

Expanded Skills - Coordinating Pain Treatment with Colleagues

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Module 10

EXPANDED SKILLS: COORDINATING PAIN TREATMENT WITH COLLEAGUES

Goal:

The learner will be able to assess pain patients for the need to refer or consult and effectively communicate with both patients and colleagues and come to an agreement and understanding of each patient's comprehensive treatment plan.

After completing this module participants will be able to:

- Define the role of a medical “home” for patients with chronic pain
- Effectively co-manage patients with pain as part of an interdisciplinary pain treatment team
- Consult with specialists and other healthcare providers regarding complex patients with pain and addiction when appropriate
- Refer patients with pain appropriately for pain, addiction, and/or behavioral assessment and treatment

Professional Practice Gaps

Guidelines, developed by the American Pain Society and the American Academy of Pain Medicine based on an extensive review of the literature, recommended multidisciplinary care for pain, and that when opioids are prescribed for a chronic pain patient, a single clinician should be identified who is primarily responsible for the patient's overall medical care¹. However, multidisciplinary pain centers have decreased in number and are not an option for most patients with chronic pain². Individual pain providers, thus, now need to coordinate care among themselves to provide the same multidisciplinary care in multiple settings. A survey of physicians found that they do not feel they have time to consult with other providers regarding their patients being treated for chronic pain³. Training in coordinating pain care and improved communications among pain providers is likely to lead to more efficient consulting, which will help address the barrier of not enough time. In a needs analysis survey for developing this training program, 18 physicians and nurse practitioners surveyed rated strong agreement (mean=4.4/5) that they would be interested in CME on the topic: "Patient co-management by primary care and specialists" ⁴. In fact, this topic was rated second highest of nine topics to potentially be covered on this website, after "best practice in using opioids." This suggests that providers do not feel well prepared to fulfill the role of "home" clinician for chronic pain patients.

INTRODUCTION

Contents for this module:

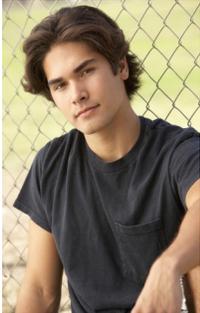
- Effective and efficient coordination of care among the providers in multidisciplinary pain treatment, including:
 - Consultations and communications among primary and ancillary treatment activities

- Effective referrals for seamless transitions across levels of care
- Coordination of past and present treatment

If substance abuse develops in the context of chronic pain, it tends to be a long-term problem. Therefore, continuity of care is particularly important¹.

At the end of this module, we will ask you to set some goals for your practice based on what you learn in this module.

The following case is presented throughout this module, providing you an opportunity to practice clinical applications:



Case Introduction: Mr. Henry Rowe, 26 years old

Chief Complaint: Ankle pain

Brief History: Mr. Rowe has been in physical therapy on and off for the past 6 years due to overuse injuries from gymnastics, especially ankle pain. As his gymnastics career ended, Mr. Rowe described a period of depression. He also was briefly in counseling for binge drinking when he was depressed. He specifically asks for hydrocodone, because he has heard from some new friends that "it works."

MULTI-MODAL APPROACH

Multi-Modal Approach to Chronic Pain Treatment

Multi-modal approaches to chronic pain treatment involve at least two professionals from different specialties involving the following aspects of care.

- physical
- vocational
- psychological

This approach is a comprehensive and coordinated approach that recognizes that substance use disorders affect all aspects of the patient's life is needed. Many programs utilize at least an exercise program and some form of psychological therapy. More intensive therapies tend to have more successful outcomes than less intensive programs¹.

Pain treatment teams include social workers, mental health counselors, addiction treatment facilities, and local self-help groups (i.e., Narcotics Anonymous) to treat a patient with chronic pain. Diagnosing a substance use disorder in the context of chronic pain management with opioids is a complex and difficult task that is often oversimplified. It is not obvious what constitutes normal opioid use and addiction, so a pain treatment or addiction specialist often is needed.

Multidisciplinary Pain Clinics

Ideally, there would be a multidisciplinary pain clinic in which all of the above specialists would work together to help patients with chronic pain. Unfortunately, there are only a few such centers, primarily in major medical centers.



DID YOU KNOW?

Cost, availability, and lack of insurance coverage are potential barriers to interdisciplinary care¹.

STRATIFICATION OF RISK

After patient assessment and selection for long-term opioid therapy, patients can be triaged into three treatment groups based on level of risk (stratification of risk)¹:

1. Consult as needed

Consultation with specialists may be needed for assistance in assessment or stratification of risk.

The Model Policy for the Use of Controlled Substances for the Treatment of Pain⁵ states the following regarding consultation:

The provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse or diversion. The management of pain in patients with a history of substance misuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

2. Refer as needed

Determine which type of specialist is appropriate and make the necessary referrals. Be sure to include necessary information in the referral report.

3. Adapting the structure of care to match risks

The structure of care should match risk with an appropriate level of skill, treatment boundaries, and intensity of structure.

<u>RISK LEVEL</u>	<u>PATIENT CHARACTERISTICS</u>	<u>SETTING OF CARE:</u>
<u>LOW RISK</u>	<ul style="list-style-type: none"> No history of substance use problem, past or current No contributory family history of substance misuse No major or untreated mental health problems History of substance use problem (treated) 	Primary Care
<u>MODERATE RISK</u>	<ul style="list-style-type: none"> Family history of substance misuse Comorbid minor or past major mental health problem This group often has had moderate to severe pain for many years and a consequent decrease in social support⁶. 	Primary Care Management with Specialist Support (ongoing, that is, "comanagement" or refer as the needs arises)
<u>HIGH RISK</u>	<ul style="list-style-type: none"> Current substance use problem Active addiction Major untreated mental health problem 	Refer for Specialty Pain Management and/or Specialty Addiction Management if possible. Consider a consultation at a distance if none are available in your area. Note: In some cases opioids may not be indicated until the comorbidity is under control.

KEY POINTS

- Stratify patients by risk level and complexity
- Determine whether the patient can be managed in your practice with or without consultation or requires referral based on results of the assessment.

PSYCHOSOCIAL TREATMENT REFERRALS

APS/AAPM Guidelines

Regarding multidisciplinary pain treatment, pain treatment guidelines by APS/AAPM state:

*Because chronic non cancer pain (CNCP) is often a complex biopsychosocial condition, clinicians who prescribe chronic opioid therapy (CNCP) should routinely integrate **psychotherapeutic interventions**, functional restoration, interdisciplinary therapy, and other adjunctive nonopioid therapies (strong recommendation, moderate-quality evidence)...Clinicians should routinely integrate therapies that target the **psychosocial** and functional factors that contribute to or are affected by CNCP¹.*

*CNCP=Chronic non-cancer pain; **COT=Chronic opioid therapy

Physicians can implement simple, brief cognitive behavioral interventions such as careful validation of the patient's pain and difficulties, use of empathy, teaching simple mindfulness meditation techniques

and deep breathing techniques, encouraging patients to take an active approach to their pain management.

Referral to Behavioral Therapy

The American Psychiatric Association recommends the following psychosocial treatments in combination with agonist therapies, as they are helpful in improving patient ability to follow through with treatment and in avoiding relapse:

- Cognitive-behavioral therapies
- Group and family therapies
- Self-help groups
- Behavioral therapies (i.e. contingency management)
- Drug counseling



Individuals who provide these services may include psychiatrists, social workers, psychologists, and nurses.

Self-Help Groups

Self-help groups are an affordable (usually free), easily accessible form of treatment, especially in the wake of managed care⁷ and are particularly helpful when there is a substance abuse problem arising in the context of chronic pain treatment. Self-help groups can vary in philosophy (e.g. secular vs. spiritual), so patients may require referral to more than one group before finding an appropriate fit. It is a common misconception that 12-step self-help groups are only suitable for patients with religious beliefs; they are not allied with any sect or denomination. 12-step programs have been shown to be effective regardless of an individual's religious background⁸.

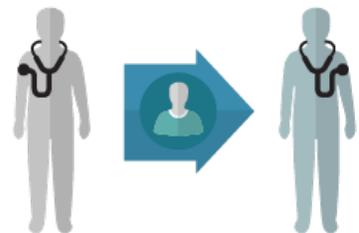
KEY POINT

- A multidisciplinary approach to pain treatment involves psycho-therapeutic interventions, functional restoration, nonopioid therapies, and the use of self-help groups, as well as substance abuse counseling and pain specialists as needed, in order to enhance success with treatment.

REFERRAL FROM PRIMARY CARE

PCP Role in Referral

Provider's encouragement, specifically during the referral process, has been shown to increase an individual's likelihood to follow through with a referral for additional services. For example, a study of self-help group referrals showed that providing an individual with extensive information about the self-help group and with a volunteer mentor from the self-help group improves attendance and treatment outcomes⁹. After making a referral, you can also promote adherence to treatment by following up with the patient and other clinicians regularly to ensure continued patient satisfaction with referred services. Patients



may require several referrals to find a format of psychosocial treatment with which they feel comfortable.

Primary care providers should refer patients needing chronic opioid therapy to a pain specialist or a substance abuse treatment center when the following situations occur:

- A brief assessment and intervention is not an adequate treatment.
- You suspect or confirm that patients are using or abusing opioids or other illicit drugs.
- Patients have a complicated medical, mental health, or substance misuse history and require intensive treatment.
- Patients request a referral.

Other situations which may warrant referral to an addiction specialist or substance abuse treatment center include the following:

- Patient has a complicated medical, psychiatric, social, or substance misuse history and requires more intensive or structured treatment than you can provide in the office setting.
- Patient is non-compliant with your office policies or treatment protocol.

It is common for complicated medical and social histories to accompany chronic pain patients. Cases in which a clear cause of pain has not been established, or for which a prior history of substance misuse arises may warrant referral to assist in diagnosis or evaluation of the chronic pain condition and to reduce risk of substance misuse. Such cases may fall beyond the expertise of the referring provider in terms of implementation and treatment modalities. Other cases, such as those surrounding patients with multiple issues in addition to pain may warrant referral to a multidisciplinary pain treatment program. In cases such as these, chronic opioid therapy will be most successful as part of an overall pain treatment program⁵.

Referral Guide

<u>PATIENTS WITH...</u>	<u>SHOULD BE REFERRED TO:</u>	<u>FOR THE FOLLOWING CARE:</u>
Complex pain conditions	Pain Specialist	evaluation and treatment
Long standing pain problems or multiple issues in addition to pain	Multidisciplinary pain clinic	evaluation and treatment
A history of addiction or substance use disorder (or indications of a drug use problem)	Consultation or referral to an addiction specialist	evaluation of risk of recurrent substance misuse, or assistance with ongoing management

WHAT HAPPENS WHEN I REFER TO A...

Studies show that patients fare better when treated consistently by one clinician who provides comprehensive care for most of their health care needs, and coordinates with other health care professionals when their skills and expertise are needed¹. Having a clinician who accepts primary responsibility for their overall medical care is likely to be particularly important for patients with CNCP, who both use health care services more frequently and have more comorbidities than other patients¹.

The following pages briefly describe the types of providers most commonly on a multidisciplinary team for treatment of chronic pain: multidisciplinary pain centers, acupuncture treatment, counseling,

pain specialists, physiatrists and rehabilitation centers, physical therapists, and substance abuse counselors. General information is provided for each topic, and additional information may be found on insurance coverage, qualifications, where to find, and duration and frequency of treatment.

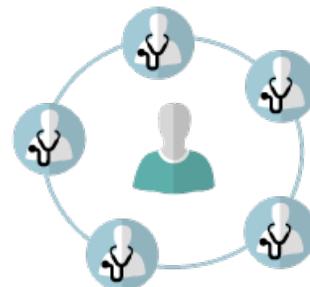
A MULTIDISCIPLINARY PAIN TREATMENT CENTER

Introduction

Prescribing providers of various specialties can be found at multidisciplinary pain treatment centers, as can be non-prescribing health care providers who specialize in the diagnosis and management of chronic pain patients¹⁰.

The multidisciplinary pain treatment team commonly include a combination of the following:

- a primary care provider
- pain-management specialists (which may include neurologists, rheumatologists, orthopedists, anesthesiologists, psychiatrists, etc.)
- physical therapists
- occupational therapists
- psychologists to help cope with the mental burden of pain management
- registered nurses to assist with day-to-day treatment
- care managers



Other team members may include biofeedback therapists, family and vocational counselors, pharmacists, dietitians, social workers, volunteers, and other support staff.

At these centers, a patient can expect to encounter:

- an integrated treatment plan
- a treatment plan which incorporates follow-up and communication between team members (IASP)

Benefits of a multidisciplinary pain treatment approach include:

- effectiveness
- economical
- improvement sustained at two- and five-year follow up periods^{11,12}

Frequency and Duration of Treatment

Duration of treatment depends on the patient but can last between several weeks and years. In an inpatient facility (a specialized type of pain treatment center), patients staying or living at the facility receive frequent care at least daily. Other patients not living at the facility may receive care on a daily, weekly, or monthly basis.

Where To Find

Multidisciplinary pain treatment programs may be found in hospitals and rehabilitation centers. You may find a clinic accredited by the American Academy of Pain Management in the Related Resources section of this page.

Qualifications

The qualifications of the providers depend on the requirements of the general facility, but in general, you can expect at least a team of medical doctors, nurses, and pain management specialists

Insurance Coverage

Treatment coverage depends on the patient's individual insurance policy. Not all therapies may be covered.

MENTAL HEALTH REFERRALS AND CONSULTATIONS

Why Mental Health Is A Concern

Chronic non-cancer pain (CNCP) often involves a complex of psychological factors in addition to biological and environmental factors. The importance of addressing the psychological factors was described in an APS/AAPM guideline on chronic opioid therapy¹:



*As CNCP is often a complex biopsychosocial condition, clinicians who prescribe COT should routinely integrate **psychotherapeutic interventions**, functional restoration, interdisciplinary therapy, and other adjunctive nonopioid therapies (strong recommendation, moderate-quality evidence)...Clinicians should routinely integrate therapies that target the **psychosocial** and functional factors that contribute to or are affected by CNCP.¹*

Individuals with chronic pain often have a comorbid psychiatric disorder. Especially common conditions include depression, anxiety, and personality disorders¹³. The USPSTF has recommended in guidelines that all adults should be screened for depression. This recommendation now includes pregnant and postpartum women, as well as those who do not have prior evidence of depression¹⁴.

Assess the patient's affect (observed emotional state) and mood (subjective) at every appointment and make appropriate referrals for counseling and support. Remember that mental health problems may arise over the course of treatment. Mental health problems are red flags for increased risk of substance use problems. Furthermore, psychosocial problems may be an integral part of some chronic pain syndromes¹. Consider referral for psychotherapy as part of the multidisciplinary treatment plan.

Most Common Mental Health Conditions With Chronic Pain

Depression is the most common comorbid condition among pain patients, followed by anxiety, substance misuse, and somatoform disorders.

Assess chronic pain patients regularly for:

- depression
- anxiety
- suicidality
- stress reactivity

Symptoms that are associated with depression or anxiety include loss of appetite, trouble sleeping, and tension.

Depression and anxiety (especially post-traumatic stress disorder, if there was a serious injury) are common among chronic pain patients (35 to 50%)¹⁵. Depression and anxiety are also more commonly comorbid with addictive disorders in chronic pain patients than in those without addictive disorders¹⁶. Many patients with chronic pain require antidepressant medications.

COUNSELING FOR PAIN COPING

Introduction

Studies have shown that cognitive behavioral therapy, behavioral techniques, self-regulatory techniques, such as hypnosis and relaxation, as well as general supportive counseling have helped chronic pain patients and have also reduced pain¹⁷. Self-regulatory techniques, such as cognitive behavioral therapy, as well as other therapies such as hypnosis, relaxation training, and general supportive counseling result in reduced pain intensity¹.

Mental health counselors play a vital role in the treatment of chronic pain patients by helping patients develop and utilize psychological interventions for chronic pain, in particular, the use of cognitive-behavioral techniques¹. Counselors should also recognize and take the opportunity to help educate patients on the use of psychotropic medications, which may be useful in the treatment of pain, as well as their other uses and side effects¹⁷.

Cognitive Behavioral Therapy for Pain Management

Current use of pain self-management strategies should also be assessed. Referral for counseling to improve pain self-management strategies may be indicated in addition to providing patient education on coping skills¹⁵. CBT is the most widely used form of therapy for helping patients cope with chronic pain that consistently has been shown to be effective¹. Its use in treating chronic pain is based on a model of chronic pain that it is influenced by thoughts, affect, and behavior in addition to the underlying biological cause¹⁸. For example, thinking negatively can lead to negative emotions, which can create muscle tension, which can increase pain. Thinking negatively can also lead to self-defeating behaviors, such as social isolation. CBT involves modifying thoughts, feelings, and beliefs in order to have better outcomes, including decreased pain and better coping with pain for improved functioning.

Three components to CBT for pain¹⁸:

1. Develop awareness of how thoughts and behaviors contribute to pain and of the possibility that patients can change them to exert some control over their pain.
2. Train in use of coping skills and strategies aimed at reducing muscle tension and emotional distress, such as relaxation exercises and distraction from the pain; planning activities to minimize pain; and cognitive restructuring, a technique that replaces highly negative pain-related thoughts with coping thoughts.
3. Apply and maintain the coping skills increasingly over the course of treatment. This includes adding reinforcing and cuing techniques, using coping skills in wider situations, and learning problem-solving skills.

How. A mental health counselor, such as a psychologist, may work with an individual for an hour per week or small groups are led by a mental health counselor or nurse and are typically held weekly for 8 to 10 weeks¹⁸.

Evidence for CBT in chronic pain treatment. CBT has been shown to be effective in reducing pain and psychosocial disability with chronic pain conditions and a number of disease-related pain conditions¹⁸. CBT has demonstrated effectiveness in pain management of chronic low back pain¹⁹, osteoarthritic knee pain²⁰, and cancer-related pain²¹.

Other effective forms of psychotherapy. A recently developed form of CBT, Acceptance and Commitment Therapy (ACT), that uses a mindfulness approach to facilitate acceptance and aims to achieve flexibility in thoughts, beliefs, feelings, and bringing behavior in line with values, has been effective in pain management²².

Frequency and Duration of Treatment

Depression and anxiety often go hand-in-hand with pain. Patients with depression or anxiety disorders in addition to their chronic pain require additional interventions, for example, cognitive behavioral therapy (CBT), which often focuses on coping strategies. Affect and mood may also benefit from relaxation strategies and biofeedback. Depressive effects of opioids also need to be considered¹. Depressed patients on high doses of opioids may benefit from weaning down to a lower dose of opioids with the addition of an adjuvant analgesic and possibly an antidepressant.



These or other mental health disorders are an indication for referral to counseling and possibly to pain and addiction specialists. Dual disorders (substance use problems and mental health problems) are an even stronger indication for management by specialists.

For information on tools that assess for depression and anxiety, see the Key Info guide on assessment on this website.

KEY POINTS

- CBT is the most widely used form of therapy for helping patients cope with chronic pain. Patient education on coping skills should also be provided.
- It is important to evaluate for and treat comorbid depression in patients being treated for chronic pain. Counseling can be an important part of the treatment.

FYI

- Many medications used to treat mental disorders also have a role in the treatment of pain¹⁷. For example, certain antidepressants are often effective in management of neuropathic pain.
- Positive self-statements are correlated with both **reduced pain** and **increased pain tolerance**; negative self-statements are correlated with **increased reports of pain** and **decreased positive outcomes**²³.

PAIN SPECIALIST

Introduction

A pain specialist is a medical doctor, often an anesthesiologist, who specializes in the diagnosis and treatment of pain. They are experts who can often identify the source or reason for the pain, as well as treat the pain itself²⁴.

Pain specialists may treat all types of pain, but most commonly treat back, neck, limb, spinal, and neurological pain; headache, arthritis, and pain from nerve damage.

Pain specialists work closely with the primary provider as well as other specialists to assist the patient. They also review the patient's medical records and x-rays if necessary, discuss the pain with the patient, and perform other tests or physical exams²⁴.

Frequency and Duration of Treatment

Pain treatment specialists can often be found at pain treatment centers. Hospitals may contain a pain treatment center or may be affiliated with one nearby. Additionally, the American Society of Anesthesiologists (ASA) may be able to assist with finding additional information for pain specialists in a given area.

Where To Find

There is one sub-specialty which is recognized by the American Board of Medical Specialties, under the American Board of Anesthesiology in Pain Management.

Doctors with this certification have completed their four years of medical school, as well as their four years studying the medical specialty of anesthesiology. Additionally, anesthesiologists who seek a pain sub-specialty must complete at least one year of training, as well as a rigorous exam (American Society of Anesthesiologist). Some pain specialists may be certified by the American Board of Pain Medicine, although this certification is not recognized by the American Board of Medical Specialties.



It is also important to note that many practitioners are entering the rapidly growing field of Pain Medicine who are not board certified. The link to the ABMS website may be found in the Related Resources section of this page and will tell you if a doctor is board-certified.

Pain specialists may also be trained as:

- anesthesiologists
- neurologists
- psychiatrists
- psychiatrists

PHYSICAL THERAPIST

Introduction

Pain treatment can sometimes be aided by physical therapy, which involves the identification of movement dysfunction, treatment, healing, and prevention of further injury and disability. Physical therapy helps to relieve pain, promote healing, and restore function and movement or help prevent further deterioration²⁵.

Physical Therapists are licensed professionals who diagnose and treat patients with conditions that inhibit the ability to move and perform physical activities. Physical therapists examine and work with each patient according to an individualized plan to promote the following:

- ability to move
- reduce pain
- restore function
- prevent disability

Interventions may include:

- therapeutic exercise
- functional training
- manual therapy techniques
- assistive and adaptive devices and equipment
- physical agents and electrotherapeutic modalities

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Physical therapists can help prevent further loss of mobility or other problems before they occur by developing exercise programs tailored to promote the health and wellness of each patient.

Physical therapists commonly consult other professionals, such as physicians, dentists, nurses, educators, social workers, occupational therapists, speech-language pathologists, and audiologists.

Where To Find

A slight majority of physical therapists can be found in hospitals or in offices of other health practitioners. They may also be found in:

- nursing care facilities
- outpatient care centers
- offices of physicians

Still, others are self-employed or working in private practices while consulting with hospitals, rehabilitation centers, nursing care facilities, home healthcare agencies, and adult day care programs to provide services²⁶.

Qualifications

Physical therapists are professionally trained specialists who have graduated from a post-baccalaureate degree from an accredited physical therapist program.

Individual states regulate the practice of physical therapy in their state. This usually requires passing scores on national examinations, such as the National Physical Therapy Examination, passing state examinations and other state requirements, and may require earning continuing education credits on a yearly basis.

Physical therapists may elect to pursue further training and become board-certified in clinical specialties²⁶. Relevant to pain treatment, specialties include Clinical Electrophysiologic, Geriatric, Neurologic, Orthopaedic, Pediatric, and Sports certifications. A search for a specialist is possible through the American Physical Therapy Association website.

SUBSTANCE ABUSE COUNSELOR

Introduction

If a substance misuse problem arises in a patient on chronic opioid therapy, you may want to consider referral to a substance abuse counselor if a pain/addiction specialist is not available in your area. Substance abuse counselors (also called rehabilitation counselors or chemical dependency counselors) are mental health counselors who help people with drug and alcohol issues, as well as gambling and eating disorders. Counselors may work with the individual, but may also commonly work with affected family members, or with community outreach programs with the goal of preventing addiction and educating the public.

The substance abuse counselor helps the patient identify behaviors and patterns related to their addiction and develop healthy patterns of behaviors and coping mechanisms through a variety of mediums including:

- One on One counseling
- Group Counseling
- Family Therapy
- Career Counseling
- Community Service²⁷

Where To Find

Substance abuse counselors may be found at hospitals, outpatient clinics, and treatment centers such as narcotics or alcoholic anonymous. They may also visit halfway houses.

Frequency and Duration of Treatment

Counseling can be done daily or weekly or can be done on a drop-in basis. A counseling session may last one to two hours. Depending on the stage of treatment and the individual's needs, a patient may see the counselor up to several times per week²⁷.

Qualifications

Depending on the state and occupational specialty, educational requirements may vary. A substance abuse counselor should have, at minimum, a bachelor's degree and a license to practice as a substance abuse counselor. This can usually be completed through completion of a certificate course in drug and alcohol counseling. Additionally, most states and many hospitals and treatment centers require licensing or certification through a master's degree.

Additionally, some counselors may become certified with the general practice credential of National Certified Counselor by the National Board for Certified Counselors. There are a number of other counseling organizations which offer certification, as well²⁷.

OPIOID ADDICTION TREATMENT

Medication Assisted Treatment of Opioid Use Disorder

Keeping in mind that most patients on chronic opioid therapy do not develop a true addiction, it does happen occasionally. There are three medication-assisted treatments for opioid use disorder:

- buprenorphine
- methadone
- naltrexone

These medications can be used to support long-term maintenance of being free from dependence on opioids (other than those being used in treatment) as they can be taken safely for years. Additionally, MAT has a higher rate of success than medication-free treatment. Whether or not medication-assisted treatment is chosen, however, psychosocial treatment is an important component of treatment and should be integrated into the overall treatment plan for your patients.

Comparing the Medications

The first two medications, buprenorphine and methadone, can be used for the initial process of quitting opioids (first stage of treatment -



detoxification) and help reduce the need for inpatient care at this stage²⁸⁻³⁰. Buprenorphine and methadone also help in managing withdrawal from opioids by relieving withdrawal symptoms and psychological cravings. These medications typically need to be continued indefinitely, because withdrawal symptoms from their discontinuation can be severe and prolonged even with a taper^{31,32}. The last medication, naltrexone, can be used after detoxification for long-term maintenance.

Mechanisms of action: Buprenorphine and methadone work via the same receptors that are responsible for problematic dependence on opioids³³. They have weaker effects and/or slower onset, so the individual does not feel "high" from taking them. In comparison to methadone, buprenorphine has milder withdrawal symptoms due to its partial-agonist property (methadone is a full opioid agonist)³⁴. Buprenorphine is as effective as methadone treatment for reducing opioid use in addicts³⁴. Buprenorphine has several advantages over methadone, including the ability to treat patients in an office-based setting, alternate day dosing, and milder withdrawal symptoms.

Naltrexone has a different mechanism. It blocks opioid receptors, that is, it acts as an antagonist. Methadone and buprenorphine are much less addicting than other opioids that have more rapid onset or potent effects that lead to addiction; naltrexone is non-addicting.

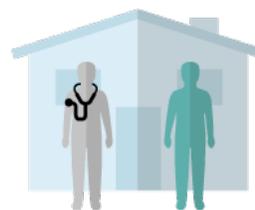
How medications are administered: Methadone treatment requires going to specialized drug treatment facilities. Providers who prescribe narcotics can prescribe (with special waiver certification), dispense, or administer buprenorphine to patients in their office, greatly expanding the availability and accessibility of opioid addiction treatment. Any prescribing provider can prescribe naltrexone.

In contrast, methadone requires once-daily dosing for opioid detox patients and twice or three times a day dosing for chronic pain treatment. Methadone, which was discussed in greater detail in the module on diversion and overdose, has unique pharmacological properties, including a variable half-life, that make it important that it be prescribed only those who fully understand it.

Naltrexone is not used for detoxification but can be used after detoxification for maintenance, after a one to two week opioid-free period³⁵. It is typically given in an extended release injection. Unlike buprenorphine and methadone, it has no physical dependence. Medication compliance and long-term success rates are somewhat lower, however.

OUT PATIENT DRUG REHABILITATION

Outpatient treatments may range from intensive treatments, in which the patient lives at home and participates in the program several days per week and several hours each day, to seeing a substance abuse counselor once per week. The latter choice often is used after intensive care is completed and so may be called *aftercare*. A variety of locations are also available, for example: a dedicated methadone clinic for detoxification from opioid addiction, a private practice, a primary care provider's office for detoxification from opioid addiction using buprenorphine, or a community clinic with group counseling. Outpatient programs offer the advantage of lower cost and less disruption to the patient's life than inpatient treatment but lack the intense, limited, drug-free structure of inpatient treatments. Some outpatient clinics may provide psychosocial support but refer the patient to a provider for medical management.



- **Intensive Outpatient Treatment** -- A minimum of 9 hours per week. This is usually advised for early stages of treatment or transitioning from Residential treatment. This option works best for a patient who has a support system in place but needs some structure without full-time supervision.
- **Outpatient Treatment** -- Less than 9 hours per week. This is the appropriate level for smoking cessation. This option works best for a patient who has a support system in place, has adequate living arrangements, has transportation to treatment, and is motivated for consistent attendance.
- **Support Groups** -- Support groups such as 12 step programs are valuable supplements to outpatient therapy of any type and are also important in supporting continued recovery. Narcotics Anonymous meetings are available, but persons addicted to opioids might also benefit from the more common alcoholics anonymous meetings.

Note: Program-level descriptions are adapted from A Guide to Substance Abuse Services for Primary Care Clinicians³⁶ and updated to the Surgeon General's report on Facing Addiction³⁷.

INPATIENT ADDICTION TREATMENT

Understanding the differences between various forms of treatment can help make the correct referral decision. Each treatment plan has a goal to help patients stop abusing substances. *Note: While it helps to estimate the appropriate level of care when making a referral, residential/inpatient treatments and outpatient treatment centers are all likely to do a formal assessment to determine the level of care needed.*

- **Inpatient and Residential Treatments**

Drug rehabilitation programs provide a place where patients live in a drug-free environment. These facilities help patients avoid the psychological, legal, financial, social, and physical ramifications of substance abuse. The cost of inpatient treatment is typically higher than outpatient treatments and many insurers will pay for this level of care only if outpatient treatment has been tried and failed. If a patient refuses inpatient treatment, a referral to intensive outpatient treatment should be considered. They may be able to help motivate the patient to get the treatment needed.

- **Inpatient Hospitalization** – This option is indicated for patients who have:
 - Severe overdose or serious respiratory depression or coma
 - Severe withdrawal symptoms complicated by multiple drugs or history of delirium tremens
 - Acute or chronic general medical conditions that complicate withdrawal
 - Psychiatric comorbidity that could be dangerous to patient or others
 - A history of nonresponse to other less intensive forms of treatment
- **Residential Treatment** -- This option is indicated for a patient who lack motivation or social support or one who needs monitored detoxification but does not need other medical or psychiatric management.

Note: Program level descriptions are adapted from A Guide to Substance Abuse Services for Primary Care Clinicians³⁶ and updated to the Surgeon General's report on Facing Addiction³⁷.

OTHER TYPES OF SPECIALISTS

Acupuncture

Acupuncture, a technique from Chinese medicine, uses fine needles inserted into specific locations on the body to control the flow of vital energy, or chi, in order to promote health or help treat various medical conditions. Practitioners are licensed by their state and may be certified by the American Board of Medical Acupuncture (ABMA). A systematic review in 2009 was inconclusive comparing acupuncture to placebo; they found acupuncture is only slightly more effective than placebo for relieving pain³⁸. Guidelines suggest considering it for lower back pain when there is no response to conventional treatment³⁹. Favorable but weak evidence has also been reported for carpal tunnel syndrome, neck pain, osteoarthritis/knee pain, and post-dental extraction pain. Evidence for pain from other conditions is mixed. Positive attitude toward acupuncture can improve outcomes.



The number of treatments depends on the person's needs and response to acupuncture. Generally, one session is not correlated with lasting pain relief. A typical treatment protocol might consist of two or more sessions per week for four to five weeks. It is common for the patient to not notice any relief with the first treatments; therefore a course of five to ten treatments is recommended before determining whether the therapy is effective (WebMD).

Some insurance plans do cover acupuncture treatment when warranted and prescribed by a specialist. However, the patient should consult with their provider to determine if the treatment will be covered and the extent of coverage.

Physical Rehabilitation Programs

Physical rehabilitation helps patients manage disorders which inhibit physical functioning. The goal of physical therapy is to help the patient to function as best as possible given the limitations of their condition. Treatment may involve a combination of medication, physical modalities, physical therapy, and the aid of assistive devices, e.g., braces or orthotics.

Common pain conditions treated through pain rehabilitation programs include arthritis, back pain, neck pain, and fibromyalgia⁴⁰.

Physical rehabilitation centers may offer broad ranges of services, including:

- therapeutic recreation
- occupational therapy
- rehabilitation psychology
- vocational services
- physical therapy
- work fitness
- aquatic therapy
- sports medicine



There are over 7,500 rehabilitation providers practicing in the U.S. The American Academy of Physical Medicine and Rehabilitation (PM&R) offers a searchable database on their web page

through which you may find a practicing PM&R provider in your area. View the PM&R locator in the Related Resources section of this webpage to be directed to their database⁴⁰.

Because no two patients are identical, rehabilitation providers create a tailored program for each patient. Such a program may consist of a combination of physical therapy, medication, and other therapies such as stretching, massage, and strengthening exercises. If surgery is necessary, rehabilitation providers work with both the patient and surgeon before and after the surgery. Because of the wide variety of issues addressed by rehabilitation providers, the patient may expect to receive treatment for weeks or years.

Rehabilitation providers must graduate from medical school and complete four years of postdoctoral training in a physical medicine and rehabilitation residency, which includes one year developing fundamental clinical skills and an additional three years of training.

Many rehabilitation providers receive additional degrees or complete fellowships in a specific area of focus, such as:

- musculoskeletal rehabilitation
- pediatrics
- traumatic brain injury
- spinal cord injury
- sports medicine

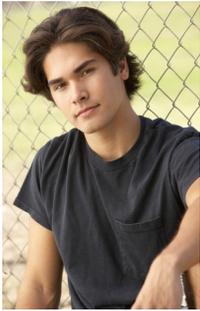
To become board certified in physical medicine and rehabilitation, rehabilitation providers are required to take both a written and oral exam. This exam is given by the American Board of Physical Medicine and Rehabilitation, or ABPMR.

Although accreditation is voluntary, many rehabilitation programs are accredited by several different commissions to meet specific healthcare standards including the equipment and professional staff, as well as the facility itself. Such accreditation organizations include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF)⁴⁰.

Physiatrists

Physiatrists are medical doctors who specialize in rehabilitation as well as diagnosing and treating pain. They treat the whole person, rather than one isolated area, with the goal of restoring as much function as possible given the patient's injury or condition. They also work towards prevention as well as treatment⁴⁰.

MR. ROWE - REFER

**Mr. Rowe****Patient:** Henry - 26 years old**Chief Complaint:** Ankle pain

History of Present Illness (repeated for convenience): Henry has been in physical therapy on and off for the past 6 years due to overuse injuries from gymnastics, especially ankle pain. As his gymnastics career ended, Henry described a period of depression. He also was briefly in counseling for binge drinking when he was depressed. He specifically asks for hydrocodone, because he has heard from some new friends that "it works."

Patient Interview

Provider: What would you rate your pain at its worst on a scale of one to 10?

Mr. Rowe: 7 or 8.

Provider: What about when you're not doing much activity?

Mr. Rowe: When I'm not active, it is a 3 or 4. But just having that lingering pain there makes me tired, so I don't go out much anymore.

Provider: What medications have you tried?

Mr. Rowe: Just over the counter stuff, which does not work. But a couple of friends who also have problems from old gymnastic injuries say that hydrocodone works.

Provider: Does your pain prevent you from doing anything in your day-to-day life?

Mr. Rowe: Well, I feel fatigued a lot, which I guess is from the pain. I also feel like I need to give my ankles a rest. I worked so hard for so long, and now I just need to take it easy, especially with my ankles. I don't want them to act up again.

Provider: How long has this been going on?

Mr. Rowe: I stopped gymnastics by the time I was 20 because of some injuries. I tried swimming, but it just wasn't the same.

Provider: Have you ever tried opioid pain relievers?

Mr. Rowe: No.

Provider: What do you know about them?

Mr. Rowe: Just what people say... Hydrocodone is pretty good for pain like I have.

Provider: Do you know anyone who has a problem with substance abuse now or in the past?

Mr. Rowe: I have some friends who do some stuff, you know, for fun, but I wouldn't call it "abuse."

Question: What referrals might Henry need? (Check all that apply)

1. Pain and addiction specialist due to risk of opioid abuse or diversion

- Feedback:
 - Possibly. Depression and history of binge drinking are risk factors for opioid abuse/addiction. Being around friends who apparently engage in substance misuse increases his risk of opioid misuse/addiction/diversion. Also, asking for a specific opioid that is frequently abused raises suspicion and should be explored further in the patient interview. Depending upon your training in safe opioid prescribing, you may choose to refer him to a specialist.
2. Support group due to past alcohol misuse
 - Feedback:
 - Appropriate for anyone and particularly in Mr. Rowe's case. Henry received treatment for alcohol misuse in the past. He has some evidence of continuing depression so he is at risk for returning to substance misuse. A history of substance misuse, friends who apparently engage in substance misuse, and depression are risk factors for opioid misuse/addiction.
 3. Psychological counseling
 - Feedback:
 - Depression is a risk factor for opioid misuse/addiction/diversion and Mr. Rowe reported a history of depression. Henry mentions that he does not go out much and no longer is able to do activities he enjoys or get exercise, which are factors that might signify continuing depression.
 4. Outpatient therapy for addiction issues
 - Feedback:
 - Possibly. Given Henry's history of addiction, friends who apparently engage in substance misuse, and depression he has risk for opioid addiction and might benefit from some outpatient counseling with a substance abuse counselor.

MAKING A REFERRAL

Information to Include

When contacting treatment providers, ask about services offered and the philosophy toward treatment. As affordability and/or insurance might be a problematic issue for the patient, a practitioner will also want to be familiar with publicly funded programs.

Providers might suggest the referral to the patient as they would when suggesting that a patient visit any other medical specialist; this will often increase the likelihood of follow-through with outside treatment.

- The provider can make the initial call for the patient in the patient's presence.
- A referral letter sent to the specialist should precede the patient's first visit.
- If requested, the treating party should communicate with the referring provider after the patient's assessment or if the patient misses the appointment.
- If possible, the primary care provider and the specialist should collaborate in the patient's treatment. The patient must sign a consent form if he or she agrees to this sharing of information.

WHAT TO TELL THE PATIENT ABOUT A REFERRAL

- Use the "Ask-Tell-Ask" approach:
 1. Ask permission to discuss something with them
 2. Tell them your concerns
 3. Ask what they thought about what you said
- Remember your role as a health provider – explain that you need to discuss drug use because you are concerned about their health. Explain why you are recommending a referral. Point out the direct relationship between their drug use and any health or social consequences they might have experienced.
- Provide as much information as possible about the provider/clinic where you are referring the patient; if you speak with confidence and knowledge about the treatment center, patients are more likely to respond more positively.
- Maintain the patient's privacy - conduct the interview in private and do not bring up the substance abuse or referral around other staff members, family, or friends without the patient's permission.

POLL: HOW OFTEN TO YOU FOLLOW UP WITHIN A MONTH AFTER MAKING ANY REFERRAL FOR CHRONIC PAIN OR ADDICTION?

Poll Responses:

1. 0-10%
 - 19% (95 votes)
2. 11-25%
 - 12% (59 votes)
3. 26-50%
 - 23% (120 votes)
4. 51-75%
 - 17% (86 votes)
5. 76-100%
 - 30% (152 votes)

Total votes: 512

PATIENTS WITH ACTIVE SUBSTANCE ABUSE

Poll Discussion: Follow-up Is Important

After making a referral, be sure to follow-up with the patient to see how it went, whether another referral is needed, or whether there are any questions or concerns.

Treating the Patient vs. Referral

Given the challenges of interdisciplinary communication between different care providers due to HIPAA and other patient confidentiality rules, patients requiring intensely coordinated care might

benefit from being referred to a facility that provides most of the care needed within a single setting where obtaining the required permissions can more readily be coordinated. If a patient is believed to have a substance use disorder, first decide if the treatment is within your realm of expertise; if not, referral to an addiction specialist or a treatment program or pain specialist may be necessary. Unfortunately, at this point, most communities have few providers who specialize in pain management with active substance use disorders and so referral to a distant treatment facility or working in consultation with such a specialist may be in order. Some pain specialists may not treat patients actively abusing substances, and may initially require they be referred to an addiction specialist. Other possible reasons for referring include that the patient's level of risk is too high to be appropriately managed in your treatment setting, or the patient has a comorbid psychiatric condition that requires special attention. Discuss the rationale for referral with the patient so they will not feel abandoned⁴¹. Before referring, consider having a psychiatrist confirm the presence of a substance use disorder (Compton, 2008). Provide information and referrals to supportive care, such as recovery groups or counseling, to improve treatment effectiveness⁴².

Coordinating Care After Referral

The role of the pain management clinician or primary care physician does not end with the referral. Continuing to act as an advocate and work with the patient and the addiction specialist improves pain treatment outcomes and can reduce opioid misuse^{42,43}. Additionally, addiction specialists who may not want their patients with substance use disorders to be treated with opioids for pain may be willing to allow this if a pain specialist is responsible for the pain treatment and helps monitor the patient⁴³. Primary care providers can coordinate care as the patient's medical home, a source for referrals who communicates with specialists and provides ongoing management⁴¹.

Collaborating on Patient Care

To promote provider communication and collaboration the Institute of Medicine suggests the following:

Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Patients should have unfettered access to their own medical information and to clinical knowledge.

Clinicians and patients should communicate effectively and share information (IOM, 2001:62).

For ideal collaboration, there should be:

- Shared understanding of roles. All clinicians and institutions treating the patient should have a shared understanding of goals and roles. Common goals and a shared understanding of roles should be achieved. Role confusion and conflict is best prevented through clear, proactive communication.
- Effective communication. Ideally, it should be frequent, timely, understandable, accurate, and satisfying.
- Shared decision making. Disagreements on treatment need to be identified and openly discussed with a goal of consensus building (IOM, 2006:212)

The patient's primary care provider should become familiar with the details of the addiction treatment program, making a note of progress and participation in the program at each primary care visit⁴³.

METHADONE AND BUPRENORPHINE

Methadone Maintenance Treatment (MMT) and buprenorphine can be used in addition to opioid therapy in chronic pain patients to help reduce substance abuse. This requires coordination between the pain management physician and an MMT Clinic⁴⁴. Additionally, buprenorphine is an effective analgesic in chronic pain patients with opioid use disorders⁴⁴. A separate form of buprenorphine is approved by the FDA for pain management.

FYI

- Effective interdisciplinary care is one of the Institute of Medicine's core competencies for physicians.
- Coordination of care for a patient with a substance abuse problem involves another mental health problem in approximately 43% of the cases⁴⁵.

DID YOU KNOW?

Maintaining privacy while treating a patient for substance use disorders can get complicated when coordinating care with multiple providers. Review SAMHSA's frequently asked questions document on the Health Information Exchange for more on the topic.

PATIENT COMANAGEMENT

The Role of the Primary Care Provider

The primary care provider may act as part of a multidisciplinary team including a pain specialist, a psychologist, and a physical therapist for the treatment of chronic pain. If chronic pain is being managed solely by a primary care practitioner, he or she also should pay attention to functional and psychosocial factors¹.

A Medical "Home" for Each Chronic Pain Patient

When opioids are prescribed for a chronic pain patient, a single clinician should be identified who is the one with primary responsibility for the patient's overall medical care¹. The "home" clinician coordinates communications among all the clinician's involved in the patient's care, but may or may not prescribe the medication. Consultation or referral is essential when the skills or services that are needed are not available in the medical home, such as pain and or addiction treatment services. The home clinician should continue in the role of coordinating communications and care. The primary care provider need not be the one to monitor the opioid therapy, although in some cases, geographic issues or patient medical comorbidities may favor that. Having the home clinician be primary care reduces medical costs, however.

If chronic pain is being managed solely by a primary care practitioner, he or she also should pay attention to functional and psychosocial factors¹. Alternatively, the primary care provider may act as part of a multidisciplinary team including a pain specialist, a psychologist, and a physical therapist.

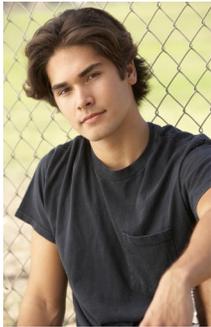
Comanagement

After evaluating a patient, a specialist may feel that the patient can be co-managed with primary care. The following steps may be important in these cases:

- Obtain legal permission to share patient information with all parties involved including addiction and pain specialists, other healthcare providers, family members, and friends.

- Establish an agreement between primary care providers, specialists, and other members of the treatment team. It should describe the care that each clinician will provide and include a communication protocol and schedule of visits.
 - Be clear about: Who is my patient? Who is our patient? Who is your patient?
- Become familiar with any addiction treatment plans.
- Continually share information as appropriate with other healthcare providers throughout the patient's treatment.

CASE: MR. ROWE



Mr. Rowe

Age: 26-years-old

Chief Complaint: Ankle pain

History of Present Illness Summary:

- 6 years of physical therapy due to gymnastics overuse injuries
- Depression and binge drinking
- Asking for hydrocodone

Case Comanagement

- Mr. Rowe's primary care physician, Dr. White, acts as the *medical home* for Mr. Rowe's chronic opioid therapy.
- Dr. White referred him to a pain and addiction specialist, Dr. Blue, due to the moderate risk factors and Dr. White's own level of expertise.
- Dr. Blue prescribed chronic opioid therapy and follows Mr. Rowe periodically. Dr. Blue also referred Mr. Rowe to a psychologist, Dr. Green, for 10 weeks of cognitive behavioral therapy to help him cope with his pain and depression. These three providers now all *comanage* this patient.
- Dr. White monitors Mr. Rowe between his appointments with the specialist and is in communication with Dr. Blue when anything changes.
- When an orthopedic surgeon entered the picture, Dr. White continued to act as Mr. Rowe's medical home and coordinated communications among all four providers.

HEALTH PROFESSIONAL IMPAIRMENT

Triggers

Any use of alcohol by health care providers is a danger to the patients they are treating, but even they are not immune from alcohol use disorders. Because patients' lives are dependent on the ability of medical professionals to think quickly and rationally, it is imperative that medical professionals not misuse alcohol. However, this is not always the case. Students and residents are under



the immense pressures of medical education and training. Practicing providers are under constant stress to perform at high levels of expectation, making it likely they will turn to alcohol as a coping mechanism⁴⁶.

Student Use

In a survey conducted among medical school students, more than 3/4 of students admitted to drinking in the past month and the rate increased during senior year⁴⁷. While students may learn about the negative health effects alcohol and binge drinking has on patient health, they may not necessarily apply that same reasoning to their own behavior. Comparison between male and female medical students found that male medical students drink at a slightly higher rate than women and their rate of binge drinking is double that of female medical students⁴⁷. Male and female medical students reported an 11-18% increase in their alcohol consumption when entering medical school. Use among male students decreased over time; use by female students remained constant⁴⁸. It is important that alcohol misuse in health professional students and residents be acknowledged. Appropriate steps should be taken to improve the health of the student as well as the health of the patients that student is treating.

Practicing Providers-Rate of Use

Substance misuse among health care providers has long been identified as a possible problem. In 1973, the AMA requested state medical societies monitor and treat provider substance misuse⁴⁹. It is important that providers be monitored for their potential misuse issues as they can have detrimental effects on patient treatment. In a sample population survey, providers with substance misuse issues most commonly had a problem with alcohol⁴⁹, with an estimated 14% of the population having alcohol-related issues⁴⁶. This translated to about 112,000 physicians in the United States impacted by alcohol misuse⁴⁶.

PRACTICE TIP

Certain medical professions report a higher rate of alcohol use. ER providers, providers in solo practice, and psychiatrists are three times more likely to have alcohol misuse problems⁴⁶.

IMPACT ON PATIENTS

Impairment on the Job

Impairment among health professionals is defined as not only being unable to practice within "acceptable standards of practice", but also the inability to provide medical services without flaws in professional judgment⁴⁶. It is important to recognize alcohol impairment among health care providers as it can negatively impact patient health as well. The health professionals may downplay their own use since they are well-aware what is/is not healthy use and feel they can control their levels (Baldisseri, 2007). However, being under the influence of alcohol while on duty can create dangerous circumstances for both the patient and the provider's colleagues as well.

Personal Use Impacts Screening Techniques

Interviews with health professionals who admitted drinking show that their own use may cloud their ability to screen patients effectively. Some of the General Practitioners interviewed would only screen for or identify a patient's level of use as high if the patient was consuming more than the practitioner^{50,51}. One's own substance use obviously is not a valid measuring tool for patient

screening. Also, health care providers may be hesitant to teach about alcohol reduction among patients when they themselves engage in the same sorts of behavior⁵⁰. This puts patients in danger since they cannot be properly identified as having an alcohol use problem if the provider has one as well.

PRACTICE TIP

Impairment among health professionals as a result of substance abuse not only puts the patient in danger of poor treatment but also can potentially affect your practice if you are co-managing the patient.

RECOGNIZING THE NEED FOR HELP

Stigma

The medical community at large has not been forthcoming about individual provider substance abuse problems⁴⁶, despite the fact that addiction among physicians was reported as early as 1869 (see review⁵²). Fear of being professionally stigmatized because of alcohol use may prevent some health professionals from seeking needed treatment⁵³. This creates a dangerous situation for patients and leads to a higher likelihood of mistreatment.

Getting Help for Colleagues

If you suspect your colleague has an alcohol use problem, you can seek to get them the help they need. Interestingly, addicted physicians that participate in a Physician's Health Program experience higher success rates (measured by testing negative for alcohol or drugs) than patients of other types of rehabilitation programs⁵⁴. Health care providers may be sent to this type of treatment as a result of peer reports, as well as complaints from patients or family members, but they may only be in the pre-contemplative stage of change⁴⁹, which opens the possibility of relapse. Please see the Related Resources section for a review of the *Stages of Change Model*.

Successfully monitoring your colleagues and taking an interest in their recovery will lend support they may need to continue improving. However, some providers are reluctant to report their colleagues for fear that their own financial and occupation status may be in jeopardy⁴⁶. In fact, the AMA requires physicians to report any ethical or competency concerns they have about their colleagues⁴⁶.



Dependence Treatment Options

Treatment of alcohol dependence is usually comprised of detoxification, along with psychiatric and medical evaluations, leading to ongoing rehabilitation⁴⁶. Twelve-step recovery programs were the treatment option of choice for a sampling of physicians with substance abuse disorders (Galanter et al., 2007)⁴⁹. These groups may provide a stable support system with peers, which aids in recovery. Those who do not voluntarily enter into this type of rehabilitation program are often referred to an inpatient program as a preventative measure against putting their own patients in unnecessary harm

⁴⁶.

PRACTICE TIP

It is important to properly identify not only your own potential alcohol use issues, but those of your colleagues, as all contributory members of the health professional staff can impact patient treatment.

SUMMARY

Here is a summary of **recommended** skills, organized by provider core competencies:

PROVIDE PATIENT-CENTERED CARE

- A provider's encouragement and follow-up, accompanied by self-help groups and mentors, is invaluable to the patient's participation and treatment outcomes.
- When recommending a referral to the patient, use the "Ask-Tell-Ask" approach.
- Stratify patients by risk level and complexity.
- Substance abuse tends to be a long-term problem; continuity of care is particularly important.

WORK IN INTERDISCIPLINARY TEAMS

- Consider a consultation with specialists and other healthcare providers or referral regarding patients with complex pain or addiction issues before prescribing opioids, depending upon your level of expertise.
- Refer patients who have chronic pain appropriately for behavioral assessment and treatment.
- A single "home" clinician should coordinate communication and care for patients on chronic opioid therapy, and take primary responsibility for the patient's overall medical care. This does not have to be the prescribing provider and may be the primary care provider.
- Engage other health care team members by updating them about shared patients.
- Coordination of care with addiction treatment facilities, self-help groups, and mental health professionals is essential for effective treatment of substance use disorders.
- Effectively co-manage patients who have chronic pain as part of an interdisciplinary pain treatment team that includes collaboration among pain, addiction, and/or mental health specialists.
- Refer patients who have complex pain conditions to pain specialists. If there are multiple issues in addition to pain, refer to multidisciplinary pain clinics or to appropriate specialists.
- Consult with or refer cases with histories of substance use disorders or indications of a drug use problem to an addiction specialist.

EMPLOY EVIDENCE-BASED PRACTICE

- A multidisciplinary approach to pain treatment involves psychotherapeutic interventions, functional restoration, nonopioid therapies, and the use of self-help groups, as well as substance abuse counseling and pain specialists as needed, in order to enhance success with treatment.

APPLY QUALITY IMPROVEMENT

- Assess the patient's mental health status at every visit due to interactions with pain and addiction risk.
- Determine whether the patient can be managed in your practice with or without consultation or requires referral based on results of the assessment.

UTILIZE INFORMATICS

- Review the Related Resource in this module entitled *Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)* which provides information on the confidentiality regulations and proper exchange of patient information when coordinating care with multiple providers.
- Use the Related Resource section of this module to help locate pain and/or addiction specialists or treatment centers in your area for a referral.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- [Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange](#)
While information regarding patients in addiction treatment programs is protected by regulations which stipulate a patient's written permission must be obtained for the release of personal information, there are also some circumstances under which patient information can be released without consent. Regardless, the regulations may interfere with care coordination. In this FAQ document, the Substance Abuse and Mental Health Services Administration (SAMHSA) weighs in on the issue by providing information on the confidentiality regulations and proper exchange of patient information.
- [BDI: Beck Depression Inventory](#)
The Beck Depression Inventory; purpose, use, administration and scoring. Also includes psychometric characteristics and evaluation.
- [Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders](#)
Comprehensive review article that explores the relationship between pain and substance abuse and offers suggestions for evaluation and treatment. Authors: Savage SR, Kirsh KL, Passik SD
- [Is Your Specialist Certified?](#)
Check the specialty board certification status of your doctor.
- [Narcotics Anonymous](#)
12 step programs for persons addicted to narcotics.
- [Referral Form for Substance Abuse](#)
A referral form which includes both doctor and patient information.
- [Stages of Change Model](#)
The Stages of Change Model illustrates how people move through various stages in a nonlinear, often cyclical, fashion. Depending on the stage a person is in, he or she will respond differently to different types of information and motivation. The model illustrates how an individual's perceptions and interest in changing a behavior may alter over time, and it provides a framework for determining an appropriate intervention (Prochaska and DiClemente, 1982).
- [The American Academy of Pain Medicine: Find a physician](#)
This search engine produces searches for accredited pain by city and state.

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