Cyberseminar Transcript

Date: October 3, 2017

Series: Spotlight on Pain Management

Session: Addressing Pain and Opioid Use Disorder in High Risk Patients

Presenter: Illene Robeck, MD

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Dr. Robin Masheb: Good morning everyone and welcome back to Spotlight on Pain Management for the 2017-18 academic year. This is Dr. Robin Masheb, Director of Education at the PRIME center and I will be hosting our monthly pain call entitled Spotlight on Pain Management. Today’s session is Addressing Pain and Opioid Use Disorder in High Risk Patients. I would like to introduce our presenter for today, Dr. Illene Robeck. Dr. Robeck is Director of Virtual Pain Care for the Richmond VA Medical Center and Co-chair of the PACT Pain Champions Initiative. Her clinical expertise includes pain care for the high risk patient. This includes patients with chronic pain as well as mental health concerns, substance use disorders and are complex medical concerns. We will be holding questions for the end the talk, if anyone is interested in downloading the slides from today please go to the reminder email you received this morning and you will be able to find the link to the presentation. Immediately following today’s session you will receive a very brief feedback form. Please complete this as it is critically important to help us provide you with great programming. Dr. Friedhelm Sandbrink, VA Deputy National Director for Pain Management will be on our call today and he will take questions related to policy at the end of our session. And now I’m going to turn this over to our presenter Dr. Robeck.

Dr. Illene Robeck: Thank you so much. I feel honored to be speaking to this group and find that it’s always difficult to create a completely up to date presentation on this topic because the information related to opioid risks is changing so dramatically, even this past weekend there was an editorial in the New York Times about the really, evolving opioid crisis, concerns about the need for treatment and really calling for a community based, country wide approach to integrating our assets to addressing this really serious problem. I have nothing to disclose and I would like to make sure that everybody understands at the end of this, really how did we get here, what’s the history and how can we understand pain care options for patients at high risk for an opioid related adverse event. And what are the opioid risk mitigation strategies for everybody on acute and long term opioid therapy and to understand treatment options.

Doctors Frieden and Houry in 2016 said, “We know of no other medication routinely used for nonfatal conditions in which patients die so frequently”. One in every 500 patients started on opioid therapy will die a median of 2.6 years after the first opioid prescription. And it is even higher still on patients receiving high dose. I’m just trying to get my… excuse me I’m having some… I’m just having some technical difficulties with my screen here, sorry. Okay, can you just tell me how I can get out of—I have the webinar information just sitting on my computer interfering with my screen.

CIDER STAFF: Yep, there’s that tab hanging off the left with an orange arrow. Just click on that orange arrow and it will collapse it out of your way.

Dr. Illene Robeck: Fabulous. Okay, I guess this what I’m going to do. What’s important is I’m not going to go into a lot of detail but it’s important to understand is that we’ve had problems related to opioids and opioid related adverse events since we stumbled upon the poppy seed back in Europe, India and China related to problems related to opium addiction. The medical community has had a waxing and waning love of opioids, thinking that it was the solution to many problems and then finding out that it created problems of its own. In the 19th century in this country, despite warnings previously found in Europe, we saw large numbers of people on opioids, especially women, but even men and children were prescribed large amounts of opioids to the point where it was felt to be a major public health crisis in the way that we are looking at it as a major public health crisis today. A survey of Boston drug stores published in 1888 found that almost 15% of prescriptions at that time contained an opioid.

By the early 20th century, opioids were felt to be so harmful as to be rarely used outside of an acute care situation. We saw minimal to no use of chronic opioid use outside of the hospital setting. And then, in 1980 there was an article to, it was a letter to the editor in the New England Journal of Medicine now called the Porter and Jick letter, in which Porter and Jick looked at hospitalized patients who received opioid therapy. And within that hospitalization demonstrated no evidence of addictive behavior and then concluded that opioids did not create problems with addiction when used in a medical setting.

We all can look back and see the problems with that letter, but that letter then was taken in a way that then further promoted the use of opioids on a more chronic basis. Simultaneously in our current crisis we now have problems with illicit opioids and simultaneously with our decreasing concerns about the addictive potential of opioids. There were drug cartels bringing heroin into never heard of areas before. Into the suburbs, into the areas in which the general population could find these illicit opioids quite easy to find. And in 1986 doctors Kathleen Foley and Russell Portenoy published a paper, small numbers opening a debate about the use of opiate pain killers for a wider variety of pain and that’s when the problems with opioid therapy and problems with opioid related adverse events began.

Meanwhile, these cells started to understand that opioids were being prescribed more and more in, by the medical community and expanded their system to a pizza style delivery system where people could get opioids with a phone call. In 1996 Purdue released OxyContin, marketed largely for chronic pain patients and they touted that it was not addictive and non—and created supreme pain relief with just twice a day dosing with aggressive marketing which dramatically increased the use of OxyContin. And we then began an era of assuming that opioids were going to be used for pain. The American Pain Society urged doctors to treat pain as a vital sign and in 1996 the American Academy of Pain Medicine issued a consensus statement supporting long term opioid therapy stating that the risks for de novo addiction was low, respiratory depression induced by opioids was short lived and antagonized by pain, tolerance was not common and efforts to control diversion should not limit opioid prescribing.

But by 2001 even Newsweek started to look at some of the growing problems associated with opioid related medications for pain. The problems with delivery of opioids into every corner of American culture began and the drug cartel starts target area for this delivery system in areas where it was known that there was high medical opioid prescribing and by 2004, Washington State Department of Labor and Industry started to notice a substantial increase in death rates from those people on disability.

By 2007 the problems associated with OxyContin its false labels and some of the false data presented to health care professionals became clear and Purdue and three executives pleaded guilty to misdemeanor charges of false branding and were fined 634 million dollars. And by 2008 drug overdoses, mostly from opiates, surpass auto fatalities as leading cause of accidental death in the United States. In 2010 the New England Journal of Medicine published their now very classic article “Flood of Opioids, Rising Tide of Deaths” and states also started to really regulate how opioids were prescribed with Ohio and Florida leading the way.

So we have the perfect storm, 1986, 2010 pain as the fifth vital sign, pharmaceutical company development of new opioids which touted less risk along with pharmaceutical company money for provider education. Outside the VA we had Managed Care with the shrinking of primary care reimbursement and time spent per patient, we had lack of funding for substance abuse treatment, lack of funding for biopsychosocial approach for pain with limitations on PT, CBT and care coordination. And in many ways the VA actually was leading the way in a positive way in this regard but we still had minimal training of health care providers in pain and addiction and we went from the transition, from the information age to the age of too much information. And patients and providers began to become desensitized to these risks.

We now have the situation in 2017, the about to be published 2015, the 2016 data it’s currently predicted that there will be over 65,000 overdose deaths with most, not all, but most due to opioids and the 2015 data already published indicated that opioids killed more than 33,000 people, nearly half of all deaths related to prescription opioids and of those related to illicit opioids, 75% of illicit opioid users had been on at one time or continued to take prescription opioids. We now have illicit opioids in pretty much everything on the streets being mixed with fentanyl. It’s mixed with almost all illicit drugs, it’s 50 to 100 times more potent than morphine, 25 to 50 times more potent than heroin and we now have the introduction of car fentanyl which is 10,000 times stronger than morphine and 100 times stronger than fentanyl. Overdoses to car fentanyl, and even fentanyl may occur in seconds or minutes and response to the usual Naloxone dose may be inadequate. The potency of car fentanyl is high enough to negatively impact first responders.

We also now understand after years of prescribing opioids chronically that there are potential risks for everybody, even those perceived to be at high risk. And while I’m not going to review this list in detail it’s important to understand that many of these risks, increase risk for people felt to be at low risk of an opioid adverse event. And also negatively impact the ability to treat pain. So we understand that endocrinophathies actually worsen pain control. Hyperalgesia worsens pain control, declining cognition worsens function, worsening symptoms related to mental health concerns, interferes not only with those mental health concerns but our ability to treat pain.

So the question is, do they work for the risks that are being entailed and extensive literature review conducted by both the VA and DoD subject matter experts who wrote the clinical practice guidelines and the CDC clinical practice guideline experts, identified no studies that evaluated the effectiveness of long-term opioid therapy for outcomes lasting longer than 16 weeks. And when you review the literature you will see multiple studies that demonstrate poor functional outcomes in chronic pain when opioids are used verses non-opioid therapies for pain.

So in 2017 the VA/DoD published their new guidelines and this was after a year and half of extensive research efforts and the year after the CDC guidelines were published. And the assumption that opioids were important in pain care became a thing of the past. And in fact, a U-turn was taken. And while I’m not going to go into detail about these guidelines they are available for you, it’s important to understand that for all patients, alternatives to opioid therapy such as self-management strategies, other non-pharmacological treatments and when pharmacologic therapies are used, non-opioids are preferred over opioids. So when we talk about how we’re going to manage pain in patients with opioid use disorder or are at high risk of an opioid related adverse event the key corner stone of pain care now is non-opioid therapy. And the new guidelines are against initiating long term opioid therapy for chronic pain. Our big concern is what to do with patients already on chronic opioid therapy.

And so it’s important for us to understand that our approach to patients already on chronic opioid therapy must be done with an understanding of how patients can either be tapered to a safer dose of opioid, no opioid or address the risk of opioid use disorder in which the patient’s opioid use disorder must be addressed as a major comorbidity. For some subset of patients, they will maintain an opioid therapy because the risk-benefit analysis determined that the risks of taper may be higher than the risk of maintenance. But every decision will need to be made on a case by case basis. But we also understand that those patients with untreated substance use disorder, concurrent benzodiazepine use, those less than 30 years of age, are at especially high risk of opioid related problems. We also recommend that we switch over to short acting opioids and the shortest period of time when opioids are used. This is a change in approach from our previous guideline and a series of opioid risk mitigation strategies. And I’m not going to go through these in detail, just to remember that every decision about opioid therapy is a constant reanalysis of risk verses benefit. We now know that the risks of high-dose opioid therapy are substantially higher than lower dose, although there is no one safe dose.

It’s important to understand here that our guidelines as well as the CDC guidelines recommend for patients with chronic pain and opioid use disorder, medication assisted treatment is the recommended treatment approach and then once that is established or simultaneous with that being established, non-opioid options available for pain. Even for acute pain, alternatives for opioid for mild-to-moderate pain are recommended whenever possible and a reassessment of acute pain is recommended whenever possible within 3-5 days to determine whether on-going opioid therapy is needed. One of the things that we have seen is that the diagnosis of opioid use disorder is substantially more common than we once thought. And we viewed some data but in one study that was actually designed to under-diagnose opioid use disorder, in the clinic, from the Geisinger Clinic, it was felt to be over 40% of patients on long term opioid therapy.

So what is DSM-5 diagnostic criteria? Problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the symptoms listed on the following slides occurring within a 12 month period. During that tolerance and withdrawal and not criteria for OUD when taking opioid pain medicine as prescribed. However, the minute there is early refills or the minute there is multiple providers, or the minute there is taking those opioids in an unprescribed way, tolerance and withdrawal are criteria for making this diagnosis even when the patient is solely on prescription opioids. I’m not going to go through this in detail right now, we’re going to review these criteria in more detail later, but it really is generally patients taking opioids in a way that is harmful to them with problems lowering or decreasing or tapering the dose, understanding the negative impact that it is having on their life.

It’s important to also understand that although tolerance and withdrawal are not part and parcel of this diagnosis for everybody on prescription opioids. When people experience withdrawal symptoms, many of these withdrawal symptoms make management of chronic pain worse. Dysphoric mood, muscle aches and cramps, insomnia, distress and irritability. And what happens is due to the inherent tolerance of opioid therapy even patients who remain on their usual dose may find that at the end of the dose, including long-acting opioids, these withdrawal symptoms may worsen the ability to take care of pain in patients on stable opioid doses.

We also know that there is a problem associated with protracted withdrawal in which symptoms of withdrawal worsen initially and then will slowly decline but remain protracted for many months after the patient has been off of therapy. And this protracted withdrawal will, in many patients, lead to recurrent use of opioids because of the severe craving associated with protracted withdrawal. So protracted withdrawal associated with opioids includes many symptoms that worsen the pain. Anxiety, depression, fatigue, dysphoria and irritability and sleep disturbances and these can last for months. For some patients in recovery from heroin dependence there were deficits in executive control functions persisting for many months and subjects who had been absent from opioids for prolonged periods showed decreased ability to focus on a task compared with subjects who had never used opioids. So we need to address some of these problems both during and after opioid therapy.

This is that article, the study from the Geisinger Clinic in which they found that the lifetime prevalence of any prescription opioid use disorder in patients on chronic opioid therapy was over 40%. This was actually an article in which the patients who were studied had to return a questionnaire. So it leads to questions about the incidences of opioid use disorder in the patients that never got around to returning the questionnaire. And another article looking at the incident of opioid use disorder it’s found that the odds ratio with prescription opioids was found to start with acute opioid therapy, with an odds ratio of three with acute opioid therapy and an odds ratio over 122 with chronic opioid therapy. Once again, the limits of this discussion are related to the fact that they were looking at patients in whom a diagnosis of opioid use disorder was made during and after opioid therapy and we now know that that is very frequently underdiagnosed, so these odds ratios, if anything, may be higher.

So I wanted to go back to the OUD criteria and start to think about ways that we can ask patients in a historical fashion, questions that would allow us to make this diagnosis and then offer treatment to appropriate patients. These are actually questions that I’ve come up with, these are not validated and I don’t advise that people use these questions specifically as much as to really start the creative processes going of what kind of questions can I ask to get a sense of which of my patients on chronic opioid therapy or even now acute opioid therapy, may meet criteria for opioid use disorder and may require that assessment and treatment as I move forward. So criteria one: opioids are taken in larger amounts or over a longer period of time than was intended. So how can you ask that question? Well, have you ever taken more opioid medicine than you were prescribed? And an answer yes to this then one you get one point and you also need to do a little sleuthing here because if you have a UDT positive for unprescribed opioids or PDMP requests for opioids from more than one provider then that would count as well, even if the patient has a denial of that process.

Criteria two: persistent desire, unsuccessful efforts to cut down. Have you had difficulty with symptoms other than pain when opioid doses are lowered? In order to be able to ask that question we need to go back to our list of withdrawal symptoms both acute and protracted and know what questions to ask there. So when we lower your opioid dose, do you have worsening problems with sleep, anxiety, ability to function?

Criteria three: a great deal of time is spent in activities necessary to obtain the opioid and, once again, how does that patient spend their day? Sometimes you can get help from families, does that patient spend time during the day revolving their day around opioid therapy? Craving or strong desire, and this is an important question to ask. Do patients crave their medicine? Do they have a hard time imagining what their life would be without the medicine? Once again, not just related to pain, but many of the other situations in their life related to mental health concerns as well as sleep and the ability to function without the medication.

Criteria three: recurrent use resulting in failure to fulfill obligations. Continued use despite having persistent or recurrent problems, important social, occupational, recreational activities are given up or reduce because of opioid use. So we need to get a history of what that patient was doing prior to opioid therapy. And whether their function has actually improved, remained the same or decreased during opioid therapy. If function has decreased during opioid therapy, someone has gone from working to not working, participating in household activities to not participating in household activities, participating in the community to not participating in the community. That needs to be very seriously considered.

For our patients in whom we now know recurrent use is hazardous and there is a discussion about tapering, is that patient able to consider a taper. For patients who have experienced an overdose, a life threatening event, who have difficulty with a taper at that time. That’s very important because we may need to be addressing the opioid use disorder rather than re-prescribing their opioids. There was a recent literature review looking at the fact that over 90% of patients who overdose on opioids have their opioids re-prescribed.

Criteria nine: continued use despite knowledge of having persistent or recurrent physical or psychological problems. And once again, we want to see what happens, in terms of the patient’s understanding of their risks, are they realistic and what are the challenges of either changing opioid therapy to a safer dose or tapering to discontinue. And we talked about tolerance and withdrawal and we’d like to know about those symptoms no matter what because that’s going to impact our ability to make changes in opioid therapy. But remember tolerance and withdrawal do meet criteria if a patient is getting opioids from non-medical sources, getting opioids from multiple medical sources or requesting early refills.

There’s also concerns that dependence on opioids in view of current risks creates a much larger problem than is recognized. And in a very impressive editorial in the archives of internal medicine. Jane Ballantyne asked the question, dependence verses addiction, does it make a difference in patients struggling with an opioid taper? Is this a distinction without a difference? We now know that opioid dependence is a complex physical and psychological state. And for patients who struggle with an opioid taper, when it is in their best interest to be on a lower opioid dose or no opioids, whether or not we have made a diagnosis of addiction or opioid use disorder may not be as critical as understanding the role of dependence here. So whether we call it addiction, complex persistent opioid dependence is a very serious consequence of long-term pain management with opioids that we need to address and be very respectful of.

We also now know that there are multiple comorbidities associated with OUD, cause and effect. These comorbidities are increased with the development of opioid use disorder and their treatment is made worse when opioid use disorder is untreated. Things like infectious diseases, Hepatitis C, HIV, Osteomyelitis, mental health concerns are made worse by opioid use disorder and the risk of developing opioid use disorder is higher in patients with mental health concerns. Substance use disorder and pain is made worse in patients with opioid use disorder. And opioid use disorder makes it much more difficult to treat patients with chronic pain.

We now see that this has impacted our entire health care system. So patients with opioid use disorder in the general health care system demonstrated alarmingly high morbidity and mortality which has now challenged our healthcare system. And we must find innovative ways to identify and treat patients. Mortality in patients with untreated opioid use disorder was ten times higher than the general population. And there’s recent articles that demonstrate that the general life expectancy in the United States is now decreasing primarily because of opioid related adverse events and the development of opioid use disorder in large segments of the population. Mortality rate was 48.6 per 1000 person-years compared to a standardized mortality ratio of 10.3. The mortality was frequently related to drug overdose and drug disorders as you would expect but also we saw increased risk of death related to cardiovascular disease, cancer and infectious diseases as well.

This is an important issue also related to our older patients and we looked at comparative mortality in patients over 50 years of age, adults with OUD to that in younger adults with OUD, and older adults with no history of OUD. Older adults with OUD were more likely to die from any cause than younger adults with OUD and the drug-related mortality rate did not decline with age. HIV-related and liver-related deaths were higher among older OUD patients compared to the same age peers without OUD. So we start to see our older patients and make that diagnosis, treating patients that are greater than or equal to 50, even greater or equal to 65, 70 and even 80 is going to be important because the quality and quantity of their life is going to be impacted by untreated opioid use disorder.

It's important for us to understand that the risk of relapse in untreated opioid use disorder is quite high. And in many studies the risk of relapse is over 90%. And for many patients, sustained treatment over years may be necessary and there are three medications approved for treating OUD: methadone, buprenorphine/naloxone and extended-release Naltrexone that are coupled with psycho-social support and the standard of care for reducing illicit opioid use, relapse risk and overdose while improving social function. When we look at the large numbers of patients in our system who have opioid use disorder, this needs to be an integrated approach with patients being treated in every sector that treats patients with chronic pain. Primary care, pain clinics, mental health as well as substance use disorder clinics.

We’re going to talk primarily today for the rest of this session on buprenorphine/naloxone because this is an office based treatment. It reduces cravings, it is best for mild, moderate, severe, mild or moderate OUD. We’re actually changing our discussion about whether to use it for severe OUD because there’s now some recent literature that when you use buprenorphine/naloxone for severe OUD in the treatment of an opioid treatment program in which there is intensive follow up, some of those statistics look very similar to methadone and it’s certainly a safer medication. Buprenorphine/naloxone especially in the non-substance use disorder setting is best for patients who have not had multiple failed attempts. And it should not be used with patients requiring ongoing opioids, but as we see from our guidelines, the number of patients who need ongoing opioid therapy for chronic pain are really very, very, very few. And we can also have an addiction-focused medical management process that fits well into a primary care or pain clinic setting. And we’ll talk a little bit about that.

Extended-release injectable Naltrexone is also available but it is really difficult to use in patients who are on currently on opioid therapy. The patients need to be completely free of opioid therapy in order to be able to use this. So for patients who are struggling with a taper, this may not be a useable first line approach but potentially useable down the road once the patient can be tapered and discontinued from opioids after treatment with another agent starts.

And here’s what the concern is. Looking at the data here on an overview of what happens with and without medication assisted treatment we can see that the risk of relapse without treatment is unacceptably high. And it’s not that nobody will be able to have non-medication assisted treatment but almost all will do better with medication assisted treatment.

And let’s look at some of the data in terms of health care costs. A lot of people will say “well we can’t afford to do this.” The problem is we really can’t afford to not do this. Because when we start to look at those comorbidities that worsen with untreated opioid use disorder. When we think about the costs to the system of poorly or undertreated Hepatitis C, the cost to the system of even one new case of Hepatitis C that can be prevented by treating opioid use disorder and the myriad of cases of Hepatitis C, HIV, that can be prevented with treating opioid use disorder we save a great deal of money and resources, not to mention, morbidity and mortality, and quality of life for the patients involved.

We also see the data from the Nurse Case Manager Model in OUD treatment in primary care. Marked decrease in hospital admissions in patients on medication assisted treatment, marked decrease in ER visits. So when we couple the marked decrease in comorbidities and ability to treat comorbidities, the decrease in hospitalization utilization, the decrease in emergency room visits, this makes sense not just from a patient care standpoint which really is huge, but also from a facility and systems standpoint in terms of use of resources.

We look at mortality rate during and after opioid substitution treatment and see marked improvement in mortality after opioid substitution treatment. Either with buprenorphine or methadone. With really, stark improvement in that mortality with treatment. It’s important to understand that we also need to treat comorbidities that have either preceded or have become part and parcel of the opioid therapy. Looking at these Veterans who prescribe opioids within a year of their initial pain diagnosis compared with 6.5% of Veterans without mental health disorders and almost 18% of Veterans with PTSD and almost 12% with other mental health diagnoses but without PTSD, the patients with mental health disorders were more likely to receive opioids as well as have adverse clinical outcomes. Especially in patients with PTSD. Patients with underlying health disorders, mental health disorders were also more likely to receive sedative hypnotics. In addition, use of opioids worsened PTSD symptomatology.

In a follow-up article by Karen Seal, when patients with opioid use disorder and concomitant PTSD had their opioid use disorder treated with buprenorphine/naloxone twice as many Veterans in the buprenorphine group, than in the opioid therapy group experienced improvement in PTSD symptoms. So ongoing opioid therapy in this population actually did nothing to improve PTSD symptoms and potentially worsened PTSD symptoms whereas treatment of opioid use disorder improved both pain and PTSD symptoms and for the Veterans who were treated with buprenorphine there was increasing improvement noted over the first two years. So that there was an initial improvement and on-going improvement over time.

There’s a number of medication assisted models in primary care and I just want to briefly review models that are from the agency for healthcare research and quality technical brief. The majority of places in the United States in which buprenorphine/naloxone is utilized are in the primary care setting. So this a medication designed to be used in primary care. And so it’s important for us to understand that this can be incorporated into a primary care clinic setting. There’s a hub and spoke model which briefly, all patients are seen in one hub for initiation of therapy and then follow up care is determined based upon the complexity of the patients’ needs and they are then seen either in the substance use disorder or primary care setting with the ability to go back and forth based upon stabilization or worsening of symptoms.

There’s a Collaborative Opioid Prescribing model where there’s also an intake with a center and patients are shifted to primary care clinics after stabilization on medication. In this model psychosocial services are provided by the hub, whereas in the hub and spoke psychosocial services are provided where the patient winds up getting their therapy.

There’s an office-based opioid treatment program. Where there’s a glue person, frequently a nurse, a social worker who works in collaboration with a primary care clinician to coordinate care. So there’s no definition of who this glue person is. And psychosocial services include regular, brief counseling by the physician or other members of the staff and other psychosocial services can vary and include integrated cognitive behavioral therapy and motivational enhancement therapy.

There’s the Massachusetts Nurse Care Manager Model and I showed you their statistics on hospitalization and emergency room use. This is similar to the office based opioid treatment model but the glue person is defined as being a nurse care manager. And the nurse care manager really handles 90% of any problems associated with patient care. And standardized treatment options and structured care for that patient. All the initial screening and education is done and, once again it’s a team based approach. The nurse case manager coordinates everything, but the team is responsible for care. The physician is a member of that team but the physician’s responsibilities are just as a member of the team and the physician co-manages a patient with the nurse care manager but use the team and use of the nurse care manager creates a much more efficient environment for delivery of this care.

We also see the Project Extension for Community Health Care Outcomes, the project ECHO out of New Mexico and we certainly in the VA have the ability to do that through our own ECHO programs. Where providers are trained, x-waivered, and then problems related to case management are reviewed in an ECHO setting. And once again, it’s important to understand that there’s a lot of different ways that we can then take this and then apply it to our own situations. In this particular situation, especially since many patients with opioid use disorder, wind up in a hospital setting and or an ED setting. There’s an inpatient initiation of medication assisted treatment and then the patient is followed up with bridge clinics, priority stabilization to primary care, direct stabilization in primary care and follow up in other mechanisms that is most appropriate for this patient. But the inpatient service takes responsibility for how a patient’s hospitalized or patients who need a hospitalization for initiation of care and there’s now more and more data about emergency room initiation of care.

So it’s important, whether you decide to get waivered to prescribe buprenorphine/naloxone or understand more about it. It’s important to understand where to get waivered, you can get waivered online through PCSSMAT, the American Academy of Addiction Psychiatry’s website has ways to get waivered, the American Society of Addiction Medicine, and the VA and DoD offer quarterly trainings if you’re interested in getting waivered, just email me and I’ll hook you up with that.

But what about treating pain in patients with OUD? Remember, go back to those guidelines, new guidelines recommend non-opioid therapies for pain that all appropriate for patients with OUD. Patients on buprenorphine/naloxone may benefit from a split dose once the dose is stabilized to treat their opioid dependent symptoms but the dose is really titrated to address opioid dependence and not increased related to symptoms related to pain. And cognitive therapies for functional restoration for pain and addiction go hand in hand. They can support and supplement each other.

We have adjuncts and alternatives to opioid therapy that are options for all patients that are now the standard of care for everybody. Treating comorbidities is important and the new pain teams, high-risk pain teams mandated now by CARA is a good way to make sure that comorbidities get treated. And within whatever setting the patient is treated, simultaneous treatment of comorbidities is going to be important for success.

There have been many innovations in the VA to help integrate care and I hope this presentation is a way to get people to think about how can I innovate within my own facility to improve treatment and integrate care. So we have high-risk pain teams, PACT based pain teams, PACT pain champions, VA Echo, expanded use of x-waivered providers, pain schools, Expanded Use of Complementary Integrated Options in PACT, coaching, whole health approaches, primary care mental health integration, substance use disorder clinic services in PACT, Pain clinics, and mental health.

We have a large number of services that have improved our ability to prescribe medication assisted treatment. Starting in 2017 we launched Buprenorphine in the VA program, and we have many, many more new policies related to improving access for medication assisted treatment. The Buprenorphine in the VA program really has a large number of resources including monthly webinars, ListServs, voluntary prescriber list, the ability to share information.

We have the stepped-care model for opioid use disorder and pain in which we’re looking at treatment alternatives, on-going monitoring of use practice guidelines, prescription monitoring, academic detailing has been a huge resource here, informed consent for patients and let’s not forget about naloxone distribution for all patients at risk of an opioid related overdose. It’s important to understand that physician management and CBT were just as effective as substance use disorder CBT management in this study. So this was a 24 week randomized clinical trial of 141 patients. They were randomized to physician management or physician management plus much more structured cognitive behavioral therapy. The physician management did not differ significantly, the impact did not significantly differ from that of physician management plus cognitive behavioral therapy. So as long as there’s a structure to physician management, many patients will do well in that situation without structured substance use disorders style treatment. What’s standard medical and physician management, establish rapport, we do what we do for all chronic diseases, review medical psychiatric and substance abuse problems, review the diagnosis, develop the treatment plan, talk about all other drugs, refer to self-help groups, delineate, reinforce program guidelines, make sure the patient has any questions answered. And once again, this can be done in a team-based approach, follow up visits can be 15 to 20 minutes and once again they look very similar to the type of visits we have for all of our chronic diseases, medication adherence, in this case we will review substance use, response to medications, lifestyle changes, impact of addiction, recovery on function, what’s going on functionally, advise once again to advise abstinence from all drugs, look at adherence and non-adherence, so whether that remains a good option of the patient and make referrals if necessary.

But for patients with chronic pain who are receiving cognitive behavioral therapy services for chronic pain a lot of what we address goes hand in hand with addiction treatment. So medical management is even more in line with the pain treatment that we are now advocating. So we look at, when we look at a biopsychosocial approach to pain, we look at pain and addiction triggers, the role of diet, the role of exercise, safe medication use and education. That’s part of pain care now. We look at the spiritual impact of pain care, sadness, helplessness, for many us we’re looking at mindful mediation as an option both for substance use disorder as well as pain care, support groups. Looking at the mind, once again this is about addiction treatment and pain treatment, sleep hygiene, relaxation imagery, reducing fear, anxiety and stress. Social interactions are now emphasized in terms of pain care. Improving family interactions, problem solving, vocational trainings, support groups, volunteering, and functional restoration.

So it’s very important for us to understand when we look at the cognitive therapy that works for addiction treatment it’s very similar to the cognitive therapy approaches that work for pain treatment. So medical management, especially when we incorporated the CBT services we’re using for all patients with pain, medical management in a primary care or pain clinic setting is quite feasible for patients who need opioid use disorder treatment that can be accomplished in the primary care setting.

There’s much that we need to do in terms of future research. Is there a difference in relapse rate for patients with prescription opioid use disorder alone? Are opioid use disorder related to both prescription and illicit opioids? What is the true incidence of opioid use disorder in all patients with chronic pain, when everybody is screened, go back to those questions. Can we create a questionnaire that we can validate and ask of everybody on chronic opioid therapy to determine, well what is the true incidence of chronic opioid use disorder in our patients who are on chronic opioid therapy? Can we create a validated screening tool? Is there a difference in treatment outcomes with and without MAT for patients with prescription opioid use disorder, diagnose with mild, moderate or severe, we make assumptions that we may have more leeway with patients with mild opiate use disorder, but that’s really not been quite studied. And what is the difference in outcomes for patients on high-dose opioids who are tapered verses switched to both medication assisted treatment for opioid dependence or maintained on full agonists for pain?

There are now some studies looking at the very high risk of opioid use disorder in patients on high dose opiates, remember odds ratio of over 122, and wondering if all of those patients need an MAT approach. We don’t know the answer to that. There are many, many more things to study and I really ask this group to look at this because a lot of our success in the future will depend on this. So chronic pain and OUD are common comorbidities that require simultaneous treatment. Treating opioid use disorder allows for greater retention treatment, improved ability to treat associated comorbidities and improved ability to use non-opioid options for pain. There’s a number of models that we may need to tweak and make our own or can follow as a way to improve options for care and cognitive approaches to pain and treating OUD go hand in hand allowing for medication management options in a number of different settings. And with that I am going to stop and ask for questions.

Dr. Robin Masheb: Thank you Dr. Robeck, this was a great presentation. And I know you had even a lot more to talk about and I’m glad we have a little bit of time for some questions. I’m going to, for the sake of time, try to combine some things and see if you can react to these. So there’s some questions about having ideas or insights about why patients with mental health diagnosis are more likely to receive opioid prescriptions when the outcomes are so negative. And then that’s related to another question that somebody else had, which is kind of as a provider, this opioid prescribing problem has been an inherited problem in terms of having patients with long standing opioid addictions who were kind of victim to poor prescribing practices, poor knowledge about how to handle these situations, that’s its very challenging. It’s not like you’re starting from scratch with patients and moving forward with the new information that we have. So I was hoping you could react to those questions.

Dr. Illene Robeck: Those are fabulous, fabulous questions. And so we didn’t have time to go through all the nuances of this history, but when we look at our old guidelines and we look at the guidelines that were recommended from about 1986 to about 2010, there was this false assumption that opioids could safely be prescribed to everybody. And patients with mental health problems maybe needed a little bit more monitoring but there was no understanding at all about the impact of opioids on mental health concerns. There was one article that looked at, one study that looked at patients in the VA, I think it was about seven or eight years ago and looked at de novo depression in patients prescribed opioids, patients who never had depression prior to opioid therapy who then developed de novo depression following opioid therapy.

In addition we now know that patients with underlying concerns, so even if they’re not major mental health concerns, stressors, depression, mild depression and patients with major mental health concerns are more likely to develop chronic pain, because we now know that chronic pain is not just related to a node susceptive pain generator, it’s not just related to the fact that I pulled my back and that muscle’s in spasm, it’s also related to the very complex issue of the endorphin system the serotonin system, norepinephrine, dopamine system that’s tied into sort of our natural pain killers. So that when we see patients with mental health concerns who have problems related to the underlying mental health concerns it also may impact that patient’s ability to respond to an acute pain situation. When we then added opiods to that, that then potentially worsened the mental health problem and also transiently treated mental health symptoms, transiently improved anxiety, depression or a sense [Unintelligible 55:14.9] only to find that overtime that transient improvement was short lived and worsened symptoms over time.

So there was a lack of understanding about that until we started to review the data since about 2010. Initially, it was felt that patients who had problems with opiates, when we finally realized that there was a problem with patients with problems were those that misused. Then we found out that half the patients who died were taking the medication as prescribed. So we now have a better understanding of how problematic that was and you’re absolutely right, we now need to address that. For many of the patients who then understand that this is riskier than we once thought, and we address the very slow taper, there’s a subset of those patients who will do fine, if we taper the medication slowly while adding other medications and non-medications for pain while treating comorbidities. Those patients may do fine but there’s going to be a significant subset of patients who have become so dependent on the opioids that they’re going to be unable to taper. We now know, that keeping them on full mu agonists will shorten their life and increase their risk of comorbidities and whether you taper or you maintain they still have a high risk of going to the streets with sudden death with introduction of fentanyl.

So treating opioid use disorder, along with comorbidities and pain is really the solution for that patient population and being able to work together with pain clinics, primary care, mental health and substance use disorder to improve options for those patients can really dramatically change how we can take care of those patients.

Dr. Robin Masheb: Thank you. So we have a few more questions and only a few minutes. What I thought I would do is just end with one, Dr. Robeck if you could just answer that one in one minute so we have a chance to tie things up and if others are interested in getting some more feedback about your questions, if you could email Dr. Robeck directly. But the last one I thought maybe you could talk briefly about is what’s going on in terms of research and what we know about long term methadone treatment and how safe that is for patients and how long can they be on that treatment?

Dr. Illene Robeck: So remember, we don’t recommend methadone treatment lightly. This is a treatment that we recommend for patients with severe opioid use disorder currently. We almost all people who can tolerate buprenorphine/naloxone it’s a much safer medication and we’re going to be seeing changes in methadone treatment, recommendations over time. But remember methadone is recommended for patients with severe opioid use disorder who have a life-threatening illness. The trajectory of methadone maintenance therapy is that patients live longer, more productive lives on methadone maintenance as opposed to lack of medication assisted treatment so that patients have a very, very high relapse rate with severe opioid use disorder without treatment. And so understand that while methadone maintenance has potential side effects and treatment challenges, the issue really is related to the alternative of not treating which is really, very, very, very significant, high morbidity and mortality within years, within a few years. What we really need to be looking at is a comparison of patients at every stage of the disease with treating buprenorphine/naloxone verses methadone and OTPs using buprenorphine/naloxone verses methadone, and in different treatment settings because that I think is the question we need to be asking. Are the patients with severe OUD best treated in OTP, meaning very structured environment with buprenorphine/naloxone which has a better side effect profile verses methadone, or is methadone going to give us an advantage in that situation as well. Those are questions we need to answer.

Dr. Robin Masheb: Thank you so much Dr. Robeck and thank you to our audience for participating and writing in with some great questions. Just one more reminder to hold on for another minute or two for the feedback form. If anybody is interested in the power point slides from today please go to the reminder email where you will see the link to the presentation. If you are interested in downloading slides from any of our past sessions, simply do an internet search of VA Cyberseminars Archive and you may use the filters to find our previous seminars. You will be receiving an email with your certificate of attendance for today’s session and please stay tuned for our next Cyberseminar which will be Yoga for VA patients with Chronic Low Back Pain, a Randomized Clinical Trial. This will be held on Tuesday, November 7th by Dr. Eric Groessl and we will be sending registration information out about the 15th of October. I want to thank you again for joining us at the HSR&D Cyberseminar and we hope to see you at a future session.

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