OREGON'S OPIOID CRISIS: SOLUTIONS FOR LOW RESOURCE SETTINGS

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OVERVIEW

Agreements

Brief overview of pain and addiction

Contextualize the opioid crisis

Why rural location makes it worse

Introduction to Opioid Use Disorder (OUD)

Review indications for medication assisted therapy (MAT)

Discuss models for MAT in outpatient, lower-resourced settings

Case study- One Community Health

AGREEMENTS

We helped create this problem. 'Legacy' patients were created by a system influenced by a myriad of forces, including:

- JACHO (pain as a vital sign)
- Pharma influence on prescribers and patients
- Patient satisfaction scores
- The FFS model, avoiding hard/difficult conversations, promoting turnover
- Economic influences (the more patients we see and the shorter visits have a financial benefit)

This is a uniquely American problem. We are 4% of the world's population, and use 80 % of its opiates

This is **still** an issue– 60 Minutes/Washington Post article on influence of the drug industry on DEA/DOJ

TIME OUT

Patients with chronic pain experience stigma in a variety of care settings

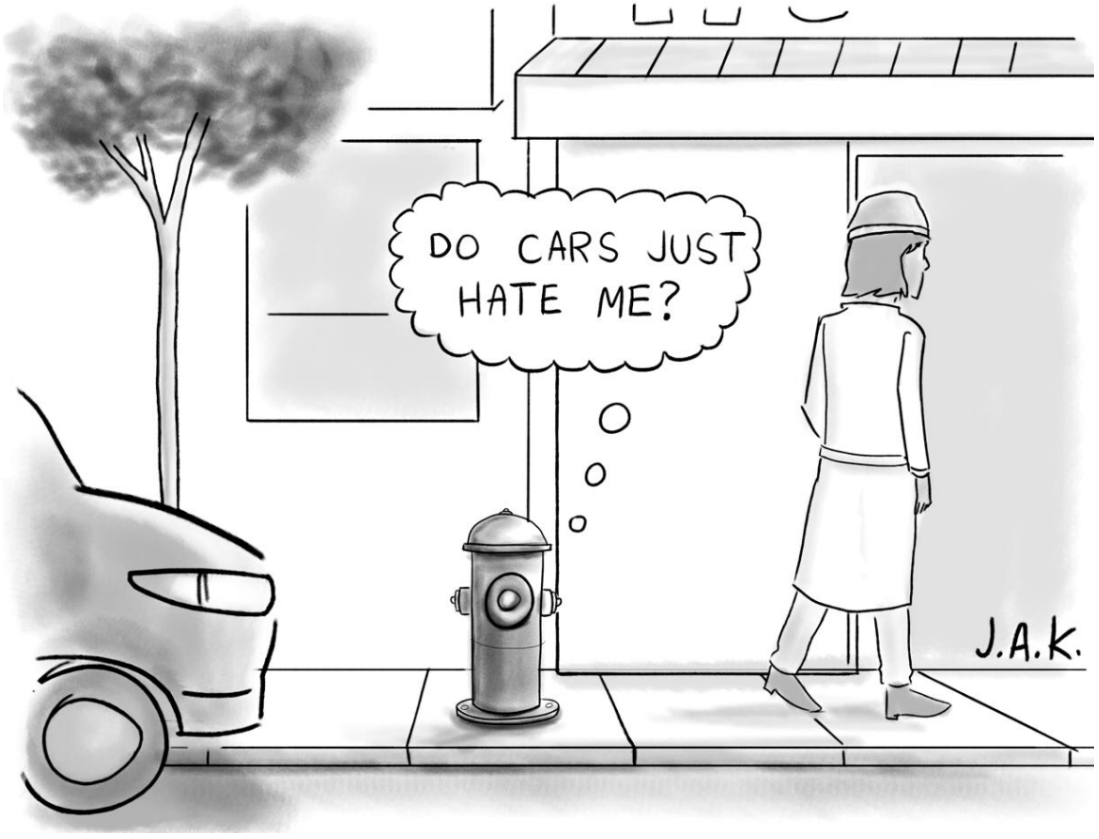
- This can be difficult for providers and staff, but can also be an opportunity

Fire hydrant = chronic pain patient

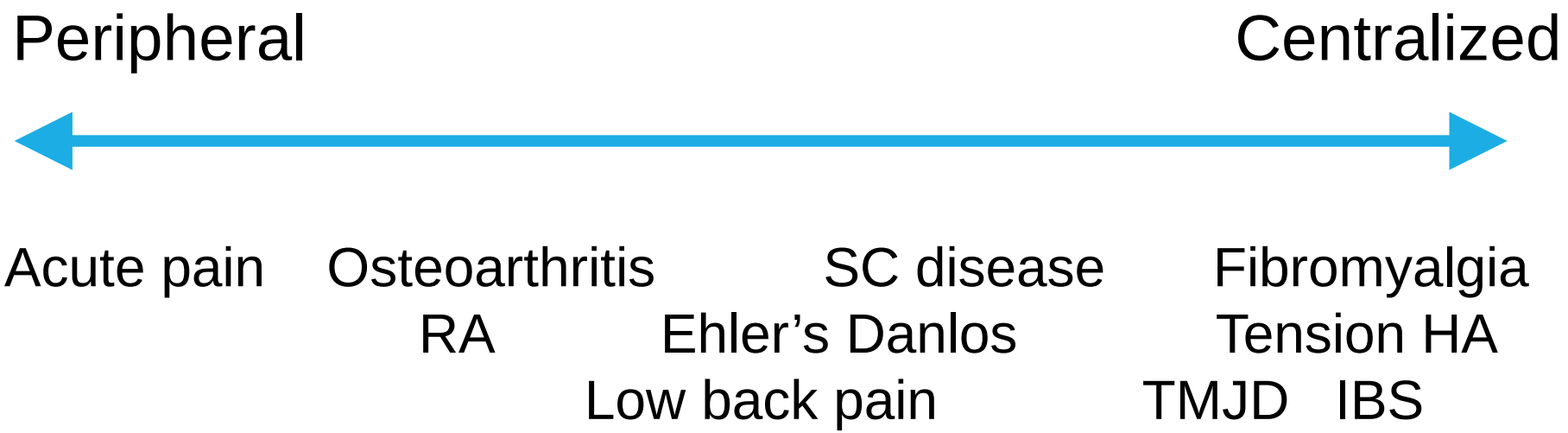
Cars = medical establishment

Reminder: this a patient population that

we all created.



PAIN PRIMER: THE SPECTRUM



Managing Chronic Pain: If Opiods, Then What? Clauw, DJ. 2017

PAIN PRIMER: ORIGINS

	Nociceptive	Neuropathic	Centralized
Cause	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
Clinical features	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
Screening tools	Ask the patient	PainDETECT	Body map or FM Survey
Treatment	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies. **NOT opiates.**
Classic examples	Osteoarthritis Autoimmune disorders Cancer pain Acute injury	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain syndrome

EFFECTIVENESS OF CHRONIC PAIN TREATMENTS

Opioids: *No Quality Evidence*

"No study of opioid therapy vs. placebo, no opioid therapy, nor nonopioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life."

Adjuvants (Tricyclics/SNRIs/Anticonvulsants):	30%
Cannabis:	10-30%
Acupuncture:	10^{+}%
Patient education:	15%
CBT/Mindfulness:	30-50%
Physical fitness:	"moderate"
Sleep restoration:	40-50%

Chou R, et al. Ann Intern Med. 2015; Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Cherkin D et al. JAMA 2016.

YET, WE (STILL) USE OPIATES FOR CHRONIC PAIN?

This is why we are here.

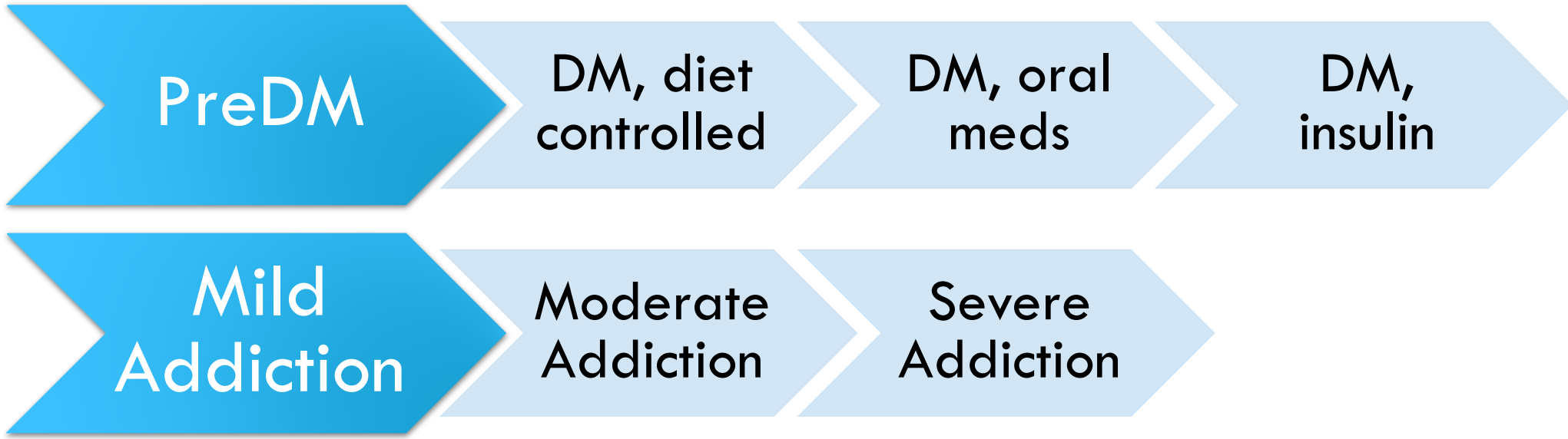
Our change of practice in chronic pain management has created a massive challenge to our system.

Many patients have become addicted to opiates for perceived functionality. This creates stigma, frustration, and harmful behaviors.

While many patients will be able to discontinue opiates, some will not. This requires our comfort, understanding, and expanded management of addiction.

COMPARISON: DIABETES VERSUS ADDICTION

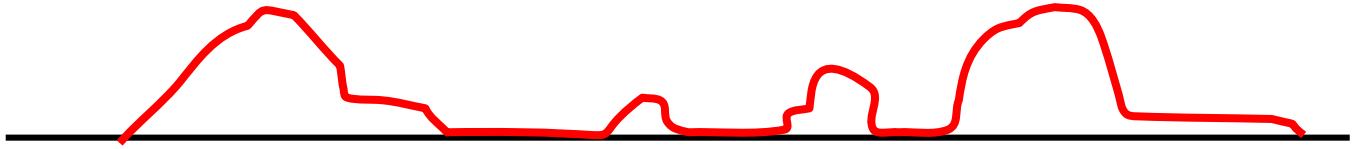
Why do we define success as binary for addictions?



SUBSTANCE USE DISORDERS: CHRONIC ILLNESS VERSUS MORAL FAILING

Asthma, Diabetes, HTN, HIV, etc.

Substance Use Disorder



Disease Activity

Time

O'Connor, JAMA 1998; Lucas, JAIDS 2005
Solotaroff, Neurobiology of Pain and Addiction, 2017

INTRODUCTION TO OUR PATIENT

58 y/o female, wheelchair bound d/t weakness/deconditioning

Inherited on ~200 MED, MS contin w/ IR morphine

Significant trauma history (ACE score >>4)

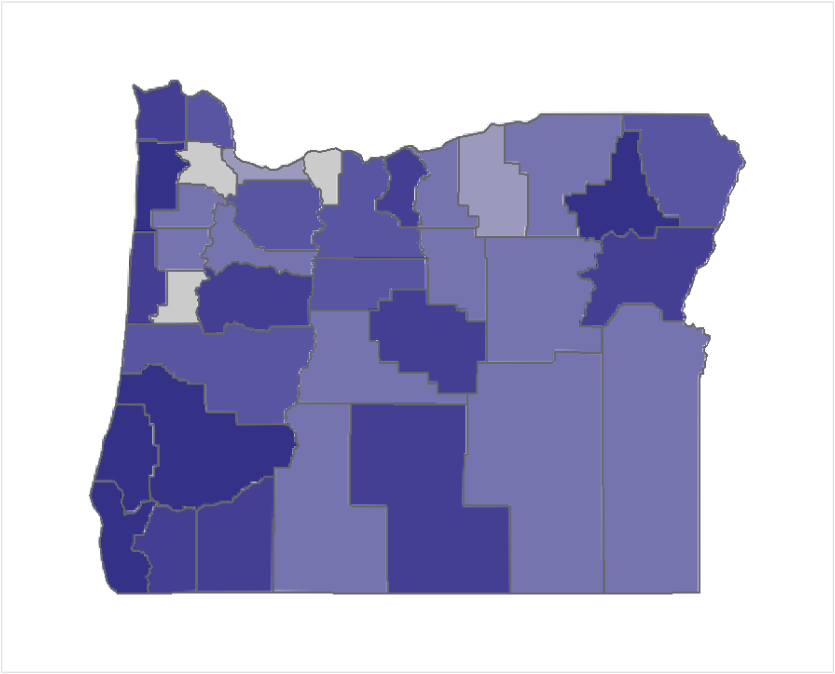
H/o depression, anxiety, COPD (2L oxygen)

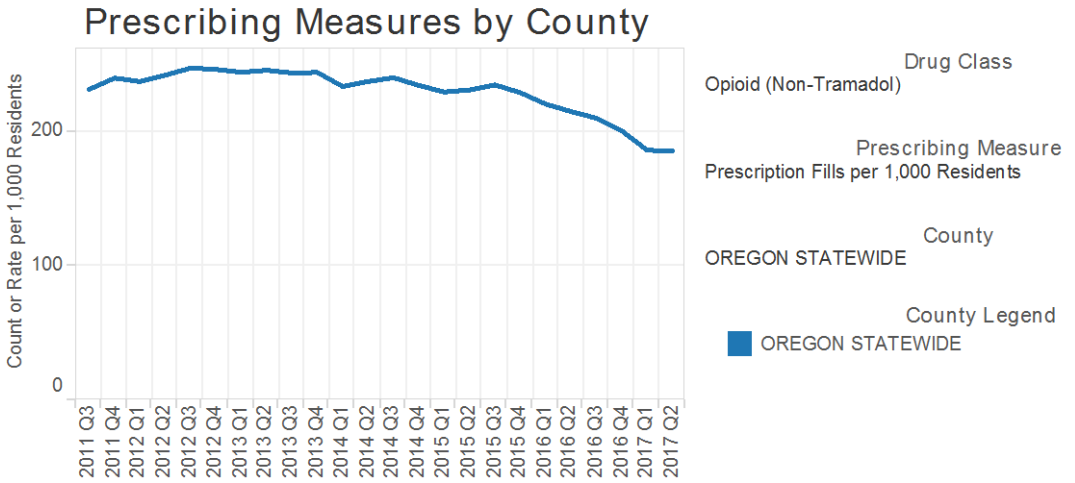
History of some early fills and highly resistant to taper

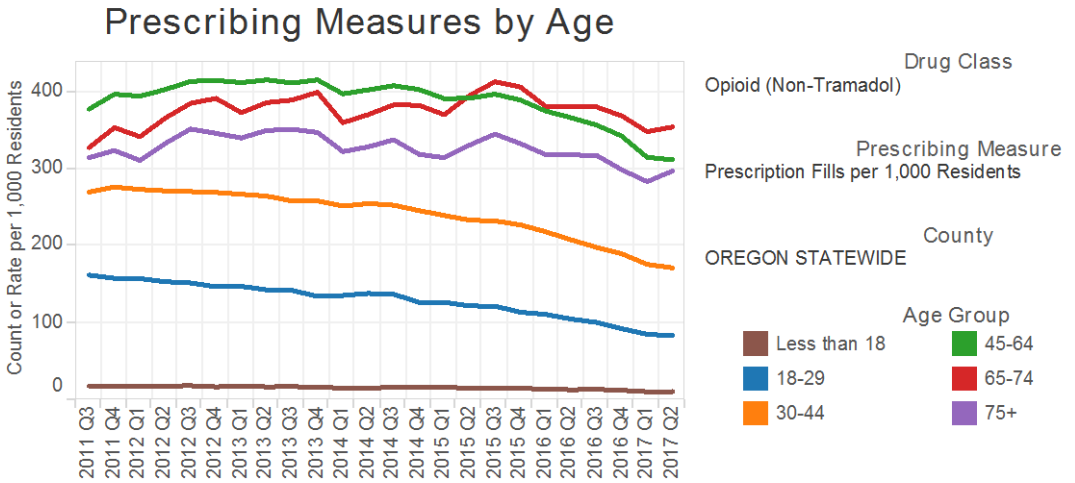
Son takes Suboxone for MAT (IVDU history)

OPIOID CRISIS: OREGON DATA

Oregon Controlled Substance Prescribing by Drug Class







http://www.oregon.gov/oha/ph/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx

TIDES ARE TURNING

OHP Expansion, Tramadol inclusion

Statewide Drug Prescribing and Overdose Measures

IMPACT ON RURAL COMMUNITIES

Factors causing increased pain burden:

- Societal norms: opiates are the 'only thing' that works for my pain. This is now generational.
- Social isolation
- Increase in poverty and unemployment in rural areas
- Stigma around addiction
- Poor access to addiction treatment or comprehensive pain centers

MORE ON RURAL IMPACT

It has been proposed that rural (vs. urban) non-medical prescription opiate use is fueled by:

1. Increased sales of opioid analgesics in rural areas leading to greater availability for nonmedical use through diversion.

2. Out-migration of upwardly mobile young adults from rural areas, increasing economic deprivation and creating an aggregation of young adults at high risk for drug use.

3. Tight kinship and social networks allowing faster diffusion of nonmedical prescription opioids among those at risk.

4. Increasing economic deprivation and unemployment creating a stressful environment and placing individuals at risk.

Keyes, Katherine M. et al. "Understanding the Rural–Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States." *American Journal of Public Health* 104.2 (2014): e52–e59. *PMC*. Web. 16 Oct. 2017.

OPIOID USE DISORDER (OUD)

Opioids taken in larger amounts for longer than intended

Persistent desire or unsuccessful desire to cut down to control use

Spending a lot of time getting, using, or recovering from opioids

Craving opioids

Recurrent opiate use causing failure to fulfill obligations at home, work, or school

Continuing to use opiates, even when it effects relationships

Opiate use causing disengagement from social, occupational, or recreational activities

Continued use, even when causing adverse events

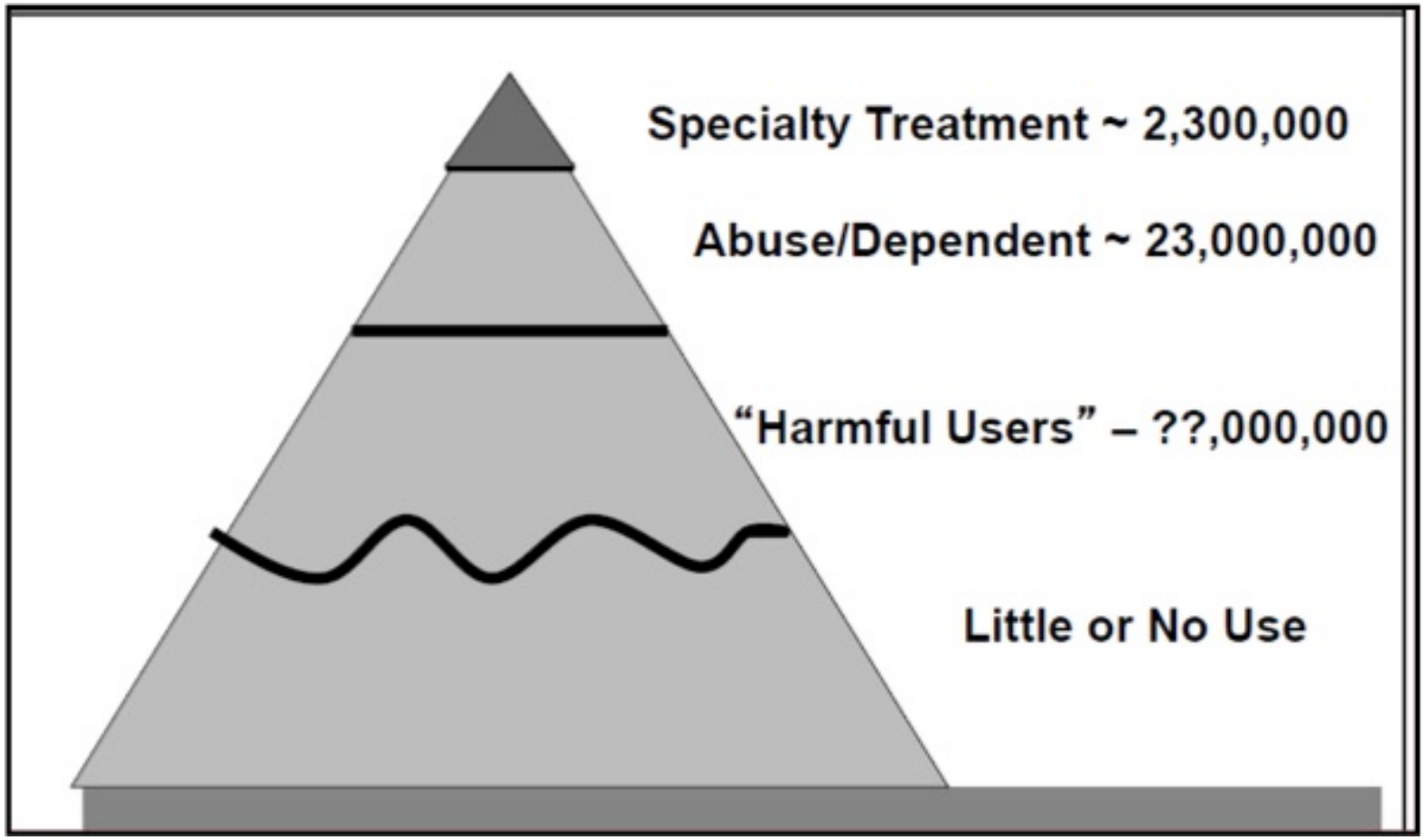
Using even when aware of a physical or psychological problem worsened by opiates

Tolerance: either increasing dose to get same effect, or a diminished effect at the same dose

Developing withdrawal symptoms which are relieved by taking more opiates or similar substances

Mild (2-3) Moderate (4-5) Severe (6+)

THE TIP OF THE ICEBURG?



25 Million Americans have a substance use disorder (not just opiates and same # as diabetes), 90 % will not get treatment.

CHANGES IN PRACTICE WILL CAUSE MAJOR STRESS TO THE SYSTEM

We do not know how many patients will need substance use treatment when opiates are discontinued

Goal #1: Reduce new patients starting chronic opiate therapy

Goal #2: Minimize the impact of practice changes on ‘legacy’ patients

Goal #3: Minimize patients moving to heroin/focus on harm reduction

MEDICATION EFFICACY, OUD

	Treatment Program Retention	Opioid Misuse	Criminal Activity
Methadone	↑ (n=3)[a]	↓ (n=6)[a]	No Effect (n=3)[a]
Buprenorphine	↑ (n=4)[b]	↓ (n=2)[b]	No data
PO NTX	No effect (n=2)[c]	↓ (n=4)[c]	↓ (n=2)[c]
XR NTX	↑ (n=2)[d]	↓ (n=2)[d]	No data

NTX = Naltrexone

Note: Suboxone= buprenorphine/naltrexone. Subutex = buprenorphine

Solotaroff, Neurobiology of Pain and Addiction, 2017

BUPRENORPHINE V. METHADONE FOR MAT

Low dose Buprenorphine (2-6mg) was less effective than methadone in retaining people in treatment.

Buprenorphine (>7 mg/day) was not different from methadone (≥40 mg/day) in retaining people in treatment or in suppression of illicit opioid use.

note that both Buprenorphine and methadone are used in treating chronic pain

Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2.

BUPRENORPHINE

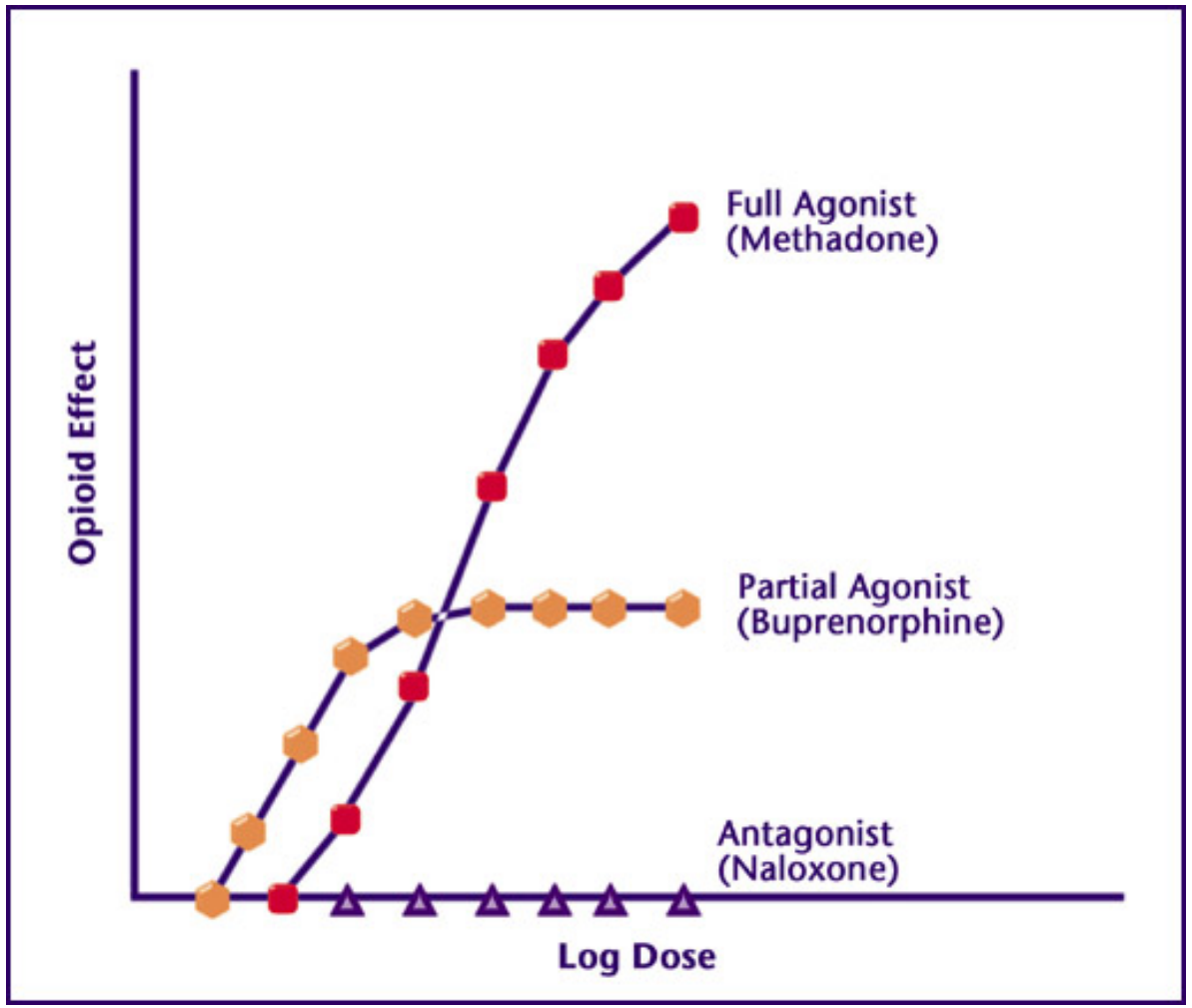
A **partial** μ-opioid receptor agonist

Decreased:

- Respiratory suppression
- Toxicity compared to other opiates
- Pain scores in patients w/ chronic pain
- Craving

Often Paired With:

- Naloxone, a full opioid antagonist (Suboxone)



THREE MODELS OF MAT DELIVERY IN PRIMARY CARE

1. 'Hub and Spoke' model

- Primary care identifies patient with an OUD (mild-severe) and patient willing to address disorder.
- Addictions center (AC) does intake, determines optimal treatment (detox, MAT, etc) based on history.
- If patient is identified as an MAT (Buprenorphine in this case) candidate, AC performs induction, stabilization, and core addictions work.
- After time (> 4mos typically) patient 'graduates' back to medical home and AC 'signs off.'
  - NOTE: AC will offer continuing behavioral health work, patient usually not required to attend.
- PCP assumes MAT ongoing.

Infrastructure required:

- Willing partners
- Monthly care calls to "run the list"

Issues:

- Insurance coverage (straight Medicare or self-pay is not covered)
- Patient acceptance/showing up to AC

MAT MODELS CONTINUED

2. Housed within the patient's medical home

- PCP does induction and management- protocols required
- Integrated or close behavioral health relationships essential
- Dr. Whetstone to describe an example

3. If no BH resources but need exists

- PCP does induction and management- protocols required
- If no existing BH resources, being creative is essential
- Requires being firm on severity of OUD provider agrees to manage – KNOW YOUR LIMIT
- Best for patients with mild-moderate OUD

RETURNING TO OUR PATIENT

Enrolled in mental health w/ CCBH. Closely co-managed with therapist (who was a CADC).

Tapered down to 90 MED

Came into the office in withdrawal (d/c'd oral opiates 24 hrs prior)

Suboxone initiated that day. BHC called the next day, assessed for withdrawal

BHC and I discussed dosing, and with the patient eventually found 8mg 2x daily was optimal

Pt sees me every other month but therapist 2 x month. Pt reports adequate pain control and increased mental clarity

BUPRENORPHINE TREATMENT AT A SEMI-RURAL MIGRANT HEALTH CENTER IN THE DALLES

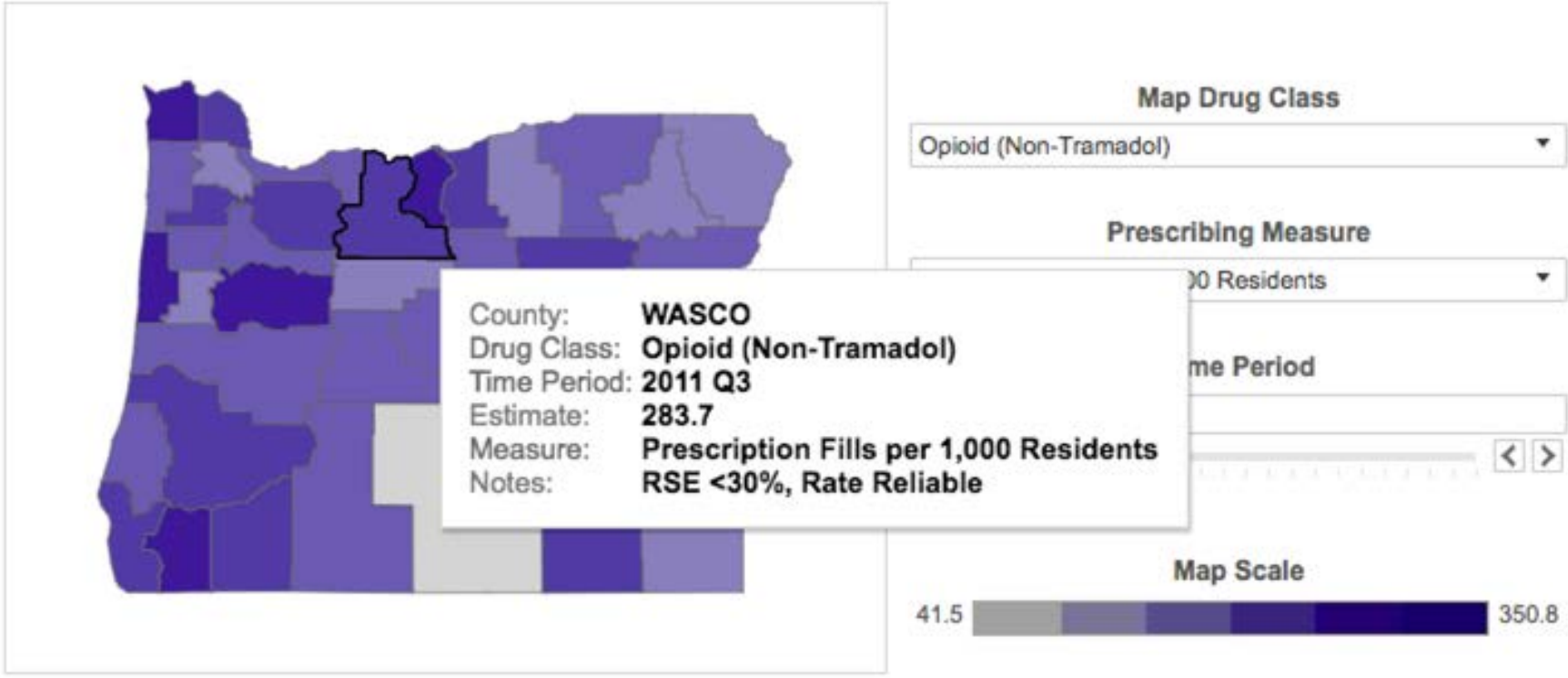
Heather Whetstone, MD

ONE COMMUNITY HEALTH

FQHC, migrant health center in The Dalles and Hood River
Large medicaid and uninsured populations
In 2011, The Dalles location was only clinic offering buprenorphine MAT in the Gorge community

THE NEED

Nearest methadone clinic in Portland
One waivered physician



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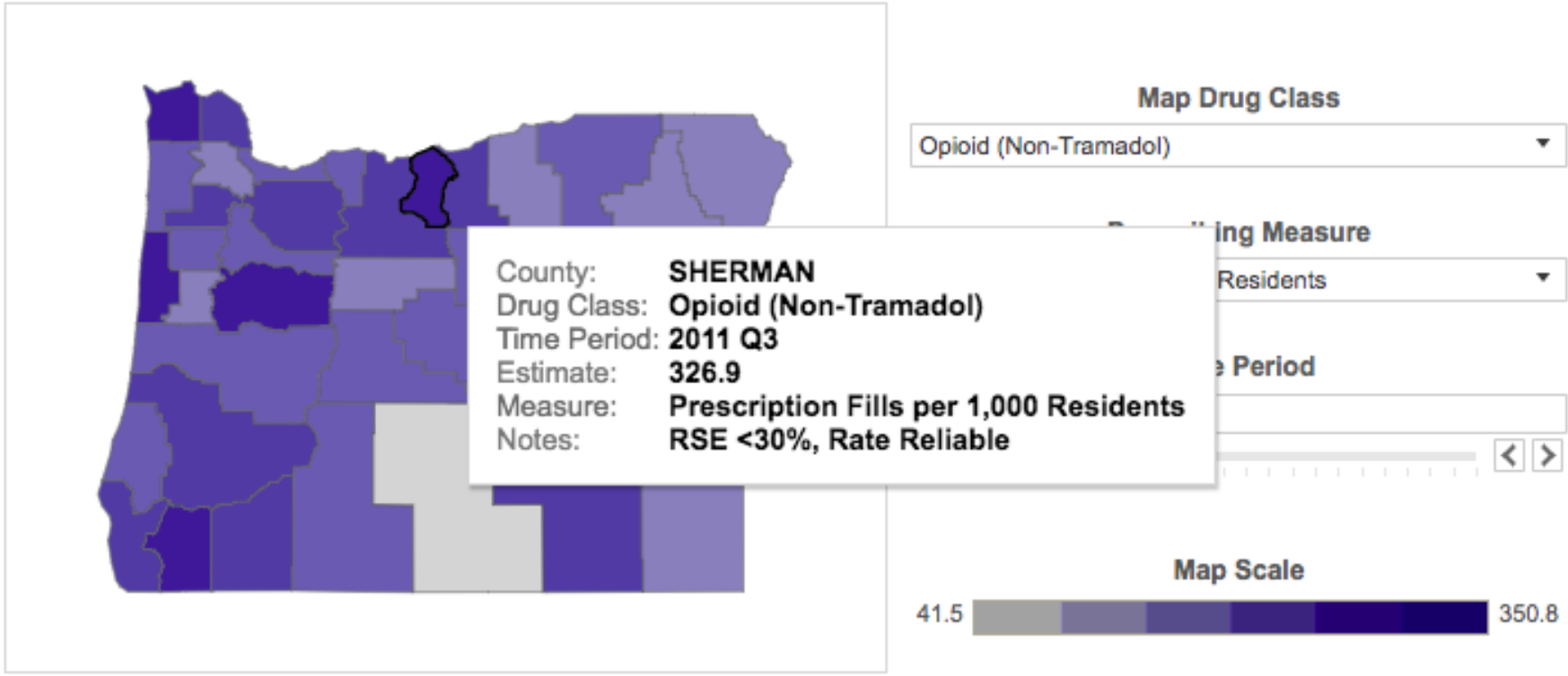
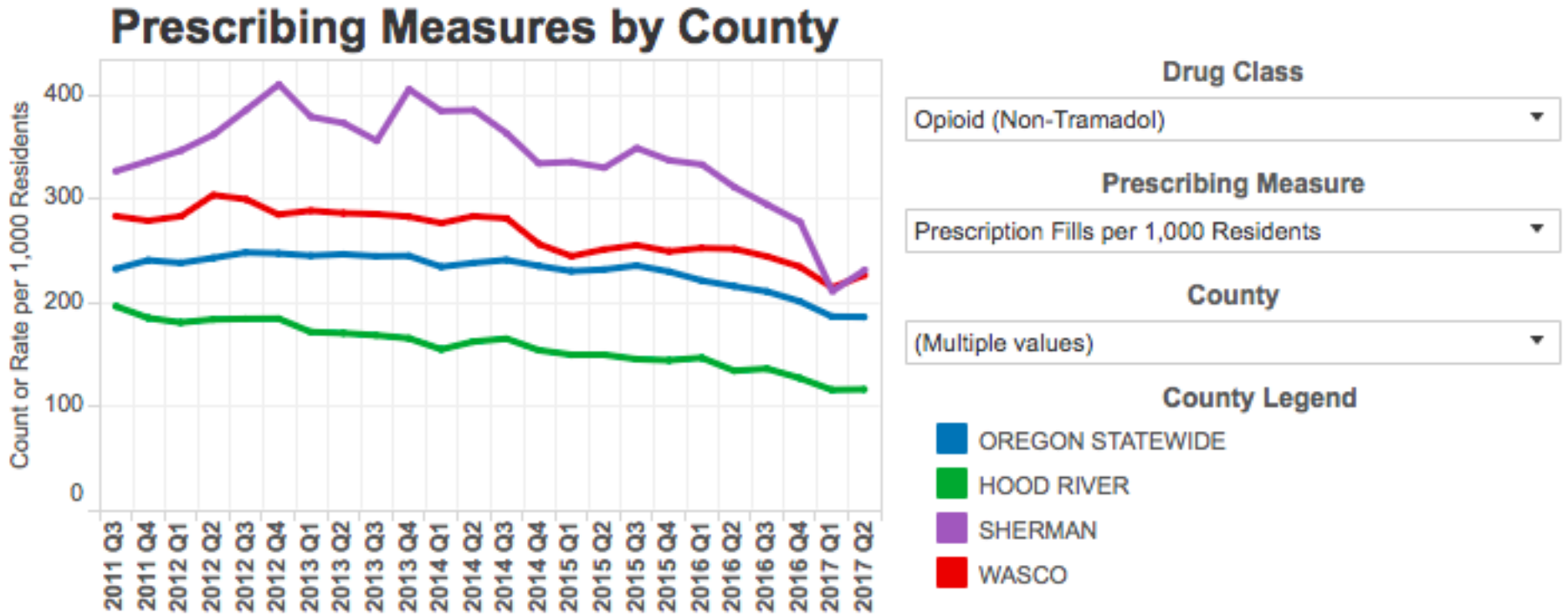


THE NEED


Prescribing Measures by County
Count or Rate per 1,000 Residents
400
300
200
100
0
2011 Q3
2011 Q4
2012 Q1
2012 Q2
2012 Q3
2012 Q4
2013 Q1
2013 Q2
2013 Q3
2013 Q4
2014 Q1
2014 Q2
2014 Q3
2014 Q4
2015 Q1
2015 Q2
2015 Q3
2015 Q4
2016 Q1
2016 Q2
2016 Q3
2016 Q4
2017 Q1
2017 Q2
Drug Class
Opioid (Non-Tramadol)
Prescribing Measure
Prescription Fills per 1,000 Residents
County
(Multiple values)
County Legend
OREGON STATEWIDE
HOOD RIVER
SHERMAN
WASCO

STARTING UP…

Workflows for new patient consultations, inductions, monitoring/maintenance

Forms, policies, procedures

Supplies (e.g. POC UDS)

Case management (CMA, RN)

- Prior Authorizations
- Patient assistance programs
- Tracking patients
- Monitoring engagement in counseling services
- DEA site visit

Identifying capacity/finding the balance

Advertising?

COUNSELING RESOURCES

Providence Gorge Counseling Services
Private therapists
Mid-Columbia Center for Living

- Monthly joint meetings
- Family dependency court
- CPS / DHS
- Peer mentors

A CASE STUDY

22 yo G1 at 23 weeks in mild-moderate heroin withdrawal presents to clinic on a Friday to get started on Suboxone ®

Standard workflow: MAT consultation -> MH intake -> Induction

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Standard workflow: ~~MAT consultation -> MH intake -> Induction~~

Enact Plan B: immediate induction!

- Setting? Inpatient vs Outpatient
- Weekend Logistics
- MAT first, MH second

Treatment partners (OB, MH, inpatient care of mom and baby, CPS)

Complications

SUCCESSES

Over 100 individual patients
Recruiting additional buprenorphine prescribing physicians
Prenatal MAT and partnership with local obstetric providers
HRSA Service Expansion Grant 2016

CHALLENGES

Misconceptions about buprenorphine
Maintaining a focus on harm reduction
Flexibility (working outside of the box)
Meeting (the expanded) community needs
Determining panel capacity
Lack of resources (e.g. NICU to manage NAS)

CLOSING NOTES

December 2016, congress passes 21st Century Cures Act

- $1 billion in grants over two years
  - Flows in priority to those states effected most, in the form of:
    - Expanded access to addiction treatment
    - Increased prescription drug monitoring
    - Training to prevent opioid abuse and overdose
    - Various public health initiatives related to drug use

Opiate prescriptions *are* decreasing and the culture is *starting* to change

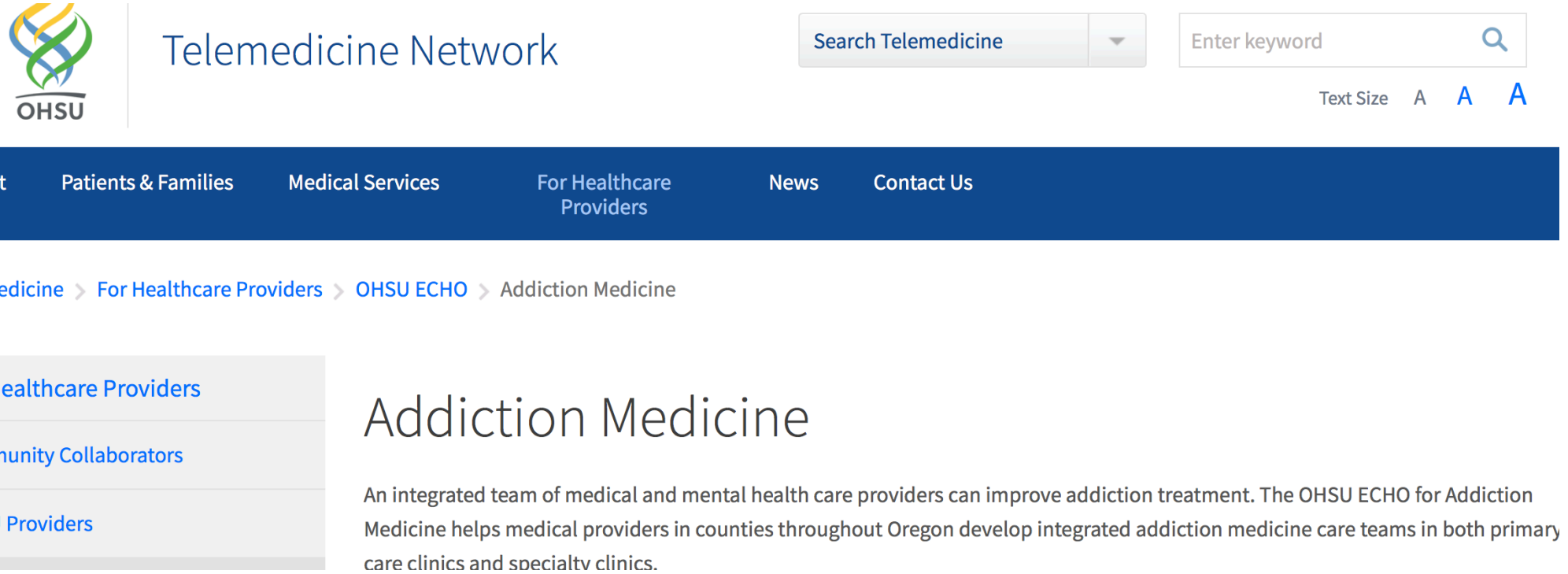
This was 30 years in the making, and we've made siginificant changes in the past five years

http://docs.house.gov/billsthisweek/20161128/CPRT-114-HPRT-RU00-SAHR34.pdf

RESOURCES

OHSU Project ECHO for addiction medicine/MAT

- Weekly interactive learning sessions, each cohort done on a quarterly basis
- CME provided, goal is to upscale all providers regardless of setting



ONE SWITCHBACK AT A TIME…