Doctor of Nursing Practice at The University of Texas at El Paso

"BUT I HAVE PAIN NOW"
8TH ANNUAL DNP PROJECT SYMPOSIUM- MAY 13, 2020

COHORT VIII

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But I Have Pain NOW

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Abstract

Pain is described as an unpleasant sensation that can be experienced differently by each individual. Pain can be acute, lasting less than 3 months, or chronic, lasting greater than 6 months. Opioids have traditionally been recommended as a routine method to treat pain. In the United States, we have an epidemic of opioid overuse and deaths. According to Lin et al. (2019), veterans are at a higher risk of opioid overdose than the general public. One alterative way to manage pain is battlefield acupuncture (BFA). The BFA protocol used in the Veterans Administration (VA) and the Department of Defense (DOD) was developed by Dr. Richard Niemtzow. Battlefield acupuncture has been used to treat both acute and chronic pain management within the DOD and VA. Working in a VA pain management center that does not prescribe opioids allows for use of complementary alternative methods (CAM) such as BFA to manage pain. When first reviewing my practice, pain was primarily treated above a level of 5 on 0-10 Defense and Veterans Pain Rating Scale (DVPRS) (Appendix 1) or described as intolerable by the veteran. This project examined offering BFA treatment to patients with all levels of pain. The process for this project improvement proved to be challenging, but the results were worth the effort. Making a change in the way I offered treatment to my patients showed me that I am able to effectively implement change

Keywords: acupuncture, pain, BFA, reflective practice

But I Have Pain NOW

Working within a pain practice that does not prescribe controlled substances allows for a unique experience with our patients. The practice focus is on helping the patient manage the pain with specialized interventions and complementary alternative modalities/treatments. Pain is a unique disorder that may be experienced differently by each person. Responses to treatments may differ as well. Our expectation of our patients is that they are open-minded skeptics. My team consists of a medical doctor (MD), nurse practitioner (NP), chiropractor, yoga instructor, physical therapist (PT), Tai Chi instructor, social worker, pharmacist, registered nurse (RN), and two licensed practical nurses (LPNs). We each play a part in our patient's success in managing their pain. Focusing in on my practice within the pain clinic and planning an improvement in the care I provided required that I looked at both the patient's needs and current practice.

Patient Needs

Pain is a common complaint of patients seen in most medical practices. Working within VA, there is no difference. Of the annually 5.7 million patients treated by VA, more than 50% of these have a complaint of chronic pain (Federman, Zeliadt, Thomas, Carbone & Taylor, 2018). In the past, pain medications like opioids were prescribed to help manage pain. In trying to manage pain effectively, an adverse effect has occurred. The use and abuse of opioids has become a nationwide problem. The abuse has led to an epidemic number of deaths related to opioid overdose. According to the Centers for Disease Control and Prevention (CDC, 2017) report, in 2017, there were more than 72,000 overdose deaths in the United States. This problem disproportionately affects the veteran population (Lin et al., 2019). In 2016, the overdose rate among veterans increased from 14.47 to 21.08 per 100,000 person-years (Lin et al., 2019).

These numbers increased despite The Veterans Health Administration (VHA) decreasing in the number of opioid prescriptions written, from 54% in 2010 to 26% in 2016 (Lin et al., 2019). The opioid crisis has affected people in every socioeconomic status. Patients and providers are looking for other ways to manage pain. One way the VHA is addressing the problem is by utilizing CAM to assist veterans in managing their pain, using techniques like acupuncture, BFA, chiropractor, aquatics, and devices. Practices like the Intervention Pain Clinic at El Paso VA are helping to change way pain is managed and decreasing the use of opioids for pain.

Current Practice

Finding an improvement problem means taking a hard look at what one does and evaluating for areas that can be improved. In order to do this, I did a 10-day review of practice. I reviewed every patient I treated. I reviewed every diagnosis I entered and any treatments completed. This was all entered in a 10-day reflective practice log (RPL). During the review of practice, I saw 49 patients during that 10-day period. Of those, 34 left with the same level of pain they came into my office with. After completing the RPL, I had to take time and examine why I chose the action that I did. I asked myself: Is this based on evidence? Was there a different or better way to address the patient's pain? In the VA pain practice, we use a Defense and Veterans Pain Rating Scale (DVPRS) to record patients' pain levels with 0 equaling no pain to 10 being the worst pain. My current treatment plans were based off the responses given by the patients. Patients with pain greater than 5 were generally sent for interventions with the MD. Patients with pain less than 5 were generally encouraged to continue with current regimen or set up a regimen and be monitored until a time when their pain increased to a 5 or above on the DVPRS.

Importance of Addressing Pain

Pain is one of the ways most people are introduced to an opioid type medication, but that is starting to change. In 2017, the Department of Defense (DOD) and the Department of Veterans Affairs (DVA) updated guidelines. Opioids are no longer the recommended treatment for management of chronic pain (Federman et al., 2018). Looking at the overdose and abuse data, it is easy to understand that the opioid crisis is an ongoing problem. Even with the decrease in prescriptions written, the overdose rate has continued to climb. That is partially because so many people are using illegal means to get drugs (Lin et al., 2019). Drugs that they may have initially been prescribed for pain are now being used because the person is addicted. The DVA and DOD are now recommending alternative non-pharmacological treatments such as acupuncture, massage, biofeedback, and yoga (Walker, Pock, Ling, Kwon & Vaughan, 2016). It is important to address pain as soon and as effectively as possible.

Description of the Problem

After completing the review of practice, I was not able to immediately notice a problem. I did exactly what was expected of me. I completed tasks and planned care following a plan the primary MD had set up and never once questioned or adjusted it. I realized that was no reason for it to continually be done. I looked at ways to change the schedule of the patients who came in for appointments, but that required more administration tasks than what I did. Then, I looked at the treatments I currently provide like BFA and local injections. I saw no area for improvement with those. Then, I tried looking into the way we record the pain numbers, but again, this was more what the nurses did than what I do. After much back and forth, my chair, Dr. Morales, asked a very pointed question: “What is it that you are trained to do?” I shot off a

list of my duties and responsibilities. The question continued to nag at me. I was perplexed for a while trying to understand the question. Clarity came with more self-reflection. I am trained to help my patients find traditional and non-traditional pain relief. I had provided them with nothing to help decrease their pain at that time. They were either scheduled for procedures with the MD sometime within the next 2 months or sent to another modality (chiropractor, interventional PT, etc.). In my reflection and attempting to find alternatives to offer, I did a literature review for alternative ways to treat pain. Chiropractor, acupuncture, and physical therapy were some of the ways identified. Several articles with positive outcomes for patients' pain after Battlefield acupuncture (BFA) were identified. Reflecting on my own practice, I am certified to provide Battlefield acupuncture within the VA. I currently only provide BFA to patients specifically consulted in for BFA or referred in from other acupuncturists. I do not need a consult to provide this treatment. I had missed an opportunity to try to intervene. This led me to the PICOT question.

PICOT Question

(P) patient seen in office with pain greater than 1 on 0-10 DVPRS

(I) offer BFA to each patient with pain greater than 1 on 0-10 DVPRS

(C) patient will rate pain on DVPRS after BFA

(O) patient would have decreased pain rating

(T) Data would be collected for 30 days

Using CAMs are a large part of my practice. I am trained and credentialed in BFA/ Auricular acupuncture (AA) and perform it on a weekly basis. Acute and chronic pain are some

of the indicated treatments for BFA. At the time of the 10-day reflection, I was not routinely offering BFA to patients with pain reported as less than 5 on DVPRS or described pain as intolerable. Patients with pain 4 on DVPRS or tolerable were given appointments to follow up later (usually 3 months). Through this reflection process, I realized I could do more to help my patients manage their pain. I could offer anyone with pain BFA.

Battlefield Acupuncture: A Historical Perspective

To better understand what BFA is, it is important to understand how it came to be. Auricular acupuncture has a long history of use in Eastern or Traditional Chinese Medicine (TCM) to treat pain and can be traced back to the *Yellow Emperor's Classic of Internal Medicine*, which is one of the first Chinese medical texts (King, Hickey, & Connelly, 2013). Western medicine had traditionally shied away from Eastern medical practices. Acupuncture, however, has been well documented as a beneficial treatment of musculoskeletal pain and injuries. Countries such as Japan, China, Korea, and France have acupuncture as a routine part of their medical military treatment due to its effectiveness and low-cost burden (WHO, 2002). In the 1950s, a physician from Lyons France, Paul Nogier, first described a microsystem that mapped the ear to specific areas of the body (Walker et al., 2016). He is credited with the creation of the inverted fetus map on the external ear, a look like a homunculus (Walker et al., 2016). Using acupuncture at these sites in the ear would offer relief from symptoms a person was experiencing. This type of somatotopic pathway has been studied, and positive correlations between treatment and points of pain/disorders have been found (King et al., 2013). Although there still remains some controversy over the maps and the corresponding somatotropic responses, the use of auricular acupuncture is growing in both the military and civilian sector.

BFA in Military and VA

In 2001, Dr. Niemtzow, an Air Force Colonel, developed a protocol using five acupoints: cingulate gyrus, thalamus, Omega, point zero, and shen men on the external ear (Figure 1). This protocol is what is used for BFA sites (Walker et al., 2016). Battlefield acupuncture is so named because it was a treatment that can be done in active combat areas that does not cause a decrease in mental clarity or ability of soldier to perform (Walker et al., 2016). Utilizing this BFA protocol, Aiguilles Semi-Permanente (ASP) needles are inserted into the ear at each site on each ear or only on one ear (based on patient assessment and response). After each needlepoint is inserted, the patient gets up to walk around, and pain is reassessed. Once pain is controlled, no other points are needed. These needles may remain in place for 3 days and then are removed by the patient if they have not already fallen out. Patients are given instructions for proper sharps disposal after removal of the needles.

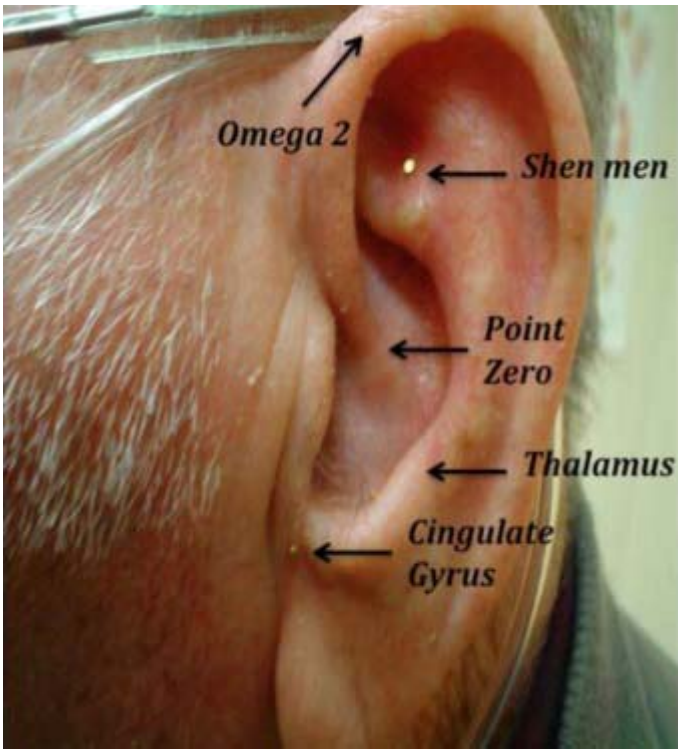

Figure 1. Battlefield acupuncture points (with approval of Richard Niemtzow, MD, PhD).

Literature Review

Due to current conflicts in Iraq and Afghanistan, many thousands of military casualties will need long-term management for a variety of physical and mental problems (King, et al., 2013). Battlefield acupuncture is one tool that is used in the active duty side and through the continuum of care into the VA. Veterans from all conflict periods may have co-morbidities that require extensive medication and therapy to manage. Just as the BFA treatment is effective in the battlefield by not clouding a soldier's ability to perform, it does not have contraindication for veterans using other medications to manage co-morbidities from battles or life. One of the longest running common concerns noted in the literature is the sites and corresponding body areas for auricle acupuncture. The sites for BFA are not part of this concern. Dr. Niemtzow's five sites are widely accepted and used. There was not a significant amount of literature that

rebutted BFA as being effective. The most common theme noted in the literature review is how to implement BFA into practice. Federman et al. (2018) reviewed individual and group types of appointments. Their researched showed that up to 82% of the patients had decrease in pain (Federman et al., 2018). There was no difference in patient response from either setting. In my practice, it is individual appointments for now.

Project Design

The first part of the project was to complete the quality improvement proposal and to get a work site approval letter. This was where I ran into a problem. We had a change of leadership, and the incoming Nurse Executive cleared through education department that I could complete my project. Historically, this was a smooth process. The education department of VA informed me and my chair that they had updated training, and they needed to identify me as a trainee during the time I was doing my project. There was at least 3 weeks of back and forth about what the University of Texas at El Paso (UTEP) required versus what the Veterans Affairs (VA) required. During this time period, the QI proposal process was completed. The QI reviewer had a question about the required informed consent, but that was easily rectified. Battlefield acupuncture is an invasive procedure. Because of the invasive treatment, an informed consent has to be obtained before the procedure can be performed. This is current practice. It required no new documentation development or approval. Once the Institutional Review Board (IRB) at UTEP was given a copy of the informed consent, they were satisfied, and my project received clearance through per UTEP IRB. Work site approval was not such an easy hurdle to overcome. Dr. Morales, my chair, and I were requested by VA to complete additional information again identifying me, a full-time VA employee, as a trainee. As a trainee, I would need to be doing "clinical hours" or "work without compensation" for the 360 hours needed for the DNP program.

After speaking with the chief of the education department several times and many calls back and forth with Dr. Morales, it was finally agreed to let me proceed with my project since I had started my program before this new training that the education department received was enacted. This will surely be a problem in the future for VA employees working on advancing their degree.

Work Setting and Resources

I work in a Department of Veterans Affairs outpatient non-prescribing pain management clinic. My primary focus inside of interventional pain is seeing follow-up appointments. I also perform treatments such as BFA, trigger point, intramuscular, and articular injections for pain. While I do not prescribe opioids, I do prescribe NSAIDs and other pain related medications. All equipment and supplies needed for implementation for the project are in good supply. I was not required to add any extra hours or time to my work schedule to complete BFA treatments.

Approach to Problem

On average, I see about 35-40 patients a week. Fridays were reserved for BFA and knee injections. Friday's clinic is also my shortest workday. Monday through Thursday, I work 9-hour days. My Friday clinic is from 8AM to 12 noon and was almost at capacity. Luckily, I can adjust my clinic as demand increases. I opened my entire schedule for BFA patients. My schedulers were informed of the change, and the patient was informed they could pick the day of the week they could come in. Offering BFA to all patients will allow me to provide better access to the patients and grow my practice.

Theoretical Framework

The framework used for this project is Promoting Action on Research Implementation in Health Services (PARIHS). This framework helps guide the implementation of proven methods into practice. The utilizing the PARIHS framework with a treatment such as BFA fits into its three primary elements: evidence, context, and facilitation (Rycroft-Malone, 2004). Battlefield acupuncture has been studied and proven to be a beneficial treatment for pain. The difficult part is facilitating BFA into an already full clinic schedule. This difficulty is part of the problem in bridging the gap between its researched usefulness and its application. Utilizing the Plan Do Study Act (PDSA) quality improvement model, I reviewed my practice and came up with a plan of action. The next step is to do what is planned. After the 6 weeks are completed, I will review once again and make any additional changes needed. The PDSA is a continual practice update model.

Population

The population treated in practice ranges from 18-98 years of age. Complaints are chronic pain or acute exacerbation of chronic pain.

Process

Over a 30-day period, I offered each patient with pain greater than 1 on DVPRS Battlefield acupuncture. If the patient accepted, they signed the informed consent after all questions were answered and they were comfortable. It was required to have a timeout before any procedure. The timeout required a witness to verify the correct patient name, date of birth, procedure, and site. After timeout, gloves were donned, each ear was prepped with alcohol, and BFA was performed. The patient was scheduled for a follow-up in 2 weeks. At that time, pain

was reassessed. There was an assessment of pain. Another BFA treatment and follow-up was offered if needed.

Desired Outcomes

Reduction in pain was the desired outcome as reported on the DVPRS. A continuation of the program for 30 days would allow for follow-ups to be completed in this project.

Budget

The cost of a 100-count box of ASP needles within the government system is estimated to be about $.050 per needle and $5.00 per treatment (Walker et al., 2016). According to ScripHesso (2020), the cost on the economy is $0.25 per needle costing about $2.50 per treatment. This cost is minimal in comparison to the price of opioid medications and treatment of addiction to opioid medications. Space was within my already allotted work area. There was a change in work hours required. No additional work hours were required, so there was no increase in cost burden to the VA. I did increase the number of patients treated. During the program, there were 16 new patients treated and 31 total treatments for a total cost of $155.

Findings and Outcomes

Over the 30-day study period, 31 total treatments were completed (see Appendix 2). Of the 31 treatments, 16 were to new veterans. The others were follow-up treatments. Descriptive characteristics such as ages of patients (shown in Table 1) ranged between 24 and 79. Gender (Table 2) was mixed and included men (11) and women (5). Pain responses ranged from no change to complete resolution after the procedure and are shown in Table 3.

Table 1

Subject Characteristics

Age	Number
18-39	4
40-49	3
50-59	6
60-69	2
70-79	1

Table 2

Gender

Male	11
Female	5

Table 3

Response after BFA

No change	2
1 point	3
2 or more points	20
Pain resolved	6

Only two patients reported no change in pain on the DVPRS. Three reported at least a 1-point change. Twenty patients reported a 2-point decrease in pain on the DVPRS. Six patients

reported pain was completely resolved. These six patients also reported a feeling of calm or relaxation after the BFA treatment.

Evaluation

The addition of BFA to scheduled appointments did add extra time to the appointment but only during the original education of the patient about BFA. Once educated about BFA, times for appointments were not as long. One problem in recruiting patients during their appointment time to accept BFA procedure and follow-up. Some patients are still in the active workforce and do not want to take time off for appointments. Some patients turn down treatment due to work/schedule obligations. Another problem encountered was knowledge and willingness to try something other than traditional Western medical treatments. For those who tried BFA and found relief, BFA is a new tool they can use to battle chronic pain. Offering BFA to all patients with pain had a positive outcome, with 94% of patient encounters reporting a decrease in pain.

Conclusions

Using BFA to treat patients with acute or chronic pain is a non-pharmacological way to decrease pain. It is quick and cost effective. Training and education of both the licensed independent providers (LIPs) and the patient will require extra time commitment. It has been documented in studies like Federman et al. (2018) that there is difficulty with trying to integrate BFA within already packed primary care visits. I acknowledge that I have the longer appointment slots due to working in a specialty practice. In my schedule, I utilized this time to build BFA practice into my clinic. It did present some challenges at the beginning. Offering and educating the patient on what BFA was and how it worked took a good deal of time. Overall,

BFA was easier to incorporate into my practice than originally anticipated. Now, BFA will be something I will continue to offer to all patients with pain. This is an effective practice change.

Discussion

The need to offer effective non-pharmacological treatments for acute and chronic pain for veterans remains a priority objective. Working in a facility that has the commitment and has already invested the time and money into alternative treatments is a valuable advantage for my practice. Utilizing the skills learned is my responsibility not just to the facility but to my patients. Reviewing my practice and scrutinizing the way I perform has been an effective lesson. Periodically, I plan to review my practice to make sure that I am best utilizing all skills acquired, such as BFA, to help my patients manage pain. VHA offered the training and certification to become a certified BFA provider. It is my job to effectively utilize this certification. The goals for this project were successfully met. I also have a new understanding of how I can review my own practice and make evidence-based changes. I believe that is the greatest goal met with this review of practice and quality improvement project.

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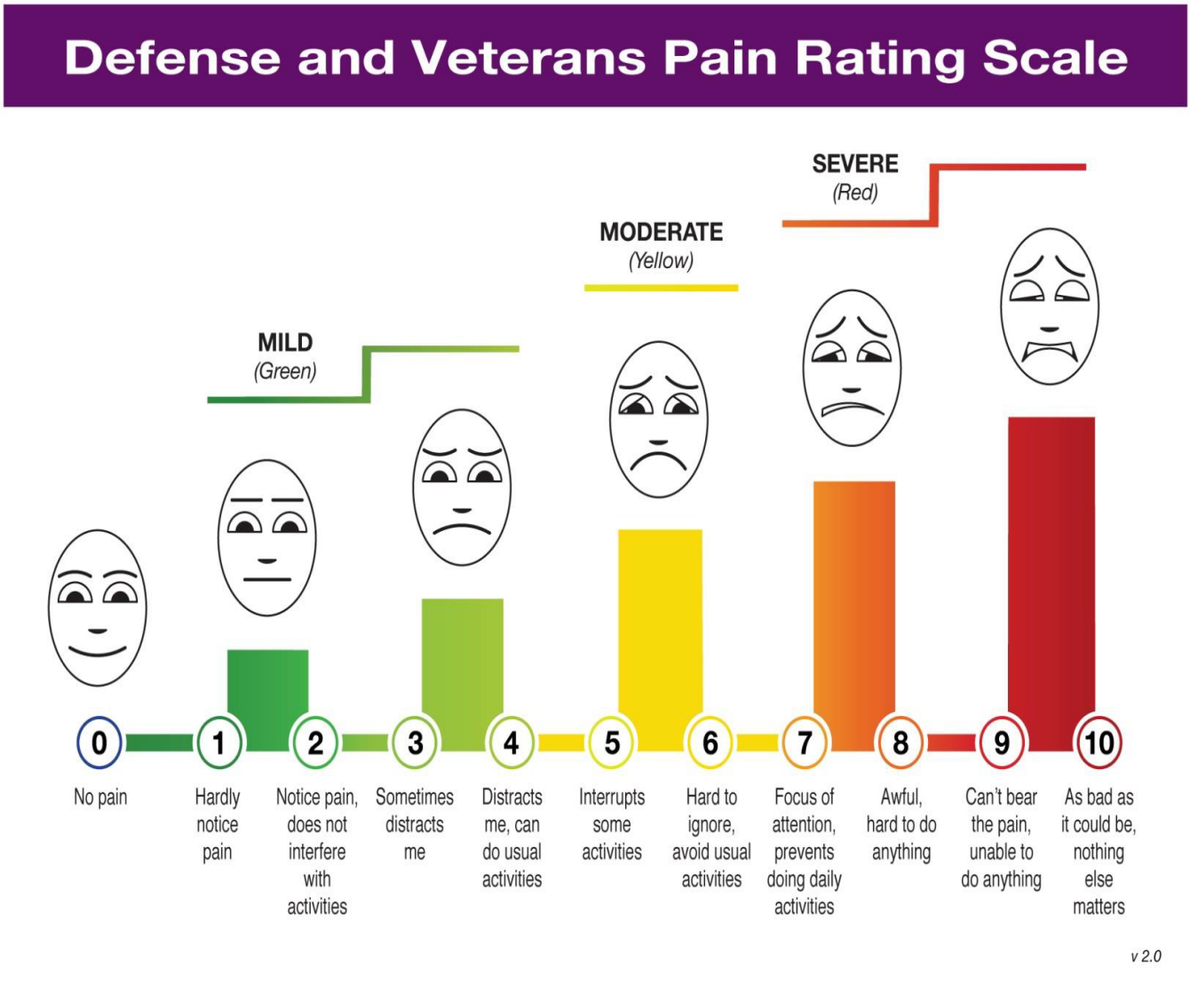
Appendix 1


Defense and Veterans Pain Rating Scale
MILD
(Green)
MODERATE
(Yellow)
SEVERE
(Red)
0
No pain
1
Hardly notice pain
2
Notice pain, does not interfere with activities
3
Sometimes distracts me
4
Distracts me, can do usual activities
5
Interrupts some activities
6
Hard to ignore, avoid usual activities
7
Focus of attention, prevents doing daily activities
8
Awful, hard to do anything
9
Can't bear the pain, unable to do anything
10
As bad as it could be, nothing else matters
v 2.0

Appendix 2

30-day Log

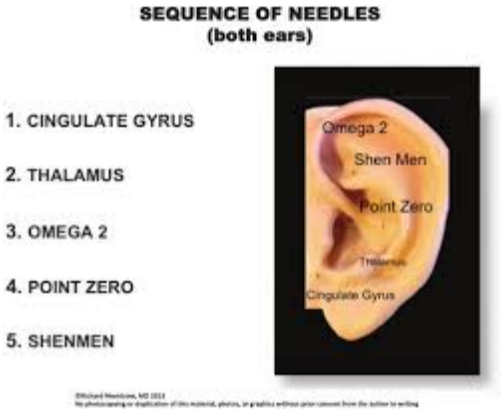
31-Jan	P.N.	4	2	53	M	N
31-Jan	T.T.	6	2	47	F	N
31-Jan	R.S.	9	6	54	M	N
4-Feb	A.Z.	8	5	53	M	N
7-Feb	M.M.	7	5	57	M	N
7-Feb	M.A.	2	0	63	M	N
7-Feb	D.H.	4	2	52	F	N
10-Feb	D.G.	7	5	47	M	N
10-Feb	T.T.	2	1	47	F	F/U
11-Feb	R.S.	6	4	54	M	F/U
13-Feb	R.B.	3	2	64	M	N
13-Feb	D.H.	3	0	24	F	N
14-Feb	J.H.	5	5	36	F	N
14-Feb	P.N.	6	3	53	M	F/U
14-Feb	R.G.	6	0	55	M	N
24-Feb	J.Z.	8	4	53	M	N
24-Feb	D.G.	5	2	47	M	F/U
25-Feb	D.H.	3	1	24	F	F/U
27-Feb	J.H.	8	6	36	F	F/U
27-Feb	R.G.	6	0	39	M	N
28-Feb	D.H.	6	4	52	M	F/U
2-Mar	R.B.	3	0	64	M	F/U
3-Mar	R.R.	6	0	30	M	N
5-Mar	A.R.	6	6	45	F	N
5-Mar	D.H.	5	3	24	F	F/U
5-Mar	R.S.	6	2	54	M	F/U
6-Mar	M.A.	3	2	63	M	F/U
7-Mar	J.Z.	6	4	53	M	F/U
11-Mar	R.S.	8	4	54	M	F/U
12-Mar	J.H.	8	4	79	M	N
13-Mar	M.M.	8	3	57	M	F/U

Appendix 3

Permissions e-mail

On Wed, Mar 4, 2020 at 9:23 AM McFelt-Williams, Stefanie Y. <Stefanie.McFelt-Williams@va.gov> wrote:
Dr. Niemtzow,
Hello, my name is Stefanie Mcfelt-Williams. I would like your permission to use the attached picture with the Battlefield acupuncture sites in my capstone project for The University of Texas at El Paso.

Stefanie Mcfelt-Williams, MSN, APRN, ACNP-BC
VA Health Care System
Interventional Pain Clinic
5001 N. Piedras Street
El Paso, TX 79930
912-564-6100 ext. 6048



Yes you may use the drawing.
Good luck
Richard
Richard C. Niemtzow, MD, Ph.D., MPH
Colonel (ret), USAF, MC, FS
Integrative Medicine Consultant to the USAF Surgeon General
Director, USAF Acupuncture & Integrative Med Center Joint Base Andrews, MD
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E-FAX:1240-559-2300.

On Wed, Mar 4, 2020 at 5:59 PM McFelt-Williams, Stefanie Y. <Stefanie.McFelt-Williams@va.gov> wrote:
May I have your permission to use this image as well.?

Respectfully,
Stefanie Mcfelt-Williams, MSN, APRN, ACNP-BC
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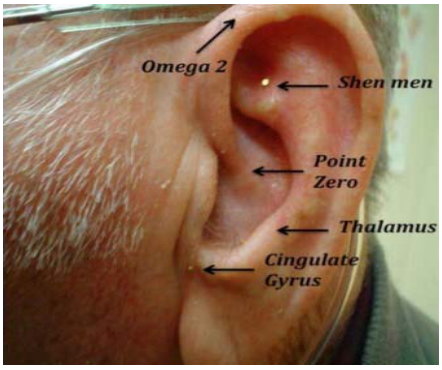

Yes you may. Good luck.
Richard
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