The OPAS Experience

An Outpatient Model for At Risk Chronic Non-Malignant Pain Patients

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THIS ARTICLE INTRODUCES a therapeutically and financially viable clinical model for caring for patients with chronic non-malignant pain (CNMP) who are at risk of or have addiction problems. While this article is directed primarily toward those with prescriptive authority, it will be of interest to anyone involved in caring for patients with CNMP.

The Olympic Pain and Addiction Services (OPAS) was founded in 2004 as a private, non-subsidized chronic pain and addiction medicine service to serve a rural area on the Olympic Peninsula in Washington. My background providing primary care in this rural and relatively underserved setting, experience in medical acupuncture dating to the early 1980s, and a keen interest in helping patients with CNMP and addiction, and the realization that many patients at risk or with established chemical dependencies (CD) did not have access to proper medical help for their CNMP led to the formation of OPAS. While Jefferson County, where we are located, has a population of about 20,000, demand for our services remains high.

The Clinical Model

OUR GOAL is to provide comprehensive and integrative services for individuals who suffer from CNMP and/or addiction. Patients are referred to us by their primary care provider (PCP). After an initial consultation, patients are introduced to our policies and are invited back for ongoing specialized care. We recommend that our clinicians be the sole prescriber of chronically prescribed psychoactive medication for these patients. All primary care and acute pain problems are directed back to the PCP for evaluation and treatment.

Either before or after a 40-minute group counseling session, patients are seen individually for 5 to 15 minutes. From a financial standpoint, this allows us to bill for evaluation and management services that involve about 45 minutes face-to-face with the patient and more than half of the time spent in counseling. While a small percentage of patients have difficulty with a group setting, for the vast majority, the therapeutic benefits are apparent. Indeed, a number of these patients may not always be best served by one-on-one encounters. Our clinicians are likewise satisfied, because they can use some of their teaching skills without the typical constraints of time. The group setting also allows for additional educational aids and a comfortable setting for discussions. We consider eight participants an ideal group size. Theoretically, this limits the time any one patient has to spend in the office to little over an hour.

Patients are generally seen weekly to start. As they progress, they cut back to once a month. While stabilized patients can be referred back to their PCP for ongoing care, we find the majority of patients prefer to continue to see us for their specialized needs, simply because of a fear of being "poorly understood" by their PCP. In addition, some PCPs are uncomfortable prescribing the psychoactive medications these patients require.

A few patients require medications to be dispensed daily and some come in a couple times a week or weekly for their medications. Most patients, however, pick up their medications from their pharmacist.

Universal Precautions

THE PATIENTS TREATED in this setting have complex medical and psychiatric histories. Covering their unique needs in a 5-to-10 minute period would be impossible if standard procedures and "Universal Precautions" were not in place.

"Universal precautions" were first widely used in the treatment of patients at risk of acquiring or having infectious diseases (1,2). The concept explains why healthcare providers who come into contact with bodily fluids now routinely wear gloves and it implies sound judgment. In a situation where significant risks are present for individuals, and there are no simple and immediate ways to determine individual risk, everyone is considered at risk and screened and treated accordingly.

Routine mammograms and airport security checks both are examples of the use of "universal precautions."

Gourlay et al introduced "universal precautions" by advocating routine urinalyses and other screening tools on patients who are being considered for or are chronically prescribed opiates (3). At OPAS, for patients who are at significant risk of developing or having a CD, "universal precautions" involve the entire treatment plan. While research is lacking to prove the effectiveness of these precautions, our patients benefit from an approach that assumes that they are chemically dependent or at significant risk of developing CD (4).

Dosing and Monitoring of Patients

THE PHARMACOLOGY of opiate preparations, dosing implications, and medication duration all need to be considered. As a result, it is unusual for a patient with chronic pain to be prescribed an opiate other than methadone or buprenorphine.

"As needed" dosing is strongly discouraged, because it plays into the self-medicating behavior of a patient with the active disease of addiction, and may well end up rewarding such behavior.

Our patients benefit from comprehensive monitoring that involves family, an interdisciplinary healthcare team, and regular office visits. Fortunately, so much of what benefits a patient with CNMP often benefits a patient at risk of CD.

Our patients range from simply having difficulty adhering to medical advice to outright loss of control over the use of their medicines. We intend for all of our patients to eventually have no issues regarding opiates used, dosage, frequency, complications, unmanaged side effects, lost prescriptions, and availability of prescriptions. While for some this will involve abstinence models, for most others some form of ongoing pharmacological management will be indicated. The outright heroin addict does benefit from methadone or buprenorphine for pain if it is properly prescribed with precautionary and adjunctive modalities. Just like a diabetic—whether on insulin or not—an opiate-dependent individual needs education and ongoing complementary care if complications from his or her disease are to be minimized.

For universal precautionary reasons, including the need to avoid complications from opiate neuro-sensitization, the vast majority of opiates we prescribe are methadone or buprenorphine. While even in our specialized and experienced setting, we have patients who have fatally overdosed on methadone or a combination of licit and illicit drugs, we consider the benefits of methadone prescribing to outweigh the risks. It is a tragedy that buprenorphine is not more widely covered by third parties, especially because it is clearly a safer medication. It is also worth noting that the dangers and contraindications of acutely and chronically mixing benzodiazepines and other sedatives with opiates need further widespread dissemination.

Distinctions between Pseudo-Addiction and Addiction

OUR FACILITY MAKES NO DISTINCTION between pseudo-addiction and addiction. Our priority is to provide pain management while eliminating problematic medication use. Mutual trust must be established and our policies help this process. Patient statements such as "I lost my drugs," or "The pharmacist didn't give me them all to me," or "I missed my appointment so I borrowed some," or "There's no way that could be in my urine," or "I just hurt so bad I took more than you prescribed," we translate into "What extra help is indicated so that issues around the use of these medications goes away?" Based on a host of contextual issues the interventions will vary, but there are some general principles that help.

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The distinction between CNMP and CD is relatively moot. While standard medical care is indicated to recognize and treat acute and progressive nocioceptive pain, we consider CNMP and CD to be primarily CNS diseases and all interventions aimed at promoting better CNS function are indicated—be they behavioral, psychological, spiritual, energetic, nutritional, or medical. Indeed, CNMP has central neuro-physiological correlates similar to those encountered in CD.

In the context of our specialized services for CNMP, taking pain medications as needed is relatively contraindicated. Since untreated CD is the chief complication of taking controlled substances and could be considered an extension or progression of "chemical coping," we strive to limit "self-medicating," especially in

high-risk patients. We tell them to take simply what is prescribed and let us determine at their next visit the appropriate ongoing dose or to call us if concerns are significant. Preparing patients for pain flare-ups is essential. Breakthrough pain challenges us to use what we have learned about non-pharmacological coping. If patients have concerns about acute nocioceptive problems, they need to be evaluated by their PCP prior to any additional usage of prescription medications.

We take "aberrant behavior" to be a pejorative term and not clinically helpful. We see patient behavior to be more or less consistent with the nature of the medicines used in our culture, resulting in proper use that may be problematic. "Normal" people have difficulty adhering to medical regimens (5). It is all the more to be expected that we would observe non-adherence to our prescriptions when dealing with substances that have the potential of "hijacking" an individual's reward system, causing withdrawal, and are associated with all the cultural taboos and moral issues around taking "addictive" substances. Hence, we need to assume behavior associated with self-medicating and drug-seeking behavior will be regularly encountered in patients for which we are prescribing controlled substances and should be seen as falling well into a "normal" distribution curve.

When to Make a Referral

WHEN DOES THE OBSERVED BEHAVIOR(S) require OPAS-like services for intense CD or further psychiatric treatment? When dealing with potentially life-threatening disease processes, it is best to be conservative. We believe any patient who has significant risk factors or is not doing well with his or her current therapy that includes controlled substances be evaluated by a specialist or, at a minimum, be cared for in a setting where "universal precautions" are used.

What are the significant risk factors?

WHILE THERE IS A PAUCITY OF FORMAL RESEARCH on the subject, we have a relatively short list of risk factors based on what we know about CD and risks of diversion:

- History of CD in a first-degree relative or current/previous household. Personal history of tobacco dependency, other CDs, or other behaviors associated with the reward system being "hijacked." Examples of some of these other behaviors include eating disorders, gambling, sexually-related compulsions, self mutilation, exercise addicts, forms of religious "fervor," etc.
- Comorbid psychiatric issues: ADHD, history of psychosis, post traumatic stress disorder or early childhood trauma, anxiety disorder, personality disorders, etc.
- Age: As in all learned behavior, the older one is when first exposed to a rewarding substance, the less likely addictive patterns will emerge. The exception is when there is already a significant history of addictive patterns present.
- Significant disability, including state aid.

Conclusion

PROVIDING WIDESPREAD ACCESS to OPAS-like services is a challenge. Implementing "universal precautions" in a typical primary care outpatient setting is not recommended if attempting to integrate the care of high-risk patients into standard patient flow. Furthermore, support and guidance for integrating our services into a primary care setting has been lacking. We hope that our experiences will guide such efforts and allow the emergence of other facilities suited to treat at risk CNMP patients with opiates.

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