Regulating Complexity

In this month’s issue of *Pain Medicine*, Dr. Hadjistavropoulos and colleagues outline clinical and policy recommendations to improve pain control for older adults in long-term care facilities in both Canada and the United States. This article accurately and succinctly outlines the scope of the pain epidemic in both the United States and Canada. The authors acknowledge that as many as 80% of older adults in long-term care report some level of pain [1]. This threatens to become an international health care crisis with the aging of both countries’ populations. Twenty percent of the United States and Canada is predicted to be over the age of 65 years by the years 2040 and 2031, respectively [2,3]. The authors are very sensitive to the challenges that have been traditionally faced when implementing educational programs, guidelines, and policy, as well as the lack of a true clinical improvement seen with years of research and quality improvement. The authors convened an interdisciplinary panel of leading clinicians and administrations from both countries. The panel was intent on creating a set of recommendations that could be rapidly implemented to improve the interface between policy and clinical care.

I commend the authors for approaching this integrative challenge with sensitivity and realism in regard to the barriers that face implementation of public policy and prevent translation into improved clinical outcomes. However, in an effort to ameliorate suffering, I would argue that it is easy to forget that pain is a syndrome with multiple contributors, especially in this complex, dynamic, and vulnerable population. Pain refers to a cadre of neurologic, visceral, somatic, emotional, psychological, spiritual, and cognitive pathology. It cannot be rapidly assessed in a 5-minute snapshot and then treated pharmacologically. I believe that a simple assessment tool and rapid care plan undervalues the benefit of true interdisciplinary work and may actually divert resources during the first 24 hours of the admission and a critical adjustment period for the patient. Long-term care should be a consistent and nurturing environment for residents. We should be encouraging teams to familiarize themselves with the complexities of these patients and to embrace all potential contributors to suffering. If physical pain has not already been addressed in the acute care setting, a standing order for medication should suffice in the short term.

Long-term care facilities will need to plan and gear up for chronic disease and symptom management with multifactorial contributors. The field is rapidly growing in size and complexity. The authors acknowledge that 32% and 14% of adults older than 85 years of age are currently residing in nursing homes in Canada and the United States, respectively [4,5]. It is also important to acknowledge that 25–30% of Americans currently die in nursing homes, and this number is predicted to rise [6]. Nursing home placement is a marker for mortality. In 1986, 58% of persons over the age of 85 years old admitted to a long-term care facility died within that year [7]. A major challenge in improving pain control for older adults in long-term care, or more realistically improving quality of life, is changing the therapeutic culture and clinical goals. Identifying a single cause of pain with a pharmacologic intervention and improvement overtime is a curative model of treatment. A palliative model is likely to improve clinical outcomes by adjusting expectations, embracing symptom management and ongoing reassessment. These residents are dynamic patients with changing needs and physiology as well as increasing complexities.

The disease burden and frailty of nursing home residents is well recognized. Placement is often a stigma for abandonment and can complicate the first few days to weeks of an admission. There is an emotional, social, and philosophical adjustment that comes with nursing home residency. Families are often anxious and unfamiliar with the facility and routine; patients may be disoriented, frightened, or lonely. In addition to a loss of independence, fear of illness, and possible death, a loss of personhood and identity may be complicating perception of symptoms and assessment of needs. In the short term, it would improve communication, build trust, and decrease anxiety to rush to outline the patients’ expectations and goals of care. Certainly a need for pain medication may be identified in this process, but the goal would be to open
dialogue and prioritize the patients’ most troubling symptom.

As Hadjistavropoulos and colleagues acknowledge, pain management is specialized work that requires specific training in geriatrics and access to appropriate medications and providers. The authors identify that policy support is needed to maximize benefit from the use of nurse practitioners. They also highlight the need for long-term care facilities to be responsible for provision of appropriate resources, infrastructure, and public transparency when caring for elders. The policy recommendations emphasize the need for financial, clinical, and physical support without mandating a specific performance measure to achieve improved pain control and new models of care. But where precisely should clinical care and policy interface to optimize pain management for those residing in long-term care facilities? Although documentation of pain evaluation and management is a requisite for facility certification, there is often a disconnection between documentation and true clinical impact. We need to expand clinical recommendations and challenge our local providers to embrace the complexities of pain control, establish appropriate and meaningful assessments, improve team communication, maximize resources available, and document system and clinical improvements. The variability in patient cultures, clinical expectations, nursing home size, financial resources, location, and clinical affiliation may make continental regulations impractical.

The true clinical-policy interface occurs at the level of the direct care provider. A comprehensive and ongoing assessment of pain and suffering requires more than a snapshot of the patient at a standard interval. If we are truly interested in behavioral changes, effectiveness of pain control, ability to perform, or tolerate activities of daily living provision, appetite, cognition, or emotional well-being, we need to be training and empowering our hands-on providers. This is often the staff member with the most intimate relationship with the patient and family. They are often able to identify personal stressors and changes in condition, which are sources and symptoms of pain. A single pain champion will not be able to provide the ongoing support necessary to achieve true pain control. They cannot substitute for the intimacy and familiarity that comes with a continuum of care. A champion may be appropriate to liaison between staff and prescriber, and establish systems of communication and/or care planning.

It is easy to agree that we need to improve pain control in both the United States and Canada for our older adults in nursing homes. It is much more difficult to create clinical guidelines that are not onerous and result in improved care for the patient. We should be setting clinical goals rather than procedures, and then establish the policy to maximize resources available to long-term care facilities so that they can achieve these expectations on a local level. The nursing home themselves may be more adept at recognizing and harnessing their strengths. Appealing to these groups and harnessing their energy and values may provide a more caring and successful environment.

In conclusion, we need to remember pain is a complex syndrome that cannot be assessed in a snapshot. Our nursing home populations are growing in size and complexity. We need to foster ownership and creativity on the direct caregiver level. Public policy should reflect that our trained providers are our local experts at the interface of regulation and clinical care. A bottom-up approach to improving pain control, quality of life, and clinical outcomes in the nursing home, complimented by appropriate regulatory and financial support, will likely lead to a healthy competition, creativity, and, ultimately, success.

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