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Treating Veteran's Chronic Pain

Stephanie A. Chiappa, MSN, AGPCNP-BC, Dr. Joy Elwell, Dr. Brittania Liebela, Chief Nurse NP Mark Bielawski

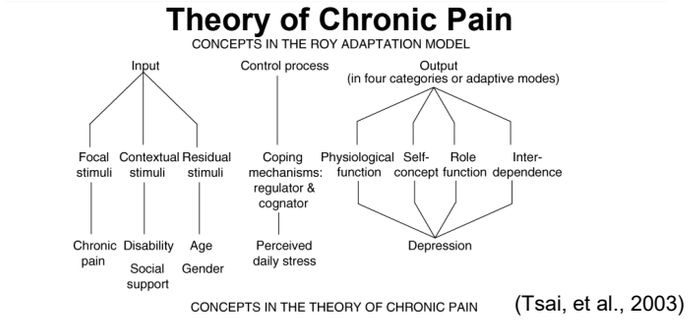
Background Information

- Chronic pain is one of the most common presenting complaints in the ambulatory care setting (NHIS, 2015)
- Chronic pain is reported highest among the United States (U.S.) veteran population (Zelaya, Boersma, & Moy, 2020)
- Chronic opioids are initiated if the patient is not adequately managed from pharmacologic, interventional, psychological interventions (Institute of Clinical Systems Improvement, 2011)
- Long-term opioid therapy (LTOT) has been associated with adverse health outcomes including the correlates of potential development of opioid/substance use disorder, accidental death, and suicide (Kerns, Krebs, & Atkins, 2018)
- Ambivalence towards long term opioid adjustment is largest barrier to opioid management in primary care (Hale et al., 2019).

Significance of problem

- Over 50% of male & Over 75% of females report chronic pain nationally (Department of Veterans Affairs & Department of Defense, 2010)
- 74% of veterans report serious psychological stress related to the chronic pain (Zelaya, Boersma, & Moy, 2020)
- Healthy People 2030 Goal: Healthy people 2030 "to reduce the impact on loved one of chronic pain that frequently limits life or work activities & Reduce the past-year nonmedical use of prescription drugs (Office of Disease Prevention and Health Promotion, 2020)
- Opioids were involved in nearly 70% of all overdose deaths in 2018 nationally and 30% locally in CT (NIH,2019)

Theoretical Framework



(Tsai, et al., 2003)

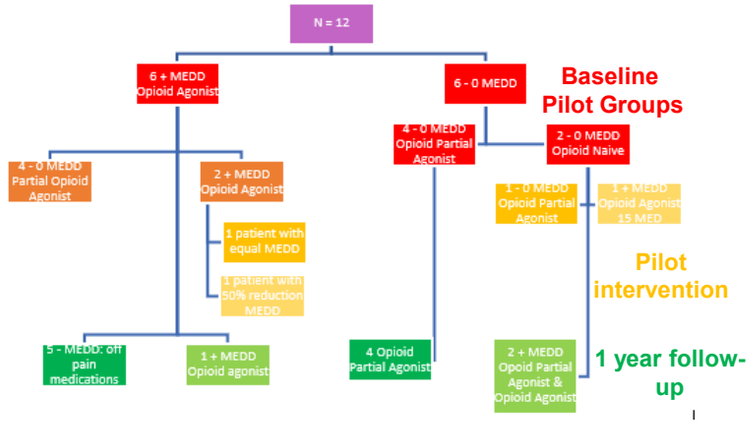
Purpose

Determine through a program evaluation if a NP- led chronic pain clinic embedded in primary care can effectively implement evidence-based guidelines to reduce long term opioid therapy based on Morphine Equivalent Daily Dosing over a 6-month pilot-study and one year follow up

Design & Methods

- CDC Framework for program evaluation with logic model as a goal-based evaluation design
- Evaluation of stored de-identified data from Electronic Health Record from participants: Morphine Equivalent Daily Dose (MEDD) before and after program implementation
- Completion of risk- mitigation strategies: completed urine toxicology screen, naloxone use education and prescription, suicide screening, prescription drug monitoring program (PDMP), de-prescribing benzodiazepines

Results



Primary Outcomes

Pilot Study: 6 patients +MEDD: 4 patients achieved 0 MEDD (67%) - statistically significant p value <0.0069

One year follow up: 5 out of 6 original +MEDD achieved 0 MEDD (83%)

Pilot Study: 6 patients - 0 MEDD: 4 patients remained on partial opioid agonist = 0 MEDD, 2 others: 1 + MEDD, 0 MEDD partial opioid agonist

One year follow up: 0 MEDD: 4 remained on partial opioid agonist = 0 MEDD, 2 others: +MEDD partial opioid agonist and full agonist therapy

Secondary Outcomes

100% of patients participants had risk mitigation strategies implemented

Group Comparison

Comparing the two cohorts: + MEDD vs. – MEDD: The chi-square was 0.4444 with one degree of freedom with a p-value of 0.5050. No significance between the two groups.

Conclusions

NP- led chronic pain clinic embedded in primary care can successfully reduce LTOT in those with high-impact daily pain applying evidenced based guidelines even with a small sample size.

Implications for Practice

Developing a NP- led program could help other specialties achieve goals in implementing evidence based practice.

References

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