PAIN MANAGEMENT SURVEY OF HEALTH CARE FOR THE HOMELESS CLINICIANS

Summary of Results

Health Care for the Homeless Clinicians' Network
National Health Care for the Homeless Council
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NATIONAL
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COUNCIL

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BACKGROUND

The Health Care for the Homeless (HCH) Clinicians' Network is a membership group within the non-profit National Health Care for the Homeless Council. The Council has a cooperative agreement with the Health Resources and Services Administration of the U.S. Department of Health and Human Services to provide training and technical assistance to health centers receiving HCH Program funding. These health centers are known as HCH grantees, and a large portion of the HCH Clinicians' Network membership comes from these HCH grantees.

The Steering Committee of the HCH Clinicians' Network sets the clinical agenda for the Council to address priorities and challenges in the provision of health care for those who are homeless. During the 2008 Annual HCH Clinicians' Network Membership Meeting, pain management was identified as an important clinical topic and later chosen as a priority area for the Network Steering Committee. A literature review was conducted to examine the type of research, resources and clinical guidelines relevant to chronic pain management practices with individuals experiencing homelessness and other marginalized populations. The literature review revealed a gap in information regarding pain management practices for clinicians serving those who are homeless, and a task force was created. The task force developed a survey to examine the current practices, available resources, attitudes and perceived needs in providing pain management for homeless patients in health care for the homeless settings, analyzed the results presented here, and made recommendations to addresses needs and gaps.

METHODOLOGY

In May 2010, all clinicians with email addresses (780) from the HCH Clinicians' Network and the Respite Care Providers' Network (another membership group within the Council) were invited to participate in an online survey regarding chronic pain management with individuals who are homeless. (See the Appendix for a copy of the survey instrument.) Email recipients were encouraged to forward the invitation to their colleagues who also provided pain management services to patients who were homeless. For this study, *pain* was specified as chronic, non-malignant pain.

The survey instrument was developed using Survey Monkey. Email addresses and computer IP addresses were not documented to ensure anonymity of responses. The survey included 31 total multiple choice and open-ended questions. Quantitative data were analyzed using PASW Statistics 18 software. Qualitative data were reviewed and categorized into major themes (in vivo). Any qualitative responses that fell into predetermined response options from multiple-choice questions were moved into those categories. Responses that fell within the established themes were quantified and are reported here.

RESULTS

A total of 121 individuals accessed the online survey out of the 780 individuals who were sent an email survey invitation. Given that 43 email addresses bounced back from the invitation, the response rate was approximately 16 percent. Of those who accessed the survey, two declined to participate, one skipped all the questions and 17 did not answer questions beyond the demographics section. The remaining 101 individuals' responses were analyzed. Unless otherwise noted in the report, the response rate for most questions was above 95 percent.

Participants

Participants were from 26 states in the U.S. and 1 province in Canada. Based on regions defined by the U.S. Census Bureau, 40% of participants were from the West, 17% from the Midwest, 27% from the South and 15% from the Northeast.

The top five clinical roles represented were: advanced practice nurses, non-psychiatric physicians, nurses, social workers and case managers. There was overlap between some of the clinical roles since participants were permitted to choose more than one response, e.g. nurse who is also an outreach worker [Table 1]. Compared to the HCH Clinicians' Network and the Respite Care Providers' Network members with reported clinical roles, survey participants were more likely to be advanced practice nurses, case managers and physician assistants, and less likely to be nurses and social workers.

Table 1. Clinical roles of survey participants (N=101) compared to clinical roles of HCH Clinicians' Network and Respite Care Providers' Network members (N=722)

	Survey Participants		Clinicians' Network and Respite Care Providers' Network Members	
	Frequency	Percentage	Frequency	Percentage
Advance Practice Nurse	31	30%	120	17%
Physician (non-psychiatric)	25	25%	173	24%
Nurse	16	16%	171	24%
Social worker	13	13%	118	16%
Case manager	10	10%	43	6%
Physician assistant	7	7%	22	3%
Mental health specialist	5	5%	14	2%
Outreach worker	3	3%	16	2%
Substance abuse counselor	3	3%	6	1%
Physician (psychiatric)	2	2%	9	1%
Other - Psychologist (2), Program Director, Clinical manager, Acupuncturist	5	5%		

*Percentages may not add up to 100 as one individual may hold more than one clinical role.

The length of time participants have provided health care for individuals who are homeless ranged from less than one year to 30 years (median was 7 years). The most frequently reported work settings were HCH grantees within Community Health Centers, HCH grantees that were stand alone entities and shelters [Table 2].

Table 2. Settings where participants practice

	Frequency	Percentage
HCH grantee within Community Health Center	35	34%
HCH grantee stand alone	31	30%
Shelter	24	23%
Medical respite program	16	16%
Mobile unit	15	15%
HCH grantee within Department of Public Health	14	14%
HCH grantee within hospital	7	7%
Other - AIDS service organization, Assisted Living Facility, Emergency department, Federal government, Homeless hospice, Non-HCH grantee homeless clinic at day service center, Non-HCH grantee homeless clinic within a health department, Urban Indian clinic, Joint Committee on Health Policy working with Medicaid/Medicare members	9	9%

*Percentages may not add up to 100 as participants may work in more than one location.

Pain management programs

All participants were asked to estimate the percent of visits in which they managed chronic pain (89 responded). Responses ranged from 0 to 80 percent with a median of 20 percent. Sixty percent of the respondents reported that they were licensed to prescribe opiates. These clinicians were asked to estimate the percent of patients with chronic pain to whom they prescribed opiates (52 responded). Responses ranged from 0 to 90 percent with a median of 10 percent.

All participants were asked to identify which clinicians at their sites were routinely involved with the management of patients who experience chronic pain from a predetermined list. Primary care providers (e.g. MD, NP, PA) were the most commonly reported clinicians involved in the care team for chronic pain management, with nurses a distant second. The third most commonly reported group of clinicians included social workers, psychologists/psychiatrists, substance abuse counselors and case managers [Table 3].

Table 3. Clinicians routinely involved in chronic pain management

	Frequency	Percentage
Primary medical provider (e.g. MD, NP, PA)	90	89%
Nurse	65	64%
Social worker	45	45%
Psychologist or psychiatrist	41	41%
Substance abuse counselor	41	41%
Case manager	39	39%
Pharmacist	22	22%
Other - Acupuncturist, Dentist, HIV counselor, Medical respite care, Optometrist, Pain specialty clinic, Peer counselor, Urgent care medical provider	8	8%

*Percentages do not add up to 100 as participants were given the option to check all that apply.

Participants were asked to choose what structures, processes and materials of a predetermined list were available at their sites to assist with pain management. A large minority of participants reported no available resources for pain management [Table 4]. The most commonly reported resources were general policies and procedures and patient/provider agreement for treatment with opiates. A substantial minority of respondents reported having case management, case conferences, informed consent for use of opiates and addiction medicine specialist on staff. A very small minority had a pain management specialist on staff or pain groups.

Table 4. Resources to assist with pain management

	Frequency	Percentage
General policies and procedures	60	59%
Patient/provider agreement for treatment with opiates	59	58%
Case management	48	48%
Case conferences	39	39%
Informed consent for use of opiates	36	36%
Addiction medicine specialist on staff	33	33%
Trainings	22	22%
Standardized progress notes for patients on opiates	20	20%
Registry or list of patients on opiates	16	16%
Special guidelines for clients from substance abuse rehabilitation facilities	12	12%
Pain management specialist on staff	8	8%
Pain groups	2	2%
None	19	19%
Other - Referrals (pain management, substance abuse and mental health), Group forming to study pain management practices, Narcotics policy in development, Addiction specialist and social worker assess mental health and substance status then follow patient with provider	5	5%

*Percentages do not add up to 100 as participants were given the option to check all that apply.

Respondents were asked to rate how much they agreed or disagreed with various statements about pain management at their sites. A vast majority of respondents agreed that pain management is a significant issue at their site and that pain management is difficult with patients who have a history of addiction. A smaller majority of respondents agreed that it is difficult to distinguish between managing pain and addiction and they frequently struggle with issues around pain management. Less than half agreed that managing pain is a priority at their site and a small number of respondents agreed that they adequately manage pain at their site. Three quarters of the respondents agreed that successful pain management is gratifying [Table 5].

Table 5. Clinician attitudes towards pain management

	Agree	Not sure	Disagree
It is difficult to manage pain in patients with a history of addiction.	90(91%)	6(6%)	3(3%)
Pain management is a significant issue in my practice.	90(91%)	6(6%)	3(3%)
I frequently struggle with issues surrounding pain management.	78(79%)	7(7%)	14(14%)
I find successful pain management gratifying.	73(75%)	14(14%)	11(11%)
It is difficult to distinguish between managing pain and addiction.	68(69%)	11(11%)	20(20%)
Managing chronic pain is a priority at my site.	48(49%)	25(25%)	26(26%)
We adequately manage pain at my site.	23(23%)	37(38%)	38(39%)

Participants were asked if they routinely measure level of pain and function in ongoing pain management. Sixty-three percent of respondents reported that they routinely measure level of pain while only forty percent routinely measure level of function. If respondents reported yes to routinely measuring level or function, they were asked to provide the names of the scales used (55 and 26 responded respectively). Of those routinely measuring level of pain, 82% reported using a numerical pain scale – in particular, 67% reported using a 1-10 scale. Less than 4% reported using other numeric instruments such as the 1-5, Braden and Mankoski scales. Thirteen percent reported using the Wong-Baker FACES assessment tool and less than 2% use the Brief Pain Inventory and the Edmonton Symptom Assessment System. Of those routinely measuring level of function, 31% reported they do not use a specific scale or instrument, 27% use a numerical pain scale and 19% assess Activities of Daily Living.

Available treatments

Participants were asked to report which pharmacologic treatments they prescribed and/or dispensed at their sites. While only 69% reported prescribing and/or dispensing opiates, the vast majority of respondents reported prescribing and/or dispensing NSAIDs, neuropathic pain medication, muscle relaxants, and analgesics at their sites [Table 6]. A few participants listed other treatments: anticonvulsants, non-opioid patches (e.g. Lidoderm) and topical ointments (e.g. Ben-Gay).

Table 6. Pharmacological interventions prescribed and/or dispensed

	One or more type prescribed or dispensed	Neither prescribed nor dispensed	Not sure
NSAIDS	93 (94%)	2 (2%)	4 (4%)
Analgesics	92 (94%)	1 (1%)	5 (5%)
Neuropathic pain medications	88 (90%)	4 (4%)	6 (6%)
Muscle relaxants	85 (88%)	5 (5%)	7 (7%)
Opiates*	64 (69%)	24 (26%)	5 (5%)

*N=93

When asked about the types of toxicology screenings used in medication management at their sites, 55% of respondents reported using urine screens. Fourteen percent reported using medicine-specific blood screens and 5% reported non-quantitative blood screening. Thirty-two percent of respondents reported not using any toxicology screens.

Participants were also asked to report which non-pharmacological treatment options were available at their sites or affiliated sites from a predetermined list. Cognitive behavioral therapy was the most frequently reported option while physical therapy and an addiction medicine specialist were about 50% [Table 7]. A minority of participants reported the availability of acupuncture, chiropractics, massage therapy and yoga. Other non-pharmacological services reported included reiki, osteopathic manipulative treatment, acupressure and yoga-like classes.

Table 7. Available non-pharmacological interventions

Non-pharmacological intervention	Available	Not available	Not sure	N
Cognitive behavioral therapy	55 (61%)	31 (34%)	4 (4%)	90
Addiction medicine specialist	49 (52%)	45 (48%)	--	94
Physical therapy	45 (51%)	42 (48%)	1 (1%)	88
Acupuncture	26 (29%)	63 (70%)	1 (1%)	90
Chiropractics	19 (22%)	66 (78%)	--	85
Yoga	10 (12%)	72 (85%)	3 (4%)	85
Massage therapy	9 (11%)	73 (87%)	2 (2%)	84

Attitudes of licensed prescribers

A majority of prescribers would consider prescribing opiates to patients with historical use of alcohol, stimulants and illegally obtained sedatives although less than half would consider prescribing to those with historical use of illegally obtained opiates. In general, a minority of prescribers would consider prescribing opiates to patients with current use of alcohol, stimulants, illegally obtained sedatives and illegally obtained opiates – the one exception being that over half would consider prescribing opiates to patients with episodic use of alcohol. A substantial minority of prescribers would not prescribe opiates to patients with historical or current use of the substances mentioned [Table 8].

Table 8. Clinicians who would prescribe opiates based on current or historical use of specified substances (Prescribers only, N=59)

	Historical use	Episodic use	Abuse	Dependence	Would not prescribe
Alcohol	41 (70%)	32 (54%)	6 (10%)	10 (17%)	10 (17%)
Stimulants	43 (73%)	15 (25%)	3 (5%)	3 (5%)	20 (34%)
Illegally obtained sedatives	37 (63%)	11 (19%)	2 (3%)	3 (5%)	19 (32%)
Illegally obtained opiates	27 (46%)	13 (22%)	2 (3%)	6 (10%)	26 (44%)

*Percentages do not add up to 100 as participants were given the option to check all that apply.

An overwhelming majority of prescribers agreed that they were comfortable discussing non-opiate medications, non-pharmacological treatment options and non-physical aspects of pain [Table 9]. They were somewhat less comfortable discussing opiate medications. Even fewer were comfortable with discussing development of a treatment plan, diversion, or discontinuation of opiate treatment.

Table 9. Clinician comfort discussing pain related topics (Prescribers only)

	Agree	Not sure	Disagree
Non-opiate medications	56 (98%)	1 (2%)	–
Non-pharmacological treatment options	54 (95%)	3 (5%)	–
Non-physical aspects of pain (e.g. pyschological)	52 (93%)	3 (5%)	1 (2%)
Opiate medications	47 (84%)	5 (9%)	4 (7%)
Diversion (selling or trading prescribed opioids)	44 (77%)	7 (12%)	6 (11%)
Developing a treatment plan for severe chronic pain	41 (73%)	7 (13%)	8 (14%)
Discontinuing opiate treatment when indicated	40 (71%)	9 (16%)	7 (13%)

Participants were asked to evaluate how much they agreed or disagreed with the ethical nature of requiring a list of treatments in conjunction with opiate prescription. Almost all prescribing respondents agreed that it would be ethical to require a patient to participate in non-opiate treatment of pain or pain management contract [Table 10]. About 90% reported that it would be ethical to require participation in a controlled environment, mental health treatment, substance abuse treatment or random toxicology screenings. A slightly smaller majority endorsed treatment for unrelated medical conditions.

Table 10. Clinician attitudes regarding the ethical nature of requiring patient participation in specified treatments in conjunction with opiate prescription (Prescribers only)

	Agree	Not sure	Disagree
Pain management contract	56 (98%)	1 (2%)	–
Non-opiate treatment of pain	55 (98%)	1 (2%)	–
Controlled environment (e.g. program with staff supervised medications)	52 (91%)	2 (4%)	3 (5%)
Mental health treatment	51 (90%)	3 (5%)	3 (5%)
Substance abuse treatment	51 (90%)	4 (7%)	2 (4%)
Random toxicology screenings	50 (88%)	4 (7%)	3 (5%)
Treatment for unrelated medical condictions (e.g. diabetes, cancer)	47 (83%)	5 (9%)	5 (9%)

Clinical protocols

Prescribing participants were asked if they followed a standard protocol for specified steps in the pain management process (51 responded). While ninety percent reported following a standard protocol for assessing level of pain prior to developing a treatment plan, only 69% reported a standard protocol for assessing level of function. Sixty-five percent follow a standard protocol for initiating opiate pain medications, 53% for discontinuing opiate pain medications and 27% for re-initiating pain medications.

Almost 60% of respondents reported that they would prescribe opiates to a patient who did not have means to secure their medications. These respondents were then asked to qualitatively describe plans they have developed with patients to secure their medications (27 responded). The open-ended responses were categorized into major themes and listed below as frequencies. Almost half of the respondents who described their plans reported that they prescribe small or short-term amounts of opiates [Table 11]. Over 20% reported discussing safety concerns with their patients, recommending that their patients keep their medications on their person and encouraging patients to give medications to shelter staff to manage.

Table 11. Clinician plans for patient to secure opiates (Prescribers only, Open-ended, N=27)

	Frequency	Percentage
Small prescriptions, short-term dispensing, regular visits	13	48%
Discuss safety concerns of having opiates	7	26%
Keep medications on person	6	22%
Shelter staff holds and manages medications	6	22%
Keep medications in a personal lock box	4	15%
Leave medications with a trusted friend or family member	4	15%
Discourage conversations about and showing medications	3	11%
Nurse holds and manages medications	3	11%
Do not have a plan	2	7%
Keep medications in locked box or locker at shelter	2	7%
Case management	1	4%
Clinic holds medications	1	4%
Social service agency holds medications	1	4%

Successful strategies

All respondents (prescribers and non-prescribers) were given the opportunity to qualitatively describe the successful practices they encountered in managing chronic pain with patients at their sites (38 responded). These descriptions were assessed for common threads and coded based on the themes that emerged. Approximately 25% of the respondents described a set policy or protocol for managing chronic pain. Some of these included: specifying clinicians who could prescribe to a patient, requiring patients to come for follow up to receive medication refills, starting patients with non-opiate pain medications, using templates for taking medical history and assessing pain. Another 25% were able to provide non-pharmacologic treatments for chronic pain, such as acupuncture, range of motion exercises and osteopathy.

Utilizing patient/provider agreements and consent forms was another strategy used by respondents (18%), as well as asking patients to participate in regular visits to the clinic (16%). A small number of respondents (11 %) reported the use of clinic or system-wide patient registries to track prescriptions and referring patients for pain management evaluation and treatment. A few respondents (8%) reported having multidisciplinary team meetings within their sites, collaborations with agencies outside of their sites to improve the coordination of care and exploring the mental or behavioral health component of pain. A minority of respondents (3%) reported having an addiction medicine specialist on site and substance abuse groups as successful strategies. A more substantial minority of the respondents (16%) reported that they did not have or were not sure of successful strategies in managing chronic pain their sites.

Clinician challenges and needs

All participants were asked to describe the most significant challenges experienced in managing chronic pain with patients experiencing homelessness (81 responded). Qualitative responses were divided into major themes and the most frequent are noted here. The top reported challenge was medication misuse by patients, including addiction to prescribed pain medications (28%), diversion (26%) and current addiction to or use of non-prescribed substances (20%). Another major challenge for respondents was ensuring continuity of care, including patient follow up and adherence (22%), integration of care (17%), providers following established guidelines or treatment plans (14%), access to specialty services like pain clinics (12%), communication between providers (11%) and coverage of services (10%). Other challenges in managing chronic pain included evaluating chronic pain (17%), use of non-pharmacological treatments for chronic pain (17%), medication storage for patients (17%) and gaining support for opiate prescribing (11%).

Participants were asked to rank their top five gaps in knowledge and skills regarding pain management from a pre-determined list (83 responded). To create the top five gaps overall, values were removed from the rankings and tallies for each response were calculated [Table 14]. The top five gaps in pain management knowledge and services offered to patients identified by respondents were the following: availability and accessibility of non-pharmacological treatment options, availability of specialty consultation services, evidenced-based treatment options for patients with substance abuse issues, continuity of care with providers at other sites and consistent prescribing practices between providers.

Table 14. Gaps in pain management knowledge and services offered to patients (N=83)

	Frequency	Percentage
Availability and accessibility of non-pharmacological treatment options	57	69%
Availability of specialty consultation services	54	65%
Evidenced-based treatment options for patients with substance abuse issues	47	57%
Continuity of care with providers at other sites	44	53%
Consistent prescribing practices between providers	39	47%
Identifying and responding to signs of diversion	23	28%
Managing pain in patients with cognitive disabilities	23	28%
Identifying and implementing interventions to prevent future chronic pain	21	25%
Utilization of pain assessment tools and processes	17	21%
Assessing the risks and benefits of prescribing opiates	15	18%
Negotiation skills in developing treatment plans	15	18%
Understanding the experience of pain from the patient's perspective	14	17%
Treating patients with pain associated with physical disabilities (e.g. spinal cord injury)	11	13%
Patient education of treatment options and prescription use	8	10%

All participants were asked how the HCH Clinicians' Network of the National Health Care for the Homeless Council could assist their sites from a predetermined list of activities (90 responded). The most common response (82%) was for the Network to develop adapted clinical guidelines for the treatment of chronic pain in patients experiencing homelessness. The second most common response was for the Network to provide examples of pain management policies, procedures and forms from other sites (72%). Sixty-two percent of respondents would like the Network to provide trainings on pain management and fifty-nine percent want to see recommended clinical outcome measures tailored to pain management. A smaller group of participants (38%) identified advocacy for pain management policies as a way for the Clinicians' Network to assist their site.

Six participants offered additional areas in which they wanted assistance from the Network:

- Guidance on facilitating multidisciplinary treatment planning sessions
- Information on non-pharmacological therapies to assist clients with pain management
- Advocate for universal health care
- Negotiation skills in developing treatment plans
- Assessing the risks and benefits of prescribing opiates
- Managing pain in substance users

KEY FINDINGS AND RECOMMENDATIONS

In general, the results show that chronic pain is common in homeless patients and a significant issue for clinicians. However, many clinicians manage chronic pain alone, without structures or processes in place, and without enough access to specialty and non-pharmacologic care. Challenges include working with patients with past or current substance use and determining and managing addiction and diversion. Clinicians have difficulty managing chronic pain in patients with a history of addiction and find it difficult to distinguish between the two. Prescribers experience

discomfort around discussing treatment plans, diversion, and discontinuing opiates, as well as managing addiction and diversion. Despite this, most clinicians find successful pain management gratifying.

The number one way respondents reported that the HCH Clinicians' Network could assist them in their pain management needs was to develop adapted clinical guidelines for the treatment of chronic pain. The second most reported way the Network could assist was to provide examples of pain management policies, procedures and forms.

The main recommendations identified by the task force are to:

- Develop chronic pain management programmatic guidelines, which would include clinical guidelines (in progress)
- Develop a policy statement in collaboration with the Council Policy Committee regarding pain management funding and resource needs
- Develop a research project in collaboration with the HCH Practice-Based Research Network to evaluate implementation of a model pain management program, which may include qualitative interviews with providers and consumers
- Prepare a manuscript of survey results for publication

APPENDIX: PAIN MANAGEMENT SURVEY OF HEALTH CARE FOR THE HOMELESS CLINICIANS

Introduction and Consent
The HCH Clinicians' Network of the National Health Care for the Homeless Council invites you to participate in this clinician survey of the current needs and practices of providing chronic pain management for homeless patients. Please take a moment to complete this survey if you are a clinician who is in anyway involved in managing chronic pain for homeless patients. Your answers will help the Council develop resources and learning opportunities intended to improve clinical skills and health outcomes for homeless patients experiencing chronic pain. Survey participation is completely voluntary and you may stop at any time. No personally identifying information will be collected and all survey responses will remain anonymous. The survey may take approximately 20 minutes to complete.

Instructions
Please complete the following questions and statements to the best of your ability. If you do not see an appropriate answer for your self or health care site, check "other" and describe your situation. Comments should be concise as there is a word limitation on open-ended responses.

Note: for the purposes of this survey, "pain" is defined as chronic, non-malignant pain.

1. **I am a(n):** (Check all that apply)
    a. Advance practice nurse (e.g. NP or CNS)
    b. Case manager
    c. Dentist
    d. Medical assistant
    e. Mental health specialist
    f. Nurse
    g. Outreach Worker
    h. Pharmacist
    i. Physician (non-psychiatric)
    j. Physician (psychiatric)
    k. Physician assistant
    l. Social worker
    m. Substance abuse counselor
    n. Other (please specify) _____

2. **I have provided health care for the homeless population for _____ years.** (Fill in the blank)

3. **I practice in the state of _____.**

4. **I work with a:** (Check all that apply)
    a. Health Care for the Homeless grantee or subcontractor within a Community Health Center
    b. Health Care for the Homeless grantee or subcontractor within a Public Health Department
    c. Health Care for the Homeless grantee or subcontractor within a hospital system
    d. Stand alone Health Care for the Homeless grantee or subcontractor
    e. Respite care program
    f. Mobile medical unit
    g. Homeless shelter
    h. Other (please specify) _____

5. **The following clinicians at my site are routinely involved with the management of patients who experience chronic pain:** (Check all that apply)
    a. Case manager
    b. Nurse
    c. Pharmacist
    d. Primary medical provider (e.g. MD, NP, PA)
    e. Psychologist or psychiatrist
    f. Social worker
    g. Substance abuse counselor
    h. Other (please specify) _____

6. **The following pharmacological interventions for pain management are prescribed and/or dispensed to patients at my site.**

	One or more type prescribed	One or more type dispensed	Both prescribed & dispensed	Neither prescribed nor dispensed	Not sure
a. Analgesics (e.g. acetaminophen)	□	□	□	□	□
b. Muscle relaxants (e.g. cyclobenzaprine, baclofen)	□	□	□	□	□
c. Neuropathic pain medications (e.g. tricyclic antidepressants)	□	□	□	□	□
d. Nonsteroidal anti-inflammatory medications (e.g. aspirin, ibuprofen)	□	□	□	□	□
e. Opiates (e.g. codeine, hydrocodone, hydromorphone, oxycodone)	□	□	□	□	□
f. Other (please specify) _____					

7. **The following non-pharmacological interventions are available for pain management at my site or an affiliated site.**

	Available	Not Available	Not Sure
a. Acupuncture	□	□	□
b. Addiction medicine specialist	□	□	□
c. Chiropractics	□	□	□
d. Cognitive behavioral therapy	□	□	□
e. Massage therapy	□	□	□
f. Physical therapy	□	□	□
g. Yoga	□	□	□
h. Other (please specify) _____			

8. **I routinely measure level of pain in ongoing pain management of patients at my site.**
    a. Yes (please provide the name of the scale below)
    b. No
    c. Not sure

9. **I routinely measure level of function in ongoing pain management of patients at my site.**
    a. Yes (please provide the name of the scale below)
    b. No
    c. Not sure

10. **We utilize the following toxicology screens in medication management at my site.** (Check all that apply)
    a. Blood (medication-specific quantitative results)
    b. Blood (non-quantitative results)
    c. Urine
    d. Not sure
    e. We do not utilize toxicology screens at my site.
    f. Other (please specify) _____

11. **I am aware of the following structures, processes, and materials that exist at my site to assist with pain management:** (Check all that apply)
    a. Addiction medicine specialist on staff
    b. Case conferences
    c. Case management
    d. General policy and procedures
    e. Informed consent for use of opiates
    f. Pain groups
    g. Pain management specialist on staff
    h. Patient/provider agreement for treatment with opiates
    i. Registry or list of patients on opiates
    j. Special guidelines for clients from substance abuse rehabilitation facilities
    k. Standardized progress notes for patients on opiates
    l. Trainings
    m. None – We do not have structures to assist with chronic pain management.
    n. Other (please specify) _____

12. **I agree with the following statements regarding chronic pain management at my site.**

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
a. I find successful pain management gratifying.	1	2	3	4	5
b. I frequently struggle with issues surrounding pain management.	1	2	3	4	5
c. It is difficult to manage pain in patients with a history of addiction.	1	2	3	4	5
d. It is difficult to distinguish between managing pain and addiction.	1	2	3	4	5
e. Pain management is a significant issue in my practice.	1	2	3	4	5
f. Managing chronic pain is a priority at my site.	1	2	3	4	5
g. We adequately manage pain at my site.	1	2	3	4	5

13. **On average, I spend time managing chronic pain in _____ percent of patient visits.** (Fill in the blank)

14. **I am licensed to prescribe opiates.****
    a. Yes (continue to 15)
    b. No (skip to 24)

This section is for licensed opiate prescribers ONLY.

15. **Of the patients with whom I spend time managing chronic pain, I currently prescribe opiates to ____ percent of those patients.**

16. **I follow a standard protocol for the following steps in pain management:** (Check all that apply)
    a. Assessing level of pain prior to developing treatment plan
    b. Assessing level of function prior to developing treatment plan
    c. Initiating opiate pain medications
    d. Discontinuing opiate pain medications
    e. Re-initiating opiate pain medications (after discontinuation)

17. **I feel comfortable discussing the following topics with patients:**

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
a. Non-physical aspects of pain (e.g. psychological)	1	2	3	4	5
b. Non-pharmacological treatment options	1	2	3	4	5
c. Opiate medications	1	2	3	4	5
d. Non-opiate medications	1	2	3	4	5
e. Developing a treatment plan for severe chronic pain	1	2	3	4	5
f. Diversion (selling or trading prescribed opioids)	1	2	3	4	5
g. Discontinuing opiate treatment when indicated	1	2	3	4	5

18. **I prescribe opiates to patients that may not have means to secure their medications (e.g. living in homeless shelters or on the streets, lacking a personal "locker").**
    a. Yes (In the space provided below, please describe plans you have developed with patients to secure their medications)
    b. No

19. **I would consider prescribing opiates to a patient with _____ alcohol:** (Check all that apply)
    a. Episodic use of
    b. Abuse of
    c. Dependence on
    d. Historical use of (i.e. in remission or recovery from)
    e. I would not prescribe opiates in any of these situations

20. **I would consider prescribing opiates to a patient with _____ illegally obtained sedatives, such as benzodiazepines.** (Check all that apply)
    a. Episodic use of
    b. Abuse of
    c. Dependence on
    d. Historical use of (i.e. in remission or recovery from)
    e. I would not prescribe opiates in any of these situations

21. **I would consider prescribing opiates to a patient with _____ illegally obtained opiates.** (Check all that apply)
    a. Episodic use of
    b. Abuse of
    c. Dependence on
    d. Historical use of (i.e. in remission or recovery from)
    e. I would not prescribe opiates in any of these situations

22. **I would consider prescribing opiates to a patient with _____ stimulants, such as cocaine or methamphetamine.** (Check all that apply)
    a. Episodic use of
    b. Abuse of
    c. Dependence on
    d. Historical use of (i.e. in remission or recovery from)
    e. I would not prescribe opiates in any of these situations

23. **When prescribing opiates in the treatment of chronic pain, I believe it is ethical *when indicated* to require patient participation in the following:**

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
a. Controlled environment (e.g. program with staff supervised medications)	1	2	3	4	5
b. Mental health treatment	1	2	3	4	5
c. Non-opiate treatment of pain management	1	2	3	4	5
d. Pain management contract	1	2	3	4	5
e. Random toxicology screenings	1	2	3	4	5
f. Substance abuse treatment	1	2	3	4	5
g. Treatment for unrelated medical conditions (e.g. diabetes, cancer)	1	2	3	4	5
h. Other (please specify below) _____					

This section is for ALL providers.

24. **The most significant challenges I experience in managing chronic pain with patients experiencing homelessness are:** (Open ended)

25. **I see the following gaps in pain management knowledge and services offered to my patients:** (Rank the top 5 gaps – with 1 being the largest gap)
    a. Assessing the risks and benefits of prescribing opiates
    b. Availability and accessibility of non-pharmacological treatments options
    c. Availability of specialty consultation services (e.g. pain, addiction medicine)
    d. Consistent prescribing practices between prescribers
    e. Continuity of care with providers at other sites (e.g. medical clinics, medical respite care facilities, emergency departments)
    f. Evidence-based treatment options for patients with substance abuse issues.
    g. Identifying and implementing interventions to prevent future chronic pain
    h. Identifying and responding to signs of diversion
    i. Managing pain in patients with cognitive disabilities
    j. Negotiation skills in developing treatment plans
    k. Patient education of treatment options and prescription use
    l. Treating patients with pain associated with physical disabilities (e.g. spinal cord injury)
    m. Understanding the experience of pain from the patient's perspective
    n. Utilization of pain assessment tools and processes
    o. Other (please specify) _____

26. **The Health Care for the Homeless Clinicians' Network of the National Health Care for the Homeless Council can assist my site in addressing our pain management needs by:** (Check all that apply)
    a. Advocating for pain management policy changes
    b. Developing adapted clinical guidelines for the treatment of chronic pain in patients experiencing homelessness
    c. Providing examples of pain management policies, procedures and forms from other sites
    d. Providing pain management trainings (you may specify topics in the next question)
    e. Recommending clinical outcome measures tailored to pain management
    f. Other (please specify) _____

27. **Clinicians and homeless health care sites need training and support regarding pain management in the following areas:** (Open ended)

28. **We have found the following practices and programs to be particularly successful at our site for treating homeless patients with severe chronic pain:** (Open ended)

29. **If I could ask my patients any question about pain management, I would ask them this:** (Open ended)