

Pain Assessment and Pain Management Podcast – Episode 3

Introduction: Welcome to the Pain Assessment and Pain Management Podcast. This series is part of a larger pain, hypertension, and cardiovascular disease initiative to educate providers on patient pain and medication management with considerations for over-the-counter pain relief for patients with high blood pressure and cardiovascular disease.

This series portrays the patient and clinician's experience with assessing and managing pain. This podcast is intended to be a guide to educate providers on the pain assessment tools available and provide practical applications for assessing and managing pain at different stages in the patient's journey. The patient used in this series is an actor who is a 65-year-old Black man with a history of hypertension, hyperlipidemia and obesity who had a knee replacement surgery. Any recommendations or information provided are not to be construed as a directive, endorsement or medical advice.

Disclaimer: The opinions expressed in this podcast are solely those of the presenter and not necessarily of the American Heart Association/American Stroke Association (AHA/ASA). The AHA/ASA does not endorse any specific products or devices.

[Begin reenactment]

PAUL ARNSTEIN: Hi Frank, it's good to see you again. I looked over the imaging and questionnaires completed ahead of today's visit. How are you doing?

FRANK WILLIAMS (patient): I guess I'm okay. I just thought this pain would be gone by now. It's been six months since the surgery.

PAUL ARNSTEIN: Unfortunately, about 20% of patients still have significant pain six to twelve months (Rice, 2018) after the type of surgery you had. While the imaging shows you've healed well and no more surgery is needed, we have this unanticipated problem of persistent pain that we have to deal with now.

FRANK WILLIAMS: I agree. I have to get this pain under control so I can get back to doing the things I used to do.

PAUL ARNSTEIN: Frank, one of the questionnaires you filled out before coming in is what we call a Brief Pain Inventory. It showed that your pain ranges from 1 to 4 in intensity with an average score of "3." Does that reflect your pain experience over the past month?

FRANK WILLIAMS: Yes.

PAUL ARNSTEIN: I know at times you've had difficulty assigning a number to your pain intensity, but on the scale of 0-10, where "zero" is "no pain" and "10" is the "worst possible pain," how strong would you say that your pain is right now?

FRANK WILLIAMS: It's a "3" right now. I've been asked so many times; I now know the differences in the pain scores.

PAUL ARNSTEIN: That's great to hear. Those intensity numbers show that the treatment we've used have worked about as well as they usually do— achieving a 30% reduction in pain. It also showed that this level of pain interferes quite a bit with your daily activities, sleep, mood and relationships. Is that true? Is that what bothers you the most?

FRANK WILLIAMS: Yes, I just can't seem to do the things I want or need to do.

PAUL ARNSTEIN: I'm sorry to hear that. As for your mood, it's common for people with pain that lasts this long to be feeling "blue." Have you been sad about this persistent pain, and its effect on your life?

FRANK WILLIAMS: Yes, I have.

PAUL ARNSTEIN: Well Frank, we've known each other for only a few months, and I can't find the best combination of treatments to help. I think you need to go to a specialty clinic where pain specialists in medicine, interventions, rehabilitation, psychology complementary integrative therapy can work together to develop an individualized plan to help you to think, feel and do your best. Would you be interested in going there and getting a comprehensive evaluation to see what additional treatments could help?

FRANK WILLIAMS: Paul, are you giving up on me?

PAUL ARNSTEIN: No Frank, I'm doing what I think is best for you. I'm not abandoning you, and maybe I should have referred you there earlier. I'm suggesting this because I'm concerned about you, and I am uncomfortable with making other recommendations that are outside my area of practice, and I want you to be safe, especially given your personal and family cardiovascular risks.

FRANK WILLIAMS: Okay, thank you for explaining. I'll get the evaluation at the specialty clinic.

[Begin Interview]

KRISTIN COLSON: Welcome to episode three of this Pain Assessment and Pain Management three-part podcast series. My name is Kristin Colson, and I am a Quality Programs Manager with the American Heart Association. As always, we have Paul Arnstein with us today. Paul is a certified family nurse practitioner, clinical nurse specialist, and a pain management nurse. He is also an Adjunct Professor of Nursing at

the Mass General Hospital Institute of Health Professions and an independent pain educator and consultant.

We just heard that Mr. Williams is experiencing persistent pain from his surgery. So, Paul, what are some best practices to prepare for a visit with a patient like Mr. Williams who is coming to see you for pain that is, perhaps, beyond the scope of your expertise and resources?

PAUL ARNSTEIN: Doing preliminary work before the visit helps the visit go smoothly. Having the patient fill out pre-visit questionnaires, reviewing notes of established goals and responses to treatment helps. The treatments are evaluated based on their effect on pain, activity, unwanted side effects and overall patterns of daily living and health. If I didn't know, I would ask a case manager about accessing chronic pain services in my area.

KRISTIN COLSON: That's a great idea to involve your case manager. Now, let's talk more about the pain management goals for Mr. Williams. How do you know if the goals you established for him were both realistic and achievable?

PAUL ARNSTEIN: An international group of leading pain researchers has set some measures for determining treatment success for chronic pain. A patient is deemed a "responder" to a specific treatment if a 30% reduction in pain is achieved. The CDC has added that a similar degree of improvement in functioning should be a measure of successful chronic pain treatment. From the patient's point of view, even a 10% reduction in pain is considered by some a treatment success. So generally, when pain is chronic, I use a 10-30% improvement as being realistic and achievable.

KRISTIN COLSON: Mr. Williams did reach that 30% reduction. So that's great, but it seems his pain is still preventing him from doing the things he used to do. So how is the assessment of chronic pain different from assessment of acute pain?

PAUL ARNSTEIN: For chronic pain, in addition to assessing current pain intensity and functional impact, you want to find out what the patient notices as triggers, or factors they associate with variations in these outcomes. I also ask what aspects of the pain bothers them the most. Keeping a Pain Diary can help with that. Often, what is most bothersome and changeable is the impact pain has on mood, roles, relationships, and valued activities. Thus, you want to evaluate the sensory component, psychosocial impact and meaning they derive from living with pain. Do they perceive their life as ruined, or pain as a challenge to overcome or a punishment for wrongdoing?

These multidimensional assessments can be lengthy and are hard to do in settings where frequent, brief pain assessments and reassessments are done, such as in the hospital. Validated assessment tools focusing on the multiple dimensions of pain can provide a sense of a treatment focus, but given the complexity of Mr. Williams' case, I felt the pain specialty clinic would be best equipped to evaluate and offer treatments to him.

KRISTIN COLSON: In this case, you were able to offer Mr. Williams more specialized care, but in addition, you mentioned he had a depressed mood. Why wouldn't you also send him for a psych consult?

PAUL ARNSTEIN: Although he could benefit from a psych consultation, if the patient is not at risk of harming themselves or others, referring them to a full-service pain specialty clinic is better. They have treatments that help pain and depression simultaneously. Given that both pain and mental illness have stigmas attached to them, I found that even carefully worded statements that they need psychological or behavioral health services are interpreted as "He thinks it's all in my head..." and likely they won't follow through. According to the National Institutes of Health (2019), a full-service pain specialty clinic offers medication, restorative, interventional, behavioral, complementary and integrative approaches to assess and treat pain. They would identify the best treatment based on his level of depression and other factors.

KRISTIN COLSON: Oh! I didn't realize pain specialty clinics offer all those resources. For clinicians who may not have access to pain specialty clinics, are there simple tools they can use to do a multidimensional assessment for a chronic pain patient?

PAUL ARNSTEIN: Yes, you should choose a tool that is appropriate for your population and setting, ease of use and ability to document meaningful information. The Defense and Veterans Pain Rating Scale (DVPRS) is a good one when the four supplemental questions are added to the standard pain intensity and functional dimensions. In primary care settings, the CDC recommends using the Pain, Enjoyment, and General Activity also known as PEG Scale, which is a three-question screening tool, assessing pain level, enjoyment of life, and general activity over the past week.

KRISTIN COLSON: That's very interesting. Are there any other tools that you would use in assessing pain?

PAUL ARNSTEIN: Of course. More comprehensive pain scales such as the Revised Short-Form McGill Pain Questionnaire Version-2 and the Brief Pain Inventory (BPI) are straightforward and provide valuable insights but require permission or a license agreement for non-clinical uses, such as research. There are also many freely available disability measures appropriate for patients with pain. The NIH-developed PROMIS Pain Interference short form reliably measures how much pain interferes with physical, cognitive, emotional, recreational and social activities, with additional sleep and enjoyment in life questions. Also, the World Health Organization Disability Assessment Scale, called the WHODAS II, is a 36-item questionnaire that assesses six domains of functioning that are affected by pain.

KRISTIN COLSON: This has been really insightful. It's good that there are many options and tools available for clinicians. In your expertise, is there a way to objectively measure a patient's functioning?

PAUL ARNSTEIN: There are several assessment tools, but the two easiest ones are the "6-minute walk test" and the "Timed Up & Go," which times the patient's ability to

stand from a seated position to walk 10 feet. I find having the patient use a pedometer or other device with a fitness monitor capable of displaying and sharing data on a day-to-day activity pattern can also be useful, while helping the patient find the balance of avoiding sedentary or overexertion tendencies.

KRISTIN COLSON: Thanks for explaining that. You mentioned earlier that there can be stigma attached to pain. Can you expand on that?

PAUL ARNSTEIN: There is a stigma attached to pain that is often internalized, making patients feel “less than” or “unworthy of” treatment. This has led many to avoid seeking medical care, withdrawing, or in severe cases considering suicide. Sometimes professionals unknowingly act in a way that contributes to this stigma. Unconscious bias, among other factors, is historically linked to discrimination, exclusion, and pain care disparities. Twenty percent of patients with chronic pain leave professionals who do not take their pain seriously, and 80% of primary care practices have discharged patients with chronic pain. Thus, opportunities to improve cultural and linguistic competence in pain care is evident.

KRISTIN COLSON: Wow! This is important information. It definitely sounds like there’s room for improvement there. What advice do you have for others on how to address stigma in their pain assessments?

PAUL ARNSTEIN: Be aware of your own biases, and how those are inadvertently expressed verbally and non-verbally to patients. Avoid labeling, stereotyping, disregarding patient’s reports and requests, or abandoning them. If pain is more intense or persistent than expected, find out why. Identify how the patient’s values differ from yours. And if any values are in conflict such as expressiveness versus stoicism in communication about pain, recognize that stigmas compound other stigmas such as gender, race, age, mental illness, etc. If you don’t understand the patient’s responses, rather than jumping to conclusions, convey empathy, curiosity and humility as you try to understand.

KRISTIN COLSON: That’s great advice, Paul. In the previous questions, you referenced unconscious biases. What should clinicians be mindful of as they work to recognize and overcome them?

PAUL ARNSTEIN: Unconscious biases are natural and don’t make us “bad.” Recognizing and acknowledging them can help us be more compassionate empathetic, and patient centered. When assessing chronic pain, the biopsychosocial model is better than the biomedical approach we tend to embrace. Respectfully engage the patient and their caregivers; and avoid stigmatizing language like “complaining” or “drug seeking.” Promote trust and address their perceived needs in an equitable way.

KRISTIN COLSON: Thank you, Paul for your expertise and insights during this three-part series on pain assessment and pain management. This podcast series is part of a larger pain, hypertension and cardiovascular disease initiative to educate providers on patient pain and medication management with considerations for over-the-counter pain

relief for patients with high blood pressure and cardiovascular disease. To learn more about the initiative, upcoming events and to access on demand education on this topic, please visit heart.org/painmanagement. My name is Kristin Colson and thank you for listening.

[End of Series]

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