Providers Clinical Support System

Addressing OUD in BIPOC Communities Part 3: Substance Use Disorder Care for Native Americans

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June 27, 2022

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Today's Presenter

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Anthony Dekker, DO

- Tony is currently the CMO of the Division of Developmental Disabilities, State of Arizona and a volunteer member of the Primary Care Service Line at the Gallup Indian Medical Center in the Indian Health Service. He provides services in addiction and pain medicine, primary care and is part of the team working on the COVID epidemic.
- He completed his Osteopathic education at Michigan State University in 1978. He completed his internship and family medicine residency at the Chicago College of Osteopathic Medicine and an Adolescent and Young Adult Medicine fellowship at Rush-Presbyterian-St Luke's Medical Center in Chicago. As a Public Health Service Scholar he served Chicago's South Side for fourteen years. He was Professor and Chair of Family Medicine at the Kansas City University of Medicine, and clinical professor at George Washington University and the Burrell University and Dr. Dekker is board certified in Family Practice and Osteopathic Manipulative Treatment, Adolescent and Young Adult Medicine, Addiction Medicine and Pain Medicine.

Disclosures

- Dr. Dekker has no financial nor professional conflicts of interest to disclose.
- Contents of the lecture are for educational purposes.
- Dr. Dekker does not represent any federal or state organization and his opinions are simply his opinions for this educational program.
- Not all harm reduction views are supported by the federal government or SAMHSA, though some harm reduction approaches have demonstrated promising results.

Target Audience

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Objectives

- To be aware of the comprehensive needs of American Indians and Alaska Natives in regard to SUD care
- Have an understanding of the pharmacology and risks of controlled substances;
- Develop a basic awareness of the problems of abuse, addiction and diversion in Indian Country;
- Insure multidisciplinary management of the evaluation and treatment of pain and SUD

4 Pillars of the Colonial Matrix of Power

1. *Control of Economy*-land appropriation, labor exploitation, control of natural resources
2. *Control of Authority*-government, normative social institutions, military
3. *Control of Gender and Sexuality*- family, education
4. *Control of Subjectivity and Knowledge* - epistemology, education and formation of subjectivity

Quijano A. Coloniality and modernity/rationality. Cultural Studies 2007;21(2-3):168-178.

Subjugated Knowledge

July, 1922 THE MODERN HOSPITAL 41

SUPPLANTING THE MEDICINE MAN*

By ARTHUR E. MIDDLETON, Chief of Construction Section, Indian Bureau, Interior Department, Washington, D. C.

NOT so long ago that the period and conditions are reminiscent or unfamiliar to those individuals who have aided and are still aiding in the moral, spiritual and physical advancement and perpetuation of the Red Man, the fight against disease was waged under the most trying disadvantages.

Then the Indian had just begun reluctantly and doubtfully to yield to the influences of civilization and, though accepting some of its customs, still clung with tenacious hold to the ideas and habits formed in the early history of the race and regarded with mingled skepticism, contempt and fear the white man's methods of healing the sick. When disease came upon him he stoically bore its pains and rigors and following the

eral exceptions, in the vast region extending from the Mississippi River to the Pacific Ocean and from the Gulf of Mexico to the Canadian border. The exception referred to are the hospitals located at Carlisle, Pa., Cherokee, N. C., Mount Pleasant, Mich., Hayward, Keshena and Oneida, Wis.†

The school hospitals are designed solely for the treatment of children and the typical plan usually provides two separate wards for the sexes with screened and glazed porches adjunct thereto, convalescent ward, operating, waiting, nurses', dining, bath and toilet rooms and kitchen. At some of the larger schools, however, isolation and private wards and disinfecting rooms are provided. The agency hospitals while in-

Colonial and Medical Authority

OBSTETRIC PROCEDURES AMONG THE ABORIGINES OF NORTH AMERICA.—Dr. Eli McClellan, Assistant Surgeon U. S. A.,

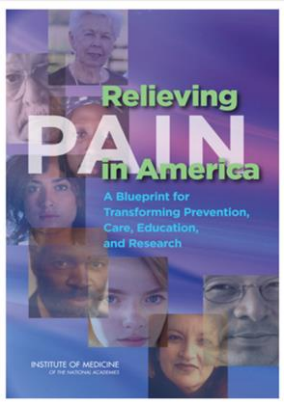
"Promiscuous sexual intercourse among the unmarried of the Apache Indians is common. They are polygamists. The women are unclean and debased. The Navajoes, a branch of the Apache tribe, live in the rudest huts and lead a drunken, worthless life. The women are debased and prostituted to the vilest purposes. Syphilitic diseases abound. Polygamy

McClellan, E. (1873). Obstetric Procedures among the Aborigines of North America. *Clinic of the Month*, 99-106.

Understanding the Effects of Prejudice, Discrimination and Inequity in the Body

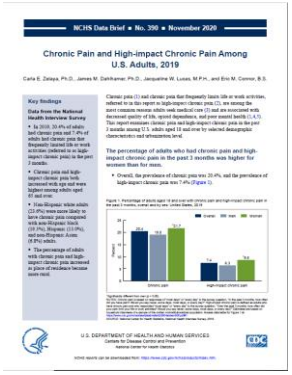
- Sheer exhaustion, burn-out and overwhelm about the pervasiveness of prejudice, discrimination and inequity
- Hopelessness/powerlessness and resignation (stop voting, listening to news…)
- Inability to recognize signs of resiliency and resistance in one's self and community
- Withdrawal from relationships in one's own community
- A pattern of not speaking-up followed by a sense of resentment/shame/self-blame

Chronic Pain as a Major Public Health Problem



Institute of Medicine (IOM) Report (2011)

- The financial burden of chronic pain exceeds those of cancer and heart disease combined.



2019 National Health Interview Survey (NHIS) (2020)

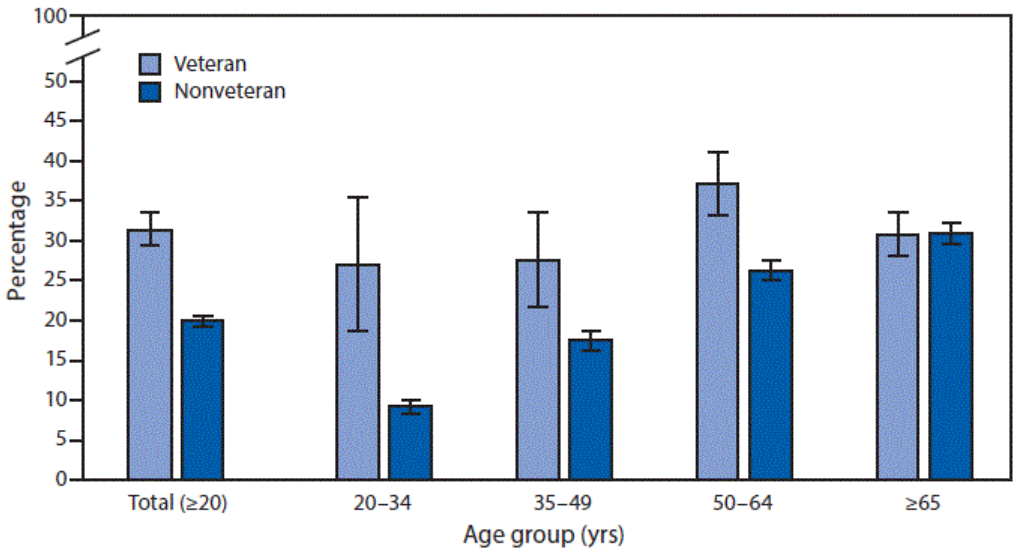
- 20.4% of adults in the US had **chronic pain** in 2019, and
- 7.4% had **high impact chronic pain,** defined as chronic pain that frequently limited life or work activities.
- Groups with higher rates of high-impact chronic pain include women, those over 65, Non-Hispanic white adults, and those in rural locations.

National Academies Press http://www.ncbi.nlm.nih.gov/books/NBK91497/; Zelaya CE et al. NCHS 2020 Nov https://www.cdc.gov/nchs/data/databriefs/db390-H.pdf

Prevalence of Pain Among Veterans

Chronic pain is more common in Veterans than non-Veterans.

- In a national survey, **31.5% of Veterans vs. 20.1% of non-Veterans reported experiencing chronic pain in the past three months.**
- Chronic pain was defined as pain on most days or every day in the past three months.
- Veterans of all age groups except those ≥65 years of age were significantly more likely than non-Veterans of the same age group to experience chronic pain.



QuickStats: Percentage of Adults Aged ≥20 Years Who Had Chronic Pain, by Veteran Status and Age Group — National Health Interview Survey, United States, 2019 (cdc.gov)

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Pain Management and Opioid Safety

The VA 2018-2024 Strategic Plan included Pain Management and Opioid Safety in the list of Focus Areas.

- The co-occurrence of pain and mental health conditions often result in high impact pain.
- Pain, medical and/or mental health comorbidities are often related to military service and require Veteran-specific expertise.
- Veterans are at higher risk for harm from opioid use and accidental poisoning than non-Veterans.
- Pain is the most common factor among Veterans who die by suicide, and there is a close correlation between pain intensity, suicide risk and death rates.
- **Pain care requires a systematic coordination of medical, psychological and social aspects of health care (integrated care).**

https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf; Ashrafioun et al., J Pain. 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

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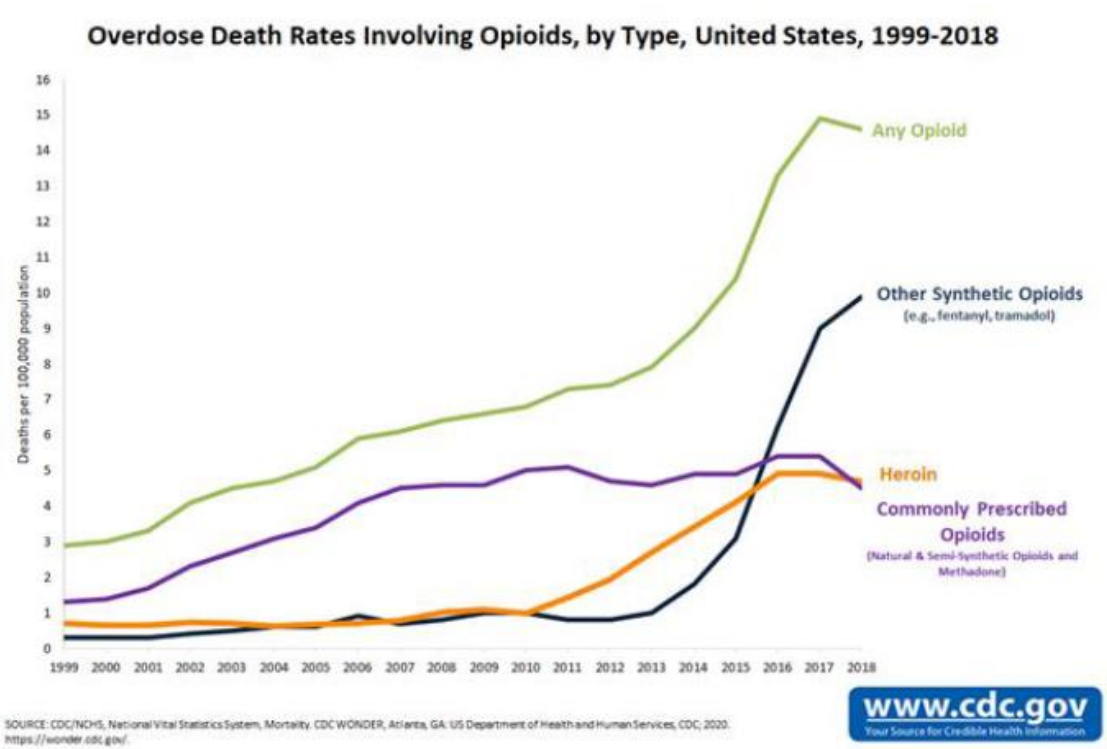
Overdose Death Rates by Opioid Type

Overdose Deaths due to Synthetic Opioids on the Rise



https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

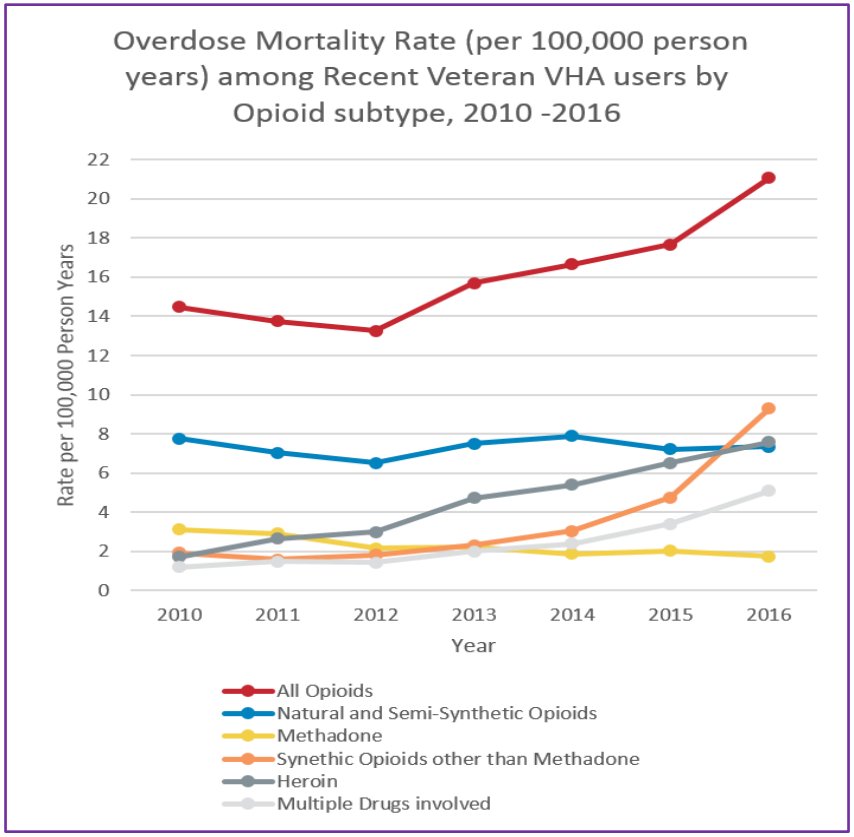
In the past several years, the relative contribution of drug type to overdose deaths has changed: initially primarily **prescription opioids**, then also **heroin** and more recently **synthetic opioids** (such as carfentanil).

Now, **polysubstance** use is common, such as the combination of opioids with sedatives and/or stimulants.

Opioid Overdoses Among Veterans in VHA

Veterans are at Elevated Risk for Death due to Overdose

- 6,485 Veterans receiving care in VHA died from an opioid overdose between 2010 and 2016, with increasing rate over that time period.
- **In 2016 alone there were 1,271 deaths of Veterans in VHA, or 3.5 per day.**
  - This is 1.5x greater than the general population opioid overdose mortality rate.*
  - 62% of VHA Veteran overdoses involved opioids.



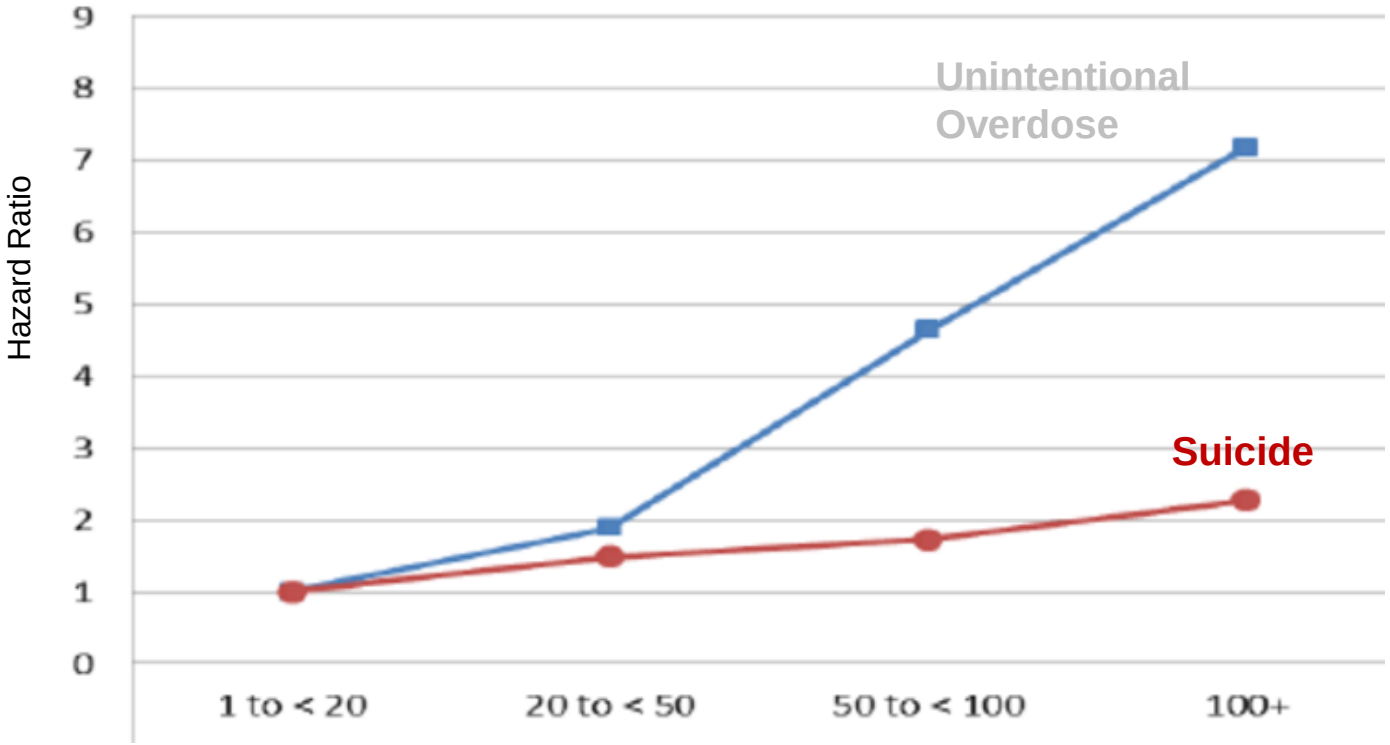
**This equates to a mortality rate of 21.1/100,000 among VHA Veterans and 13.3/100,000 in the general population.*

Data from Lin LA et al. *Am J Prev Med. June 2019;* https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#page=1

Dosage and Risk of Overdose

Opioid Dosage and Risk of Death (Patients with Chronic Pain)

- Bohnert AS et al. JAMA 2011 Apr 6 https://pubmed.ncbi.nlm.nih.gov/21467284/; Igen MA et al. Opioid Dose and Risk of Suicide. Pain. 2016 May https://pubmed.ncbi.nlm.nih.gov/26761386/



Multiple studies demonstrate **higher doses carry higher risk of opioid-related death**.

- This may in part reflect the **prevalence of mental health comorbidities** in patients with chronic pain.

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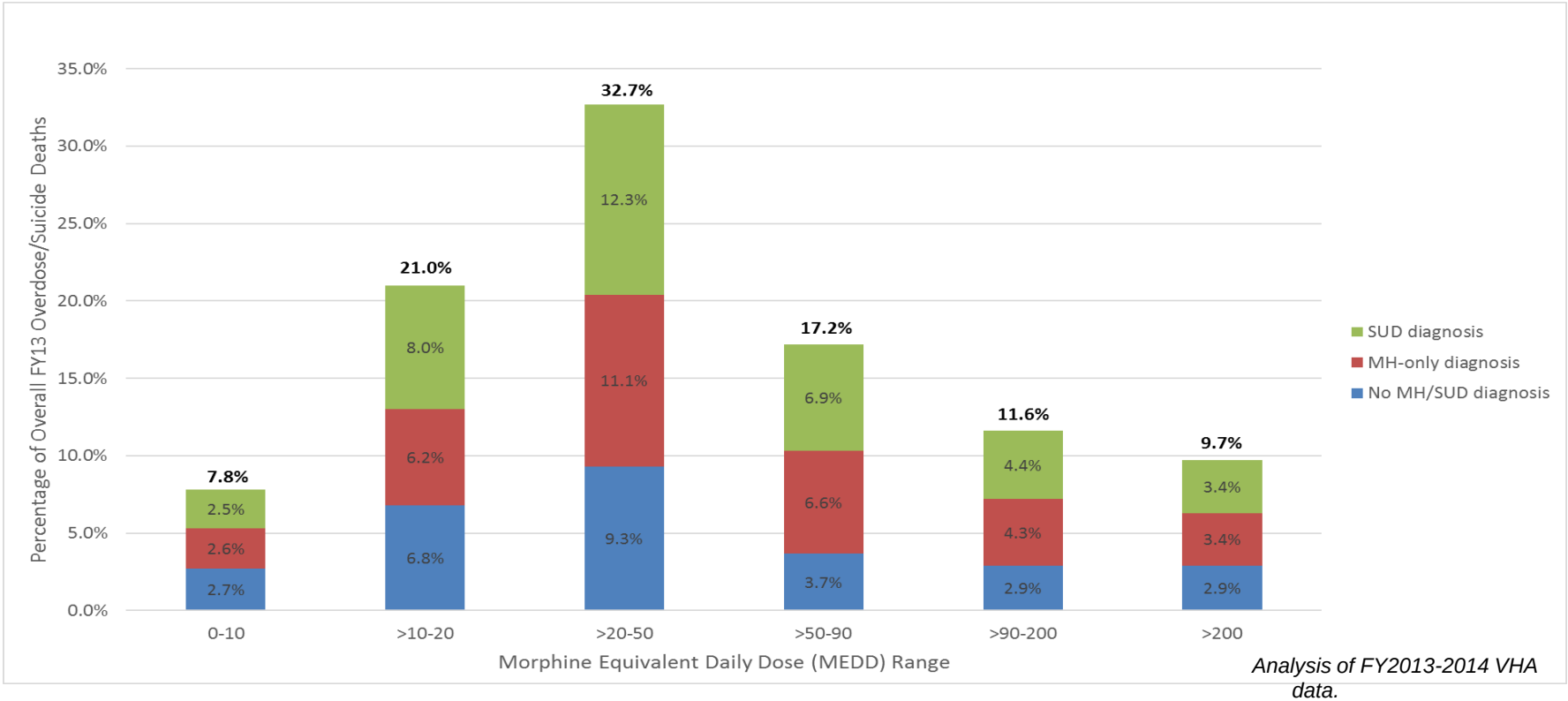
Overdose/Suicide Mortality Data Among VHA Veterans Demonstrate: No Safe Opioid Dosage



Analysis of FY2013-2014 VHA data.

Of the Veterans who died from overdose/suicide:

- Almost **4/5** were **prescribed < 90 Morphine Equivalent Daily Dose** (MEDD).
- Almost **3/4** had **Mental Health diagnosis (including Substance Use Disorder)**
- More than 1/2 had MH/SUD diagnoses and were prescribed < 90 MEDD.

Unpublished Data from the Patient and Family Education Resource Center (PERC).

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Risk Factors for Overdose and Opioid Use Disorder (OUD)

Risk Factors Include:

- Opioid prescription, including:
  - Dose and Duration
  - Type (Extended-Release/Long-Acting forms)
- Interaction with other medication/drugs, such as sedative hypnotics

Prescribing factors

- Medical comorbidities (e.g., chronic pulmonary disease, sleep apnea)
- Mental health comorbidities (e.g., depression, bipolar disorder)
- Substance Use

Patient factors

Park et al. J Addict Med 2016 https://pubmed.ncbi.nlm.nih.gov/27525471/

Summary: Pain and Opioid Overdose Epidemiology

- **Chronic pain in Veterans is more common, and more often severe** than in the general US adult population. AI/AN veterans have a higher frequency and intensity.
- **Mental health comorbidities often result in high impact**, or severe **pain**.
- Pain is the most common factor among Veterans who die by suicide.
- Veterans are 1.5x as likely as the general population to die from an opioid overdose.
- **Higher dosages carry higher risk of opioid-related death**; however, **no dose is completely safe**.
- **Risk factors for Opioid Use Disorder (OUD) and overdose** include:
  - Higher dosages
  - Extended-release/longer-acting forms
  - Drug-drug interactions, such as with sedative-hypnotics (e.g., Benzodiazepines)
  - Medical comorbidities such as sleep apnea
  - Mental health comorbidities
  - Substance use

First, a Definition: What is Pain?

What is Pain?

In 2020, the International Association for the Study of Pain (IASP) Task Force Reconvened for the first time since 1979 to develop an updated definition of pain:

OLD Definition:

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage **or described** in terms of such damage."

NEW Definition:

"An unpleasant sensory and emotional experience associated with, **or resembling** that associated with, actual or potential tissue damage."

IASP
International Association for the Study of Pain

Pain is Now Recognized as:

- A different phenomenon from nociception.
- Influenced by biological, psychological and social factors.
- An experience that is learned throughout the life course.
- **A personal experience to be respected regardless of objective evidence of tissue damage.**

https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=10475

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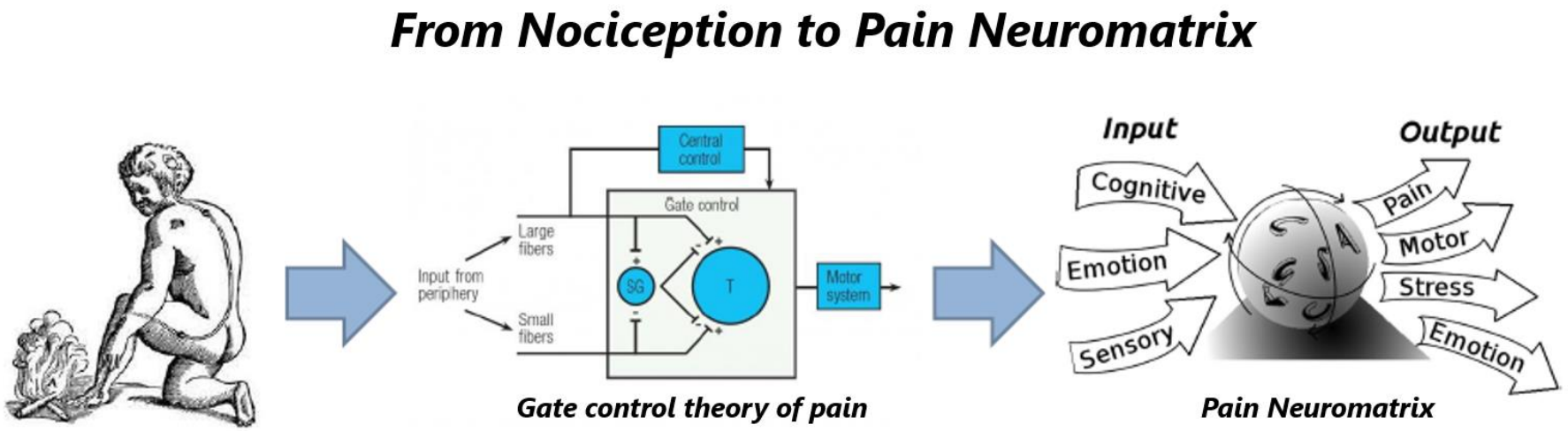
What is Pain? (continued)

Visualizing the Mechanisms of Pain

Our framework for the underlying mechanisms of pain has evolved from basic nociception in the 17th century to Gate Control Theory (1965) to the Neuromatrix model involving the input and output of interacting domains (2012).

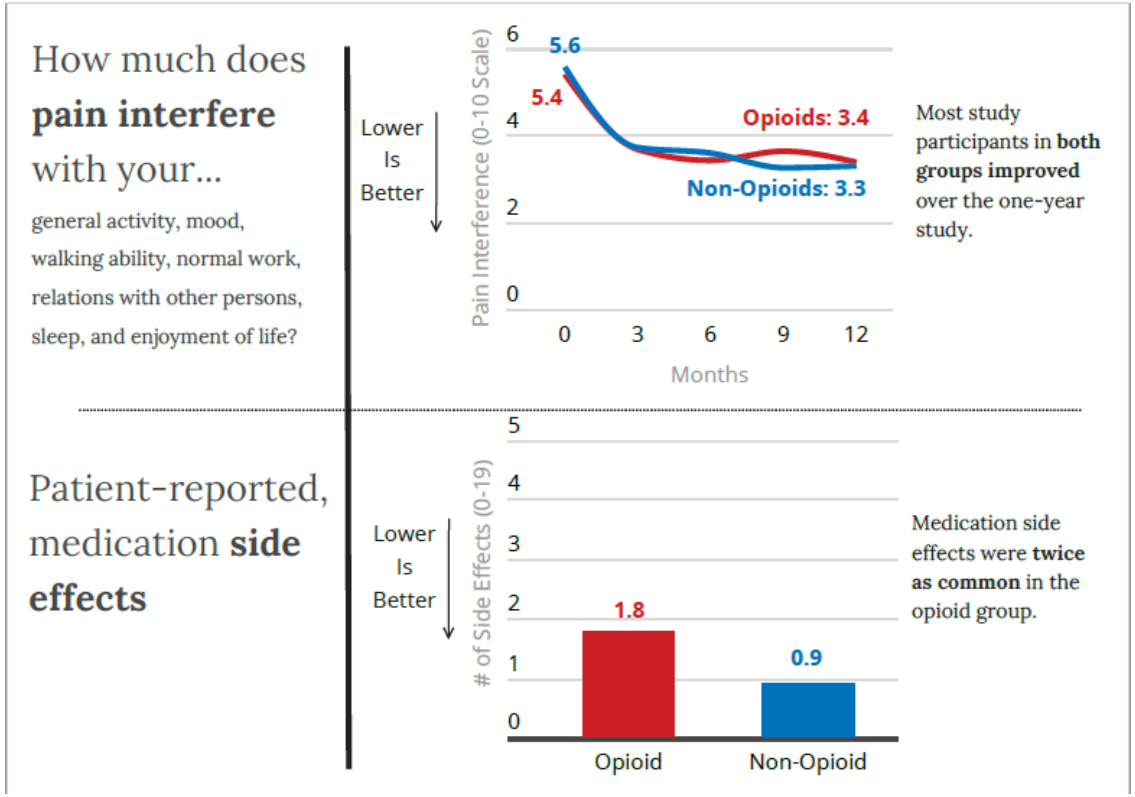


Descartes 1664; Melzack and Wall, Science 1965;150(3699):971-9
https://pubmed.ncbi.nlm.nih.gov/5320816/; Leung J Prim Health Care 2012; 4(3):254-8
https://pubmed.ncbi.nlm.nih.gov/22946077/

No Benefit from Opioid Therapy for Pain Control After 12 Months

The SPACE Randomized Controlled Trial (2018)

Among 240 VA patients with long-term back, hip, or knee pain treated for 12 months, **opioids did not work better than non-opioids for chronic pain and resulted in twice as many side effects**.



Krebs et al. JAMA 2018 https://pubmed.ncbi.nlm.nih.gov/29509867/

The Biopsychosocial Model Approach to Pain Management

Key Components:

- Biological Factors (e.g., diagnosis, age)
- Psychological factors (e.g., mood, stress)
- Social factors (e.g., social support, spirituality)

Goals:

- Improve the experience of pain
- Enhance physical functioning
- Promote activities of daily living
- Increase quality of life (QoL)

https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

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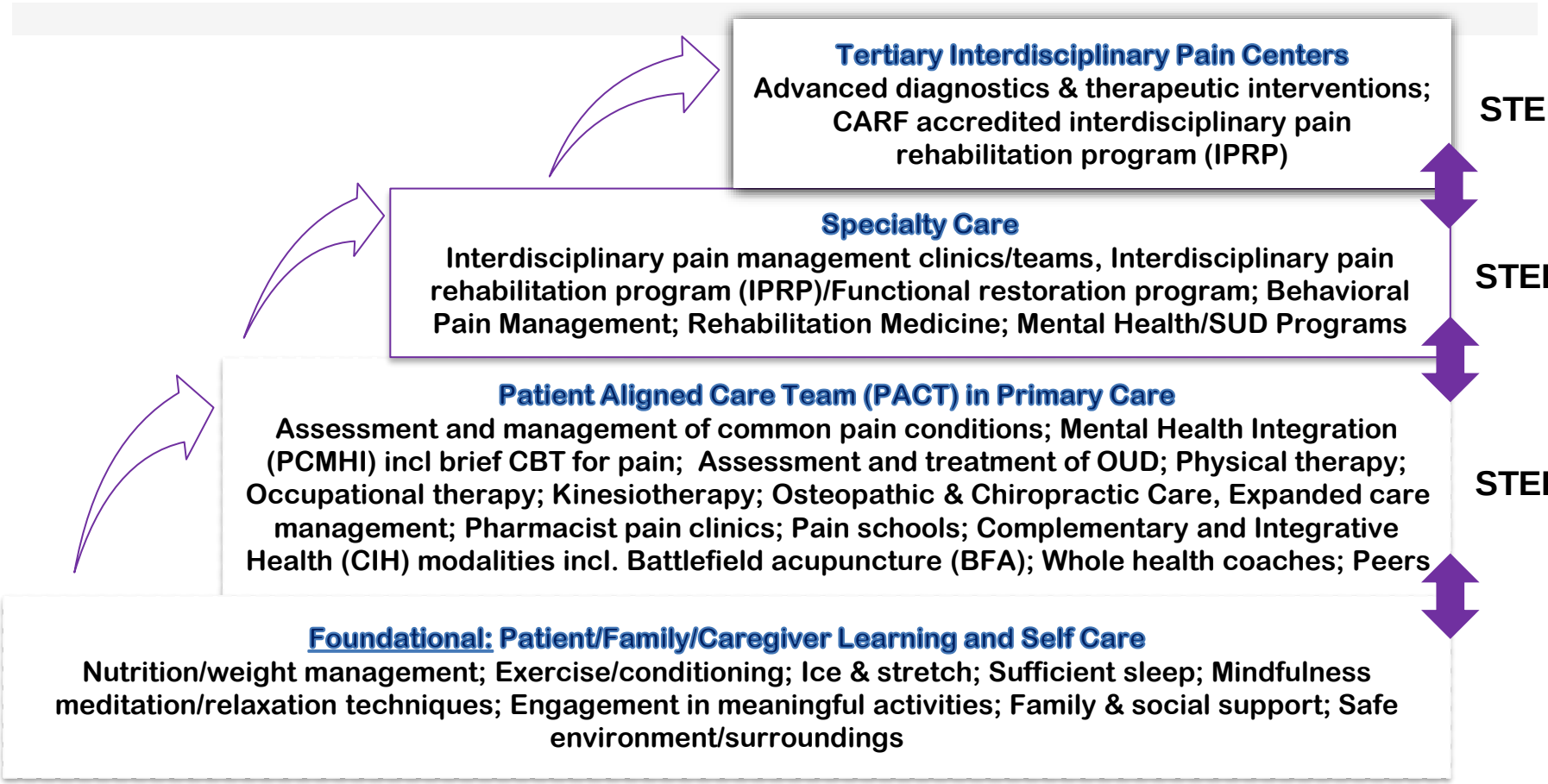
The Stepped Care Model for Pain Management



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Summary: New Principles of Good Pain Care

Integrated Collaborative Pain Care that is Patient-Centered

- **Pain** has been **redefined as being a complex personal experience** and is influenced by biological, psychological, and social factors (**biopsychosocial model**).
- Pain care in VHA is **moving away from the use of opioids** and **towards multimodal, interdisciplinary pain care** that takes a "**Whole Health**" approach in order to provide individualized care.
- **Foundational** is **self-care/self-management.**
- The **Patient Aligned Care Team (PACT) in Primary Care** is the **Medical Home** with integrated Mental Health services and direct access to pain care modalities.
- The **PACT team and Pain Management Teams/Specialty Care work collaboratively** and coordinate pain care across service lines.

Five A's used in Pain evaluations

- Analgesia
- Activity
- Adverse Reactions
- Aberrant Behavior
- Affect

Chronic Pain Treatment

- 1) Medications: Oral, Sublingual, Topical, Intrathecal
- 2) Modalities: PT/OT, Acupuncture, Micro-current, TENS, OMT, Fascial Distortion Therapies
- 3) Exercise, Rehab, Weight-Loss: PT, Dietitian
- 4) Interventional: Superficial, Joint, Selective Nerve Root, Sympathetic Chain, ESI, RF, Cryotherapy, SCS, Intrathecal Pumps
- 5) Behavioral Health: Psychotherapy, Psychiatry, CBT, Biofeedback, Mindfulness, Support Groups
- 6) Complementary/Alternative Care/Body Work/Traditional Indian Medicine

Medications

- Medications typically include NSAIDS, Acetominophen, Anticonvulsants, SNRIs/SSRIs/MAOIs, TCAs, NMDA antagonists, Corticosteroids, Viscous Supplements, anesthetic patches, Muscle Relaxants, Homeopathic agents, Biologics, MAT, Naltrexone and Opiates
- **Future**: non-classical (NOP) opioid receptor agonists?, CB2 agonists?, medical marijuana?

Non-opiate treatments

- Cognitive Behavioral Therapy (**CBT**)
- Exercise and Activity therapy*, diet and weight management
- 1st line and 2nd line options: acetaminophen and NSAIDs; gabapentinoids, SNRI's, and TCA's
- Topical modalities and interventional treatments
- Multimodal/Multidisciplinary **approaches** have favorable response vs single modalities
- * The most important

Non-opiate risks

- **Acetaminophen** toxicity thresholds between 2-3000mg.
- **NSAID** precautions with both COX1 and COX2 inhibitors. Be wary of long-term concerns for **cardiac, GI, CKD, anticoagulants**.
- **Gabapentinoids** – risk associated with fall, dizziness relative to dose initiation and titration
- **SNRI** – loading and taper strategies, rare incidence of Serotonin Syndrome.
- **TCA's** – Cardiac and dizziness related risks
- **Corticosteroids** – Hormonal and Glucose precautions
- **Lidocaine Analogs** – Cardiac and Toxicity risks
- **Muscle Relaxants** – Fatigue, Fall risks

Goals of Treatment

1. Improve quality of life and psyche, function, and performance of ADL's.
2. Ensure safe and reasonable treatment for underlying condition(s).
3. Maintain clear rationale for utilization based on patient's risk factors and response.
4. Encourage autonomy, coping and healthy lifestyle choices to improve long-term outcomes.

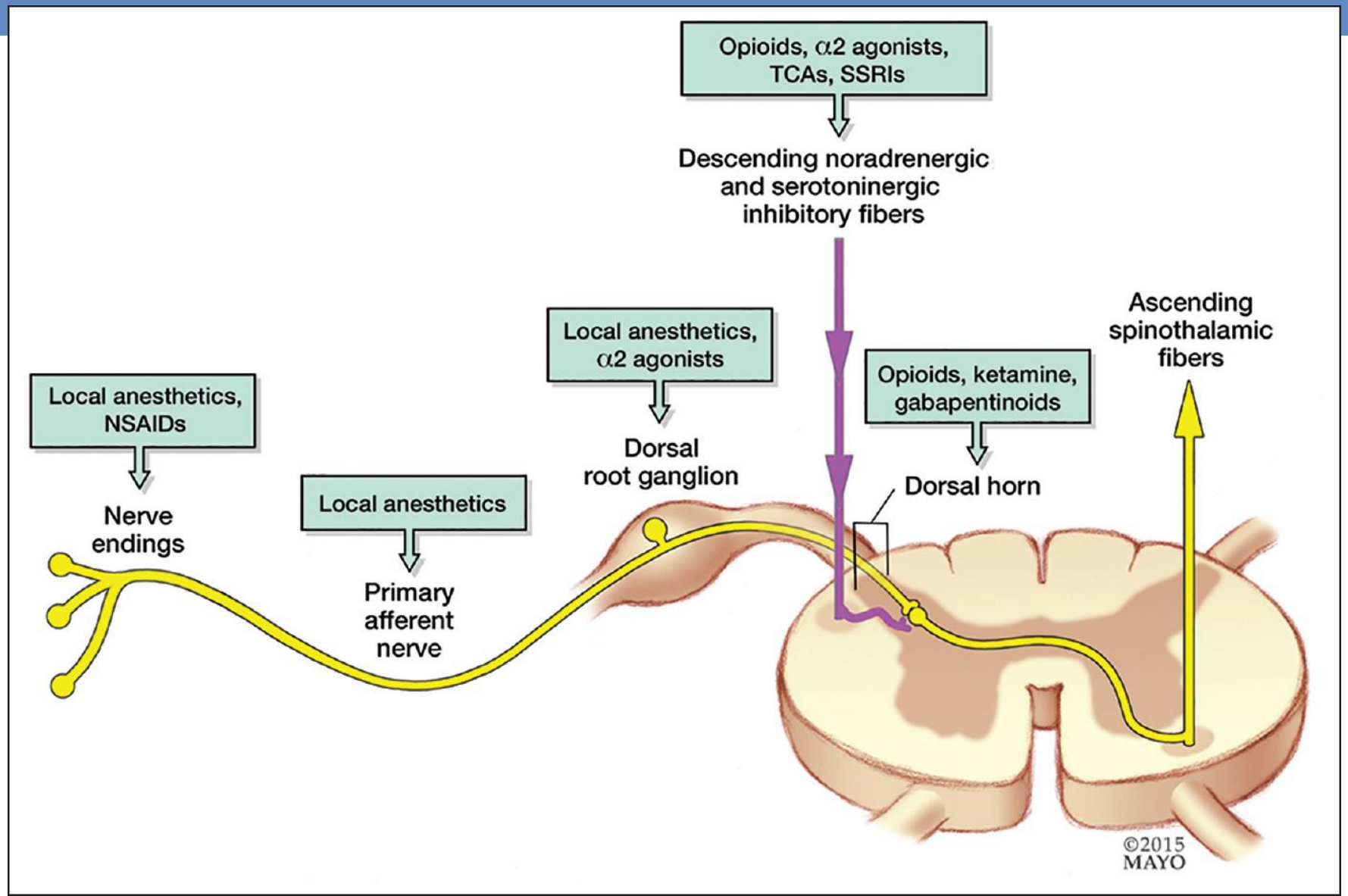
Therapeutic Objectives

- Will patient be able to reasonably perform routine work and family obligations?
- Will patient transfer, walk, and routinely exercise? Will patient remain sedentary?
- Will patient be able to reliably perform ADL's and executive functioning without significant harm to self?
- Will patient commit to behavioral modification and interventions when appropriate?

Documentation

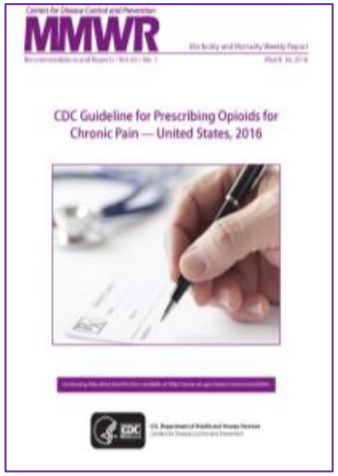
- Assess and document the signs and symptoms consistent with pain and dysfunction.
- Describe the setting and provocative activities that lead to complaints.
- Be descriptive with findings: What type of pain: myofascial, joint, facet, radicular, spastic, neuritic and correlate findings on exam with ROM, strength evaluation and special testing.
- Tailor plan based on objective complaints 1st line.

Nociceptive Pathway



Evidence: The CDC Opioid Prescribing Guideline (2016)

"Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with **insufficient evidence to determine long-term benefits** versus no opioid therapy, though evidence suggests risk for **serious harms that appear to be dose-dependent**."



"Clinical decision-making should be based on a relationship between the clinician and patient, and an understanding of the patient's **clinical situation, functioning, and life context**."

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

VA/DoD 2017 Clinical Practice Guideline: Opioid Therapy

- If prescribing opioids: **use the shortest duration and lowest dosage.**
- **No dosage is absolutely safe**; strong recommendation against increasing opioid dosage >90 MEDD.
- **Avoid long-acting opioids for acute pain, as PRN, or upon initiation** of opioid therapy.
- Opioid dose **reduction should be individualized** to the patient.
  - For **OUD**, offer **medication treatment (m-OUD)**.

4) Opioid Therapy for Acute Pain

- **Acute pain:** use alternatives to opioids; use multimodal pain care, **if using opioids prescribe for ≤3-5 days.**

https://www.healthquality.va.gov/guidelines/Pain/cot/

Opiate Prescribing

- Opioids are commonly prescribed for chronic pain despite poor empirical evidence of long-term efficacious relief.
- In 2012, 259 million prescriptions were written for opioids, enough for one bottle per adult American.
- CSPMP monitoring in Arizona has documented a 55% drop in opioid prescribing in AZ since 2012
- All prescribers are being followed
- New regulations implemented 26APR2018 in AZ
- DEA has full visuals on CSPMP/PDMP
- All states became interactive in 2020 (MO)
- 2021 DEA dropped training requirement for XDEA

National Institute on Drug Abuse. (2015). Drugs of Abuse: Opioids

Long-Term Adverse effects

1) Addiction/Tolerance/Dependence (risks)

2) Opioid-Induced Endocrinopathy: suppression of hypothalamic-pituitary-gonadal axis via inhibition of GnRH. Most notable changes to **sex-hormones and Vitamin D-25-OH**

3) Hyperalgesia Syndrome/Sensitization: Increased pain as a result of long-term opioid use generally different from original injury (difficult to diagnose). Pain may gradually normalize with decrease in opiate. This may be more pronounced wind-up phenomenon with **Fibromyalgia.**

4) Respiratory Suppression in Apneic Disorders, COPD

5) Depression/Anxiety/Sleep Disorders

American Academy of Pain Medicine (AAPM) 29th Annual Meeting. Poster 135. Presented April 11, 2013.

Risk Stratification

- Rates of nonmedical prescription opioid use were greatest among W**hite** and **Native American men** in the Midwest and West, with annual incomes less than $70,000, previously married, and with a **high school-level education or less.**
- Prescription opiate use disorder are linked to a variety of mental health disorders: **PTSD**, borderline, schizotypal, antisocial personality, persistent and **major depressive disorder**, and **Bipolar I disorder**.

Safety

- Safe and effective opioid therapy for chronic pain requires clinical skills and knowledge in both the principles of opioid prescribing and on the assessment and management of risks associated with **opioid abuse, addiction, and diversion.**
- **AI/ANs have a higher risk ratio.**

Considerations to Ask

- Is it medically reasonable to initiate or continue current regimen?
- If so, for how long at current dosage?
- Is it safe?
- Are their long-term concerns?
- Is there evidence of Aberrant Drug-Related Behaviors?
- Are supportive and evidence-based treatments being *continually* trialed?

CDC Opiate Prescribing Guidelines

- Opioids are **not** first-line for chronic pain.
- If opioids are used, they should be combined with **nonpharmacologic therapy** and **nonopioid pharmacologic therapy**
- Establish and measure goals for pain and function with each assessment and **track accountability/progress.**
- Prescribe the lowest effective level, practicing caution with dosing **>50 MME/day**, and **document justification** for dosing **>90 MME/day**.
- Prescribe no more than needed for acute pain. Utilize **Opiate Risk Tools** and documented pain agreements.

USDHHS, CDC, Guidelines for Prescribing Opioids for Chronic Pain 2016

2016 CDC Recommendations

- Frequently reassess risk of harm and risk factors; taper or discontinue as appropriate. Be prepared to address **common opiate-related adverse effects.**
- Utilize **PDMP(CSPMP), all states** and toxicology routinely.
- Avoid/minimize **benzodiazepine** and opioid prescribing whenever possible. Utilize **multidisciplinary teams.**
- Be prepared to offer or refer for **MAT** with buprenorphine or methadone in combination with behavioral therapy for high-risk patients.
- Practice extreme caution with **methadone**, never rotate/initiate higher than 10mg PO TID due to variable pharmacokinetics.

Purpose **of the Guidelines**

- To provide recommendations on opiate prescribing for chronic pain (adults with pain lasting > 3 months) outside of active cancer treatment, palliative care, and end-of-life care for primary care clinicians and serve as a **relative safety and documentation standard.**
- **2019 CDC follow up. Do not apply the guidelines uniformly to all.**
- **2022 CDC Public Comment 10APR2022**

Relevance of Current Guidelines

- Improve the communication of benefits and risks of opioids for chronic pain amongst patient's and clinicians.
- Improve the safety and effectiveness of pain treatment.
- Hopefully reduce the morbidity and mortality of long-term opioid therapy.
- Help recognize appropriate referrals or initiation for Medication-Assisted Treatment.

Taper Strategies

- Taper slow enough to minimize symptoms and signs of opioid withdrawal.
- **10%** decrease per week is reasonable starting point; however individualized care and psychosocial support should be endorsed.
- **10%** decrease per month may be better tolerated in long-term opiate patients. Methadone slower.
- **Rapid tapers** may be more appropriate with recent overdose or suspected **Aberrant Drug-Related Behaviors. 89% of AZ 2016 deaths**
- **Consider MAT** if taper intolerable or pregnancy.

PDMP Monitoring

- Evaluate whether there **are multiple providers, early refills, high dosages, or dangerous combinations** at higher risk for overdose.
- Every prescription to every 3 months.
- **Practice caution** with out-of-state patients or limited access scenarios.
- **Consider medication counts.**
- **Does not include OTP (methadone clinics) or dispensed meds (ED, Urgent care etc).**

Patient Discussion

- Discuss information and confirm patient awareness of all prescriptions.
- Review medications and safety risks. MME assessment.
- Reinforce patient agreement and monitoring needs.
- Discuss care with other providers when appropriate. Coordinate goals.
- Evaluate possibility of Substance Use Disorder, misuse, abuse, or diversion.

Behavioral Health Support

- Comprehensive pain-management plans can decrease the physical and emotional impacts of chronic pain and better suit patient care needs.
- Stress-reduction techniques, work with a cognitive behavioral therapist (CBT), relationship counselor or pain support group.
- Talking to others in addition to the provider about chronic musculoskeletal pain can help ease the pain symptoms.

Practice Pitfalls

- Establish ground rules and stick to them with a documented Pain Agreement.
- Avoid complete cloning of charts.
- Do not blindly continue high-risk regimen without succinct and transparent plan and justification on each visit.
- Do not allow frequent early-refills.
- Minimize management of high-risk patients without coordination with pain management, psychiatry, and/or addiction.
- Do not have erroneous delays in mailouts.

How did we get here

- Institute for Healthcare Improvement- Don Berwick, Minimize or eliminate Pain in Healthcare
- Joint Commission, Policy and Procedures for Pain Evaluation and Care
- Pain and the 5th Vital Sign
- Increase in opioid prescribing by 400%
- Perdue Pharma and other manufacturers and Distributors
- Provider Education
- PDMP CSPMP
- BOMEX and licensing boards

Relationship of opioid termination and OD and suicides

- British Medical Journal, January 2020
- Oliva et al , VA Menlo Park CA and Yale University with several authors
- 1,394,102 veterans with an outpatient prescription from FY 2012-2013
- 799,668 stopped opioid prescriptions (57.4%)
- 2887 deaths from overdose or suicide
- Stratified by length of treatment, less than 30 days, 31-90 days, 91 to 400 days and greater than 401 days

Time on opioids

- 30 days or less, 32%
- 31- 90 days 8.7%
- 91 to 400 days 22.7%
- Greater than 401 days 36.6%

OD Hazard ratios for opioid termination

- 30 days or less, 1.67
- 31- 90 days 2.8
- 91 to 400 days 3.95
- Greater than 401 days, 6.77

Suicide hazard risks for opioid termination

- 30 days or less, 2.02
- 31- 90 days , 3.43
- 91 to 400 days, 4.78
- Greater than 401 days, 7.99

OD vs suicide outcomes

- 1851 Overdose
- 1249 Suicide
- 13 excluded because of missing data
- Increase risk with opioids greater than tramadol, increased morphine mg equivalants (MME), number of medical diagnoses, mental health or substance use disorder, younger, male and being single.

Agnoli et al, JAMA, 3AUG2021

- Tapering was associated with an adjusted incidence rate of 7.6 mental health crisis events per 100 person-years compared with 3.3 events per 100 person-years among nontapered periods (adjusted incidence rate difference, 4.3 per 100 person-years [95% CI, 3.2-5.3]; aIRR, 2.28 [95% CI, 1.96-2.65]). Increasing maximum monthly dose reduction velocity by 10% was associated with an aIRR of 1.09 for overdose (95% CI, 1.07-1.11) and of 1.18 for mental health crisis (95% CI, 1.14-1.21).

Controversies

- Limits on MME
- Many MAT providers but few prescribers
- Cost and effectiveness of Residential Treatment Care
- Effectiveness of Sober Living Homes
- Naloxone distribution
- Buprenorphine diversion
- SAMHSA and DEA dropping required XDEA training
- Requirements of BC Pain Medicine Consultation for Opioids over 90 MME

Where to we go from here

- Recognize those in need
- Support NM and AZ efforts to increase providers able to prescribe MAT (SAMHSA recent drop of XDEA requirements)
- Realize that treating addiction is complex and multidisciplinary
- Remove Stigma of addiction
- Decriminalize the diagnosis of substance use disorder to maximize acceptance to treatment
- Realize this is a moving target as new substances of abuse are coming
- Enhance use of the community services

Thank You, Questions?

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

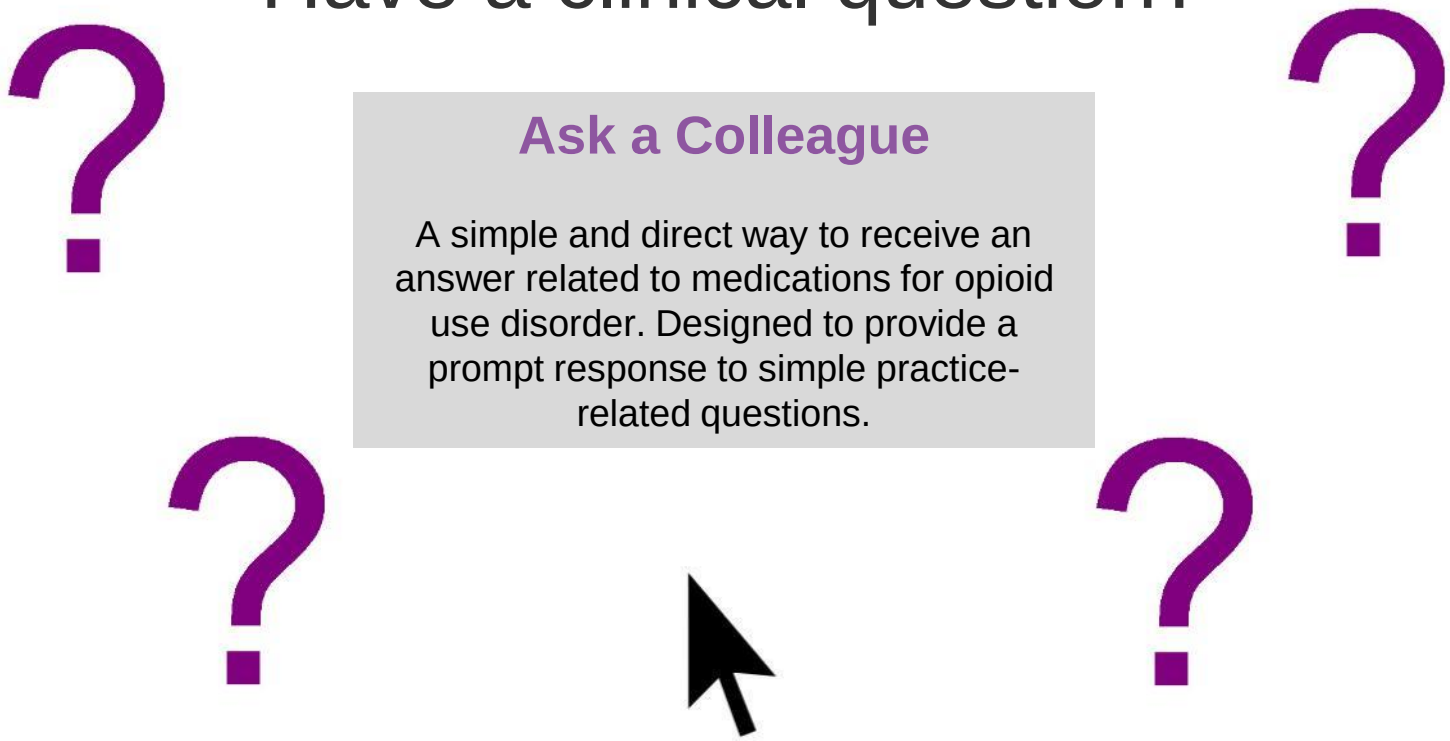
For more information visit:

https://pcssNOW.org/mentoring/

PCSS Providers Clinical Support System

PCSS Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

PCSS Providers Clinical Support System

PCSS Providers Clinical Support System

PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Mental Wellbeing
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

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