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Improving Quality of Life in Veterans with Chronic Pain through Patient Engagement

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Abstract

Background: Various psychosocial factors affect follow up care among veterans with chronic pain. Engaging veterans by giving them the choice to decide contact modality for after clinic visit increases likelihood of successfully reaching patient and adherence to recommended pain management.

Purpose: To engage veterans through self-determined effective communication method: telephone, email or Myhealthvet for follow up care. The intervention aims to improve chronic pain self-care by assessing number of medications used for pain, numeric pain rating and quality of life score.

Framework/EBP Model: The Iowa Model and 5A's will guide implementation and assessment of this project. Patients will self-determine the best modality for follow up care and the chosen modality will be used to contact patient. Ease of contact will be assessed based on number of attempts made before contact initiated.

Evidenced-based Intervention: Communicating with patients using a modality they prefer increases likelihood of being able to contact patient for follow up care. There is no difference in outcomes when other modalities are used compared to phone calls.

Results/Outcomes: The DNP student was successful at making contact with all the patients with one to two attempts. All the patients rated their pain scores at least one point less on average and quality of life scores improved by two points on average. There was however no change in the number of pain medications used regularly.

Conclusion: Engaging patients by having them choose their preferred method of communication may increase rates of follow up contact among veterans with chronic pain.

Introduction

Personalized health care is an important emerging concept that challenges current ways of health care provision. At the core of health care is the patient who is a beneficiary of health-related services to alleviate suffering or improve quality of life. For this care to be beneficial and resourceful, trust between patient and provider is a crucial factor. They decide together what the end goal ideally will look like, sometimes this needs to be negotiated. Veterans have unique challenges that must be considered in the context of their current state of health. Therefore, central to personalized care is the development of a plan of care that is based on comprehensive health status, risk stratification, shared goals and tracking measures (Simmons, Wolever, Bechard & Snyderman, 2014). The mutually beneficial outcomes benefit both parties and improve core measures and population health among the veteran population.

Challenges that affect veterans have been studied based on their particular cohort struggles to help concentrate relief measures. A qualitative study conducted to illustrate their unique challenges shows that they have different perspectives when they come back and are working to acclimate to civilian life. While social support is acknowledged as a protective factor, there are substantial obstacles they face in locating and accessing support to unaccommodating institutions (Ahern, Worthen, Masters, Lippman, Ozer & Moos, 2015). Veterans from previous wars who had difficulties with transition faced long term concerns with homelessness and premature mortality (Ahern, Worthen, Masters, Lippman, Ozer & Moos, 2015). It is these and other issues that are taken into context when negotiating a plan of care for a veteran. To the degree that this is negotiated successfully, the higher the likelihood of improved readjustment to civilian life. It is therefore vital that veterans participate in their plan of care for improved health outcomes.

The Veterans Administration (VA) is focused on patient engagement with a goal of

improving population quality outcomes as well as individual patient outcomes. Patient engagement is defined by the VA as any procedure practice or policy that involves, supports and encourages collaboration between patients, healthcare providers and organization through recognizing patients and their families as active members of the health care team (VA, 2016). It is mutually beneficial when patients are participating in their care because it may lead to greater responsibility in their overall outcome, and for the provider, increased patient satisfaction which translates to greater reimbursement.

Chronic pain among veterans can be a difficult topic of discussion and the VA understands the clinical challenges in successful management of pain and safe prescribing, so they implemented the Opioid Safety Initiative (OSI) (VA, 2017). The initiative was a guideline based on systematic reviews of epidemiology and clinical evidence for chronic pain management so that healthcare providers have a framework for evaluating, treating and managing each individual's needs. In this context this, a quality improvement project seeking to decrease use of narcotics among primary care providers at a San Diego internal medicine clinic enlisted NP-led telephone follow up after clinic visits to assess chronic pain management. A group of the patients were contacted, and their chronic pain management discussed, including interventions that were in their plan of care which they were participating in to decrease their pain. The project was successful in encouraging use of non-pharmacological modalities, however, one of the areas of improvement identified was finding a way to decrease the number of attempts made to reach the veterans to engage.

With the patient centered-care being an important concept, the VA has been engaging patients through different tools between primary care provider visits. There is a pre-visit, visit, post-visit, between visits and classes/clinic patient engagement tools that the VA has already

incorporated (VA, 2016). Follow-up calls and myhealthvet secure messaging between visits give the patient and provider a chance to evaluate recommended plan of care and whether there are any problems that have come up. Being proactive in the process increases patient-provider trust and promotes engagement of the patient with their plan of care. Therefore, the follow up project set to explore the result of engaging veterans who are struggling with chronic pain by having them self-determine the best mode of communication, phone call or myhealthvet.

Background/clinical problem

There are many different hypotheses that can explain challenges related to difficulties in successful communication with veterans. Successful communication in the context of the project was the ability to reach and communicate with the veteran without having to leave messages. If veterans are given the option to choose the best mode of communication, will this decrease the number of attempts a provider makes to reach veteran? The quality improvement project was created to engage patients by giving them the option of contact through phone calling or use of myhealthvet. Technology has provided multiple forums for patients and providers to communicate synchronously and asynchronously. While phone calls have been the mainstay modalities of communication, there are other modalities that within the guidelines of patient privacy could be used to communicate vital information between patient and providers. Various concerns have limited a widespread adoption of current technology, including privacy matters, liability concerns and reimbursement issues (Lee & Zuercher, 2017).

Purpose of evidence-based project

To engage veterans through self-determined effective communication method: telephone, or myhealthvet for follow up care. The intervention aims to improve chronic pain self-care by assessing number of medications used for pain, numeric pain rating and chronic pain quality of

life score.

Institute of Medicine's (IOM) 2012 report by McGinnis, Saunders & Smith discusses the importance of patient engagement in health care (McGinnis, Stuckhardt, Saunders & Smith (2013). (McGinnis, Stuckhardt, Saunders & Smith (2013). Engaged and informed patients have better outcomes and improved populations than otherwise because they are more likely to consider the context in which the provider is recommending the care leading to adjustments at times to improve adherence.

Evidence based interventions

Evidence based framework and scales used to guide implementation of the project include The Iowa model of evidence base practice, 5 A's, the American Chronic Pain Association Quality of Life Scale, and Numeric Pain Rating scale will guide implementation and assessment of this project. Patients self-determined the best modality for follow up care and the chosen modality was used to contact patient. The patient's primary care provider informed the patient of the project and had the patient complete the self-determination form. Ease of contact was assessed based on number of attempts made before contact initiated. The underlying assumption was that communicating with patients using a modality they preferred decreased the number of times a provider had to tried to initiate contact with veteran.

The Iowa model of evidence-based practice is a practice framework with a purpose of guiding clinicians in the use of evidence to improve health care outcomes (Rycroft-Malone, J., & Bucknall, T. (Eds.). (2011). Using the framework as a guidance, the problem focused trigger was through the identification of a clinical problem: having to call veterans multiple times unsuccessfully to initiate contact. The team consisted of principle investigator, academic faculty advisor and student. The relevant background literary research was completed with a finding of

sufficient research information that illustrated improved outcomes when patients were actively involved with their care. The primary outcome measured was evaluating number of attempts required to initiate successful contact with a veteran. Secondary outcomes include assessment of pain numerically, assessment of quality of life in the context of chronic pain, and the number of medications a veteran used regularly to achieve subjective tolerable pain levels. Additionally, reimbursement methods can be realized to compensate for the care provided, including phone calls.

5 A's is an intervention framework by Agency for Healthcare Research and Quality (AHRQ) based on five steps: agree, advise, assess, assist and arrange (2012). These steps are not necessarily used stepwise during the interview with the veteran, but it is a dynamic discussion that reviews the self-care behaviors that the veteran has agreed to utilize and their efficacy. The assess step sought feedback on health behaviors attempted. Advise step provides relevant and specific information about behavior change. Assist step may include referring a veteran to a resource like support group or website. Agree step reviews specific achievable behavior goals collaboratively set with veteran. Finally, the last step is arranging or recommending follow up appointment after setting a behavioral goal.

The numerical pain rating scale and chronic pain quality of life score scales are easy to use validated tools that were used with each patient during every interview to assess changes. The numerical pain rating is a zero to ten scale, with zero being no pain and ten being the worst ever. The quality of life score was the opposite with zero score being not being able to function and feeling worthless and helpless to ten being able to accomplish everything desired. Veterans were able to generally rate what the average pain level was and sometimes this was correlated with the quality of life. Usually a lower pain rating was reported with higher quality of life scoring.

Methods

Study design was quality improvement project at a VA in a Southern California internal medicine clinic. IRB approval was obtained in June 2017 and in the following month, all the 17 patients were contacted using their self-identified mode of communication. Participant demographics patients were aged from 30-70 years, both male and female of Caucasians, African American and Hispanic veterans with chronic pain who had a same primary care provider. The patients were provided a document that allowed them to choose between phone call or myhealthvet for follow up office visit. The phone calls were done at the internal medicine clinic during business hours at random times between office visits. No appointments had been made for the phone visits. During the phone calls the following was reviewed: average numerical pain level, chronic pain quality of life score and number of pain medications used.

Results

70% of difficult to reach patient were contacted successfully with the first attempt compared to the previous quality improvement project. Average scores of numerical scores, number of pain medications used and quality of life had no significant changes.

Discussion

Chronic pain affects quality of life and patients with chronic pain seek different modalities to manage it. Engaging patients in the plan of care may positively improve quality of life for the patient and improve satisfaction scores for the provider. Decreases in numerical pain levels and increase in quality of life scores and, patient's satisfaction score may correlate with the level of patient engagement in their self-care and consistency of follow up care.

The project was limited by the small number of patients in the project as well as only those who agreed to be contacted. Those veterans may have been more readily available than a

different population, perhaps those that work full time or may not have access to their mobile/home numbers at all times.

Conclusion

Engaging patients by having them choose their preferred method of communication may increase rates of follow up contact among veterans with chronic pain.

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