BRIDGING THE GAP OF CARE FOR CHRONIC PAIN PATIENTS’

by

Stormy Paige Lantz

A scholarly paper submitted in partial fulfillment of the requirements for the degree of

of

Master of Nursing

in

Clinical Nurse Leader

MONTANA STATE UNIVERSITY
Bozeman, Montana

November 2019
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ABSTRACT

Aim: Examine the need for multidisciplinary pain management support for primary care providers at a provider based ambulatory care setting in western Montana.

Background: Although chronic pain ailments make up a significant portion of primary care provider visits, many providers do not feel equipped to manage nonmalignant chronic pain and often fear legal consequences of opioid prescribing. With gaps in pain specialist availability, provider comfort, and geographical and financial challenges, Telemedicine may help alleviate provider stress through the delivery of emotional support and structured case discussion and consultation, assisting providers with communication strategies, mental health referrals, and difficult decision-making surrounding opioid prescribing.

Method: Twenty six primary care providers received an electronic questionnaire to assess their pain management needs and views regarding the training, challenges, expectations, and impact of implementing Telehealth at their current organization.

Results: Five out of twenty six providers participated in the project. Eighty percent (80% “n=4”) of providers said they would use Telehealth for pain management if it was available to them, identifying interprofessional collaborative practice, initial evaluation and treatment plan recommendation, ongoing treatments, and education as the most useful telehealth applications.

Conclusion: Chronic pain management is a problem for primary care providers. Future research on small, rural organizations using telehealth to meet their patients’ pain management needs and additional needs assessments are needed to gain insight into providers engagement levels prior to moving forward with implementation of a Telehealth program at this organization to ensure a successful implementation.
INTRODUCTION

“Americans are affected by pain more than heart disease, diabetes, and cancer combined” (McGeary, McGeary, Gatchel, Allison, & Hersh, 2013, p.422), placing chronic pain as a leading medical disorder in America. Chronic pain affects more than 100 million people in the United States and accounts for 20% of outpatient visits, 12% of all prescriptions, and over 100 billion dollars in direct and indirect expenses (Rosenquist, 2018). With over 100 million adults in the United States living with chronic pain the need for accessible, affordable, quality pain management has never been more apparent.

In 2001, as part of a national effort to address the widespread problem of underassessment and undertreatment of pain, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now known simply as The Joint Commission (TJC), rolled out its pain management standards which helped grow the idea of pain as the ‘fifth vital sign’, requiring all healthcare providers to assess and address pain at every visit. In efforts to address this widespread problem by designating pain as the ‘fifth vital sign’ were more problems created? A vital sign is objective. Pain, while a symptom, is subjective. McCaffery (as cited in Duckworth, 2019) defined pain as “whatever the experiencing person says it is, whenever he/she says it does”. Following the movement of pain as the ‘fifth vital sign’ in conjunction with pharmaceutical companies reassuring the medical community that patients’ would not become addicted to opioids, the nation found itself in the midst of an opioid epidemic. Since 1999, deaths involving prescription opioids have increased by more than five times, and over 200,000 people have died from prescription opioids (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2018).
In today’s world, finding a provider willing to tackle pain management among the opioid epidemic is extremely difficult, as many primary care providers feel unequipped to manage pain and often fear legal consequences of opioid prescribing. Primary care providers face challenges in providing effective treatment, including lack of training in pain management, time constraints, lack of consensus on optimal treatments, and controversies surrounding the use of opioids for chronic non-cancer pain (Matthias, et al., 2010).

Nationally, there is a shortage of providers who specialize in pain management, with only one certified pain medicine specialist for every 28,500 people with pain, impeding efforts to develop efficient, cost-effective health care delivery models for treating the vast population of patients with chronic pain (Institute of Medicine, 2011). This specialist shortage is amplified in rural settings. Montana covers 145,552 square miles, with an estimated population of 1,050,493 people; 680,900 of those individuals living in rural Montana (Rural Health Information Hub, 2018). Montana’s rural demographics present not only a geographical barrier to quality pain management but financial and socioeconomic barriers as well. Rural residents are more likely than their urban counterparts to be in poorer overall health, suffer from more multiple chronic or serious illnesses and disabilities, be uninsured or under-insured, be living in poverty, lack social support, and experience delays in obtaining care that is not available (Eaton et al., 2014).

Access to health care in rural communities is often hampered by long travel distances, which is exacerbated by poor secondary roads and winters with inclement
weather conditions, such as those found in Montana (Eaton et al., 2014). The distance a patient has to travel to access a clinic where specific pain management services are offered limits access to nonpharmacological treatment (Giannitrapani et al., 2018), which is an important component of holistic pain management. Telehealth technologies can bridge geographic distance and improve patients' quality of care in communities where access to pain specialists have previously been unavailable (Eaton et al., 2014).

One facility located in western Montana, provides healthcare to a five-county region and currently does not have a pain management clinic. As a result, pain management falls onto the shoulders of the primary care providers in the community. With gaps in pain management physician availability, provider comfort, and geographical and financial challenges, how do healthcare providers and patient advocates bridge these gaps? Might Telehealth be the answer?

Telehealth or Telemedicine is a term coined in the 1970s, which literally means “healing at a distance” (Strehle & Shabdem, 2006). According to the World Health Organization (2010, p. 8), telehealth is defined as “The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies (ICT) for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of healthcare providers, all in the interests of advancing the health of individuals and their communities.” This increasingly popular avenue of healthcare delivery has become a viable option for the delivery of quality pain management support in rural areas where these resources may be limited or nonexistent.
Purpose

The aim of this project was to obtain supportive and improved access to quality pain management for patients by examining the providers’ pain management needs at a provider based ambulatory care clinic located in western Montana, to improve community access. Provider opinions were considered a priority regarding utilizing Telehealth services to meet this need.
REVIEW OF THE LITERATURE

As specialized pain clinics are not widely available, the majority of chronic pain continues to be managed in the primary care setting. “Chronic pain is the leading reason for patients to see their primary care physician, and accounts for 21% of emergency room visits” (Jamison, Gintner, Rogers, & Fairchild, 2002, p.93). Although chronic pain ailments make up a significant portion of primary care appointments, many primary care physicians are uncomfortable providing pain management, specifically when it comes to the use of opioid therapy for non-cancer pain. In a cross-sectional study of primary care physicians conducted at 12 academic medical centers in the United States (n=572) only 34% physicians reported they felt comfortable in managing patients with chronic pain (O’Rorke, Chen, Genao, Panda, & Cykert, 2007). Upshur, Luckmann, and Savageau (2006) conducted a study with 111 primary care providers across eight community clinics who reported 37.5% of adult appointments in a typical week involved patients with chronic pain complaints. Providers reported inadequate training for, and low satisfaction with delivering chronic pain treatment.

Providers report

Difficulties and frustrations associated with uncertainty regarding patient motivations and engagement in care, fear of causing harm, the inherent subjectivity of pain, coexisting disorders, lack of social support, and the overall “emotional toll” of chronic pain management. (Hulen, et al., 2018, p.1575)

Concerns regarding addiction and dependence play an important role in pain management decisions and are significantly associated with levels of clinician frustration (Dobscha, Corson, Flores, Tansill, & Gerrity, 2008). A semi-structured interview study of
primary care providers, registered nurses, licensed practiced nurses, psychologists, and social workers (n=60) at two VA medical centers found that provider perceptions of barriers to reducing opioids and improving the use of nonpharmacologic pain management therapies (NPTs) for patients with chronic pain clustered around availability and access; barriers to NPT access included geographical (patient distance from service), financial (out-of-pocket cost to patient), temporal (treatment time delays), and cultural (belief that NPTs increased provider workload, perception of insufficient training on NPTs, perceptions of patient resistance to change, confrontation avoidance, and insufficient leadership support) (Giannitrapani et al., 2018).

Limited literature focusing on Telehealth for chronic pain management exists; many studies are still in progress and not yet complete. A recent literature review conducted by McGeary, McGeary, and Gatchel (2011) using universally endorsed MeSH search criteria, revealed only 32 MEDLINE references focusing on telehealth for pain, compared to a very large number of references covering Telehealth (14,164 references) and pain (104,564 references).

In review of a study conducted by Haozous et al. (2012), Telehealth was found to be a feasible and effective way to deliver cancer-related pain management education and increase competence among rural health care providers; 93 providers from 16 sites participated in pain management case conferences. The case conference participants scored significantly higher on perceived competence in treating pain compared with clinic providers who did not attend. While this study was focused on the treatment of
malignant pain, it is reasonable to assume these results would be similar of non-cancer pain as well.

Dario et al. (2017) conducted a systematic review with meta-analysis of 11 randomized control trials that investigated the effectiveness of any Telehealth-based intervention, in isolation or in combination with other interventions, for non-specific low back pain, focusing on the effectiveness of interventions delivered by Telehealth on pain, disability, function and quality of life in non-specific low back pain. Findings found that Telehealth-based interventions used in isolation are not more effective than minimal interventions for the reduction of pain and disability in chronic non-specific low back pain.

In looking at cost-effective care, a randomized controlled trial of the cost comparison to the patient for a Telemedicine versus in-person visit found that direct patient costs were significantly lower in the Telemedicine group than in the in-person visit group. The median cost range $133 vs $443 respectively; more patients were highly satisfied with the Telemedicine consultation than with the in-person consultation (Pronvost, Peng, & Kern, 2009).

Interventions to address chronic pain management and assist clinicians with opioid prescribing in the primary care setting are emerging. One approach, the creation of clinician-led multidisciplinary peer review groups, reviews challenging cases and provides primary care providers with treatment recommendations (Hulen, et al., 2018). The literature demonstrates that primary care providers report low satisfaction levels and high levels of frustration with treating chronic pain (Bergman, Matthias, Coffing, &
Krebs, 2013), however, multidisciplinary pain management peer groups have shown to be effective in reducing the stress and frustrations associated with this complex patient population.

These peer-based multidisciplinary groups help alleviate provider stress through the delivery of emotional support and structured case discussion and consultation, assisting providers with communication strategies, mental health referrals, and difficult decision-making surrounding opioid prescribing (Hulen, et al., 2018). Ball, Wilson, Ober and Mchaourab (2018) conducted a study of primary care providers (n=24) participating in Specialty Care Access Network-Extension for Community Health Outcomes (SCAN-ECHO) program in pain management; SCAN-ECHO is a video teleconferencing-based training program where primary care providers are trained by a specialty care team to provide specialty care. The pilot study revealed positive outcomes in terms of primary care providers’ confidence and knowledge in treating patient with chronic pain. The mean number of correct post participation answers per participant increased from 6.8 to 8.2 (t-statistic-2.75, df=23, P<0.05) (Ball et al., 2018).
METHODS

Telehealth pain management was explored as a potential resource for chronic pain management at a not-for-profit health system providing services to an estimated 97,000 residents of Lewis & Clark, Broadwater, Jefferson, Meagher, and Powell counties in western Montana. Implementing a Telehealth program is an organizational change, requiring staff engagement. This project focused on provider engagement and defined need by means of a needs assessment as the first step in considering Telemedicine.

The needs assessment was distributed to twenty-six primary care providers, currently prescribing opioid therapy for chronic non-cancer pain, employed at the health system. Seven physician assistants, three nurse practitioners, three doctors of osteopathic medicine, and thirteen doctors of medicine formed this collection of providers.

Theoretical Underpinnings

In developing a needs assessment for pain management, both need and access must be understood. “Health needs assessment is a critical component of health service planning, however, defining needs is difficult due to the inherent complexity of the concept of “need,” so it is not surprising that numerous definitions have been proposed” (Asadi-Lari, Packham, & Gray, 2003, p.1). Meanwhile, access in healthcare can be perceived as “the opportunity to reach and obtain appropriate health care services in situations of perceived need for care” (Asadi-Lari, et al., 2003).

Bradshaw’s 1972 taxonomy of social needs theory identified four types of needs: normative need, felt need, expressed need, and comparative need. Bradshaw defines
normative need as the expert’s evidenced-based opinion on what is needed in any given situation (Cookson, Sainsbury, & Glendinning, 2013). “Normative needs are not absolute, they are changeable as a result of change in knowledge and the changing values of society” (AlDossary, Martin-Khan, Bradford, Armfield, & Smith, 2017, p.3). Felt need is paralleled with want. Bradshaw suggested that felt need is usually not taken into account, although hearing the views of the people themselves is an important aspect of assessing the need for a service. Peoples’ perception might be founded on a limited knowledge of services and therefore they will not feel the need for a service that they do not know exists (Cookson, et al., 2013). Expressed need is felt need turned into action. Expressed need is commonly used in the healthcare services where waiting-lists are taken as a measure of unmet need. Comparative need is obtained by studying the characteristics of the population in receipt of a service (Cookson et al., 2013). Need established by this method is the gap between what services exist in one area and what services exist in another (AlDossary et al., 2017).

In this needs assessment, the expressed need was identified by searching online for pain management specialists and pain management clinics in the community. Search results indicated one pain management specialist in the service area, however, upon further investigation, this provider does not accept all insurance carriers and only performs interventional pain management. The organization surveyed, had a pain management specialist who left in March 2018, leaving roughly 1600 patients that returned to their primary care provider for their pain management needs. The lack of pain management specialists in the community identifies the expressed need. This survey was
a subjective measure where input from the primary care providers helped gain clarity to the felt need of those providers.

In addition to Bradshaw’s taxonomy of social needs, Florence Nightingale’s environment theory was used to guide this project. Nightingale never wavered from the idea that a basic human right was high-quality patient care provided by a dedicated nursing staff. It is the basic human right, that those individuals affected by pain, have access to high-quality, cost-effective, pain management. Nightingale envisioned the extension of nursing as the essential force which would meet the growing healthcare needs in sectors outside of the hospital (Selanders & Crane, 2012). The focus of nursing in this model is to alter the patient’s environment in order to affect change in his or her health. Using this theory, Telehealth is viewed as a change in environment, in order to affect change in those suffering from pain in rural settings.

Ethical Issues

Given the projected involved human subjects, requests were submitted to the Institutional Review Board (IRB) for exemption July 11, 2019. Anonymity, confidentiality and informed consent are important ethical considerations that should be taken into account (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). In viewing the ethical considerations that accompany a questionnaire-type project, the online survey software SurveyMonkey was chosen to create and distribute to potential participants. Utilizing an online questionnaire helped ensure all participants remained anonymous. The customizability of this survey platform allowed flexibility in answering questions so that no one question required a response, as participants should have the
right to choose not to answer specific questions. With any project endeavor, participants should be given the content, sponsorship, and purpose of the questionnaire, so that they may make an informed judgment about whether they wish to participate. To accomplish this, an email was sent to all primary care providers within the organization detailing the content of the project as well as the purpose of the questionnaire. Participation in this project was strictly voluntary and by choosing to complete the questionnaire via the link provided in the email, informed consent was assumed. The project was declared to be exempt from the requirement of review by the IRB in accordance with the Code of Federal regulations, Part 46, section 101.

**Sample and Setting**

The needs of providers who were currently working as primary care providers and whose organization was supportive of implementing a telehealth platform were the focus of this project. Therefore, primary care providers at a provider based ambulatory care setting in western Montana whose leadership is committed to investing in Telehealth services were surveyed. All 26 (7 men and 19 women) primary care providers were asked to participate in the assessment and sent the electronic questionnaire. The survey population was 100% Caucasian and comprised seven physician assistants, three nurse practitioners, and sixteen physicians. Participants had to be currently employed and working as a primary care provider at the health system at the time of the survey. To maximize participation, follow-up emails were sent to providers before closing the survey.
A mixed methodology approach was undertaken to conduct a needs assessment. The main premises of this methodology is that “such integration permits a more complete and synergistic utilization of data than do separate quantitative and qualitative data collection and analysis” (Wisdom & Creswell, 2013, p.1). The survey instrument was developed through review of the literature and discussions with the organization’s leadership.

Consisting of open-ended, Likert scale, and multiple choice questions, providers’ pain management felt needs and views regarding the training, challenges, expectations, and impact of implementing Telehealth to meet these needs were explored (Appendix A). Primary care providers completed questionnaires in which they self-reported their clinical training (physician, nurse practitioner, or physician’s assistant) and years in clinical practice (< 5 years, 5 to 10 years, 10 to 15 years, >15).

Primary care providers were asked to estimate what percentage of their current patient panel they were treating for chronic pain and how many visits this accounted for in a week. Using a Likert scale, providers were asked if they felt the treatment of chronic pain was a problem in their practice, if they preferred to manage chronic pain themselves, if they felt patients were reluctant to accept referral for pain management, and if they felt Telehealth for pain management would be beneficial. Providers selected among the following response categories: ‘strongly agree’, ‘agree’, ‘undecided’, ‘disagree’, and ‘strongly disagree’.
Analysis

Responses were summarized using descriptive statistics. Participants with missing data were excluded on a question-by-question basis. Responses to open-ended items were reported descriptively.
RESULTS

Surveys were completed by five of the 26 primary care providers (19% response rate). Primary care providers (PCPs) who participated were (100% “n=5”) physicians; 60% (n=3) had been a healthcare professional for >15 years, 20% (n=1) for 10-15 years, and 20 % (n=1) for 5-10 years. Sixty percent (60% “n=3”) of the providers who participated estimated pain management comprises <25% of their patient panel, while 40% (n=2) estimated 25-50% of their patient panel. When asked roughly how many patients do you see for chronic pain in a week, 20% (n=1) of providers responded >15, another 20% (n=1) responded 5-10, and 60% (n=3) answered 0-5.

Primary care providers needs for pain management services at their organization and their opinions and thoughts regarding utilizing Telehealth services to meet this need were surveyed. Overall, PCPs who participated agreed chronic pain is a problem in their practice (see Figure 1). Lack of resources, providers “dumping” chronic pain patients they no longer wished to treat, difficulty getting improvement, lack of alternatives to opioids, and limited access to chronic pain specialty services were all identified as barriers to managing pain in their current practice. When asked, “I generally do not refer patients to pain management programs, I prefer to manage chronic pain myself,” providers disagreed (see Figure 2). Overall, providers agreed that patients were reluctant to accept referrals for pain management (see Figure 3).

Related to prior experience providing or receiving Telehealth services, 20% (n=1) of PCPs had previously utilized telehealth for psychiatry, burn, and stroke at other organizations; Sixty percent (60% n=3) replied they would need training in the operation
of the Telehealth equipment having not used it previously, requesting their staff have the training. Eighty percent (80% “n=4”) of PCPs who participated would use telehealth for pain management if it was available, identifying access to specialty care, anything helps, and preference for those difficult to treat pain patients to see a specialist, as reasons they would utilize Telehealth for pain management, however, providers responses were neutral when asked if Telehealth for pain management would be beneficial to their practice (see Figure 4). When asked if they have any specific clinical outcome expectations they would like to see with Telehealth, one physician responded: “I would like them to take over management of pain patients.” Interprofessional collaborative practice, evaluation and treatment plan recommendations, ongoing treatments, and educational presentations were highlighted as the most useful Telehealth applications (see Figure 5). Cost, workflow, space, and identifying lead personnel/coordinator were identified as potential barriers to implementation at the organization.
Figure 1. Primary care providers' assessment of chronic pain in their practice

Treatment of chronic pain is a problem in my practice

Answered: 5   Skipped: 0

Figure 2. Primary care providers' interest in managing chronic pain

I generally do not refer patients to pain management programs; I prefer to manage chronic pain myself.

Answered: 5   Skipped: 0
Figure 3. Primary care providers' perceptions of patients willingness to accept pain management referrals

My patients are reluctant to accept referrals for pain management.

Answered: 5  Skipped: 0

Figure 4. Primary care providers’ thoughts on the benefit of Telehealth for pain management in their practice

Telehealth for pain management would be beneficial to my practice.

Answered: 5  Skipped: 0
Figure 5. Primary care provider interest in available Telehealth pain management programs

In which of the following scenarios would Telehealth for pain management be most useful to your practice? Please select all that apply.

Answered: 5  Skipped: 0

- Interprofessional Collaborative Practice: 2
- Initial Evaluation & Treatment Plan: 2
- Ongoing Treatments: 4
- Education, CME Presentations: 2
- None of these: 1
DISCUSSION

Primary care providers’ pain management needs and opinions regarding utilizing Telehealth services to meet these needs were assessed at a rural provider based ambulatory care setting in western Montana. The results showed that providers felt pain management is a problem in their current practice, identifying lack of resources, providers “dumping” chronic pain patients they no longer wished to treat, difficulty getting improvement, lack of alternatives to opioids, and limited access to chronic pain specialty services as barriers to managing pain in their current practice. These perceived barriers are consistent with those observed in the literature (Hulen, et al., 2018).

Unpredictably, the five providers who participated in the project were all licensed physicians; no advanced practice providers (APPs) participated. In speaking with the organization’s leadership, the advanced practice providers function as extenders of the physician on the care team at this facility and often see a majority of the physicians’ pain management patient panel, allowing the physicians to see more new patients’ and those requiring in-office procedures. It is unclear why none of the APPs participated, perhaps they do not check their business email as often as the physicians or feel their opinions are not valued at this organization? Given the APPs involvement in treating patients’ with chronic pain at this facility, it is important their opinions are accounted for prior to moving forward.

As the organization looks to bridge the gap of care for chronic pain patients in this community, Telehealth may be a viable option, however, the low response rate suggests limited provider interest. Provider engagement is a vital component in order to ensure
successful implementation of Telehealth. Further studies are needed to ascertain engagement. Given the low response rate with this project, an alternative design approach is indicated. A focus group may be effective in facilitating discussion of provider needs and allow for more in-depth considerations.

Everyone, regardless of income, race, gender, age, status or geographic location, should have access to effective pain management. Nursing leaders are responsible for advocating for patients within the healthcare delivery system to effect quality, safe, value-based outcomes and facilitate the lateral integration of evidenced-based care across settings and among care providers to promote quality, safe, and coordinated care while including an awareness of global environmental, health, political, and geo-economic factors in the design of patient care. Pain management is not one-size-fits all. Having identified the lack of specialized pain management in the community, healthcare leaders must continue to address the gap in care for chronic pain patients. Telehealth has the potential to address this gap in care, should providers’ take an active role in collaborating in the development of community partnerships to establish health promotion goals and implement this strategy.

Limitations

There were several limitations to this project. First, this needs assessment was restricted to a single primary care clinic. These results may not generalize to other primary care environments. In addition, the low response rate had the potential for nonresponse error or sampling bias as those who chose not to respond may have had
different opinions or needs than those who participated. Other potential limitations include not addressing the perceived needs of other stakeholders, such as patients.
CONCLUSION

There was not a sufficiently large sample size to be able to draw meaningful conclusions, however, findings suggested primary care providers wanted more support for treating their patients with chronic pain and would support implementing Telehealth services. Concerns about workflow integration, training, and space will need to be addressed to ensure successful implementation. Should the organization move forward with Telehealth implementation, a readiness assessment should be conducted to identify where the organization’s strengths lie, assist in clarifying needs, and pinpoint where problems may arise during the implementation process to help ensure the organization can support and sustain the program. This needs assessment can serve to guide the direction of the Telehealth platform.

In a society where physician burnout is already a concern, healthcare leaders must ensure they are offering providers the support they need to alleviate the stress associated with chronic pain management. Chronic pain is not going anywhere. No cure exists. Healthcare providers need to feel comfortable and supported in their management of chronic pain.
REFERENCES


APPENDIX A

NEEDS ASSESSMENT QUESTIONNAIRE
1. Are you licensed and/or certified as a:
   o Physician
   o Physician Assistant
   o Nurse Practitioner

2. How long have you been a healthcare provider?
   o <5 years
   o 5-10 years
   o 10-15 years
   o >15 years

3. What percentage of your patient panel would you estimate you are treating for chronic pain?
   o <25%
   o 25-50%
   o 50-75%
   o >75%

4. In a typical week, roughly how many patients do you see for chronic pain?
   o 0-5 patients
   o 5-10 patients
   o 10-15 patients
   o >15 patients

5. Treatment of chronic pain is a problem in my practice
   
   Strongly Disagree    Neutral    Strongly Agree

6. I generally do not refer patients to pain management programs; I prefer to manage chronic pain myself.
   
   Strongly Disagree    Neutral    Strongly Agree

7. My patients are reluctant to accept referrals for pain management.
   
   Strongly Disagree    Neutral    Strongly Agree

8. In your opinion, what is the number one barrier to managing chronic pain in your practice?
   
   ____________________________________________________________
9. **Do you have any experience providing or receiving Telehealth services?**
   - o Yes
   - o No

10. **If Yes, what type of care did you provide/receive using Telehealth?**

11. **Telehealth for pain management would be beneficial to my practice.**

    1  2  3  4  5

    Strongly Disagree    Neutral    Strongly Agree

12. **In which of the following scenarios would Telehealth for pain management be most useful to your practice? Please select all that apply.**
   - o Interprofessional collaborative practice: case reviews
   - o Initial evaluation and diagnosis with recommended treatment plan
   - o Ongoing treatments; Ability for my patients to be treated/managed by a pain management specialist
   - o Education, CME Presentations
   - o None of these; please elaborate

13. **Assuming satisfactory reimbursement and no regulatory and licensing barriers for Telehealth, what are some of the reasons you would not use this technology? Please select all that apply.**
   - o Security and privacy of patient information
   - o Patients aren’t interested
   - o Won’t work with current practice workflow
   - o Not interested
   - o Don’t see a need to add to practice
   - o Other; please elaborate

14. **Do you have any specific clinical outcome expectations you would like to see with Telehealth?**

15. **Would you require training in the operation of the Telehealth equipment?**
   - o Yes
   - o No

16. **If yes, please elaborate on your training needs:**

17. **What do you foresee as barriers to Telehealth implementation at your facility?**
18. If telehealth for pain management was available I would utilize this service.
   - Yes
   - No

19. Why or why not?

   ________________________________________________________________

20. Please share any additional comments and/or suggestions:

   ________________________________________________________________