

A community-based approach to the treatment of pain and addiction

Maureen A. Allen, MD,
BN, CCFP(EM)
St. Martha's Regional
Hospital, Antigonish, NS

Correspondence to:
Maureen Allen;
jimandmoe@eastlink.ca

This article has been peer
reviewed.

The need for a national plan to address pain and addiction has never been more urgent. More crucial, however, is the development of grassroots strategies to address the unique challenges faced by rural communities.

The data on abuse of prescription drugs have been sobering. Globally, it has been estimated that North Americans consume a staggering 80% of the world's opiates.¹ More alarming still is the corresponding death rate attributed to prescription opiates, which has surpassed that of both heroin and cocaine.² Canada has become the second largest per capita consumer of prescription opiates, next to the United States.¹ Dr. Thomas Frieden, director of the Centers for Disease Control and Prevention, stated in a 2011 address to physicians that "the number of deaths from prescription opioids had surpassed those from car crashes, heroin, crack cocaine, firearms and suicide combined in some US states."^{3,4} Despite these sobering statistics, only 9% of physicians surveyed viewed prescription drugs as a major problem.⁵

The need for physicians and other health care providers to be part of the solution to this public health disaster is evident. We need to come together with stakeholders to not only advocate for patients, but also to show leadership and solidarity within our communities.

OUR DISTRICT HEALTH AUTHORITY

The following pain and addiction strategy was developed in collaboration with multiple stakeholders within our community of Antigonish, NS. Stakeholders included

addiction services, palliative and chronic pain services, pharmacy, psychiatry, quality and risk managers, family physicians and emergency personnel.

The town of Antigonish boasts a population of 5000 and has a regional hospital with a capacity of 79 acute care beds and 10 alternative-level beds. Medical support is provided by 20 family doctors, 1 cardiology nurse practitioner, and specialist support in internal medicine, general surgery, psychiatry, anesthesiology, obstetrics and pediatrics. Within our service catchment area of 8000 km², 3 other smaller health care facilities exist. Together, these 4 facilities serve a total population base of 44 515. All of these facilities offer emergency and inpatient services around the clock.

Specialty pain resources in our district include a community-based chronic pain clinic, which offers services 1 day a week. The clinic is built on a model of collaborative care and includes a local physician, an occupational therapist, a physiotherapist and a social worker who works in our psychology department. The team helps patients establish goals of care specific to their needs. Patients are then offered an 8-week pain self-management program, which is provided by the chronic pain team and encompasses broader concepts of pain management. Patients are referred to the clinic by family physicians, emergency departments and nurse practitioners. Our community wait list to access chronic pain services dropped substantially when our chronic pain clinic was introduced and made referrals more timely and relevant to patients' needs. Some clients from our district had been on a provincial wait list to access chronic

pain services for 4 years when our program was first implemented in January 2008. To date, our wait times have decreased to 4 months.

Other specialty services that address pain and suffering in our community include a palliative care team of 3 physicians, who share one full-time position, and 5 nurse consultants. This is an inpatient and community-based resource that is offered within the district to all facilities.

INTRODUCING A PAIN AND ADDICTION STRATEGY

The pain and addiction strategy was introduced into our 12-bed emergency department in Antigonish with the plan of implementing it in other district facilities that offer emergency services.

The strategy was put into practice to help address high-risk patterns of controlled substance use and to offer tools to health care personnel to manage pain in acute and chronic care settings, as well as at the end of life. For patients with a history of chronic pain who used the emergency department on a regular basis to manage flare-ups, a comprehensive pain plan was developed that incorporated involvement of the patient, their family physician and others involved in the patient's care.⁶ Our goal was to gently

guide patients to the program while offering clinicians tools to manage patients' flare-ups when they presented to the emergency department.

LITERATURE REVIEW

Models of care that address pain and addiction in rural communities are difficult if not impossible to find in the literature. A MEDLINE search did not reveal any comparable strategy to what our district introduced. There is, however, an emerging body of evidence that is recognizing the role of pain plans in the emergency department for patients with a complex history of pain.⁶ The basis of the pain plan is to help patients find more effective strategies to manage their complex pain through pain self-management programs and other legitimate pain services. Other models of care have addressed pain and addiction individually,⁷⁻⁹ but we were unable to find any models that addressed both in a comprehensive way.

PROGRAM OBJECTIVES

We had 5 program objectives:

1. To provide physicians and health care providers with a comprehensive approach to the treatment of pain and addiction based on best practice.

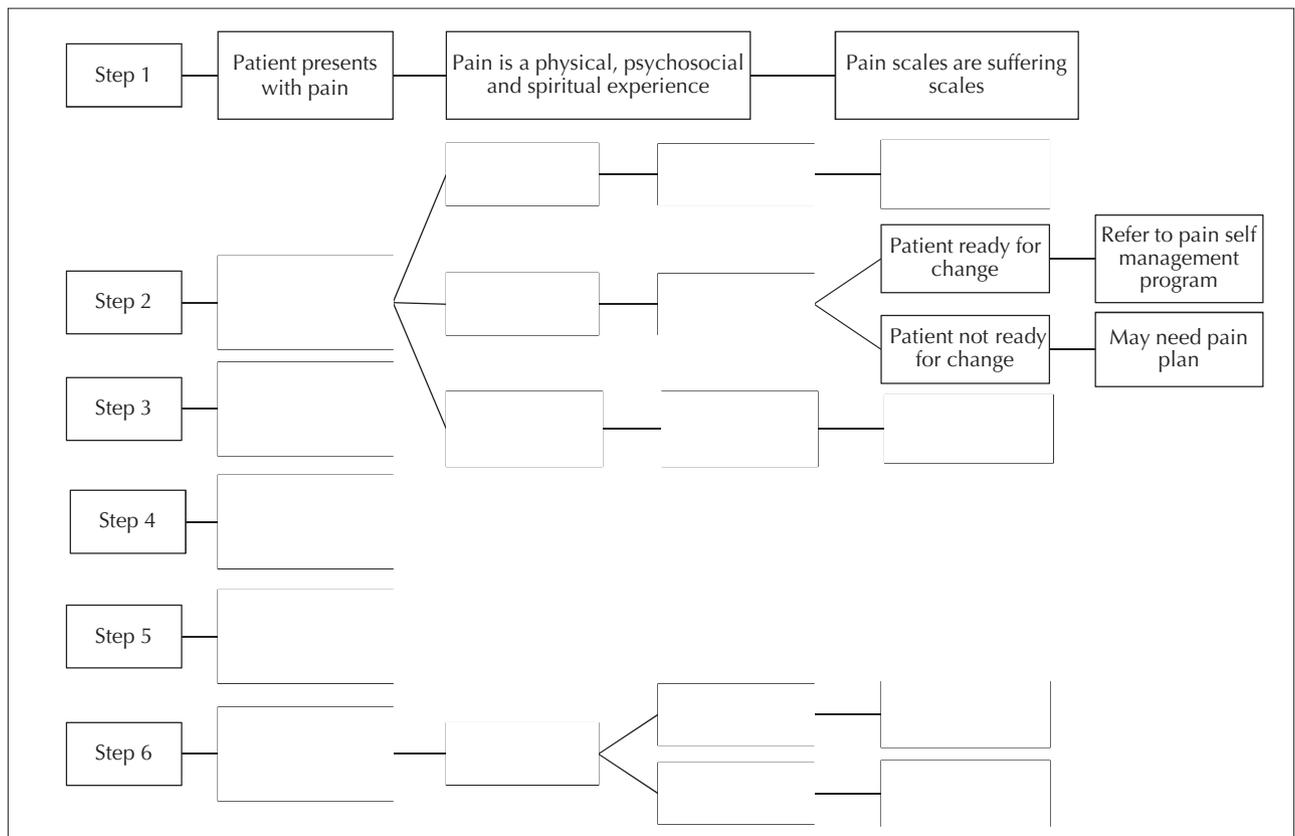


Fig. 1. A 6-step approach to treating pain and addiction.

2. To offer physicians and health care providers standardized protocols to address acute and chronic pain, and painful conditions near the end of life.
3. To reduce the dispensing of opiate refills and parenteral injections in patients with flare-ups of chronic pain who present to the emergency department.
4. To direct patients with a complex history of pain to a community-based pain program. For those not ready to attend a pain program, a comprehensive pain plan would be developed with the patient and family physician to ensure continuity and cohesiveness within the community and emergency department.
5. To stratify all patients by risk of addiction and diversion when considering controlled substances, regardless of the pain presentation, and if necessary, to direct patients to appropriate resources and services within the community.

DESCRIPTION OF THE PAIN AND ADDICTION STRATEGY

With these objectives guiding the development of our strategy, we built a 6-step approach that incorporated simple tools to address pain and addiction in the emergency department (Fig. 1). Patients identified as needing a more cohesive departmental approach to pain and addiction were individuals who continued to use the emergency department as a way of coping with flare-ups of chronic pain but were not yet ready to consider a pain self-management program as a way to help them move forward. Alternative pharmacology was introduced; if opiates were used in this population they were used orally, and patients were given medication to improve function rather than pain¹⁰ (Fig. 2). The decision to move away from opiate use was based on an emerging body of evidence that recognized the limited scope of opiates in chronic pain and concerns that opiates were contributing to poorer outcomes in the long term.^{11–13}

Pain plans were discussed with the patient and his or her family physician. Patient files were kept in the emergency department in a confidential, secure location and, with patients' consent, shared with other health personnel involved in their care.¹⁴

It was also important to rule out any new pathology that could be causing the increase in a patient's baseline pain and to be able to shift our focus from management of chronic pain to acute pain, if required. A flare-up of chronic pain was defined as an increase in the patient's baseline pain that was not

the result of new pathology or the progression of pre-existing disease.¹⁵

Tools used to stratify for risk of addiction and diversion included our provincial prescription monitoring program, urine drug testing and screening for high-risk or aberrant behaviour.⁴ Physicians were educated on the challenges and limitations of using urine drug testing in the emergency department despite it being the "gold standard" in monitoring for drug compliance and detecting the use of illicit substances.^{2,16}

Other strategies we incorporated included a no-refill policy for controlled substances among patients followed by a prescriber, and we no longer accepted written orders for parental opioids for patients with chronic disease. These patients were triaged, assessed and managed like other patients who came to the emergency department for care. We also introduced a nurse-initiated parental protocol for acute pain, and symptom protocols with suggested orders for patients with conditions at the end of life.¹⁷ This gave emergency personnel tools to initiate treatment in our palliative care population until referrals could be made.

One contentious area that we addressed was the withdrawal of meperidine from our emergency department. Meperidine had become the drug of choice for the management of chronic pain flare-ups in our department. Our goal was to help patients break the cycle of meperidine use and help them move toward self-management of pain. This act alone reduced visits to our emergency department by two-thirds, with little opposition from our colleagues or patients.

ADVANTAGES AND LIMITATIONS

The primary advantage of our pain strategy was a drop in the frequency of emergency department visits among individuals with recurrent chronic pain flare-

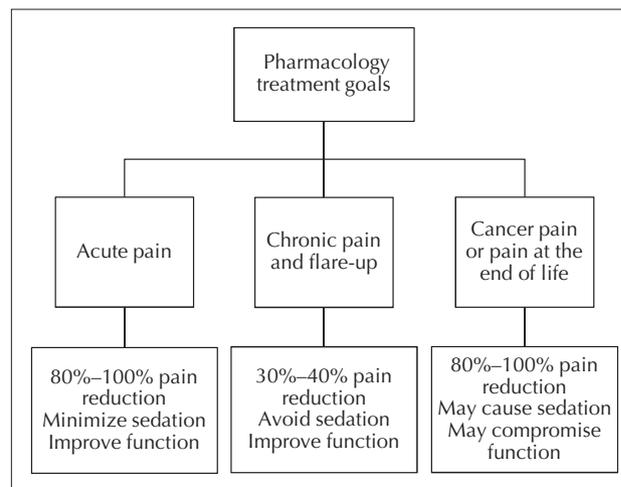


Fig. 2. Pharmacology treatment goals.

ups. Some patients stopped visiting completely after they had attended our community-based pain self-management program. Family physicians also reported a drop in the frequency of visits to their offices.

Most staff members commented on the value of having a plan in place that summarized the complex histories and numerous investigations many of the patients had undergone. Staff began to appreciate the complexity of patients' history of pain, and care became noticeably less punitive and more compassionate. There was a feeling of unification within the department when addressing the care of patients with complex pain.

Some physicians and emergency personnel, however, did have difficulty with the strategy. They felt the restrictions on opiate dispensing in chronic pain were unfair to patients. With time, they began to shift their thinking as the frequency of patient visits declined.

Although this is difficult to measure, we feel the program achieved a lower pill burden within our community, thereby decreasing the risk of unintentional and intentional deaths from controlled substances. Other benefits included a decrease in complaints to administration for inadequate pain management.

Limitations included human resources to ensure knowledge retention and to educate new staff about the pain strategy. It was also a challenge to collect and decipher data, because no collection system existed. If support staff were needed, often they were reassigned from other posts, which increased their workload.

Another challenge was the establishment of a formal review process to re-evaluate program objectives and discuss any roadblocks that could be occurring. The long-term plan is to incorporate pain and addiction reviews into our quality program and our quarterly family practice and departmental meetings. At present, weekly reviews occur informally between chronic and palliative care teams and emergency personnel.

CONCLUSION

The development of a collaborative pain and addiction strategy has the power to bring together a community. Simple tools can be developed to ensure patients are provided effective and timely pain relief in a nonjudgmental and compassionate manner while keeping them and our communities safe.

Departmental pain plans done in collaboration with patients and their family physicians have been

shown to be effective in addressing patients with complex pain histories. Pain plans also allow clinicians to manage risk while providing care in a humane and comprehensive way. Ultimately, our goal is to empower patients to become less reliant on the health care system and more in control of their health care needs.

Competing interests: None declared.

REFERENCES

1. Prescription drug misuse. Ottawa (ON): Canadian Centre on Substance Abuse; 2013. Available: www.ccsa.ca/Eng/Priorities/Prescription-Drug-Misuse/Pages/default.aspx (accessed 2013 Apr. 10).
2. Christo PJ, Laxmaiah M, Xiulu R, et al. Urine drug testing in chronic pain. *Pain Physician* 2011;14:123-43.
3. Fiore K. Deaths from Rx painkillers still rising, CDC says. *MedPage Today*. 2011 Feb. 17.
4. Heit HA, Gourlay DL, Covington EC. The truth about pain management: the interface of pain and addiction. Program and abstracts of the American Academy of Pain Medicine 23rd Annual Meeting, Feb 7-10, 2007; New Orleans, La.
5. Eriator I, Anderson A, Taylor S, et al. Community perception and response to warning signs of inappropriate drug use (abstract 140). *Pain Med* 2007;8:106.
6. Johnson S, Rees B. Rational Pain Care. Does the use of "chronic pain plans" reduce the utilization of the emergency department for chronic pain patients seeking narcotics? Available: www.rationalpaincare.com/about/our-text/ (accessed 2012 Nov. 2).
7. McGillion MH, LeFort S, Stinson J, et al. Chronic pain self-management. In: Rashedi S, Schopflocher D, Taenzer P, et al., editors. *Chronic pain: a health policy perspective*. Weinheim (Germany): Wiley-VCH Verlag; 2008. doi: 10.1002/9783527622665.ch14
8. LeFort SM, Gray-Donald K, Rowat KM, et al. Randomized controlled trial of a community-based psychoeducation program for the self-management of chronic pain. *Pain* 1998;74:297-306.
9. Grant M, Golant M, Rivera L, et al. Developing a community program on cancer pain and fatigue. *Cancer Pract* 2000;8:187-94.
10. Caudill MA. *Managing pain before it manages you*. 3rd ed. New York: The Guilford Press; 2008.
11. Large RG, Schug SA. Opioids for chronic pain of non-malignant origin-caring or crippling? *Health Care Anal* 1995;3:5-11.
12. New research findings in chronic pain: an expert interview with Frederick W. Burgess, MD, PhD. *Medscape Neurology* 2007. Available: www.medscape.org/viewarticle/553069 (accessed 2013 Nov. 26).
13. *Canadian guideline for safe and effective use of opioids for chronic non-cancer pain*. Hamilton (ON): National Opioid Use Guideline Group; 2010. Available: <http://nationalpaincentre.mcmaster.ca/opioid/> (accessed 2012 Nov. 3).
14. *Good practices guide. Circle of care legislation*. Ottawa (ON): Canadian Medical Protective Association. Available: www.cmpa-acpm.ca/cmpapd04/doc/ (accessed 2012 Nov. 2).
15. Belgrade M, St. Marie, B. *Understanding and managing flares in chronic pain*. Minneapolis (MN): Fairview Pain Management Center.
16. Heit HA, Gourlay DL, Caplan YH, editors. *Urine drug testing in primary care: dispelling the myths and designing strategies*. Pharm-Com Group; 2006.
17. Curtis KM, Henriques HF, Fanciullo G, et al. A fentanyl-based pain management protocol provides early analgesia for adult trauma patients. *J Trauma* 2007;63:819-26.
18. Bergman CL. Emergency nurses' perceived barriers to demonstrating caring when managing adult patients' pain. *J Emerg Nurs* 2012; 38:218-25.