Opioids Pain and Addiction-
Beyond the Realm of Hungry Ghosts

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Central City Concern
Disclosures

• No disclosures
Learning Objectives

• 1. Understand more about how pain patients behave and what drives aberrant behavior.
• 2. Discuss care transformation for patients with pain and Rx opioid use that occurred over the past two decades at CCC.
• 3. Understand evidence-based approaches to caring for patients with pain who meet criteria for a substance use disorder.
• 4. Discuss an integrated system of care for these complex patients and what success looks like.
What is Central City Concern?

• 1. Network of 13 FQHC’s and CMHC’s in the Portland Metropolitan region.
  • Actively serving primary care and mental health population of 8,600+
  • Medically disenfranchised patients <200% FPL
  • Frequent co-occurring SPMI, SUDS, High Medical Acuity/Complexity

• 2. SUD services embedded within the above and freestanding programs serve another 5,500 patients annually.
  • Hooper Detoxification Center
  • Letty Owing Center
  • Eastside Concern and 5 additional SUDS programs
Overdose deaths are the tip of the iceberg

For every 1 prescription opioid overdose death in 2010 there were...

- 15 abuse treatment admissions
- 26 emergency department visits
- 115 who abuse/are dependent
- 733 nonmedical users

$4,350,000 in healthcare-related costs

SAMHSA NSDUH, DAWN, TEDS data sets.
How do patients with access to Daily Opioid Therapy Behave?

• 1. Est. 35% of patients taking C.O.T. meet criteria for Opioid Use Disorder.
• 2. 71% of claimants receiving C.O.T. > 3 months are not taking their medications as prescribed.
• 3. Among “chronic pain population” with sample of 939,000 urine drug screens;
  ▪ 38% medication was absent
  ▪ 29% non-prescribed opioid medication
  ▪ 27% medication levels higher than prescribed
  ▪ 11% illicit drugs

ABSENT from this analysis was ETOH Consumption

• Andy to Add Reference Source
The “experience” of opioid analgesia

- Occurs as a potentially novel and unique experience for each patient with each exposure.
  - Opioid analgesic → Mid-brain dopamine release
    - The SAME Survival-Based Reward/Reinforcement pathway that leads to addictive drive/behavior.

The human midbrain is tasked with integrating the ‘intensity’ of the pain signal with the ‘intensity’ of the analgesic signal.

Mismatch = Euphoria or Inadequate Analgesia

What about potentiation with ETOH or other illicit substances?
A Definition of “Salience”

Webster’s: “The state of being prominent”

- Consider salience in the setting of pain:
  Analgesia → Fundamentally emotional dissociation from the experience of physical distress.

- What about medication induced: euphoria/reinforcement?
- What about opioid hyperalgesia?
- What about therapeutic dependency?
- How do these lines blur over time?
Intro Questions?
Evolution of CCC Pain Management Care: 2000-2018

• 1. “Misbehaving” patients needed management, not abandonment.
   • Pain is a co-occurring condition for many patients who use substances other than opioids.

• 2. Adoption of IOM/CDC Prescribing Recommendations

• 3. Wider knowledge regarding evidence-based practices regarding the treatment of opioid use disorder with Buprenorphine/naloxone or Methadone.
The CCC Experience of Population Transformation: **Patient Identification**

• 1. Patient identification

• 2. What tools were utilized to identify a person with a possible substance use disorder?

• 3. Once identified, what were the next steps to create a patient-centered frame for intervention?
Evidence-Based Approaches to Caring for Patients with Pain and Substance Use Disorders

• 1. What did CCC Build?
  • Continuum of care “track” based on risk and complexity of individual patients
  • All behavior can be understood if we understand the context
  • All people “behave” in order to get a need met

• 2. What is “Hot Sauce”?
  • The most complex patients are the “spiciest”, the Hot Sauce that challenges our providers and the systems we work in
  • “If not us, then who? If not now, then when?”
  • The most complex patients (co-occurring pain, SUD, MH, and other health issues) are the patients we strive to treat.
  • If we can deliver on a care plan that helps these patients, then we have successfully treated the whole person. That’s mission-driven and the right thing to do.
Evidence-Based Approaches to Caring for Patients with Pain and Substance Use Disorders

• 3. How does it work—what is the programming?
  • Medical providers (or others on the Care Teams) become aware of potential behavior outside of agreement for pain medications and/or co-existence of other SUD.
  • Referral to Controlled Substance Review Committee (interdisciplinary team – meets weekly to review cases)
  • Referral to Hot Sauce when determination is made that co-occurring pain, Rx, and SUD present a risk that is likely to benefit from SUD treatment groups, counseling, skill-building
  • Patient may continue on pain medications or may switch to buprenorphine depending on CSRC recommendation and interdisciplinary, collaborative treatment planning
  • 12-week curriculum. Patient completes program when all 12 weeks are attended
  • “Skills and pills”
    • Consistently observed transformation from arms crossed to arms wide open (mind, body, spirit as well)
  • Curriculum includes equal parts of SUD, pain management, Chinese medicine, experiential (Qi Gong and acupuncture)
Evidence-Based Approaches to Caring for Patients with Pain and Substance Use Disorders

• 4. Data on the Program
  • Introduced in 2013 with data available from 01/01/2016
  • 41 patients
  • 274 groups attended
  • Decreased referral and attendance from 2016 (189) – 2017 (75) of 60%, which correlates with decreased prescribing of pain medications resulting in smaller pool of potential referrals and increased buprenorphine prescribing for OUD with increased enrollment in other SUDS groups within Primary Care.
“Hot Sauce” Data
The CCC Experience of Population Transformation: Integrative Treatment

• 1. What was the patient experience?
  • How did this experience change over the past 8-9 years?

• 2. How clinical boundaries are set and what did the patient’s experience look like after intervention?

• 3. What did you learn?

• 4. What do we know about this patient population?
Changing Course in Opioid Therapy: Evidence-Based Approaches to Pain and Addiction

• 1. These medications change neurobiology profoundly.

• 2. Nearly all patients have been through a withdrawal experience at some point.
  • PTSD-like response for some patients
  • Programmed withdrawal avoidance
  • Resistance to change is default pathway

• 3. Introspective/perceptive impairment of the patient that is therapeutically dependent, independent of the presence or absence of a SUD.
A spectrum of patients with pain.

Disabled 58 y.o.
Six spine surgeries
Cervical+ Lumbar
Asperger’s syndrome

Divorced 37 y.o. 2 kids
L-Spine w a/p Fusion
4 level C bilat
foramenotomies

College-bound 26 y.o.
C4-T2 bilat laminectomies with
Posterior fusion of all levels
Buprenorphine in the setting of Pain and Addiction

• 1. A standard of care for more than 14 years.

• 2. What has your observation been regarding this patient cohort?

• 3. What does it look like when it doesn’t go well?

• 4. What does it look like when it goes well?
Elements of an Integrative System of Care

• 1. Values and Ethics that inform clinical operations?

• 2. Key elements that ensure a Minimum Viable Program (MVP)?

• 3. Outcomes/Data

• 4. Partnerships that help acknowledge that individuals are consumers of healthcare across the continuum.
ASAM
THE NATIONAL PRACTICE GUIDELINE
For the Use of Medications in the Treatment of Addiction Involving Opioid Use

Medications for Opioid Use Disorder
For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

TREATMENT IMPROVEMENT PROTOCOL
TIP 63

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder
Opioid Use Disorder Patient Experience


Employer → Family → Insurance Payer

Outpatient Tx. (+/- MAT)
A Fully Integrated Medical Home for Recovery within Primary Care

A FULLY DEVELOPED SYSTEM: Accountable Care Organization

ER
IC
Clinic

Inpatient

Addiction Medicine Service-Primary Care Clinic

Drug Tx

IOP

OP

Sober Housing
Restitution Center (CJ)
OTP (methadone) and/or Suboxone

Case Management/Recovery Management
THANK YOU

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