Emerging Role of NPs and PAs in Pain Management

Nurse Practitioners and Physician Assistants offer the best hope for dealing with the resistance of Primary Care Physicians to provide appropriate pain management for chronic pain patients.

By Jennifer Schneider, MD

As the public becomes increasingly aware of the availability of potent drugs for pain relief, the number of patients seeking pain management is rising. Unfortunately, because of addiction issues, fear of regulatory scrutiny, and lack of knowledge, many primary care physicians are reluctant to maintain patients who have chronic non-cancer pain on opioids. Ever-increasing numbers of such patients are getting referred by primary care providers to pain specialists for initial evaluation and treatment but, when the treatment includes chronic opioids, many internists and family physicians are reluctant to take back the patients and continue prescribing scheduled drugs for them. As a result, pain specialists are left with an ever-growing number of patients in their clinics who require ongoing follow-up for medication management.

Medication management of chronic pain can be time-consuming and complex. Chronic pain patients are often depressed because of the adverse consequences that their pain syndromes have had on their lives. Typically, they are initially defensive because previous health care providers, family, and/or friends may not have taken the patient's pain problem seriously enough or expressed that "it's all in your head." Such patients need an empathetic ear and respectful treatment. Additionally, if opioids are prescribed, their use requires not only familiarity with the drugs, but also attention to potential problems of abuse and addiction. Patients who are on chronic opioids need to be seen on a regular basis (every 1-3 months) to be monitored and reassessed. All these factors make medication management of chronic pain a time-consuming process—something that many physicians are reluctant to undertake.

Fortunately, a new paradigm is emerging that can alleviate the shortage of health practitioners who will provide medication management of chronic pain patients. Nurse Practitioners (NPs) and Physician Assistants (PAs) are taking an increasingly active role. Currently, pain clinics are often headed up by one or more interventionalists (often, anesthesiologists) whose focus is on invasive procedures. Some of them also provide pharmacologic treatment. Recognizing the need for medication management, pain clinics are increasingly hiring physician assistants, nurse practitioners, and nurses to assess the patients, prescribe pain medications, and monitor the patients' progress with follow-up visits and clinical urine drug testing. In some practices, the clinician providers function fairly independently in their role of medication management while in others there is an ongoing collaboration with the physicians. In yet other pain clinics, the physicians initiate invasive and/or medication treatment, and then collaborate with NPs and PAs to extend their reach and to reduce the overall cost of long-term medical management of their patients. Additionally, those NPs and PAs with additional training in pain medicine have, at times, found homes in primary care practices, where they can provide pain management services that might otherwise not be available.

Articles about nurses' role in pain management are increasingly appearing in the nursing literature. For example, the role of nurses in a pain and palliative care program established at the Veterans Administration Medical Center in Salt Lake City in 1999 was provided by Jennings.[1] More recently, Kaasalainen et al[2] surveyed 16 nurse practitioners in long-term care facilities in Ontario. Canada, and found that a gap in physician

availability exists in such facilities but that the available NPs are not being used to their full potential in managing pain among elderly residents. The barriers to NP pain management included time constraints; prescribing restrictions; lack of knowledge; difficulties in assessing pain; physician, staff, resident, and family reservations about use of opioids; and poor collaboration with physicians.

Role of the Physician Vs. Non-Physician Provider

In preparation for this article, I spoke with several nurse practitioners, physician assistants, and nurses in different states who work in pain management settings. In some cases they were part of a pain clinic headed by interventionalists who did injections, implanted spinal cord stimulators, and performed other invasive procedures. Some of the physicians also did medication management, whereas in other pain clinics the role of the physician was basically limited to doing procedures, while the NP or PA did the initial evaluation and assessment, prepared a treatment plan, and initiated prescribing medications. The clinician providers also had follow-up visits with the patients. In other practices, the NPs worked more closely with the supervising physician who, at the end of the initial visit, reviewed the results with the NP, personally saw the patient, and made the final decision on the treatment plan. In such practices, it was the non-physician provider who usually saw the patient for follow-up of medication management, and the physician might be consulted only if there were unresolved issues. NPs were also usually the team member who saw the patient for follow-up of procedures.

Typically, NP s and PA s perform the following roles in a pain practice:

- Initial assessment and formulating a treatment plan if possible
- Ordering urine drug tests, interpreting the results, and consulting as needed with the toxicologist at the clinical lab
- Discussing the case with physician, to a greater or lesser extent, depending on the NPs' level of expertise, the physician's usual involvement in such cases, and the particular case in question
- Writing prescriptions (NPs can write for schedule II drugs in most states; PAs in some states need physician's signature.)
- Preparing and dictating reports to referring physicians, including recommendations for treatment
- Referring patients for addiction treatment if warranted
- Follow-up visits for medication management, including patients who were initially treated with invasive procedures but now require medication management
- Follow-up visits for implants and procedures

NPs and PAs usually see patients for 45-60 minutes for their initial appointment, and for 15-30 minutes for follow-up. They may spend more time with the patient than do physicians in follow-up visits.

Registered nurses in pain practices are also playing increasing roles. An NP related that at the multidisciplinary pain practice where she works, the two RNs are the "implant coordinators." They manage intrathecal pumps (recently less so) and spinal cord stimulators. They coordinate the surgical schedule and make follow-up calls for intervention and triage. They also field questions about medications, depending on their level of knowledge about these drugs.

Medical assistants (MA s), who for years now have increasingly filled the role that RNs and LPNs used to have in outpatient practices, can also be trained to be effective team members in a pain practice. In my office, for example, my medical assistant has assumed responsibility for ordering urine drug tests (UDTs). Because of her interest in increasing her knowledge base, she is now able to interpret the test results, and to consult with the laboratory if she has questions. Other doctors and MAs in my office now come to her with questions about UDT's. She also worked out a system whereby she knows when to pull the charts of patients whose medication renewal is coming up so that I can write the prescriptions without the patients having to phone in each time.

The Expanding Role of PAs and NPs in pain management

It is clear that the role of nurses in providing pain management is expanding. This is happening in two ways:

- **Expanding Job Scope.** Within a given clinic, the role of the midlevel provider tends to increase as his or her experience increases. One PA related that her training consisted of "a couple of courses in PA school and then a year and a half in a methadone clinic." She said, "My responsibilities in the practice are increasing as I learn more." Other clinicians reported that as the confidence of the physician in them increased, there was less need for consultation with the physician. A NP whose training was working as a hospice nurse says, "As pain management becomes more my specialty, the docs rely on me more."

One certified Family Nurse Practitioner who is an ARNP

(Advanced Registered Nurse Practitioner) started out with an internist who did pain management. He did the initial consults and established the initial treatment plan, while she did the follow-ups. Over their four years together, her role in pain management gradually grew. When the physician relocated, it proved to be difficult to transition his 500 chronic pain patients to other providers. In the end, the NP found a family physician willing to be her medical director. She continues to see the original patients, plus additional ones referred to her for medication management by anesthesiologist/pain specialists in her community. She works independently and describes her practice as follows:

"My initial consult is about 1 hour long with the patient, and is comprised of a thorough history and a complete physical. Of course, the paper work takes about an additional hour to complete. I do an ORT [Opioid Risk Tool] score, Zung depression score, and CAGE [an alcoholism assessment tool] as my baseline screening tools with a baseline urinalysis/drug test with immunoassay and GCMS testing for all opiates and illicit drugs including heroin and Ecstasy. I do not prescribe any opiates on the initial visit. I then follow up in about 10 days. My follow up visits are scheduled every 15 minutes. Of course, some pa-tients take 2 minutes and others take 30 minutes. I always document Passik's "4 A's" if they are on opiates. [These are Analgesia, Adverse effects, Activities of daily living, and Aberrant drug-related behaviors.[3]] I see about 90% of my patients every month. Some I see every two months, but only if they live far away or are in financial distress. If that is the case, I require them to provide me with self-addressed envelopes for mailing scripts. On my methadone patients, I obtain yearly EKGs to assess for a prolonged QTc. [A prolonged Q-T interval is a potential adverse effect of methadone treatment.] I do not belong to the ASPMN [American Society for Pain Management Nursing] and am not credentialed by them or any other body for pain management. Maybe once I finish my doctorate that will be my next step."

Notice that this nurse practitioner has become very knowledgeable about urine drug testing. As physicians are seeing more pain patients and the time that can be dedicated to each visit is becoming shorter, the clinical team needs access to tools that can result in increased efficacy during the office contact. In particular, management of the patient's pharmacotherapy is typically time-consuming. The more detailed information that can be gathered regarding medication usage, the less time is spent guessing about what the patient is doing.

In pain practices, pharmacotherapy and urine testing are increasingly managed by non-physician providers. Some clinical laboratories provide not only comprehensive drug testing but also can assist PAs, NPs, and RNs to become knowledgeable about most aspects of urine drug testing, thus relieving the pain practice's physicians from the time-consuming responsibility of managing urine drug testing.

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Regarding the role of NPs, the independent nurse practitioner whom I interviewed adds, "I do see the role of mid-level providers expanding in regard to the management of chronic pain due to a lack of practitioners willing to care and prescribe for this patient population. Barriers to care for this population are fed by lack of knowledge regarding chronic pain care, fear of regulatory scrutiny, and personal opinions regarding the use of opiates for non- cancer pain."

• **Increased Hiring of Non-Physician Providers at Pain Clinics.** As the role of individual NP s and PA s expands, greater numbers of them are being recruited by pain specialists who find themselves reluctantly providing medication management for an increasing number of patients who were referred to them for severe pain and have not sufficiently benefited from procedures alone. The staff of one multidisciplinary pain clinic currently consists of two pain specialists who provide a spectrum of services include pharmacologic and interventional, one physiatrist, a psychologist, a Family Nurse Practitioner, and a nurse. The medical director of the clinic told me recently that they are now providing ongoing medication management for some 2,000 patients. The primary care physicians who initially referred these patients are not interested in taking them back for medication management. To help with this enormous patient load, they recently hired two additional NP with experience in pain.

An NP whom I interviewed works in a multidisciplinary pain clinic staffed by one pain specialist who does procedures, an osteopath who does intakes and also manipulation, and a clinical psychologist. The NP's role is both medication management and assessment of the results of injections. She reports, "The doctors in my clinic don't want to continue writing opioids. They want to return the patient to the PCP to take over the prescribing, but the PCPs are reluctant."

Nurse Training in Pain Management

Because the major role of nurses in pain management is a relatively new one, there are few formal programs to educate nurses. A comprehensive pain management nursing text was published in 1999 (McCaffery and Pasero[4]). Written by two nurses, it provides practical tools and guidelines for treating patients' pain in all clinical settings and age groups.

In 1990, a group of nurses already doing pain management formed the American Society for Pain Management Nursing, an organization for Registered Nurses interested in pain management. ASPMN now has 1,806 members (ASPMN, personal communication, 9/10/07) and holds annual educational meetings. Its mission is to "advance and promote optimal nursing care for people affected by pain," and its goals are to promote access to quality care, public awareness, professional resources, education, and professional recognition. For the past two years, and together with the American Nurses' Credentialing Center, ASPMN has been offering a certification examination in pain management. As of September 2007, 552 nurses were credentialed by ASPMN, undoubtedly many of them Nurse Practitioners.

Of course, because the pain management field is relatively new, many nurses and PAs — just like many physicians who treat pain — received their training on the job. Many have no specific credentials. For those who do, it was most likely their

on-the-job experience, rather than a formal program, that prepared them for the examination that led to their credentials. One NP spent four years working as a hospice nurse. Before taking the ASPMN exam she attended a brief physicians' exam preparation course. Interested NPs and PAs attend courses aimed at physicians. Courses are also now offered online for physicians and nurses. For example, see Medical Directions, Inc.[5]

Unfortunately, some NPs told me that they have faced the same excessive regulatory scrutiny that physicians often complain of. At least some nursing boards have little experience and little tolerance for NPs who prescribe scheduled drugs and may discipline them harshly. At present, NPs do not have many educational resources for learning about setting appropriate boundaries for patients, monitoring them, and recognizing abuse or diversion.

What is clearly needed at this time are additional educational opportunities for clinician providers. One NP whom I interviewed, Louann Hart,[6] has developed a printed module to educate clinicians practitioners in pain management. It is now being used in a pilot study at the University of Kentucky.

Conclusion

The role of NPs and PAs in chronic pain management is only going to increase. They are our best hope for dealing with the increasing reluctance of primary care physicians to provide appropriate pain management for patients with chronic pain. The medical director of a large pain practice summed it up succinctly: "I actually can see the greatest role for non-physician providers being in medium to large primary care groups who need an in-house medical pain management capability. That is where they can do the most good. And we will need a lot of them if things keep going the way they are in the physician world! But this will only work when training for such providers becomes a little bit more formalized." Let's hope that their professional organizations make it a priority to expand their educational opportunities, both in pain management and in related addiction medicine issues, and that these boards become more supportive of the increasing role of nurse practitioners and physician assistants in treating pain. ■

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