



PAIN MANAGEMENT IN HOME HEALTH PRACTICE

Resources and guidance for home care professionals.

ABSTRACT

This resource document provides clinicians in home care practice with general guidance, assessment tools, research, and case studies for assessing and managing patients' pain.

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Pain Management in Home Health Practice

The International Association for the Study of Pain (IASP) defines pain *as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage* (IASP 2018). The IASP is clearly directing clinicians to appreciate that pain is not a sensory experience resulting from nociceptive input, but is instead a subjective experience that emerges from the complex interactions of both biological and psychosocial factors unique to every person. The literature advises the informed clinician to take into account a patient's anxiety, depression, psychosocial stresses, and multiple medical comorbidities when serving patients with painful complaints (Cady et al 2016). By directing attention to how the clinician communicates with the patient, there is the hope and possibility of avoiding the possible iatrogenic effect of pain catastrophization.

Assessing Pain in the Home Health Setting and the Importance of Language

When assessing a patient's pain level, it is necessary that all Certified Home Health Agency (CHHA) staff use a standardized means of objectifying the patient's painful complaints (OASIS question M1240) and to use the same method at each visit. While the 0-10 VAS scale is indeed a validated instrument, another instrument may prove to be most appropriate and an easier-to-use tool. One such tool, *The Functional Pain Scale*, is a validated instrument with individuals aged 65-years or older (Gloth 2001). It allows all clinicians to use a common language when interacting with patients and affords the CHHA consistency between clinicians by using only a handful of terms when engaging with patients (i.e. tolerable/intolerable pain, interfering with active/passive activities or not). Most CHHA's have policy and procedures in place to address pain as a way of standardizing practice. Within this resource is a sample pain policy containing the tools recommended here. The authors strongly advise clinicians and CHHA alike to consider adding this pain policy where a policy doesn't exist or modify existing pain policy to match the sample provided.

While an accurate objective measure of a patient's pain intensity is compulsory, so too is the clinician's need to consider the impact that pain has on a patient's daily function. Can they self-mobilize despite the pain? Are they completing Activities of Daily Living (ADLs) despite the pain? What is the patient's pain preventing the patient from doing, and how often does it impact them? The clinician can look to the OASIS C2 question M1242 to illustrate the importance of pain's impact on a patient's function when developing an appropriate plan of care and establishing the patient's goals/objectives.

- M1242 reads: Frequency of Pain ***Interfering with patient's activity or movement:***
- 0 Patient has no pain
 - 1 Patient has pain that does not interfere with activity or movement
 - 2 Less often than daily

- 3 Daily, but not constantly
- 4 All of the time

It is the clinician's responsibility to discover through the interview or assessment what specific activities the patient is challenged to complete as it directly relates to the patient's **function**, during both **active and passive** activities (e.g. walking and reading, respectively). It is important to recognize that a patient's pain intensity may seem profound, but a patient's subjective report of pain intensity will often fail to correlate with the clinician's expectation of their ability to cope and/or complete their ADLs in spite of painful complaints. Patients are often resilient and will have independently discovered means of coping with their pain. They are often capable of living fulfilling lives despite painful problems; such patients have thrived in spite of their pain, independent of formal interventions. The clinician must be sensitive to each patient's needs and be careful not to "make a mountain out of a molehill", utilizing effective skills to communicate with patients so they can better understand why they are feeling as they do. It is imperative that the clinician be able to engage patients without eliciting catastrophization.

Pain catastrophization (PC) is a cascade of negative cognitive and emotional responses to pain (Sullivan 1995). PC is comprised of three factors: (1) magnification of pain, (2) rumination on pain, and (3) feelings of helplessness over pain (Darnall 2012). PC is considered one of the primary psychological factors that worsen pain and contribute to pain chronicity (Darnall 2014). PC can be worsened the more anxious and/or powerless a patient feels about his pain, which is correlated with higher pain intensities and lower effects of descending inhibitory noxious control (DNIC) (Weissman-Fogel 2008). Psychological factors, including PC, may also act indirectly to result in reduced physical activity, which may directly lead to reduced muscle flexibility, strength, tone, and endurance (Turk 1999).

Clinicians need to have strong communication skills to avoid imposing psychological stresses upon the patient or increasing patient anxiety. It is the role of the clinician to be able to inform the patient about why she hurts, without using language that is unclear by avoiding jargon and language that is vague or even potentially frightening. The clinician should use language that has little emotional meaning (e.g. pain vs. discomfort, rupture vs injury) to empower the patient and maintain (or improve) her locus of control. Medicaese and jargon should be avoided at all times.

A common means of helping individuals better understand concepts without the utilization of often-overwhelming (medical) terminology or circumstance is the use of metaphor (Brown 2009, Nake 2014). Per Gallagher et al, "Metaphors are often novel or surprising, and emotionally engaging: they can provide a degree of imagination and visualization of abstract ideas and they involve transference of the properties of that idea to the target idea through verbal relating of events (Gallagher 2014)". It is important, however, not to use the same general metaphor with every patient. Instead, the clinician should try to develop an

individualized metaphor that the patient can relate to; it may take some time to arrive at a metaphor that is appropriate for the patient.

For example, an anonymous therapy blogger once shared this story of his interaction with a patient who was receiving services in the home after spinal surgery:

When I entered his home, he was seated comfortably in his dining room chair, drinking his coffee and reading the sports page. His posture looked more comfortable than I had ever seen, however, his face looked forlorn.

“You won’t believe what happened yesterday... I felt so helpless... There was smoke in the basement, but I cannot go down there; there are just too many steps. I told her [his wife] to call the fire department...I couldn’t believe it...In 6 minutes, I had two fire engines, an ambulance, and 2 police cars outside of my house. The sirens were blaring and they had the lights on and everything.

The firemen walked into my house with axes and I thought to myself ‘Oh God, please don’t do too much damage.’ And wouldn’t you know, they came back out less than a minute later? It was my sump pump. The motor went on it. All they had to do was unplug it. Then, for the next 30-40 minutes, they all just hung out in my yard talking. All of ‘em – the trucks, the ambulance, the cops – lights still flashing...the guys just standing in the yard and on the road talking and smoking. EVERY car that drove by was looking.

It was embarrassing. All I would have had to do was go downstairs and unplug it, but I couldn’t do anything.”

About 30 hours after my last visit, he called. I could hear the panic in his voice. The buttock pain was back again. He was crying.

He had been having his best day since surgery – he was up and moving around the house with his rollator until his weak left leg (persistent weakness since suffering radiculopathy in December) buckled beneath him. He did not fall, but in his effort to regain his balance, he had “tweaked” his buttock pain. He was in a panic. ***“What the hell is wrong? What did I do to it?”***

When a patient is scared, they are at risk of catastrophizing. In this instance, the patient is frightened. He fears that he has “done something” to his back, although the likelihood of such structural damage is small. The therapist was able to use the patient’s own experience to help him understand why he was feeling his pain:

I replied: *“Your sump pump just started smoking, that is all. The brain smelled smoke where there isn’t a fire, but decided to send 2 fire trucks, an ambulance, and some cops – sirens wailing and lights ablaze – you know, just in case. But – for now – what you*

need to understand is that to prevent yourself from falling when the knee buckled, you moved more quickly and with greater force through your back than you had done in a long time. The brain wasn't ready for it and sounded the alarm. What I want you to do is go lay down like you did last week when you had the pain then. Watch the game and practice some of the deep breathing we have practiced. It worked then, it will work today too, it is just going to take a little time...the crew still has to hang out in the front yard, share some stories and smoke their cigarettes, but they will get in their vehicles and drive away soon enough."

"Yeah, okay," he said, "That makes sense. But do they still have to keep the lights on, even if they know there is no fire?"

He got it! The tears had stopped. He was at ease. He had even cracked a little joke.

Communication is a skill. It requires wisdom, developed through years of practice and experience. It can never be perfected, but always improved upon with attention and careful listening. Patients are admitted to home health agencies with varying degrees of understanding of their medical condition, and it the responsibility of each skilled service provider to demonstrate the requisite skills to effectively communicate with every patient to determine not only the impact that a patient's pain has on his experience, but also to inform the patient why he hurts without making things altogether worse and help him develop appropriate goals for his home care experience.

An Alternative to the Traditional 0 – 10 Scale or VAS

One valid instrument to develop and reassess patient goals is the Patient Specific Functional Scale (PSFS), a “useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition (Horn 2012)”. The PSFS affords the clinician an opportunity to develop measurable goals that are specific to each patient’s unique needs, inclusive of activity and participation deficits. Only with effective patient-clinician communication informing patient-centered goals and objectives can an appropriate plan of care be developed for the patient who has a significant complaint of acute or chronic pain.

CASE STUDY EXAMPLE 1: A 67-year-old female is admitted to a CHHA s/p exacerbation of COPD. She is a 4-cigarette per day smoker who has a 35-year history of smoking 2-packs per day, until 6 months ago. She is using supplemental oxygen with conserving device at 2L. She has a significant history of anxiety and depression in addition to chronic pain for the last 20+ years; she reports that her pain “is everywhere and is always a 6/10 on the VAS scale. It seems like it is in every joint and every muscle in my body”. She reports that when she becomes short of breath, she becomes anxious, and she needs to smoke a cigarette to help calm her anxiety. She reports that her pain is annoying and seems constant, but she denies it impacting her ability to complete ADLs; she reads, watches TV, and engages socially without distraction from her pain. The patient resides on the 3rd floor of a non-elevator building and does not have portable oxygen tanks in the home. SpO₂ measures 93% at the time of initial assessment while using oxygen. The patient self-reports 1/10 dyspnea at rest, but moves quickly throughout the home, frequently provoking dyspnea of 6/10, but her SpO₂ does not reduce below 90%. The patient reports that she needed physical assistance from a neighbor to enter the home after returning from the hospital due to shortness of breath and fatigue; she has not left the home since, 3 days ago. The patient drives, has a car, and has historically acquired her own groceries.

The FPS should be scored 2/10, using the decision tree included with the document. When completing OASIS M1242, the admitting clinician would enter ‘1’ for pain that does not interfere with activity (passive or active). Despite unrelenting chronic pain complaints for the last 20 years, the patient appears to coping and the patient’s pain does not impact her function at this time. The patient’s primary barriers are environmental, coupled with reduced respiratory capacity and anxiety.

The PSFS would be a beneficial tool to use when working with the patient to establish appropriate goals/objectives. Some goals may include, but are not exclusive to: (1) walking 800 feet with M6 tank, without seated rest, to shop for groceries, (2) independently mobilize from apartment to automobile (30 steps, 80 feet) with M6 tank, (3) the patient will teach back energy-conservation strategies to not exceed dyspnea with activity to 4/10 or less. The patient can self-assess her difficulty completing these activities on a 1-10 scale as directed in the PSFS at the time of evaluation and the same scale can be used again at re-evaluation to determine progress.

CASE STUDY EXAMPLE 2: A 69-year-old male is admitted to a CHHA s/p exacerbation of COPD. He continues to smoke 6-8 cigarettes per day and has a 40-year history of smoking 2-packs per day, until 2 months ago. He is using supplemental oxygen with conserving device at 2L. He has a significant history of anxiety and depression in addition to chronic pain for the last 20+ years; he reports the pain is exclusively in his low back after injury while lifting on a construction-site and he has been on disability since. The patient reports pain that is always 5/10. He reports that when he becomes short of breath, he becomes anxious, and he needs to smoke a cigarette to help calm his anxiety. He reports that his pain is annoying and will occasionally prevent him from falling asleep in his recliner at night (he ceased sleeping in bed 18 years ago). The patient reports that his pain seems constant, and he rarely leaves the home, except for MD appointments as a result. He has a supportive daughter who brings him groceries weekly. The patient reports that he tries to watch television and socializes with visitors, but “on a bad day” the pain can be unbearable and he “just can’t concentrate.” He slowly ambulates 20 feet to his bathroom while hunched forward, resting his forearms on the hand-grips of his rollator, wincing in pain. The patient resides on the 3rd floor of a non-elevator building and does not have portable oxygen tanks in the home. SpO₂ measures 93% at the time of initial assessment while using oxygen. The patient self-reports 1/10 dyspnea at rest, but moves quickly throughout the home, frequently provoking dyspnea of 6/10, but his SpO₂ does not reduce below 90%. The patient reports that he needed physical assistance from his daughter to enter the home after returning from the hospital due to shortness of breath and fatigue; he has not left the home since, 3 days ago. The patient has a driver’s license, but no longer drives.

The FPS should be scored 8/10, using the decision tree included with the document, due to the patient’s limitations with passive activities (e.g. sleep and occasional television viewing). When completing OASIS M1242, the admitting clinician would enter ‘3’ for pain that interferes with active and passive activities daily, but not constantly. With unrelenting chronic pain complaints for the last 20 years, the patient is challenged to cope with his pain and it is severely impacting his function at this time. In addition to severe persistent pain, the patient has additional environmental barriers, coupled with reduced respiratory capacity and anxiety.

The PSFS remains a beneficial tool to use when working with the patient to establish appropriate goals/objectives. Some goals may include, but are not exclusive to: (1) walking 200 feet with rollator and attached M6 tank, (2) independently mobilize from apartment to automobile (30 steps, 80 feet) with rollator and M6 tank, (3) the patient will teach back energy-conservation strategies to not exceed dyspnea with activity to 4/10 or less.

In each example, the PSFS serves as a useful means of documentation to gauge the patient’s progress with regard to his/her function, which - as illustrated here - often doesn’t correlate with self-reported VAS. By using a standardized tool (e.g. the FPS) with common language that relates back to the OASIS documentation (M1242) and focusing on metrics

that are functionally-based to establish goals and assess progress at later dates, the CHHA is leveraged to provide patient-driven care that is also sensitive to change and progress.

What Does the Research Say About Successful Treatments for Back Pain?

Pain is one of the leading causes of disability with estimates of the prevalence of chronic pain ranging from 8% to 60% and over (Phillips 2009) and an economic burden of between \$560 and \$635 billion a year (Gaskin 2011). A large part of this cost comes from medical expenses as the individuals with pain “who are managed poorly will bounce around the health care system, becoming more and more exasperated and consuming considerable resources” (McQuay 2008).

Treatment options for those dealing with chronic pain will differ wildly in cost, risk, benefit, invasiveness and rationality, leading many patients to go down a confusing, costly and disappointing road. Unfortunately for those in chronic pain, many of the common treatment options involve surgery and pharmacological intervention that often come with little to middling benefit and significant risks. This treatment pathway likely stems from many factors including health care incentives, medical tradition, patient expectations, cultural influences and a likely outdated understanding of pain being a reflection of tissue state and that correcting an observed patho-anatomical or physiological anomaly will correct the pain.

“Extensive experimental data corroborate anecdotal evidence that pain does not provide a measure of the state of the tissues and that pain is modulated by many factors from across somatic, psychological, and social domains” (Moseley 2008). The potential risks and human cost of a purely biomedical approach to chronic pain are well reflected by the failures of lumbar fusion in chronic nonspecific low back pain and long-term opiates in chronic pain. That is not to say that surgical and pharmacological treatments do not provide patients with benefit and have no indication, quite the opposite. Total joint replacement can often provide profound relief to patients with long disabling pain (Søren 2015). Opioids play a valuable role in acute pain and management of cancer-related pain. However, the judicious use of such high-risk, high-cost interventions in context of the complex nature of pain is of utmost importance.

Non-pharmacological interventions may offer people suffering from chronic pain avenues of treatment that involve minimal risk and minimal cost relative to their surgical and pharmacological cohorts. There is evidence that in certain conditions, conservative intervention offers similar benefit at a reduced cost and risk to interventions such as surgery for meniscal tear and OA (Katz 2013) or lumbar fusion for discogenic back pain (Bydon 2014). Non-pharmacological options are often delivered by a variety of health care providers, ideally in an interdisciplinary setting, and can include things such as exercise, education, activity modification, manual therapy and psychosocial interventions such as cognitive behavioral therapy.

It is important to recognize that the overall evidence for non-pharmacological options, particularly in chronic pain, is unfortunately underwhelming at best much like all interventions for chronic pain. For example, physical activity and exercise for chronic pain

in adults, a mainstay for many physical therapists has shown limited success (Geneen 2017). Psychological interventions in particular are receiving a lot of attention and hype that doesn't quite match the available evidence (Markozannes 2017). While effect sizes continue to be modest, non-pharmacological and psychosocial interventions might be the best available interventions for common musculoskeletal pains (Babatunde 2017).

It is realistic to think that what non-pharmacological treatments offer is a "less harmful" avenue with treatments that bring other tangible benefits to patients -- These secondary improvements from interventions such as exercise are well documented and may produce benefits such as or be related to outcomes including:

- *Fall risk reduction and home safety improvements*
(http://www.cochrane.org/CD007146/MUSKINJ_interventions-for-preventing-falls-in-older-people-living-in-the-community)
- *Improved physical function in older adults*
(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002759.pub2/full>)
- *Improved bone mineral density*
(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3528362/>)
- *Reduced risk for cardiovascular disease*
(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3528362/>)
- *Reduced re-admission rates in patients with COPD*
(<http://www.atsjournals.org/doi/abs/10.1513/AnnalsATS.201401-0170C#.U08xH8ftIsc>) and CHF (<https://www.ncbi.nlm.nih.gov/pubmed/27798506>)
- *Reducing symptoms of depression*
(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004366.pub6/abstract;jsessionid=90976AF7D1FF5892114A2388C244E1A8.f01t03>)
- *Possible improvements sleep problems and associated quality of life improvements*
(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003404/full>)

Benefits such as those above have significant potential to improve quality of life, reduce risk for secondary complications, decrease health care utilization and improve overall independence and activity participation in those dealing with musculoskeletal pain. Health care providers delivering non-pharmacological interventions also have an important opportunity to be advocates for their patients who may not be receiving an acceptable standard of care and guiding them towards care pathways that better match best available evidence and patient values.

In any area of medical practice with uncertainty, it is important for clinicians to utilize their expertise to synthesize the totality of best available evidence in a way that ensures informed consent. This will allow people with persistent pain to best understand available treatment options and in collaboration with their health care provider, come to a decision that best meets their individual needs, values and goals.

Educating Patients About Pain

Pain, we all get it. As distressing as it can be for some of us, without pain, we wouldn't last too long in this world. Think about how important it is to know when we've stepped on a piece of broken glass or grabbed a hot pan on the stove. But just like our sense of smell or vision, our nervous system can be fooled into thinking we are in danger of being injured, even when we are not. Have you ever seen a magician perform an optical illusion trick and realized on the one hand that you know it's a trick, yet your brain's convinced that you saw something because your eyes watched a rabbit pulled out of a hat? The experience of pain is also influenced by other experiences and memories, much like our sense of smell or taste when we remember the chocolate chip cookies that grandma baked when we were five or six, and how good they tasted with a cold glass of milk. So like our other senses, what we experience with pain is very individualized, and is influenced by many factors that go beyond just our physical and biological structures. From the study of pain, a field commonly referred to as "pain science", researchers have learned a lot about what pain is, and perhaps more importantly, what it isn't. Use this as a guide to help better understand your experience, as well as to seek out other resources and experts that may help you if you or a loved one has been affected by the experience of persistent pain.

What pain is:

- A normal system in our body that helps to warn us of threat or danger to our safety.
- A complex interaction in our body that involves many of our systems including our musculoskeletal, nervous, and immune systems.
- Can often be influenced by non-physical factors like anxiety, fear, and joy.
- An individualized experience that is not the same for everyone.
- For most people, pain is a temporary experience that will ease with time.

What pain isn't:

- Pain does not always need tissue damage/trauma to limit our ability to do the things we want.
- Imagined.
- Pain is not a vital sign, it's an individual response to threat to immediate or potential injury.
- A reason to stop doing what you enjoy doing.
- Pain is not forever.

Some helpful pain resources:

<http://www.mycuppajo.com>

<http://www.noigroup.com/en/Resources>

<http://www.greglehman.ca/-home-section>

<https://bodylogicphysiotherapy.com.au/resources-new/>

<https://bodyinmind.org/>

Glossary of Pain Terms

1. **Acute pain** - Acute pain is usually nociceptive but may be neuropathic. Common sources of acute pain include trauma, surgery, labor, medical procedures, and acute disease states. Acute pain serves an important biological function, as it warns of the potential for or extent of injury. A host of protective reflexes (e.g., withdrawal of a damaged limb, muscle spasm, autonomic responses) often accompany it.
2. **Addiction** - a disease state typically characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. Genetic, psychosocial, and environmental factors can influence its development.
3. **Allodynia** - condition in which ordinary non-painful stimuli evoke pain.
4. **Central Sensitization** - Upregulated pain channels to the brain, down regulated pain inhibition channels and heightened awareness of nerves. Increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input.
5. **Chronic pain** - Chronic pain is pain that extends beyond the period of healing, with levels of identified pathology that often are low and insufficient to explain the presence and/or extent of the pain. Chronic pain is also defined as a persistent pain that “disrupts sleep and normal living, ceases to serve a protective function, and instead degrades health and functional capability.”
6. **Hyperalgesia** - Increased pain from a stimulus that normally provokes pain. Hyperalgesia reflects increased pain on supra-threshold stimulation. This is a clinical term that does not imply a mechanism. For pain evoked by stimuli that usually are not painful, the term allodynia is preferred, while hyperalgesia is more appropriately used for cases with an increased response at a normal threshold, or at an increased threshold, e.g., in patients with neuropathy.
7. **Inflammation** - a fundamental pathological process consisting of a dynamic complex of cells and chemical reactions that occur in the affected blood vessels and adjacent tissues in response to an injury or abnormal stimulation cause by a physical, chemical, or biologic agent. The “cardinal signs” of inflammation are redness, heat, swelling, pain, and sometimes inhibited function. They may all be present, but not all are required to be present.
8. **Neuropathic Pain** - Pain caused by a lesion or disease of the somatosensory nervous system.
9. **Nociceptive Pain** - Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors. Note: This term is designed to contrast with neuropathic pain. The term is used to describe pain occurring with a normally functioning somatosensory nervous system to contrast with the abnormal function seen in neuropathic pain.
10. **Pain** - An unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such danger.
11. **Physical Dependence** - defined as the onset of withdrawal systems when a drug is abruptly removed.

12. **Tolerance** – the need to progressively increase the dosage of a drug to achieve a therapeutic effect when the drug is used for prolonged periods.

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SAMPLE HOME HEALTH AGENCY PAIN POLICY

	POLICY MANUAL		
	PAIN ASSESSMENT AND MANAGEMENT	Effective Date:	
		Revision Date:	
		Reviewed Date:	

PURPOSE

To provide education and guidance for the assessment and management of pain interfering with movement and quality of life.

To minimize interfering pain and/or discomfort at a level that is acceptable to the patient.

To provide guidance to the interdisciplinary care team and/or caregivers involved in assisting the patient to minimize interfering pain and maximize patient comfort.

POLICY

Pain management is a high priority in the delivery of quality home health care. Each patient is assessed for pain upon admission and every subsequent home care visit.

The Agency uses methods to assess pain that are consistent with the patient's age, condition, ability to understand and ability to express/answer the assessment questions.

The Agency respects the patient's right to appropriate pain management.

DEFINITION

According to the International Association for the study of pain, "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."

Severity of pain ratings will be classified as follows:

1-3= Mild Pain

4-6= Moderate Pain

7-10= Severe Pain

PROCEDURE

1. Each patient will be screened upon admission for the presence of pain using a visual analog scale (0-10) scale, the Wong Baker Faces pain rating scale and/or the PAINAD scale as appropriate.

2. Any patient reporting having pain and/or discomfort will receive a comprehensive pain assessment to include:
 - a. Identifying if there is pain interfering with activity following the OASIS C2 conventions for answering M1242. Item intent: Consider how frequently pain interferes with sleeping, recreational activities, and watching television (not just ADLs) when responding. The intensity of the pain is **not the primary focus** for this item.
 - b. Pain intensity and character including onset, location, aggravating and relieving factors, previous treatments and the effect pain has on physical and social functioning.
 - c. Psychosocial assessment including typical responses to pain, knowledge and expectations about pain management, economic effect, and changes in mood as a result of pain.
 - d. Physical exam: site of pain and referral patterns.
 - e. Medications, allergies and/or intolerance.
 - f. Non-pharmacological interventions that relieve pain such as: positioning, relaxation, music, heat, cold and touch, massage, graded exposure, guided imagery, and medication.

 3. Ongoing Assessments by all clinicians to the home.
 - a. The Pain Intensity Scale will be used to assess the patient's pain through phone contact and/or during each subsequent visit, and with each new report of pain.
 - b. The Patient Education Guide to Pain will be left in the patient's home with instructions to be completed daily. Patient's self-report of pain interfering with activity, (sleep is considered an activity as per OASIS) will be documented in the record and reported to the interdisciplinary team, pain that is reported as 4 or greater which is not at an acceptable level will be reported to the patient's physician for collaboration on pain management program.

 4. Treatment utilizes a variety of methods:
 - a. Following home assessment, collaboration with the Physician will occur and orders will be obtained for the treatment of pain when interfering pain and/or unacceptable pain is present.
 1. Pharmacological - narcotic and non-narcotic medication used to relieve pain always considering past pain medication use, allergies, abuse or intolerance (See Intervention Protocols).
 2. Non-pharmacological – i.e. heat, cold, touch, music, imagery, relaxation techniques. (See Intervention Protocols)
 3. Psychosocial - Medical Social Work interventions
 - b. Patients will be encouraged to remain active and participate in self-care.
 - c. During acute pain, patient and caregiver will mutually agree upon activities/ exercise as tolerated. Safety is a prime concern.
 - d. A referral for pain management clinic will be discussed with the patient, family, caregiver and/or physician as appropriate.

 5. Reportable Concerns
 - a. The clinician will report the following assessments to the attending physician:
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- Interfering pain rated four (4) or greater on the 0-10 pain scale or its equivalent, after the implementation of ordered interventions.
- When a patient's perceived level of pain is persistent, acceptable and not likely to improve, the pain assessment will continue every clinical visit and the physician will be notified as necessary
- New pain or change in patient's pain, location, frequency, duration, etc.
- Constipation unresolved with ordered interventions when implemented.
- Nausea and vomiting unresolved after ordered interventions are implemented.
- All other side effects interfering with pain relief as indicated by the plan of care.