Public DSRIP Project Group

Improving Chronic Pain Management while Improving Access to Treatment of Opioid Use Disorders

Untreated opioid use disorders represent a hidden cause of avoidable ED use and hospitalizations. High rates of opioid use disorders are reflected in the finding that more people die from overdose in New York State than from highway crashes or homicide. Research indicates that clinician prescribing represents an important source of these drugs through patient sale and/or exchange of these drugs.
Addressing this problem through DSRIP requires a multi-pronged strategy.
1) We must significantly improve access to Medication-Assisted Treatment (MAT) for opioid disorders In many parts of the state, patients wait months to gain entry into either Opioid Treatment Programs (OTPs), e.g. methadone maintanence programs or to primary care-based buprenorpine treatment. The DSRIP goal should be treatment on demand such that any patient identified by EDs, hospitals, or who is being discharged from jail or prison can be referred for same-day treatment. Accomplishing such same day access will require sufficient financial incentives for physicians to obtain buprenorphine training and certification and to begin treating opioid use disorders in primary care. All DSRIP PPS programs should begin publicly reporting on access to treatment for opioid use disorders based on waiting time until entry. Progress in achieving same-day access should be directly linked to DSRIP PPS incentives. Such expanded access will not only facilitate reductions in avoidable ED visits and hospitalizations but slow the horrific epidemic from opioid related overdose. Expanded access is vital.
2) We must significantly improve in-reach into jails, prisons, parole, probation, and drug courts in order to improve access to MAT for opioid use disorders among those involved with the criminal justice system. This in-reach is best done through trained peer workers. In-reach will require effective partnerships between PPS providers and correctional agencies in order to ensure every person received the opportunity to receive MAT. A large portion of persons with opioid disorders are arrested for drug-related crimes, yet very few receive MAT. DSRIP programs must ensure that all persons with an opioid use disorder who is discharged from correctional facilities as well those involved in community corrections are engaged with MAT coupled to counselling in substance use disorder programs.
3) We must improve management of opioid use disorder within correctional facilities. With only a few exceptions,e.g. Riker's OTP program, few jails or prisons in NYS offer MAT for either maintenance or detoxifciation to inmates. This means that persons who are arrested, but not convicted of any crime, who have been receiving MAT through either a community OTP or through their primary care physician are forced to undergo detoxification, often without the aid of opioid agonists. This is bad medicine, inhumane and constitutionally dubious. It is bad medicine when detoxification is not consistent with community medical standards. It is bad medicine when pregnant inmates are exposed to risk preterm birth/misscariage due to detoxification. It is bad medicine because it often represents unwarranted interruption in MAT treatment that exposes the person being detoxed to risk of overdose on release. The research is literature is clear. Opioid related deaths spike in the first two weeks following correctional release. Moreover, forced interruption of MAT following arrest discourages patient enrollment in community-based MAT due to widespread fear of "jail detox" following arrest. Improving access to MAT within corrections, even on a limited basis, will be challenging. It will likely require active engagement of state agencies including the NYS Health of Department, the NYS Commission on Corrections, the NYS Department of Corrections, PPS providers and the New York Society of Addiction Medicine to develop joint standards for MAT within corrections that meet both correctional security concerns and that are humane and compatible with good medical practice. In the era of DSRIP, health care within corrections must be brought into the mainstream of medicine with seamless transitions upon entry and discharge.
4) We must improve management of chronic pain within primary care. Current scientific evidence is limited regarding the benefits of long-term opioid treatment for pain. The harms, including increased mortality, risk for addiction, and potential for life long treatment that often ties patients to monthly visits, are well established. Improved clinical management of this challenging problem requires improved patient informed consent regarding current knowledge of potential benefits, harms and alternatives of chronic treatment. This will require evidence-based clinician training, creation and/or expansion of patient chronic pain self management groups, voluntary limits on cliinician opioid dosing for chronic pain, i.e. 120 equivalents of morphine, and creation of new multidisplinary community programs that effectively address the needs of these highly complex patients, i.e those with dual addiction and pain. Due to the absence of dual treatment programs, many primary care clinicians struggle to manage these complex patients without sufficient resources or programs they can refer patients to. Ultimately, this dual treatment programs may prove cost effective by reducing ED visits, hospitalizations, crime, diversion, and mortality.

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