Opioids Pain and Addiction- Beyond the Realm of Hungry Ghosts

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Disclosures

- No disclosures

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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.

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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

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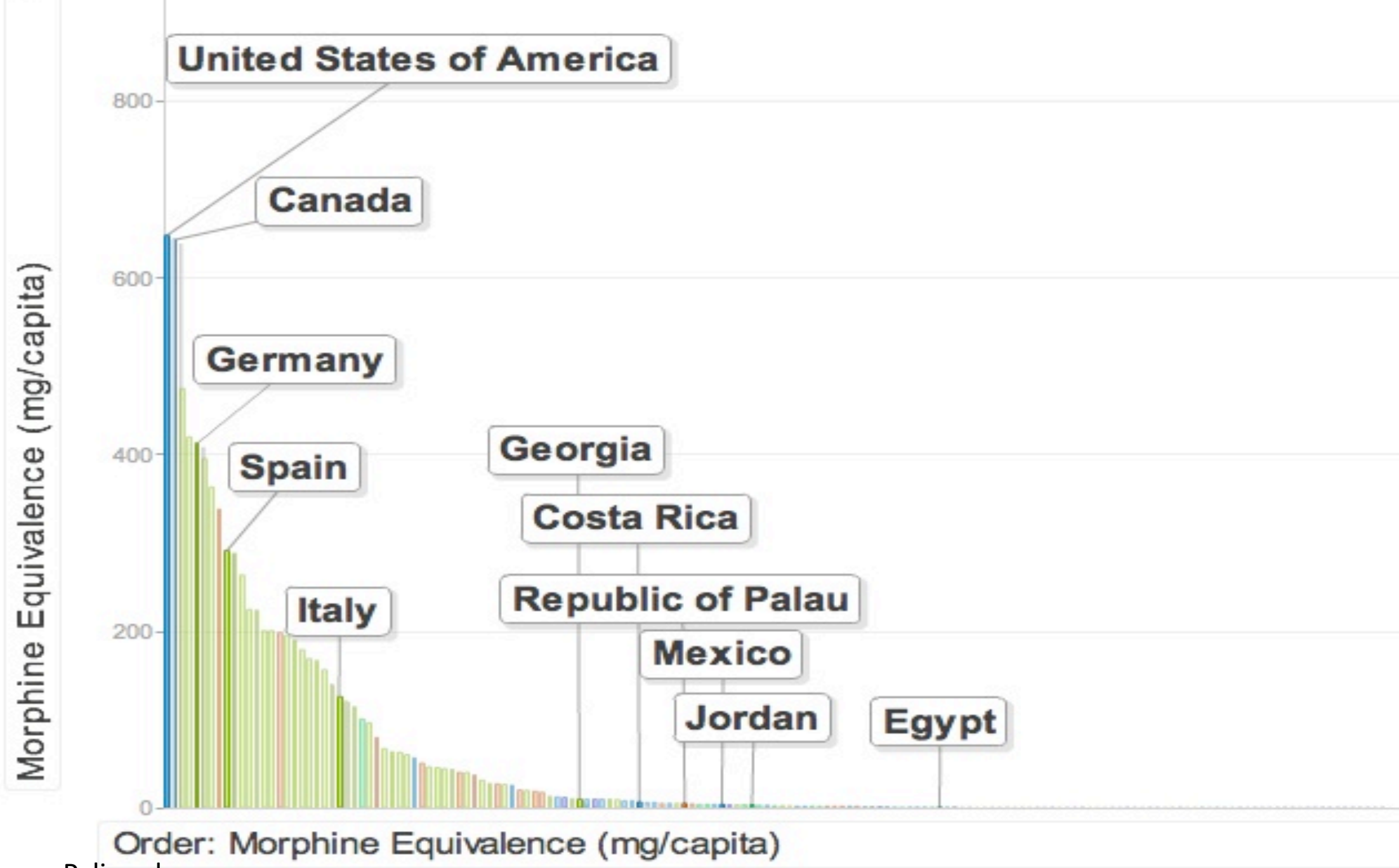

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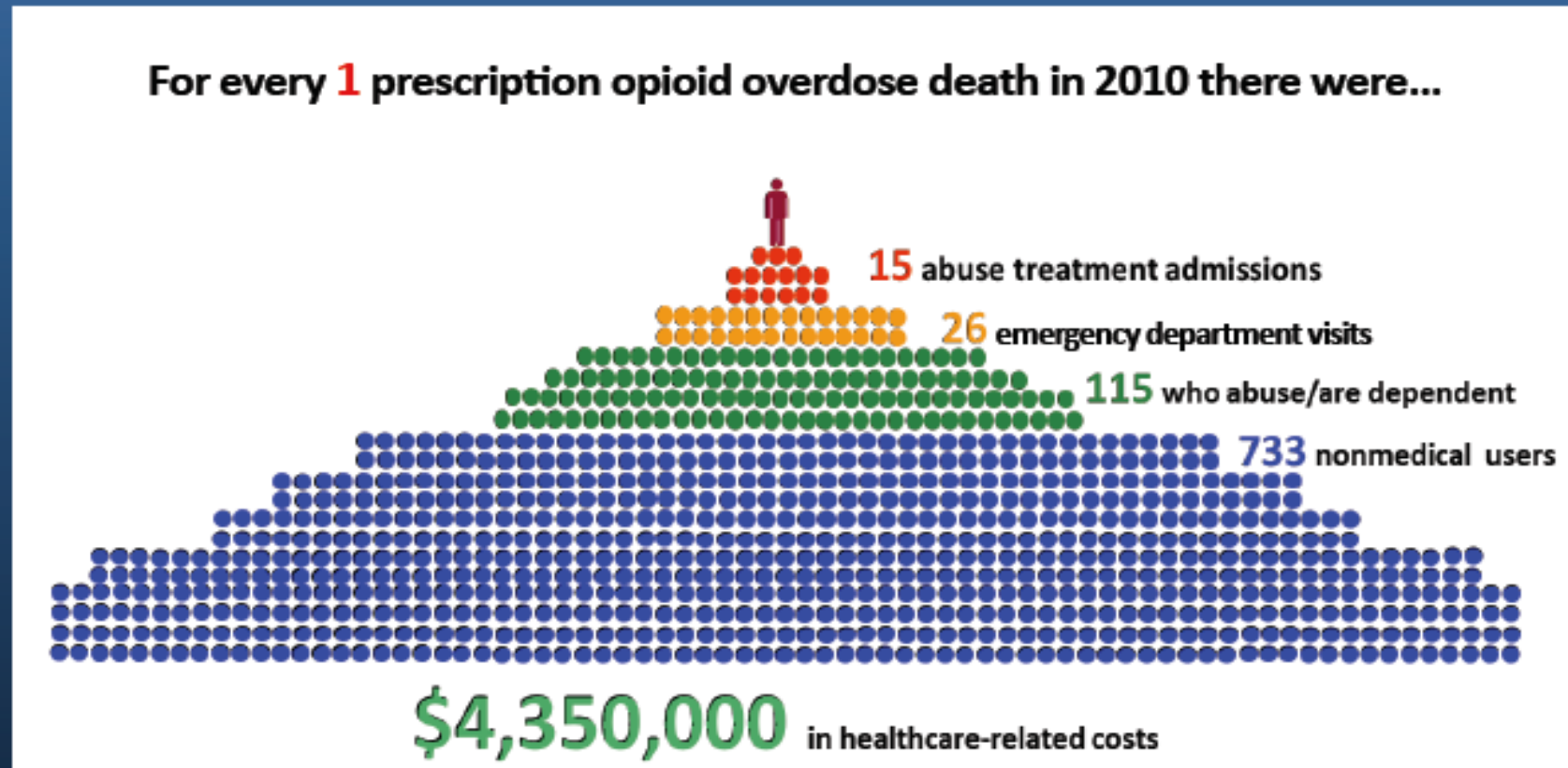
Palimed.org

Overdose deaths are the tip of the iceberg



SAMHSA NSDUH, DAWN, TEDS data sets.

Coalition Against Insurance Fraud. Prescription for Peril. http://www.insurancefraud.org/downloads/drugDiversion.pdf 2007.

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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

  <u>ABSENT from this analysis was ETOH Consumption</u>
  - Andy to Add Reference Source

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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?

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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?

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Intro Questions?

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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 opiods.

- 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.

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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?

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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.

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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)

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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.

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“Hot Sauce” Data

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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?

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Changing Course in Opioid Therapy: Evidence-Based Approaches to Pain and Addiction

- 1. These medications change neurobiology profoundly.

- 2. Nearly all patents 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.

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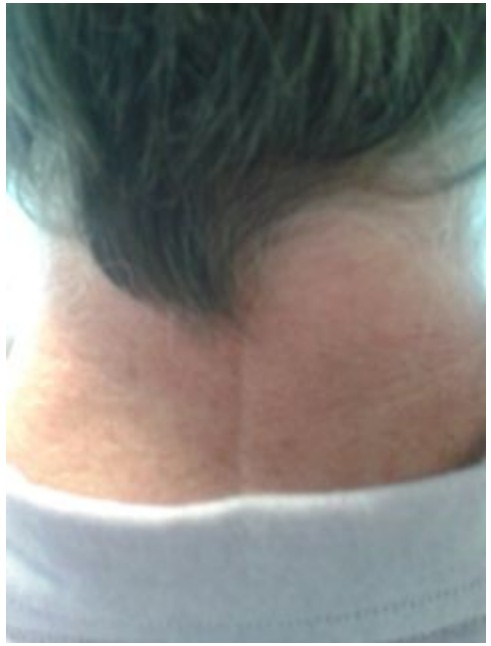
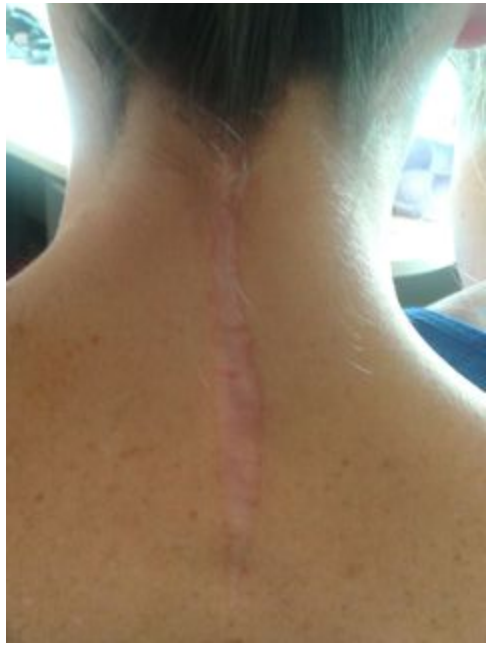
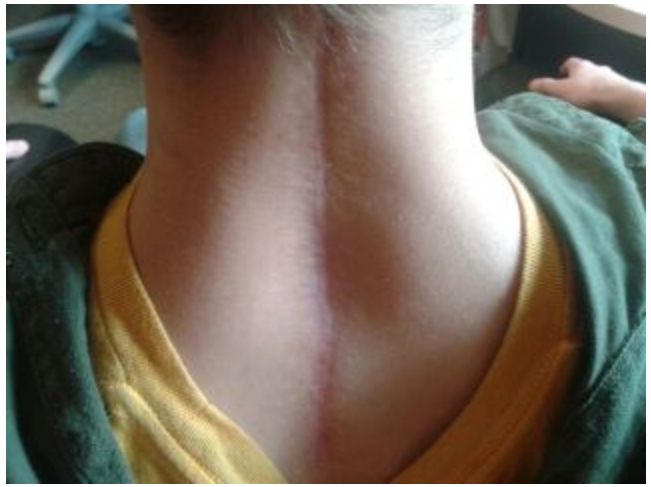
A spectrum of patients with pain.



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

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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?

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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.

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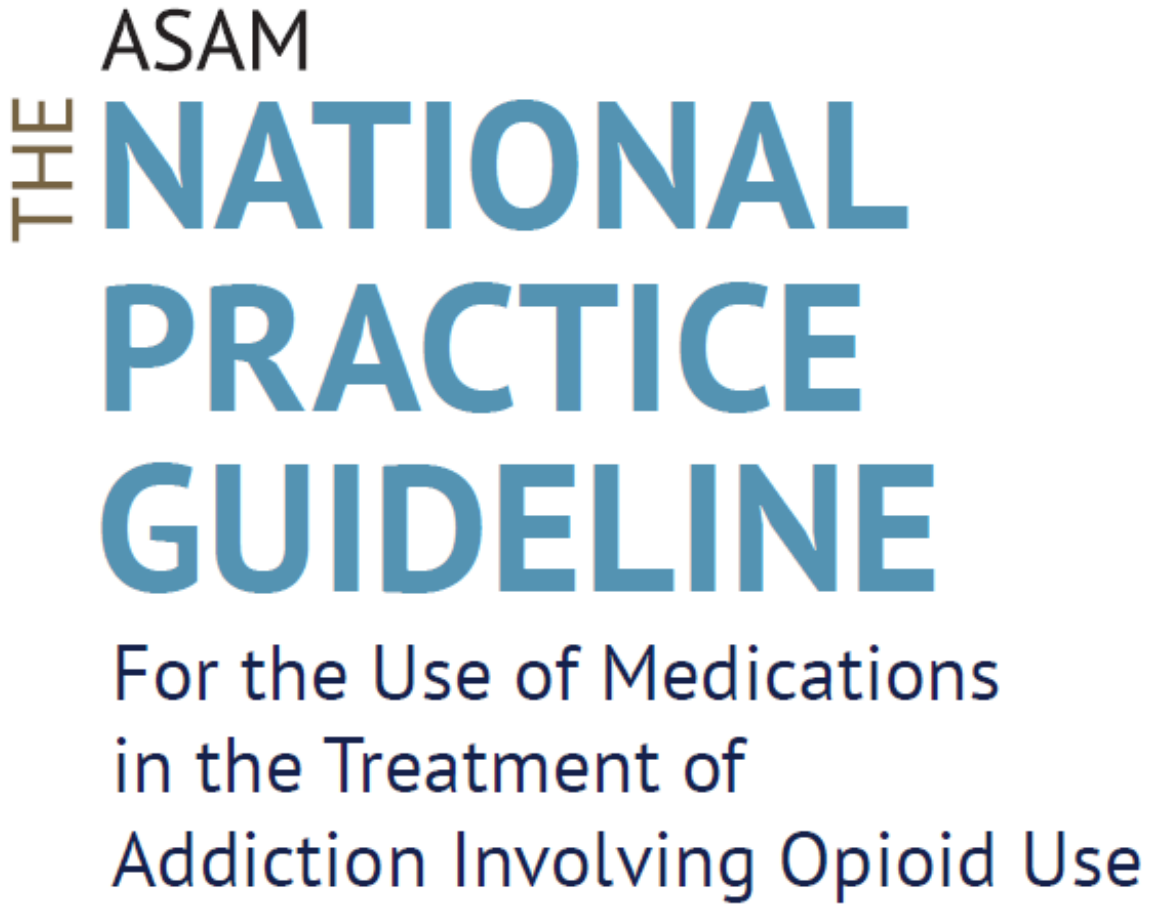

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http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf

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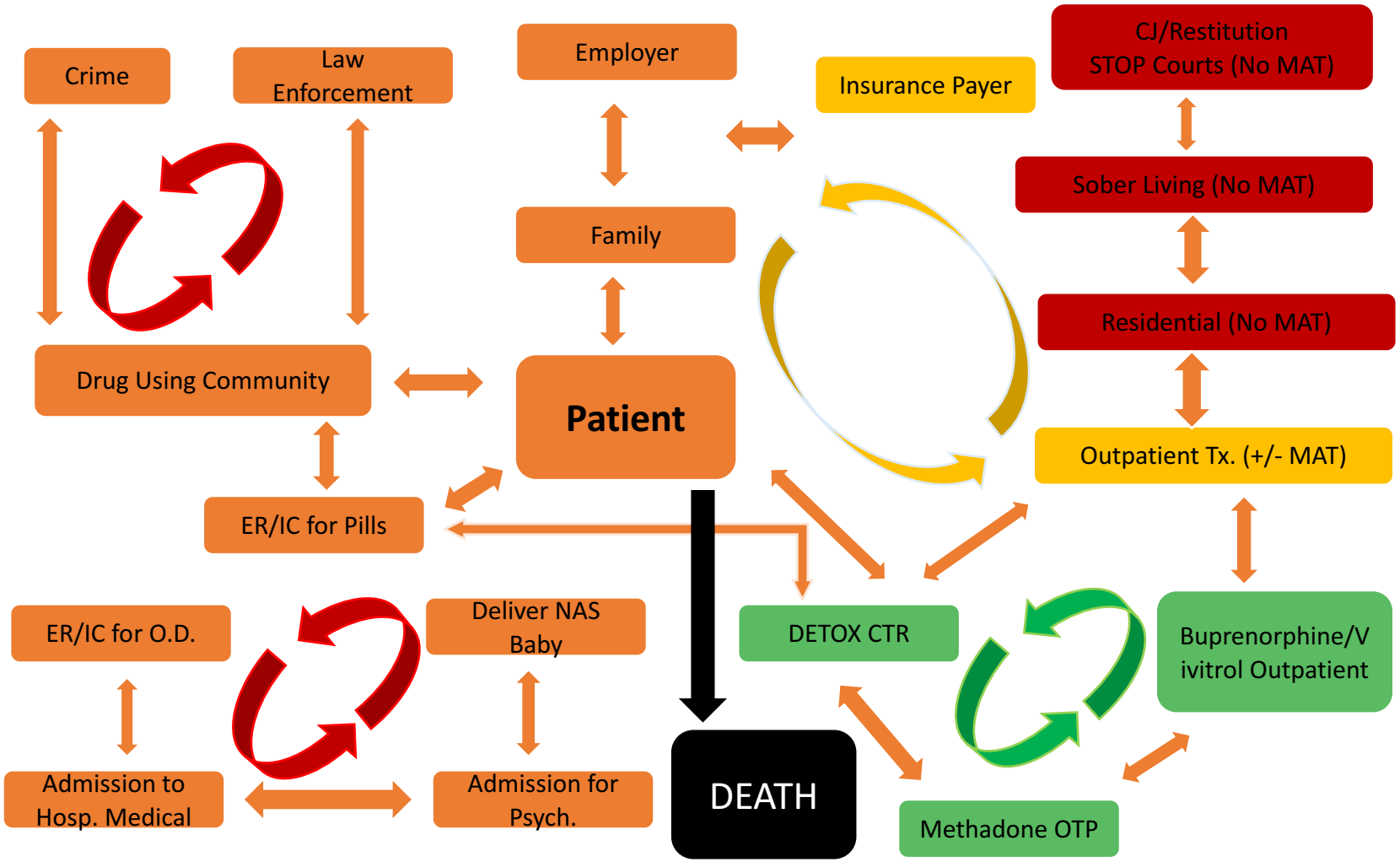
https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder

Opioid Use Disorder Patient Experience



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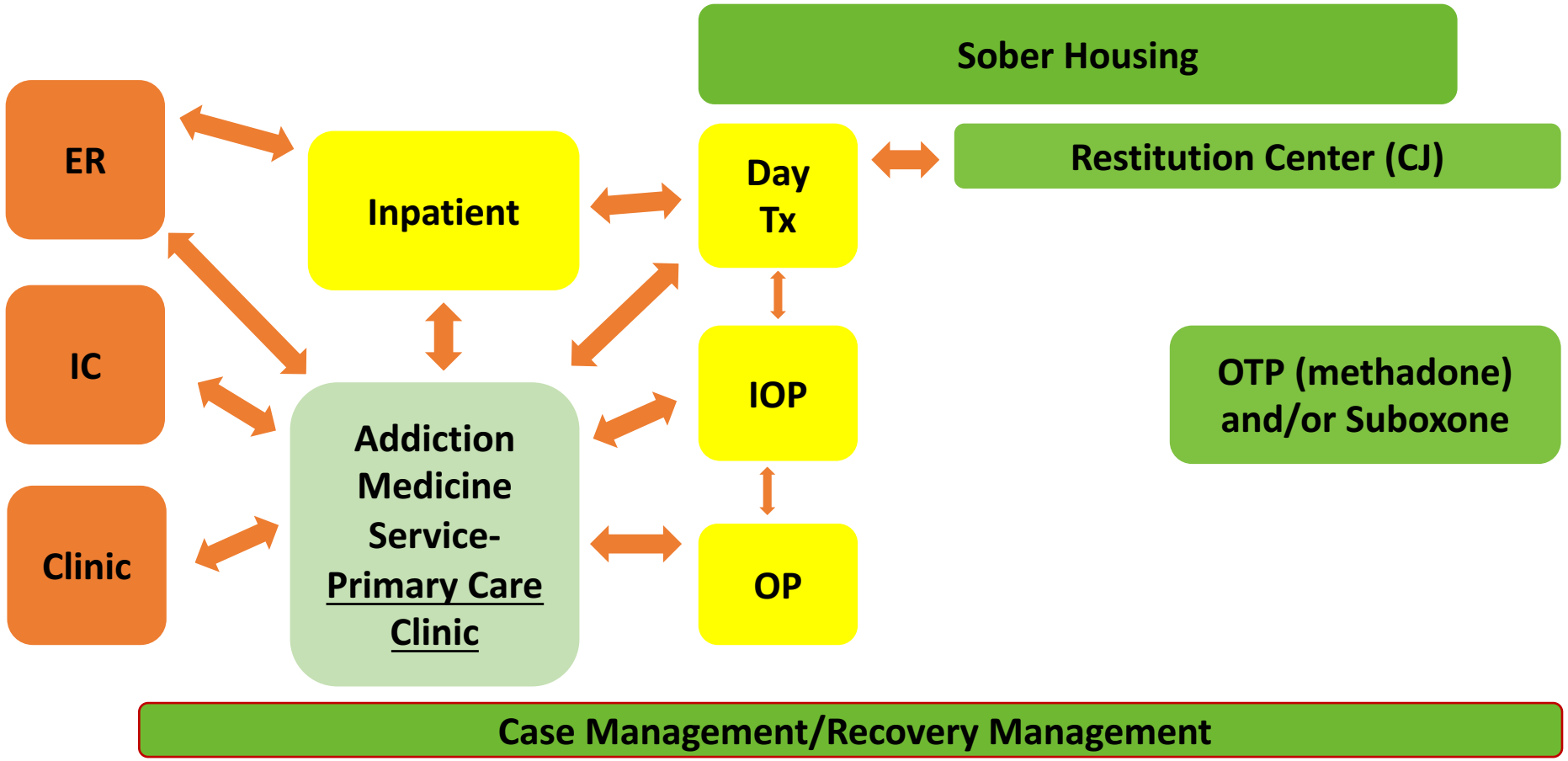
A Fully Integrated Medical Home for Recovery within Primary Care

A FULLY DEVELOPED SYSTEM: Accountable Care Organization



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THANK YOU

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