Implementation of the CAPA (Clinically Aligned Pain Assessment) Tool: Pain is More than Just a Number

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Objectives

Learners will be able to:
1. Discuss the concept of pain assessment as a social transaction between patient and clinician.
2. Summarize the outcomes of University of Minnesota Health’s implementation of CAPA.
3. Describe the lessons learned from implementing a complex and culture-changing project.

Impetus for Change at University of Minnesota Medical Center

2012

• Low patient pain satisfaction scores (HCAPH)
• Anticipation of effect of Centers for Medicare and Medicaid’s Value-Based Purchasing plan — Reimbursement based in part on satisfaction with care.
• State of Minnesota, an average of 70% of patients reported satisfaction with pain management scores (MDH, 2014)
• Staff dissatisfied with current numeric pain scale

Are Pain Ratings Irrelevant?

• Noted that fellow pain and palliative care colleagues didn’t always ask about pain intensity using the numeric scale
• In 2015, Short Survey of APS members, N=41 —Pain clinicians do not routinely use pain intensity ratings as part of the pain assessment during clinical practice.


Tide of Thought Shifting

• Reliance on unidimensional scales to guide treatment have been linked to serious adverse events: Increased incidence of opioid over-sedation from 11-24.5/1,000,000 inpatient hospital days.
• Documentation of pain is treated as a regulatory nuisance and clinical decision making is not linked to assessment data.
• Pain is complex and assessment tools need to reflect that complexity, yet be pragmatic in clinical use.
• Pain assessment is a complex communication process between the patient and clinician.

Debate on Self-Report as Gold Standard in Pediatric Pain Intensity

Pro:
• Pain is subjective and can only be assessed via self-report
• Guides appropriate treatments.

Con:
• Reliance on self-reported pain scores oversimplify the pain experience,
• Yield only marginal information on which to base clinical decisions,
• Potentially place children at significant risk for adverse events.


Pain Assessment as a Social Transaction


• Problem with self-report using a one-dimensional scale
  – Pain is a multi-dimensional complex experience
  – Numeric scale difficult for some to use
  – Requires linguistic and social skills: problematic with some of most vulnerable populations
  – Patients modulate pain behaviors and self-report based on their perception of what’s in their best interest

• Self-report as gold standard
• Major disconnect between what is advocated and what clinicians actually do
• “Pain is what the patient says it is” acknowledges subjectivity of pain, but ignores complex patient/clinician relationship
• “Pain as 5th Vital Sign” highlights significance of pain, but can be mechanistic

Examples of Contributing Factors in Pain Assessment

<table>
<thead>
<tr>
<th>Patient</th>
<th>Biologic</th>
<th>Sociocultural</th>
<th>Developmental/Psychological</th>
<th>Experience/Empathy</th>
<th>Contextual/Situational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease, clinical condition, drug influences</td>
<td>Ethnicity, access to healthcare, cultural origin</td>
<td>Age, stress, drug addiction, interpersonal skills, fear</td>
<td>Knowledge, clinical competence, empathy, institutional insensitivity</td>
<td>Language, fear/stress, Similarity to clinician, socioeconomic status</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Biologic</th>
<th>Sociocultural</th>
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<th>Experience/Empathy</th>
<th>Contextual/Situational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologic disposition, stress reactivity</td>
<td>Pt. preferences or biases, age, sex, education, ethnic background</td>
<td>Views on pain, trust/suspicion, Interpersonal skills, critical evaluation of pain report</td>
<td>Workload, interdisciplinary communication, facility resources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary of the Social Transaction of Pain Assessment

Pain assessment best described as a dynamic process, a transaction:
- Intersubjective exchange of meaning between patient and clinician
- Verbal and nonverbal interaction between patient and clinician is modified by the physiologic and social context
- Process dependent on internal/external factors to both parties and environment

University of Utah – 2012 Pilot Project

- CAPA® developed to replace conventional numeric rating scale (NRS; 0-10 scale)
- Press Ganey® scores increased from 18th to 95th percentile
- 55% patients preferred CAPA®
- Nurses preferred CAPA® 3:1 over NRS

Clinically Aligned Pain Assessment (CAPA)

"Pain is More Than Just a Number" ©
- Evaluates
  - intensity of pain
  - effect of pain on functionality
  - effect of pain on sleep
  - efficacy of therapy
  - progress toward comfort
- Engages patient and clinician in a brief conversation about pain resulting in coded evaluation

Change or Transformation?

Change is the “fixing” of past to future:
- Better, cheaper, faster, leaner, etc.

Transformation is the job of leaders:
- Building a vision
- Start with the future and work back
- Help people fall in love with the future
Transformation

The butterfly is NOT a better, faster caterpillar.

It is a NEW system.

Building an Institutional Commitment to Pain Management

- A resource manual that provided a framework to promote practice changes that would improve quality of pain management for all patients.

Steps of Implementation

1. Define the scope and team
2. Identify and manage the risks
3. Breakdown the work
4. Schedule the work
5. Communicate
6. Measure progress

From, Verzuh (2008).

University of Minnesota Medical Center – A River Runs Through It

1932 licensed beds
885 staffed beds

1. Defining the scope and team – Phase 1

Scope (Adult Inpatient)
- Medical Units
- Surgical Units
- Behavioral Units
- Obstetrics Units
- Acute Rehabilitation
- Transitional Care
- Emergency Departments
- Perioperative Services

Team
- Champion: Chief Nursing Executive
- Quality and Performance Improvement Consultants
- Data Analysts
- Electronic Health Record Consultant
- Nurse Managers
- Staff Nurse Leaders
- Nurse Educators
- Communications Department

1. Defining the scope and team – Phase 2

Scope (Adult Outpatient)
- Infusion Centers
- Clinics
- Procedural Areas
1. Defining the scope and team – Phase 3

- **Scope (Pediatrics)**
  - Process begins with validation of tool in pediatric population

2. Identify and manage the risks

**Potential failures/risks**
- Failure to gain cooperation of nurses and physicians
- Concerns of researchers using the numeric scale
- Failure to increase patient satisfaction or improve pain management

**Managing Risks**
- Buy-in from key leaders
- Contacted IRB to notify researchers of change
- Weekly monitoring of process with monthly monitoring of outcomes

3 & 4. Breakdown and schedule the work

- August 2013
- September
- October
- November
- December
- January 2014
- February
- March
- April
- May
- June
- July

- Take to Leadership groups
- Develop content of presentations
- Establish plan for data collection
- Build doc and reports to support
- Form House wide Group and unit based group
- Engage Stakeholders
- Assess current state of practice, research
- Communicate/educate all disciplines

5. Communicate

**Who**
- Special interest groups: Nurse Managers/Directors, nursing staff, physician groups, APRNs, nursing practice committees, social workers, therapists, champions

**When**
- Before, frequently throughout

**What**
- Purpose, expected behaviors, expected outcomes, patient/family feedback, process and outcome measures

**How**
- Via meetings, newsletters, intranet, patient stories, staff stories, e-mail

6. Measure progress

- **Process measures:**
  - Weekly compliance report per unit
  - Identification of individuals still using numeric scale: can be coached and counseled

- **Outcome measures:**
  - Monthly CAPA© outcomes
  - Press Ganey© pain satisfaction scores

Objective 2: Summarize the outcomes of University of Minnesota Health’s implementation of CAPA©.
Electronic Data Abstraction

Process Measures CAPA© Compliance

Outcome Measures - CAPA©

Outcome Measures - CAPA©

Outcome Measures – Press Ganey©

- Overall Pain Management
  - Staff Did Everything They Could to Help With Pain
  - Pain Well Controlled

Press Ganey© - Overall Pain Management (by month)
Anecdotes

**Patient perspective:** “Makes me feel like the nurses care more about my pain.”

**Nurses perspective:**
- “It makes sense.”
- Many had been frustrated by numeric scale and liked the change. “I hated that 0-10 scale.”

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**Objective 3**

- Describe the lessons learned from implementing a complex and culture-changing project.

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**Learnings**

- Numeric scale embedded in many different places in EHR.
- Pain assessment by many different people — Students, faculty, therapists, technicians, etc.
- Some staff are not skilled at “talking with” patients; this presented a challenge.
- Some people resist change!
- Staff can be the biggest champions!
Unexpected Occurrences

Information about the CAPA® tool

- Tool not validated according to standards of psychometrics.
- Study by Drew, Hagstrom & O'Connor-Von (unpublished) found no correlation between numerical scores and concurrent CAPA comfort domain. N=30, repeated measures
  Found that can't compare quantitative data to qualitative data.
- Donaldson (2014) recommends nonparametric approach in research design

Additional Learnings

- Staff need to recognize this as culture change versus a “project”
- Glitches happen in spite of best planning
- Ripple effects of change occur
- Barriers along the way: people, processes, tools
- Facilitators: people, processes, and tools

Implications for Outpatient Settings

- Pain screening question in clinics = numeric intensity score gathered by non-professional
  - Didn’t cue professional about patient’s pain status or concerns (documentation not readily visible)
  - Didn’t meet the intent of TJC standard to assess patient’s pain in outpatient setting

Recommendations for Outpatient Settings

- Delete numeric pain scale from intake data.
- Ask screening question: “Do you have pain that needs to be addressed at this appointment?”
- Answer flows to Vital Signs flow sheet that is reviewed by RN and provider
- CAPA available on flow sheet for charting pain assessment
- Dot phrase available for easy charting in narrative note if preferred by provider.

Recommendations in Process

- “Make it hard to do the wrong thing, and easy to do the right thing.” Joanne Disch, PhD, RN
- Educate via presentations, electronic learning, written materials, interpersonal meetings. Repeat, repeat again....
- Utilize electronic medical record to match work flow
Recommendations

• Speak to fears and concerns:
  – Fear of making an “assessment”: some nurses are more comfortable with patient’s statement of a number than trying to interpret interaction
  – MDs fear that they won’t know how to respond when nurse calls with CAPA information

• Engage executive leadership as necessary

A Tale of Two Emergency Departments

West Bank ED 2nd Quarter

East Bank ED 2nd Quarter

Summary

• Pain assessment is not merely the subjective statement of the patient, no more than it is the sole objective decision of the clinician.
• Rather, pain assessment is the intersubjective exchange of meaning between the patient and clinician.
• It is a process, which is ongoing and dependent on both the internal and external factors inherent to both the parties and their environment.

Summary

• CAPA© is an expanded way to assess pain using a transactional conversation between patient and clinician.
• Findings: Changing from the numeric scale to the CAPA© tool is a cultural change for staff and patients.
• Next steps at M Health include:
  – Expansion to most care settings within hospital system.
  – Validation of tool in adolescents
The Impact

“Nobody makes a greater mistake than he who did nothing because he could do only a little.”
Edmund Burke

The Power of Many Drops

Questions?

References

Donaldson, G., & Chapman, C.R. (2013). Pain management is more than just a number. University of Utah Health/Department of Anesthesiology. Salt Lake City, Utah: Department of Anesthesiology.

