Development and Evaluation of a Pain Program – the HeLP story

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The problem for us

- The HeLP program was developed because of an identified lack of formal training in family medicine residency programs on opioid management of chronic non-cancer pain (CNCP) and multiple challenges faced by residents' managing pts on opioids for CNCP.

Our clinic

- Academic FHT in downtown Toronto
- 12 PGY-1s, 12 PGY2s, 12 staff MDs
- Several community MDs (supervision)
- IHPs: 2 NPs, 2 team RNs, 1 antenatal RN
- 1 pharmacist,1 general RD, Diabetes team (RD + RN), Mental Health team

(2 SWs), 1 midwife

- 11,000 patients

Identified concerns

- Multiple prescribers and pharmacies
- Unsafe doses
- Unsanctioned dose escalations
- Inadequate pain control
- Aberrant drug-taking behaviours
- Verbal abuse towards clinic staff
- Patient and resident dissatisfaction

The Objective of the Program

- To improve quality of patient care, reduce aberrant drug-taking behaviours, improve family physician comfort and confidence, improve patient safety and outcomes

HeLP Program components

- A Nurse Practitioner with advanced skills in chronic pain assessment and management to lead the program and oversees an up-to-date list of pts in the program.
- Our staff Pharmacist, who is available to consult and discuss pt medication (e.g. create a taper schedule, look at drug interactions) and provide resident education.
- Our lead staff MD who consults on program development, research and brings any issues to the management team for review.

Tools for HeLP Program

- Faculty supervisors assigned to each patient
- Routine meetings between NP, faculty supervisor and resident
- Formal resident education sessions yearly plus 1:1 mentorship
- Electronic chart tools (flowsheet, requisition, alerts, opioid agreement)

What it looks like now…

- Routine visits w FMR but also periodic “check ins” with NP, especially if not doing well or change in Rx required
- NP does the back-up visits when FMR is not available or away from clinic
- NP sits in on turn-over time visits with new FMRs to support both pt and MD
- Reception knows to connect with me if pt calls (as does “Duty MD” if a HeLP pt presents”

Case for our program

- 50yr old female, B.R.
- Genetic condition, large ventral hernia, Ankylosing spondylitis
- Multiple mental health co-morbitities (MDD, PTSD, borderline traits)
- Double-doctoring, abnormal UDS
- No way to track concerns in chart easily

Case, con't B.R.

- 2017 admission note from hospital ER, pt admitted for suicide attempt using OD of her Rx'ed opioids
- During admission we find out that this is her fourth such attempt/admission
- Consult with the team, agreement to Rx bi-weekly to limit doses, while referring to iPARC @ CaMH

Case conclusion B.R.

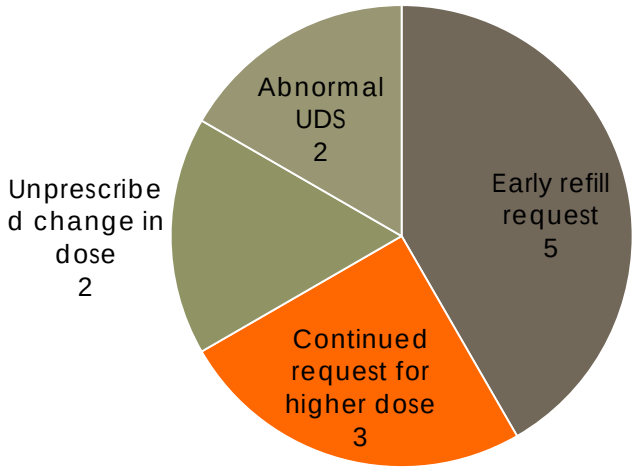
- Delayed admission for various reasons but eventually went in, now on stable dose of buprinorphine/naloxone
- Recent UDS shows codeine and 2 benzos (only Rx'ed one, by psych)
- Less risk long-term overall
- Next resident will know the whole story from shared-providers and chart flowsheet

	July 2012 – July 2013	March 2014 – March 2015	Fisher's Exact Test (2-sided)
Attempted taper	27.1%	33.3%	p=0.657
Amount of opioid prescribed (mEq/day)	106.14	89.39	p=0.049
Number of prescribers	1.87	1.42	p=0.031
Aberrant behaviour	12 (25%)	12 (25%)	p=1.00

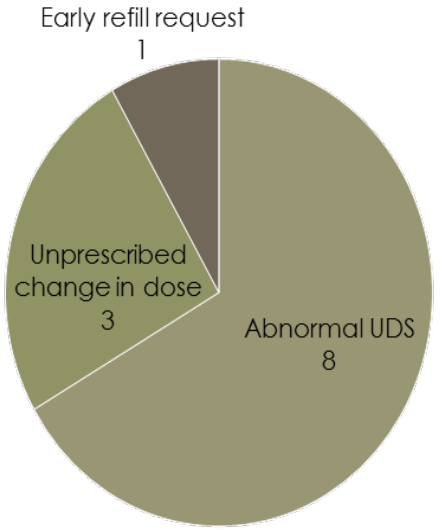
Opioid prescribing tool	July 2012 - July 2013	March 2014 – March 2015	Fisher's Exact Test (2-sided)
Opioid treatment agreement	31.3%	70.8%	p<0.001
Patient review	0%	62.5%	p<0.001
Pain flowsheet	0%	35.4%	p<0.001
Urine drug screens	12.5%	50.0%	p<0.001

Chart Review - Aberrant Behaviour

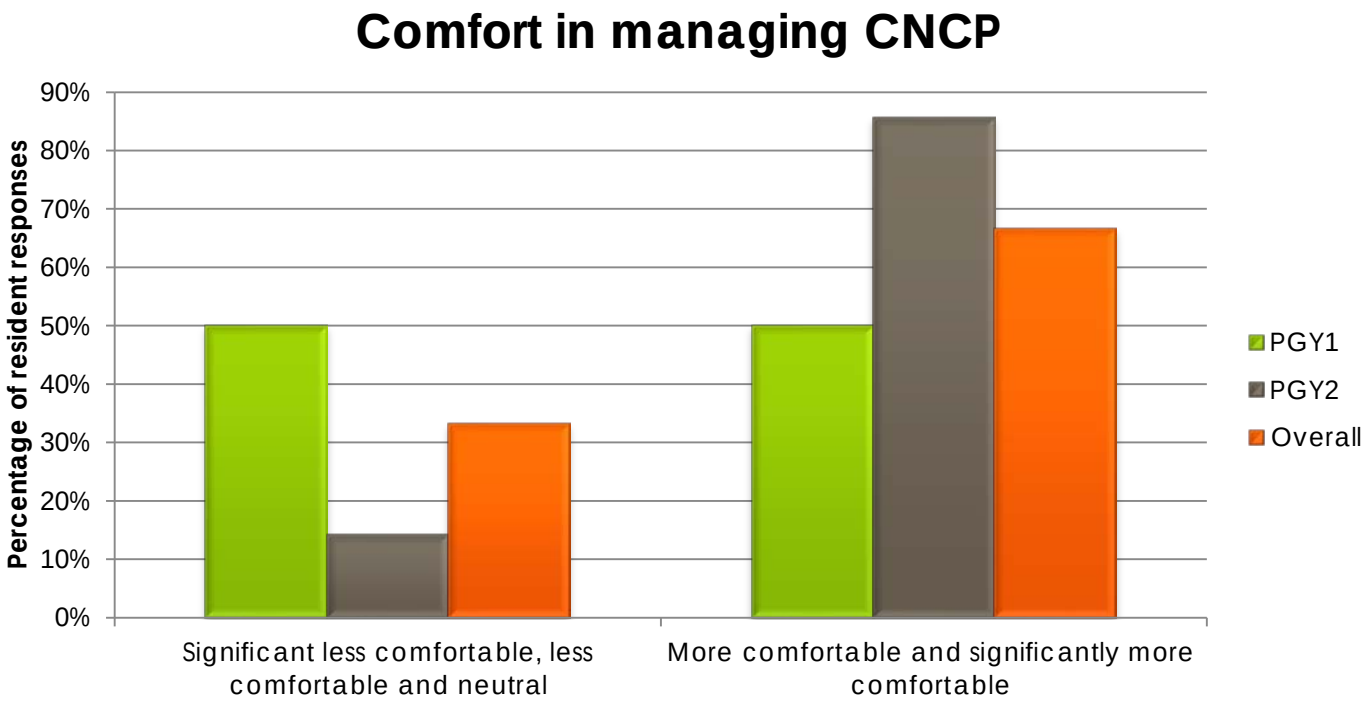
Types of Aberrant Behaviour, July 2012 - July 2013



Types of Aberrant Behaviour, March 2014 March 2015



Results – Resident Survey



Thank you! Questions…?