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Drug Use Escalates in Oregon: Primary Care Providers Caught in the Middle

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Rachel became our patient in 2005, and just like hundreds of other patients, sought medical care because her back pain was limiting her ability to remain active. She had already failed trials of NSAIDs, muscle relaxants, antidepressants and physical therapy prescribed by other physicians. She denied any past drug use and scored low on the CAGE and ORT questionnaire (screening tools for alcohol and aberrant behavior.) She did respond to a low dose opiate and became a pain patient who received low dose methadone twice a day and oxycodone as needed. Rachel was the perfect pain patient, who never missed an appointment and whose random urine drug screens were always consistent until last week. Her urine drug test returned positive for methamphetamine and Rachel was discharged from controlled substances. She had relapsed after several years in recovery. She was referred to drug and alcohol treatment and to pain management for her pain. Unfortunately, no methadone clinic would take her because she was on methadone for pain and no other primary care clinic would take her as a patient because of her meth use. The only pain management clinic, who would accept her, had no openings for six weeks. She had taken her last methadone the day before she called and was afraid that she would start withdrawing from her opiate. She was already feeling irritable and experiencing nausea and cramping. The providers in our clinic were divided. One half wanted to keep her stable until she gets into pain management as long as she was no longer using meth while the other half refused to continue to prescribe an opiate medication to a patient who had relapsed, for fear of being sanctioned. Rachel's case is a common real-life situation the health care providers in Oregon encounter every day. The number of patients using cocaine, heroin, and especially meth are increasing in Oregon, thuscontributing to a feeling of uneasiness among health care providers who have a moral obligation to treat their patients with fairness while try to avoid to be sanctioned for doing so. These pain patients do not disclose their past addiction because they know that most health care providers would turn them away, and the screening tools are not always answered honestly out of fear of being stigmatized. A lot of these patients, on Medicaid, have diagnoses that fall below the line and do not qualify for a referral to a pain management clinic. So the primary care providers find themselves dealing with patients who suffer from chronic pain that interferes with their ability to function, but who also have an undisclosed comorbid drug addiction. Data collected in 2006 by ECONorthwest indicated that illicit drug use was more prevalent in Oregon than in the nation as a whole, with a higher usage rate of marijuana, methamphetamine and the illicit use of prescription stimulants and pain relievers. About 10 percent of Oregonians age 18 to 25 use illicit drugs, this is 18 percent higher than the national rate of 8.5 percent.

The providers in our clinic decided to refer Rachel to a treatment center that prescribes suboxone, and while she is waiting for her insurance to approve the referral, she is receiving weekly prescriptions with point-of care urine drug testing. The providers in our clinic are rewriting our pain policy because of the increasing number of pain patients who relapse and get discharged. Most of these patients, who do have a compelling reason for their pain,

have difficulty finding new PCPs because of their drug use and enter the tragic cycle of "doctor shopping and emergency room visits"; thus contributing to the escalating costs of healthcare in general. Because of liability issues, the providers decided to uphold the current policy to discharge patients who relapse and to refer them for treatment. Their pain remains unaddressed. However, for the pain patients who have a history of substance use, but are not actively using, a decision was made to partner with an Addiction Treatment Center to co-manage these patients and attempt to keep them drug free. I am hoping that this new approach, derived from the Contingency Management theory in Addiction treatment and inspired by the new proposed 2012 Patient Care Model of Coordinated Care Organization that integrates physical health care with mental health, will help our pain patients remain drug free and provide a positive incentive not to engage in their addictive behavior. There is very little research on this topic, and most research findings have not made their way into practice yet. We now know that drug addiction has a hereditary and a neurobiological basis, and it is not the patients' fault when they relapse, but it is their responsibility to seek treatment. I am hoping that some readers will respond to this article by sharing their comments and their own experiences so we can all learn from each other in this era when cost constraints are driving primary care providers to treat pain as part of a holistic approach in medicine.

Danielle Blackwell, RN, MSN, FNP graduated in 2001 as a Family Nurse Practitioner from the University of Portland, thanks to a scholarship she was awarded by the Ford Family Foundation of Roseburg and the Oregon Scholarship Commission of Eugene. In her application, she had described her goal to practice in Oregon and to serve the Medicaid and uninsured population of Clackamas County. She kept her promise by founding in 2004 Oregon City Medical and contracting with Medicaid. As part of this mission, the providers at Oregon City Medical are committed to treating all patients regardless of their color, religion, financial or social status. Oregon City Medical has explored and pioneered several innovative concepts in pain management such as partnering with a licensed massage therapist and several naturopath physicians to offer to the patients other treatment modalities to replace or complement their pharmacological treatment. It is time now to add mental health and addiction treatment for a more coordinated quality care in Clackamas County.

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