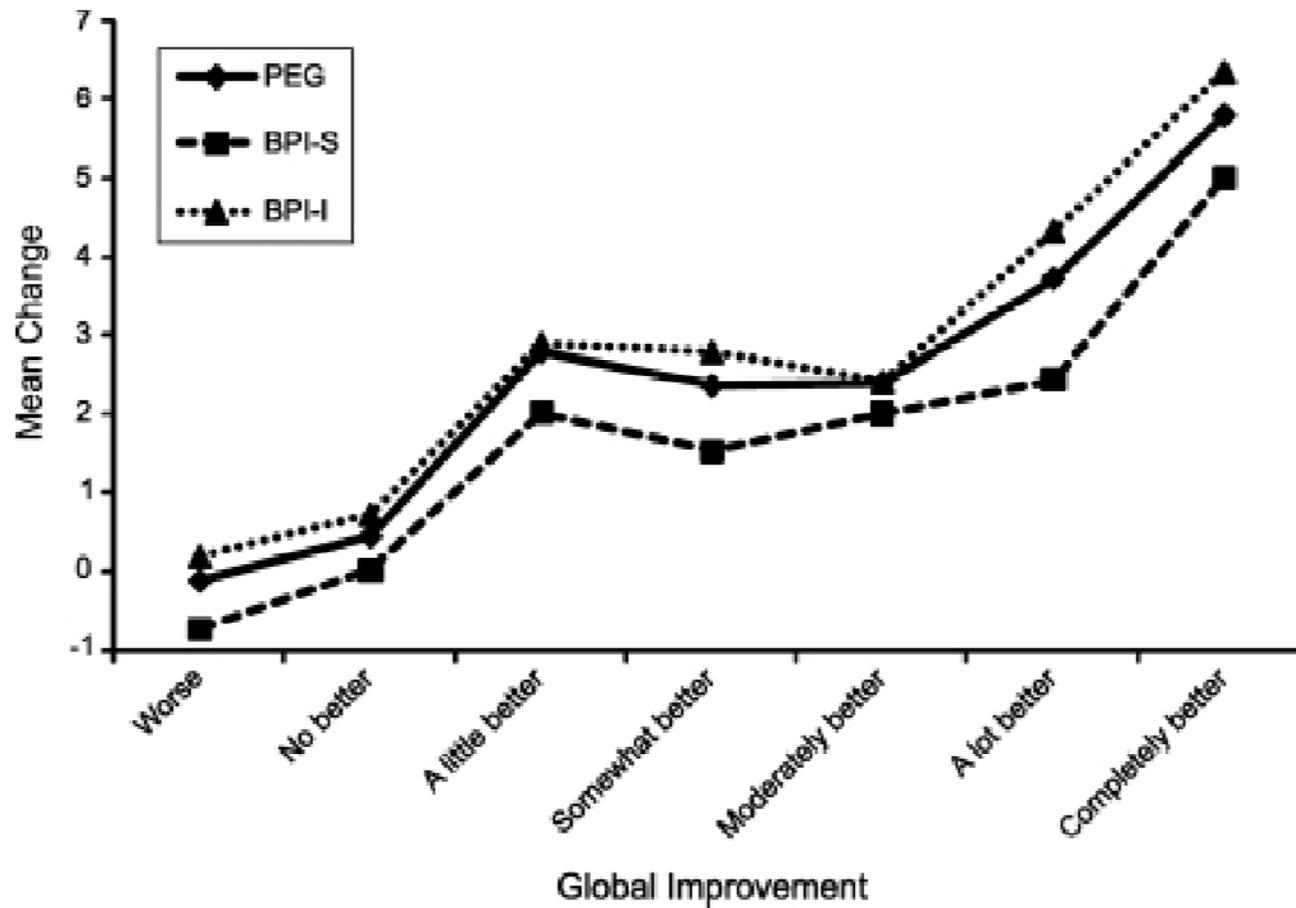


Screening-management gap

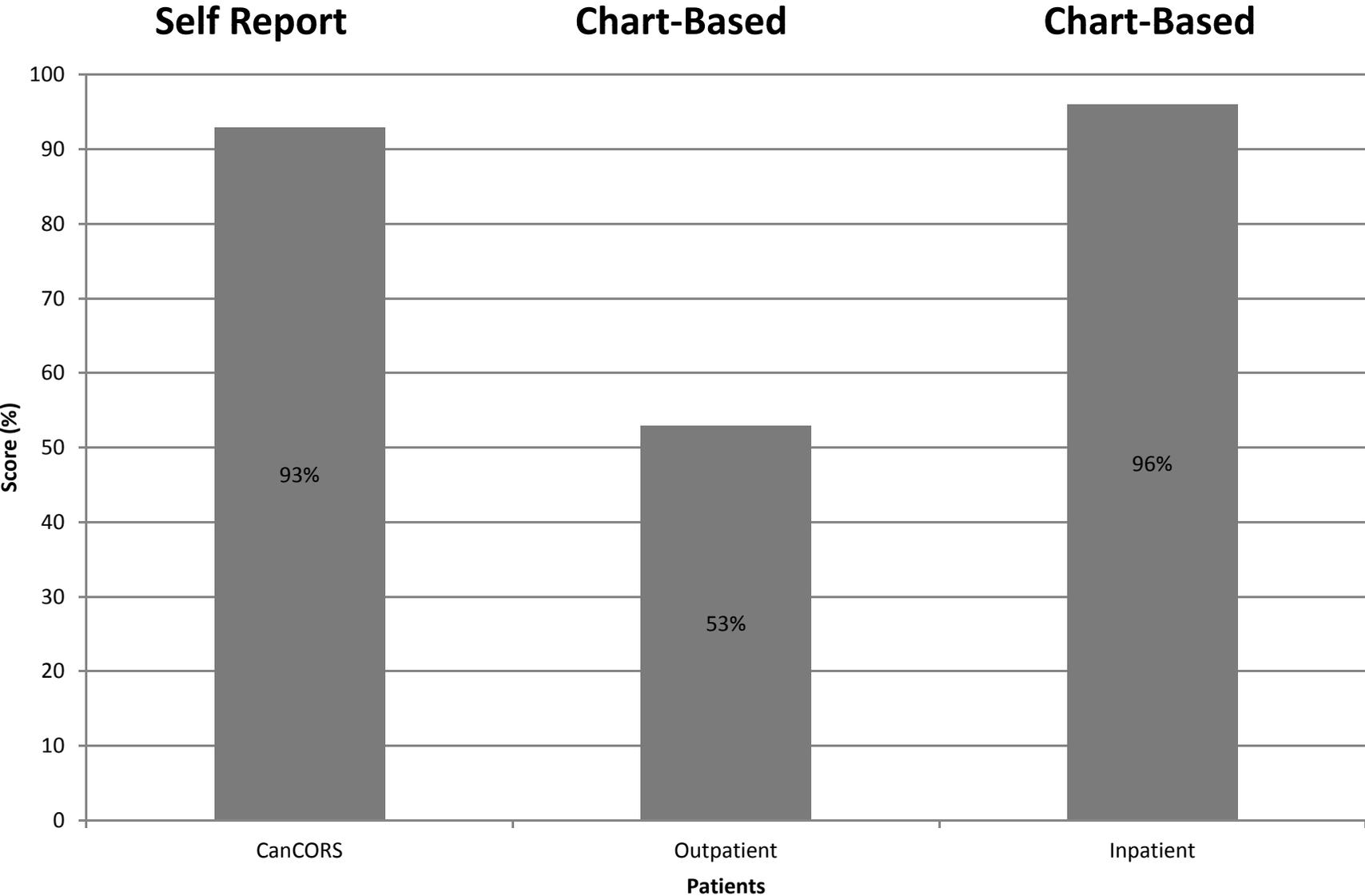
% Providers whom strongly agree with:	Percent (%)
Patients are able to rate their pain intensity	9.8
0–10 ratings by nurses accurately reflect patients pain ^b	27.5
Patients want me to ask about their pain	33.0
Pain medicines should be given when pain is severe	48.0
Pain has negative consequences on patient functioning	54.6
Pain rating is an important part of vital signs	13.5
Patients are more satisfied when pain concerns are addressed	34.9

^a Respondents are 77 providers in reference to the 140 patient sample

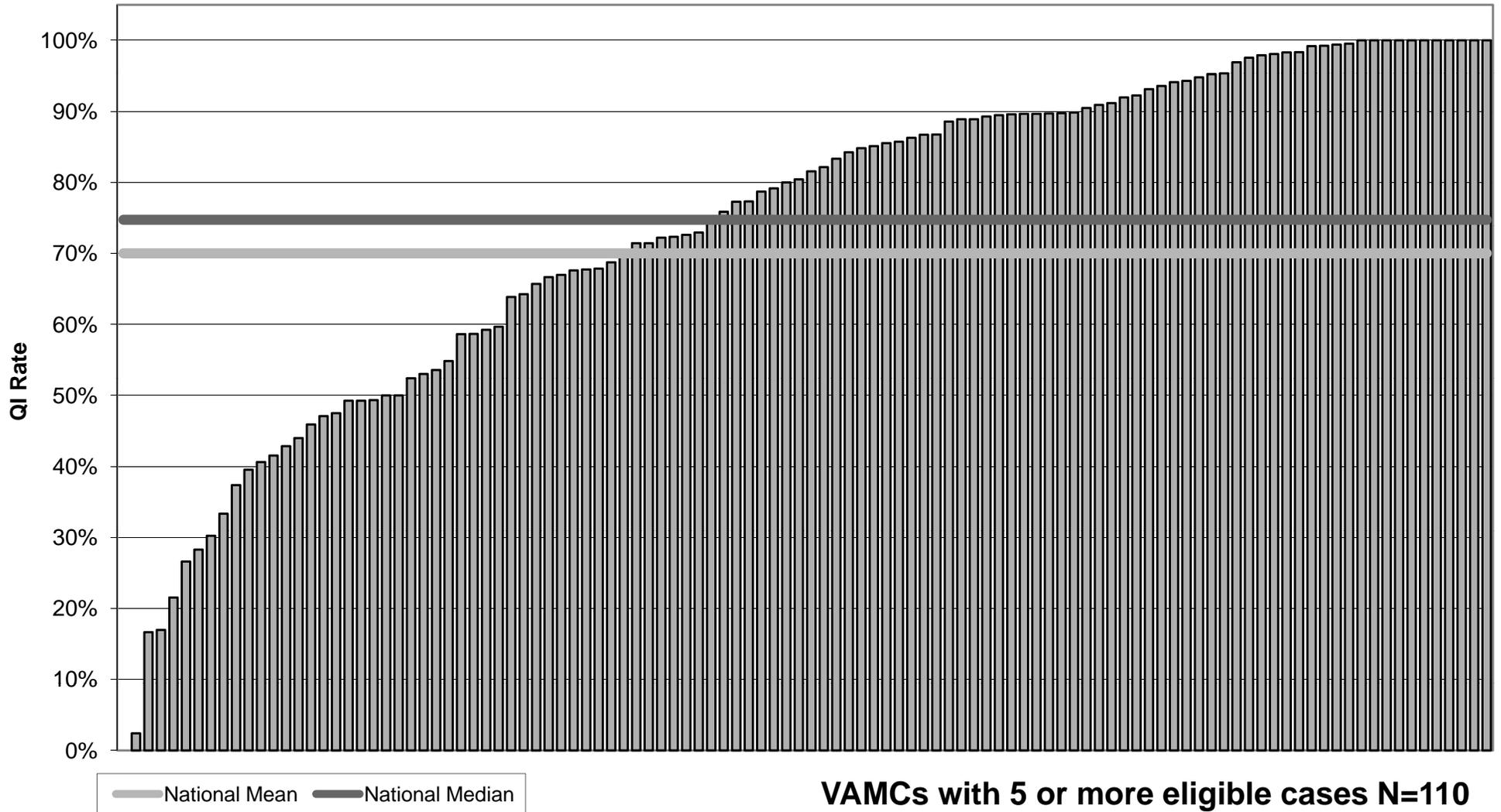
3 item PEG



Setting and Source Differences in Pain Screening



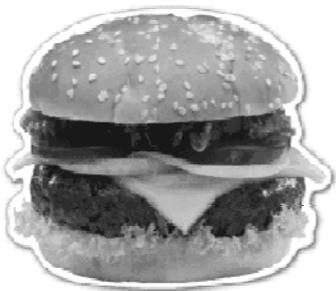
Cancer Pain



VA outpatient pain screening in advanced cancer

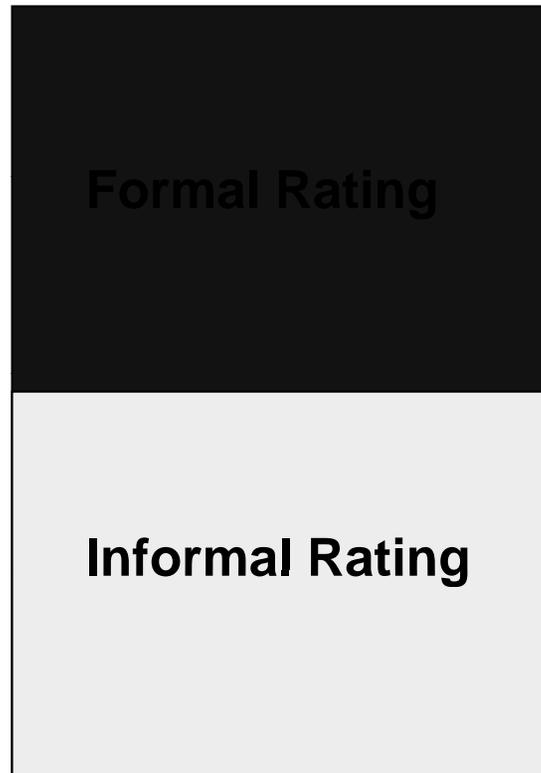
Food for Thought 3

Implementation represents a large gap in screening practice, possibly true regardless of approach or platform.



Is pain screening faithful to process?

HELP-Vets
Study:
Informal
Rating
Reduces
Screening
Sensitivity



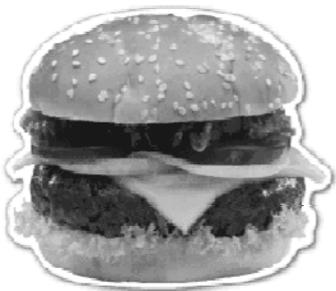
528 Pain '5th Vital Sign Ratings by Nurses

Lessons from Screening

- Some settings (cancer care) screening isn't happening
- Clinicians need assessment linked to management
- Providers need a measure of pain impact (that they believe!)
- Implementation of even simplest measures challenging

Food for Thought 4

Patient-reported outcomes offer a promising alternative, but also novel challenges related to screening

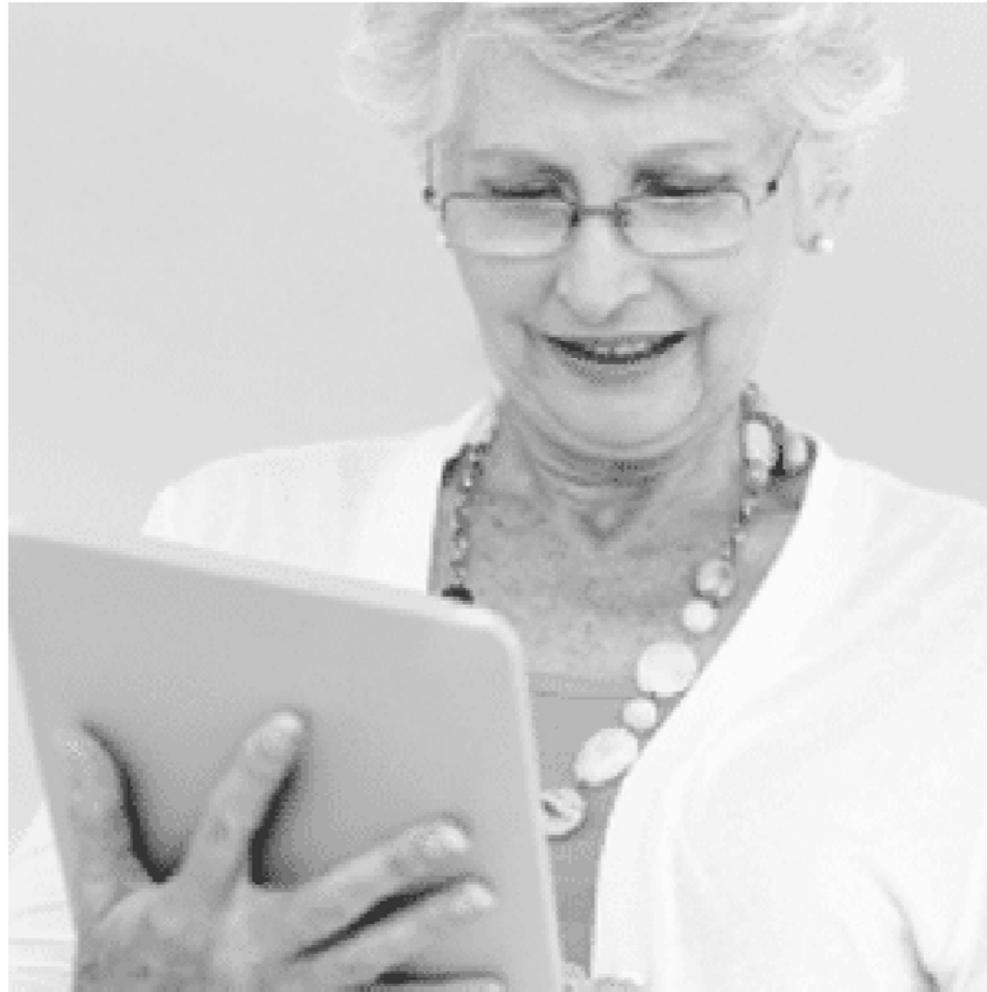


Patient Reported Outcomes

PROMIS definition “*health data provided by the patient through a system of reporting*”

- interviews, surveys, and computer assisted
 - Improve use if barrier is staff / staffing (e.g., cancer clinics)?
 - Narrow report variance & reduce the clinician & documentation components)?

The Ideal?

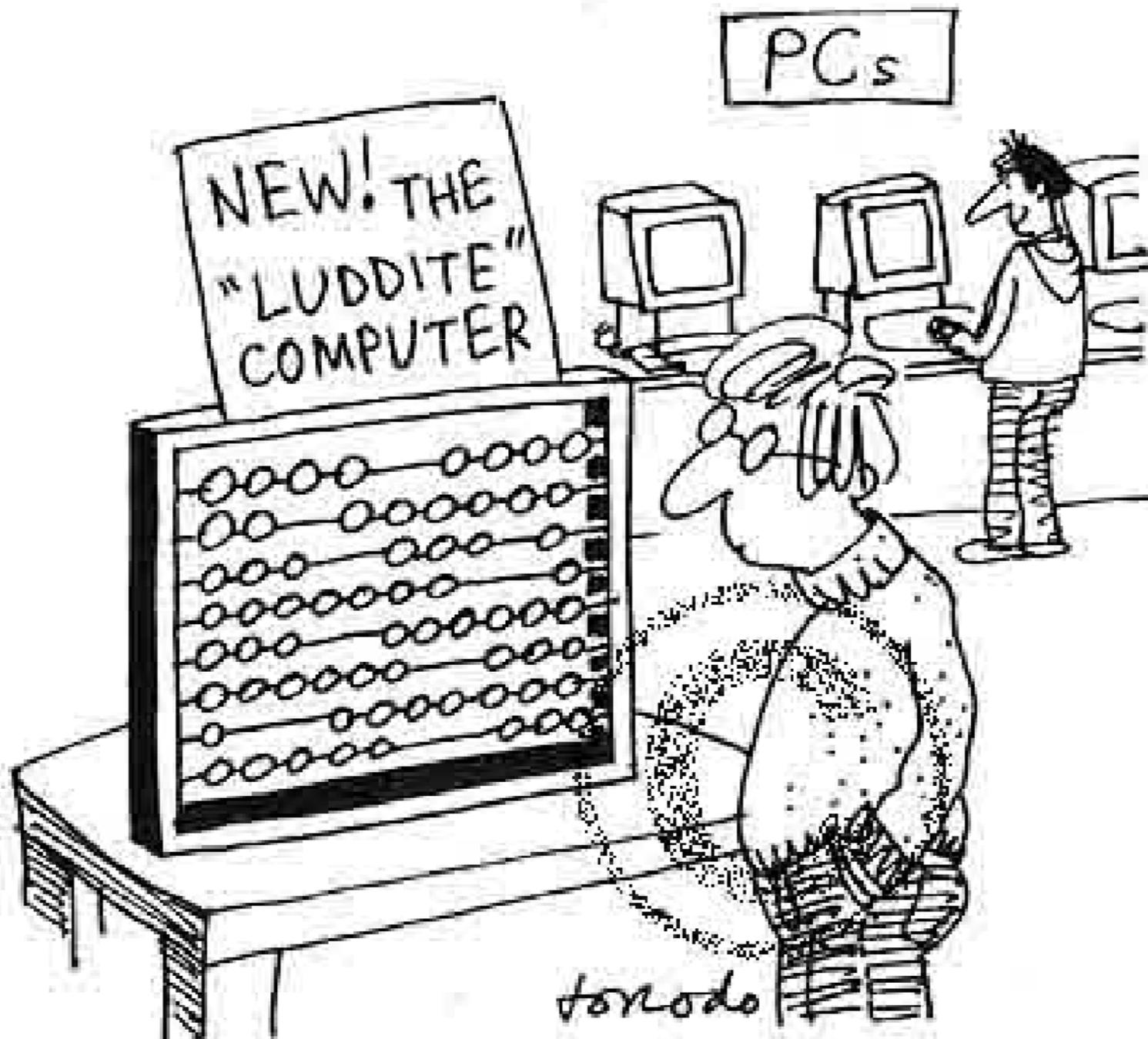


The Reality?

Visually impaired, homeless veteran with difficulty hearing walks into the clinic using a walker. He takes a seat next to a kiosk where he's asked to complete a symptom report using a computer. While loudly trying to clarify the task with a clerk, a bystander offers, "I'll help you. Just look here and fill this out."

Questions about PRO and Pain

- Could clinician detection offer superior
- What patients are at risk of unreliable reports? (Mental health, dementia, hearing, or visual impairment)
- What new forms of report variance might PRO introduce? (platform specific or environmental / bystander effects)



NEW! THE
"LUDDITE"
COMPUTER

PCs

forodo

Future Assessment



Proxy (Knowledgeable and Bystander) Reports



Self Reports
+
Clinician Documented
Reports



Patient Reports

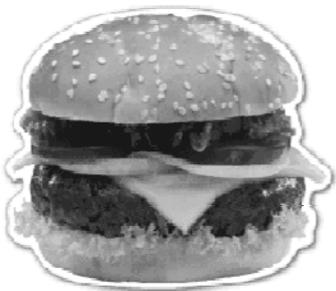


Clinician (as Proxy
and Patient- Received
Reports)

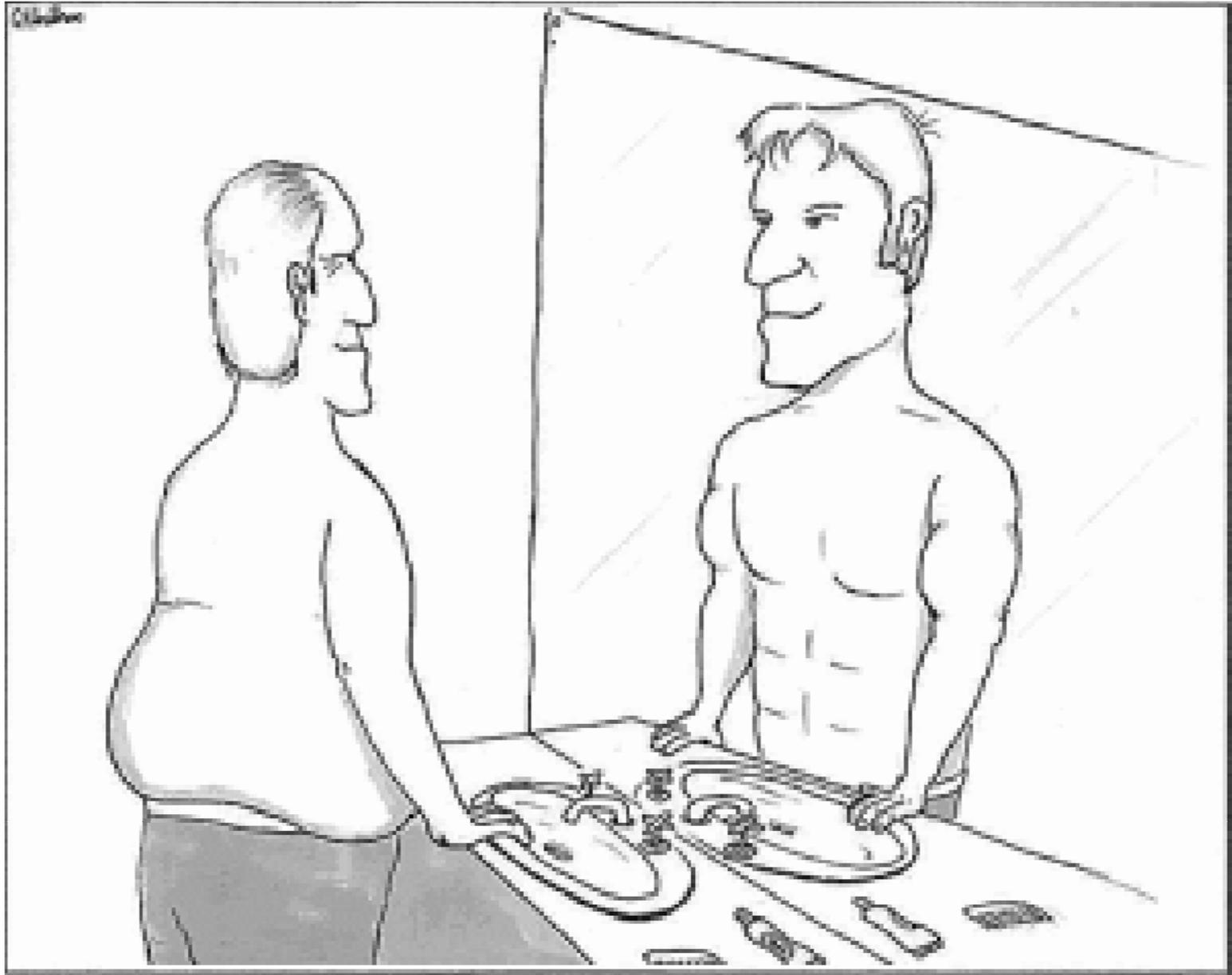


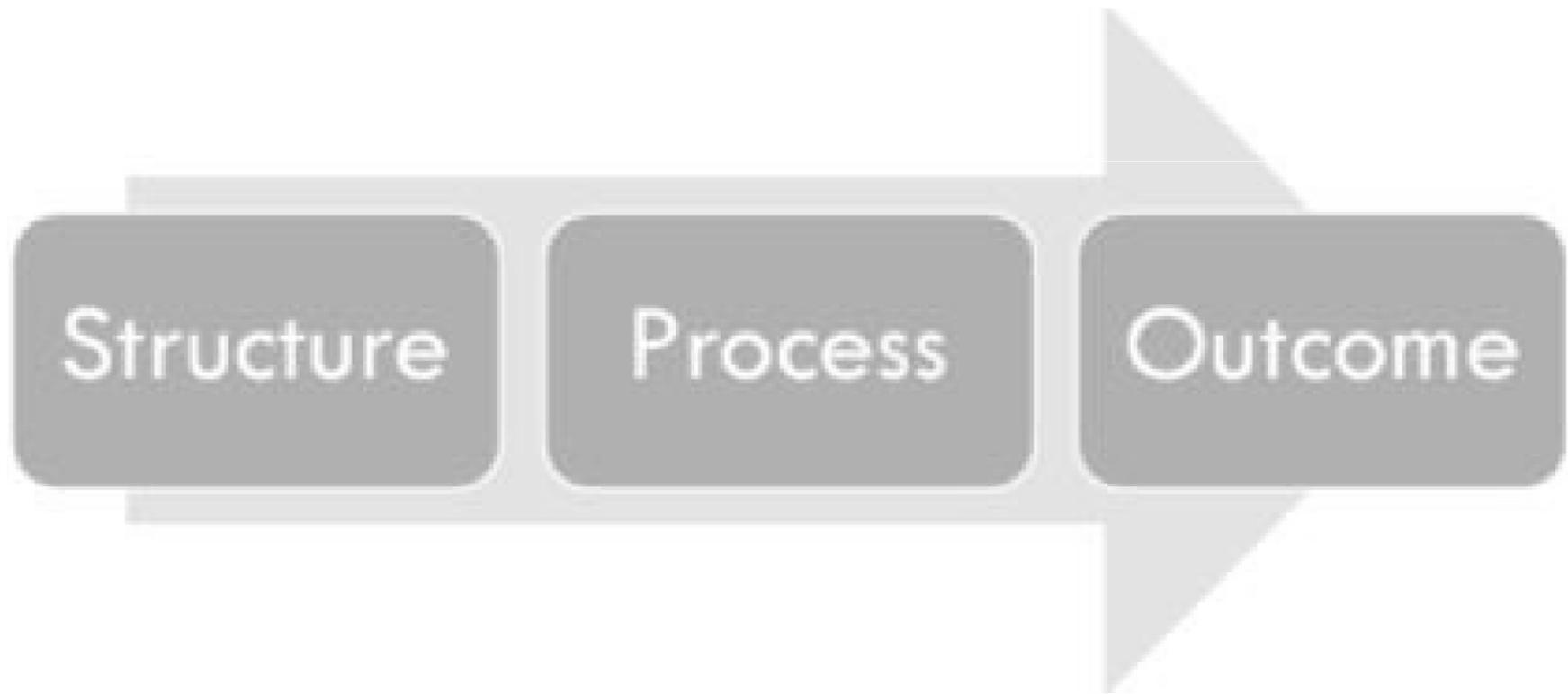
Food for Thought 5

Feedback is a critical aspect of successful intervention and quality measures provide both process and outcomes for gauging pain management.



Screening, also measurement

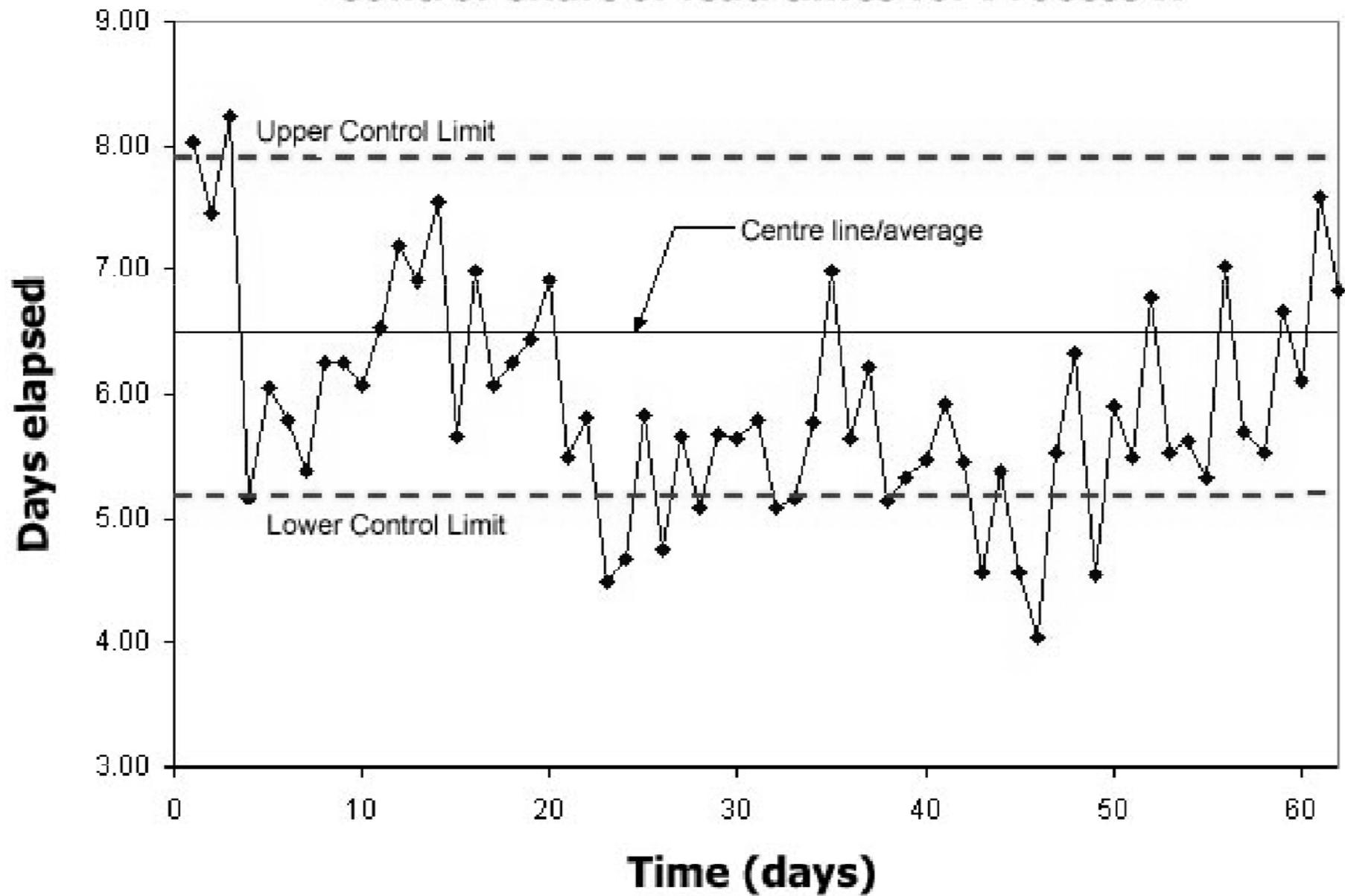




Pain Measures

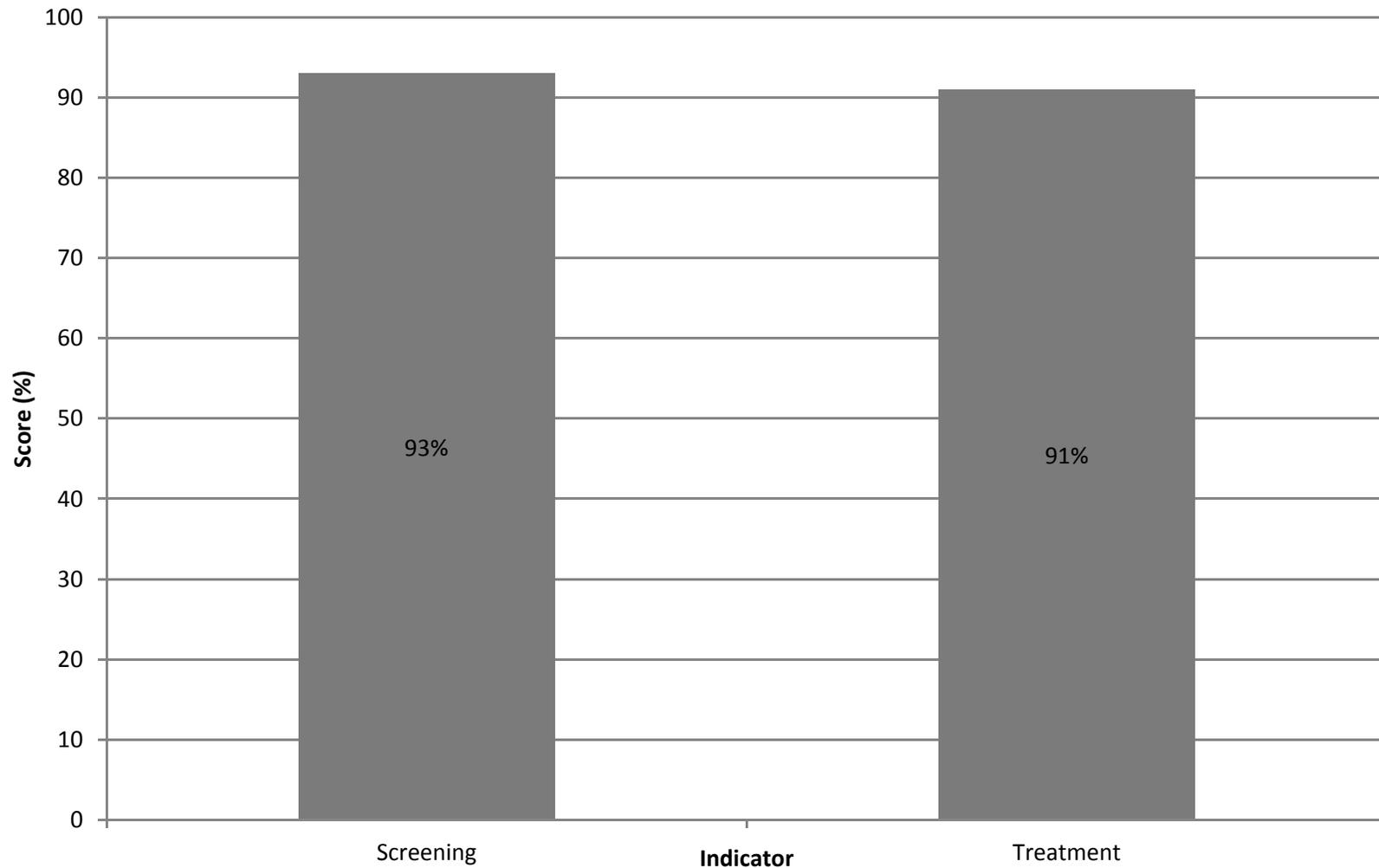
- Outcomes (Bereaved Family Survey item) vs. process (ACOVE, ASSIST)
 - Process sets cover geriatrics / primary care, cancer and its settings
- New measure efforts (e.g., CMS) moving away from process to outcomes
- To actually improve quality, have to have both!

Control Chart of lead times for Process X



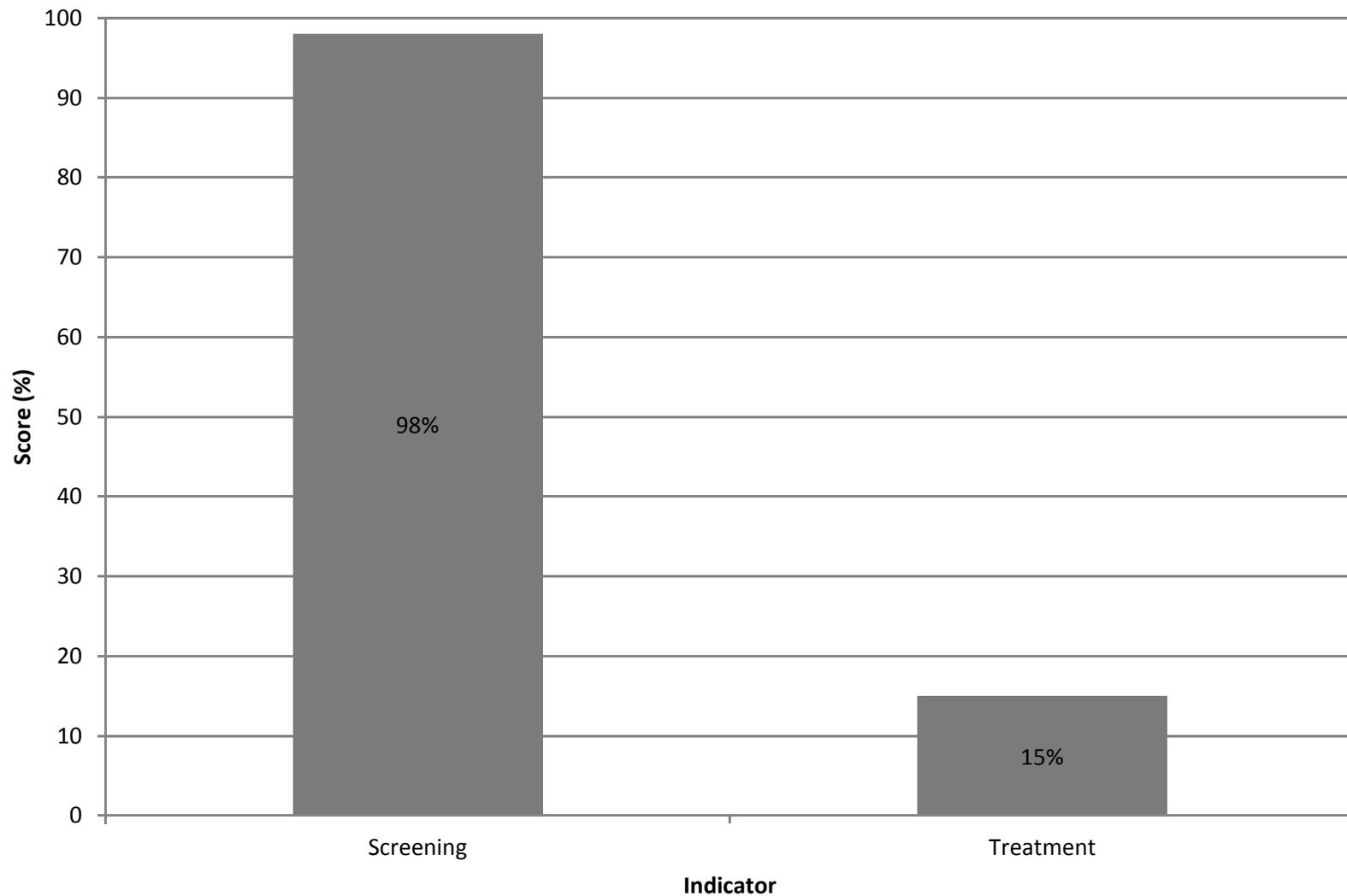
Screening and Treatment Gap Measured by Self Report in Cancer

CanCORS Pain Indicators



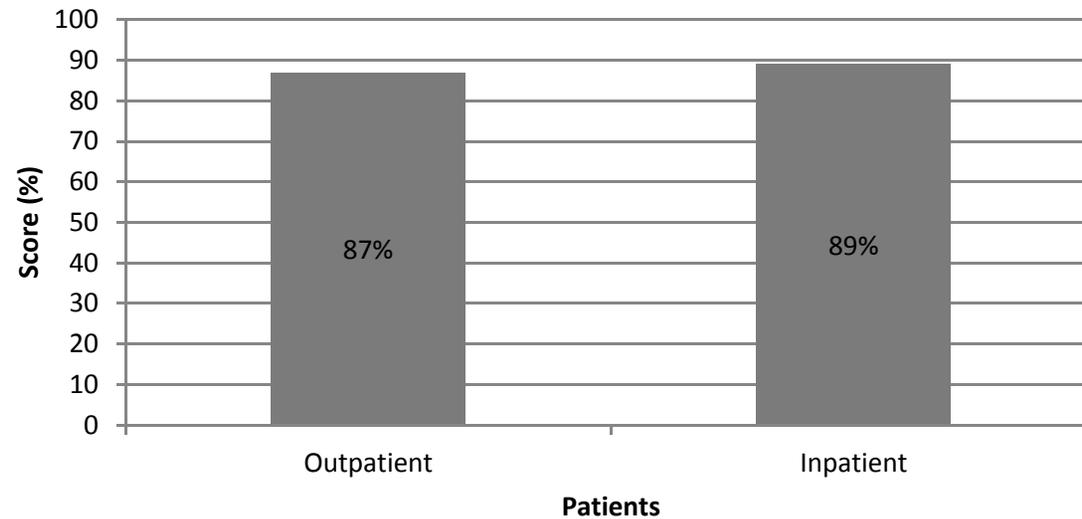
Screening and Treatment Gap Measured by Chart Documentation in Primary Care

HELP Vet Pain Indicators



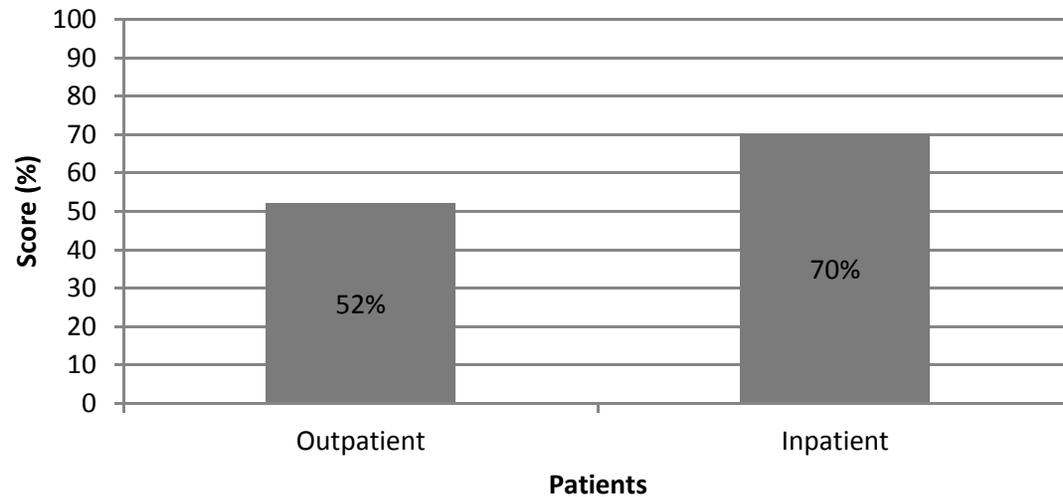
Quality Indicator 5

ASSIST Pain: Provision of Short-Acting Opioid Formulation



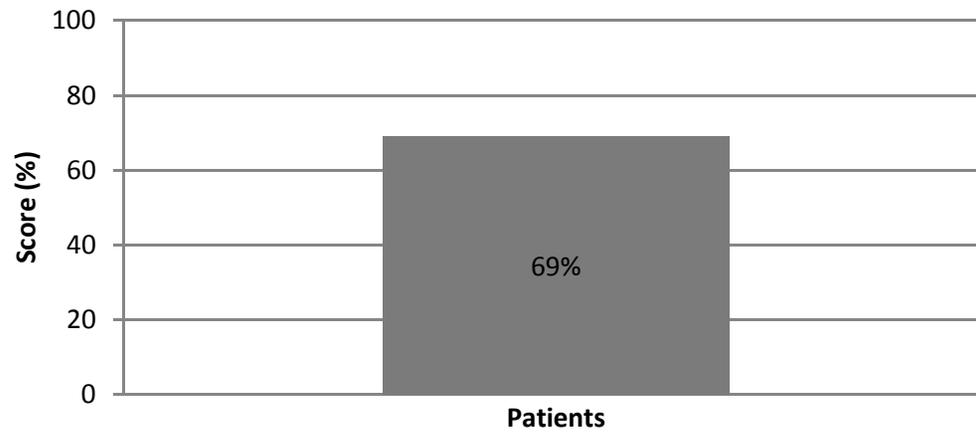
Quality Indicator 6

ASSIST Pain: Offerance of Prescription or Nonprescription Bowel Regimen



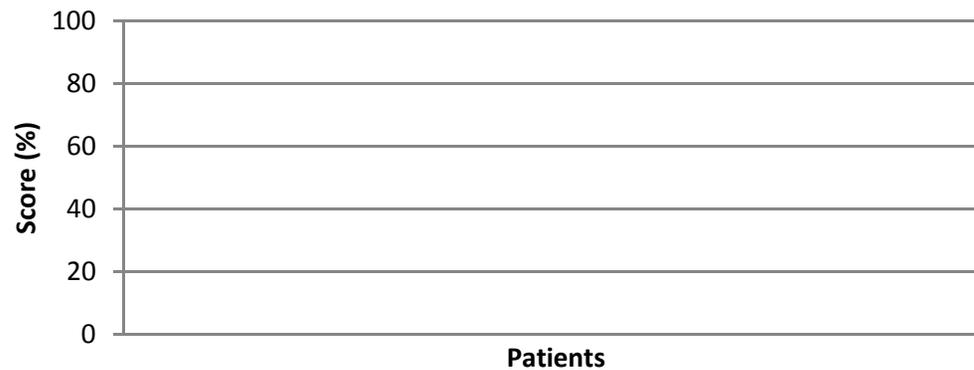
Quality Indicator 9

ASSIST Pain: Assessment of Effectiveness of Changed Regimen



Quality Indicator 11

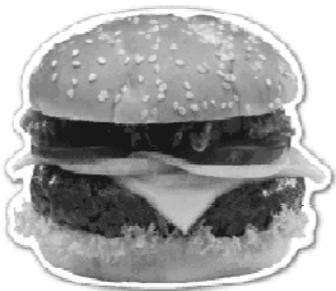
ASSIST Pain: Offerance or Contradindication of Single Fraction Treatment*



*0% Pass at Event Level

Food for Thought 6

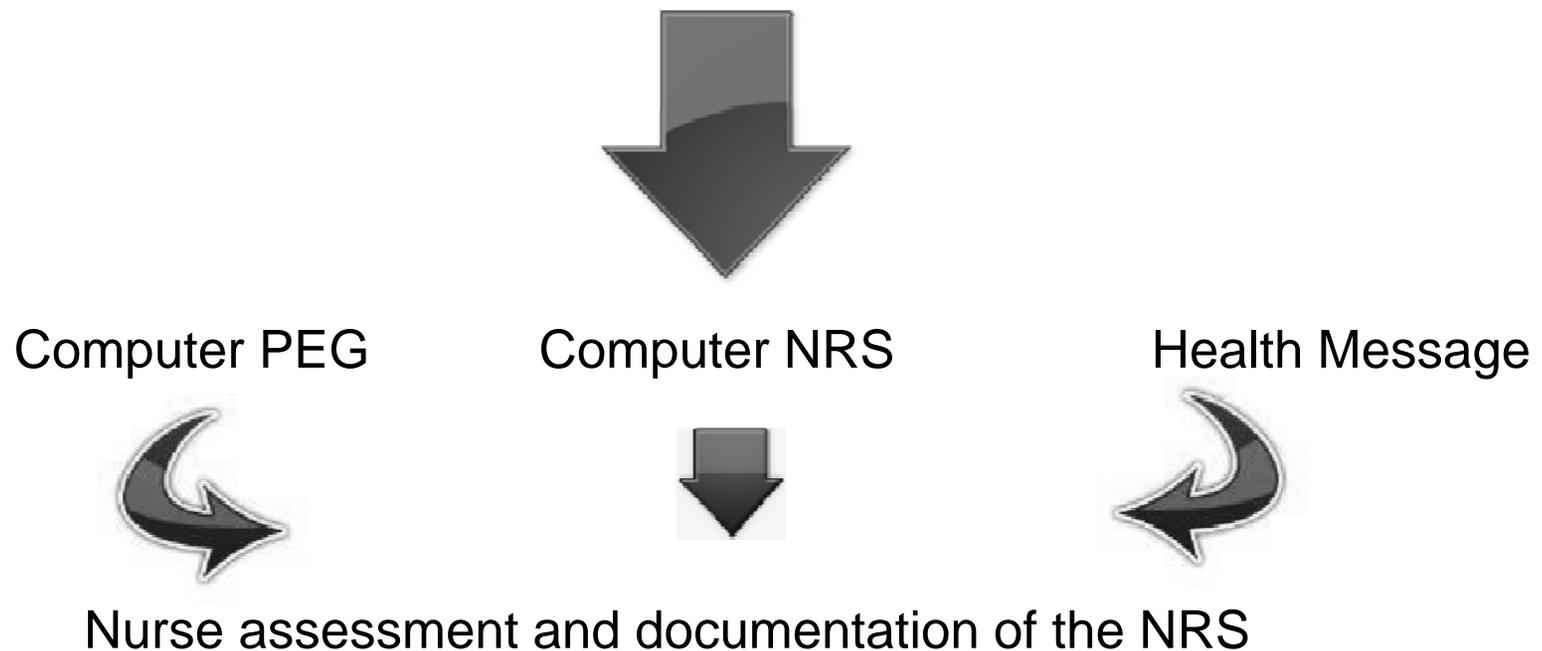
In an era of increasing HRQOL data availability pain will provide a useful paradigm for other symptoms challenges



Pain and Other Symptoms Similarity?

- Reflect subjective states, and patients tend to be multi-symptomatic
- Differing clinician resistance and standards for multiple symptom reports (e.g., dyspnea example)
- Management algorithms are different, specific

Effective Screening for Pain Study



Summary

- Pain screening barriers include clinical relevance of measure, link to management, implementation.
- Patient reports offer a solution to selected facets of screening, may pose other challenges
- Monitoring of outcome and process are possible for pain
- Appropriate to screen for multiple symptoms, but augments management challenges