Panel Introduction and Speaker Backgrounds

The next panel we're going to have is The next panel we're going to have is something that when Dr. Kapor and I were something that when Dr. Kapor and I were discussing what to have on this panel, discussing what to have on this panel, this was something that was definitely this was something that was definitely on top of both of our minds. We see a on top of both of our minds. We see a lot of patients that come in treatment lot of patients that come in treatment that are in this intersection of chronic that are in this intersection of chronic pain and substance use disorder cuz they pain and substance use disorder cuz they really go hand in hand. See so many really go hand in hand. See so many patients coming in with pain, right?

patients coming in with pain, right? needing medications or paper that are needing medications or paper that are medication that started from chronic medication that started from chronic pain. So we have an amazing panel here pain. So we have an amazing panel here for you. Um our moderator is Dr. Sautary for you. Um our moderator is Dr. Sautary Polyoro. He is our medical director for Polyoro. He is our medical director for addiction services at Northwell. Javieri addiction services at Northwell. Javieri Menz, director of consultation leazison Menz, director of consultation leazison and chronic pain at Long Island Jewish.

and chronic pain at Long Island Jewish. And Dr. Marie O'Brien, director of And Dr. Marie O'Brien, director of integrative care and pain management at integrative care and pain management at Northwell Health Mather Hospital. Thank Northwell Health Mather Hospital. Thank you so much and I give the floor to you.

you so much and I give the floor to you. >> Great. Thank you uh Dr. Hakeimi. Uh you >> Great. Thank you uh Dr. Hakeimi. Uh you know it's a really great uh and pleasure know it's a really great uh and pleasure to to be able to you know participate in to to be able to you know participate in this conversation and just want to this conversation and just want to reflect for a moment on really the reflect for a moment on really the wonderful conversations that have wonderful conversations that have happened um already this morning. Really happened um already this morning. Really starting with uh Diana and Kenny uh and starting with uh Diana and Kenny uh and moving to really thinking about all of moving to really thinking about all of our patients in a very comprehensive way our patients in a very comprehensive way and then you know really just most and then you know really just most recently with Dr. Kim's wonderful recently with Dr. Kim's wonderful presentation on kind of emerging presentation on kind of emerging concerns around substance use. And so concerns around substance use. And so we'll be talking about another really we'll be talking about another really important aspect of care and that is important aspect of care and that is kind of these this crossroad of pain kind of these this crossroad of pain with substance use disorders, right? How with substance use disorders, right? How do we think about it? How do we do we think about it? How do we understand it? What can we do um about understand it? What can we do um about it? And so um I I want to kind of first it? And so um I I want to kind of first as we as we get started say thank you to as we as we get started say thank you to to everyone that's that's uh presented to everyone that's that's uh presented so far and been part of this so far and been part of this conversation as well as a huge thank you conversation as well as a huge thank you to the entire Wellbridge um team for to the entire Wellbridge um team for hosting this this discussion and hosting this this discussion and welcoming everyone uh so wonderfully and welcoming everyone uh so wonderfully and and ourselves certainly included. So, as and ourselves certainly included. So, as we talk a little bit about our own we talk a little bit about our own backgrounds and our own clinical backgrounds and our own clinical experiences, um, Javier and Marie, would experiences, um, Javier and Marie, would you mind talking a little bit about your you mind talking a little bit about your own kind of path potentially to the care own kind of path potentially to the care that you provide and the type of that you provide and the type of clinical services um that you're clinical services um that you're actively engaged in because all of us actively engaged in because all of us have many different hats that we wear.

have many different hats that we wear. Um, and I'll certainly say that Um, and I'll certainly say that providing direct care for patients is providing direct care for patients is one that all of us value um, incredibly.

one that all of us value um, incredibly. So maybe Javier, would you would you So maybe Javier, would you would you mind starting off? mind starting off?

>> Sure, you can hear me. Great. Hi >> Sure, you can hear me. Great. Hi everyone. And I just want to echo very everyone. And I just want to echo very briefly the gratitude and the uh briefly the gratitude and the uh humility that I experience being here.

humility that I experience being here. This is an amazing facility and amazing This is an amazing facility and amazing experience u and thank you for the experience u and thank you for the invitation to speak. So as mentioned I'm invitation to speak. So as mentioned I'm the director of consultation leis the director of consultation leis psychiatry which is medical psychiatry psychiatry which is medical psychiatry as well as chronic pain over at Long as well as chronic pain over at Long Island Jewish Medical Center part of Island Jewish Medical Center part of Northwell. um the trajectory that got me Northwell. um the trajectory that got me to this point actually very very similar to this point actually very very similar to the earlier physician that we were uh to the earlier physician that we were uh you know hearing from I was actually on you know hearing from I was actually on track to become something very heroic track to become something very heroic like a surgeon a transplant surgeon or like a surgeon a transplant surgeon or something like that. Um, and then I had something like that. Um, and then I had my psych rotation and I fell in love my psych rotation and I fell in love with that. And furthermore, within with that. And furthermore, within psychiatry, fell in love with medical psychiatry, fell in love with medical psychiatry for the same reasons that psychiatry for the same reasons that were cited earlier because we can kind were cited earlier because we can kind of do many things in parallel. And so of do many things in parallel. And so for years specialized in medical for years specialized in medical psychiatry, psychiatry, psychiatry, um, I did a fellowship in that. Later um, I did a fellowship in that. Later when I I was at the Cleveland Clinic for when I I was at the Cleveland Clinic for some years and I actually got pulled some years and I actually got pulled into a very interesting patient into a very interesting patient population which was chronic pain population which was chronic pain specifically chronic disabling pain with specifically chronic disabling pain with a number of coorbidities psychiatric a number of coorbidities psychiatric mental health coorbidities as well as mental health coorbidities as well as addiction and I was invited to work in a addiction and I was invited to work in a unique department not dissimilar from unique department not dissimilar from what is occurring here it was actually a what is occurring here it was actually a day program not an not an inpatient day program not an not an inpatient facility but a day program that fused facility but a day program that fused medical care psychiatric care, pain medical care psychiatric care, pain management but also psychology, physical management but also psychology, physical therapy, OT, etc. um holistic therapies therapy, OT, etc. um holistic therapies and it was really a rewarding and it was really a rewarding experience. Now I was medical director experience. Now I was medical director of that and became pain medicine of that and became pain medicine certified etc. Also addiction medicine certified etc. Also addiction medicine certified in that space and five years certified in that space and five years ago came to Northwell and in my current ago came to Northwell and in my current role I I manage the medical psychiatry role I I manage the medical psychiatry operations but also carve out specific operations but also carve out specific chronic pain chronic pain addiction consults that I see. We have addiction consults that I see. We have kind of an ad hoc addiction consult kind of an ad hoc addiction consult service in the medical floors, but also service in the medical floors, but also I have a clinic where I see an I have a clinic where I see an ambulatory space where I see patients ambulatory space where I see patients with chronic pain, particularly ones who with chronic pain, particularly ones who are not going to respond linearly to the are not going to respond linearly to the next injection, the next stem cell next injection, the next stem cell therapy, the next device. Uh they might therapy, the next device. Uh they might have already tried that. They might have have already tried that. They might have had a few too many spinal surgeries, had a few too many spinal surgeries, etc. And at that point, we're actually etc. And at that point, we're actually thinking differently about their chronic thinking differently about their chronic pain. Um so uh a number of paths have pain. Um so uh a number of paths have gotten me here and and I love what I do.

gotten me here and and I love what I do. Um but that's in a nutshell what I do Um but that's in a nutshell what I do clinically today. clinically today.

>> Awesome. Thank you. Um so I am very >> Awesome. Thank you.

Understanding Chronic Pain and Its Overlap With Substance Use

Um so I am very fortunate um to be here with all of you fortunate um to be here with all of you today and to be able to share u what is today and to be able to share u what is truly a passion of mine as well as my truly a passion of mine as well as my amazing team out at Mather Hospital. We amazing team out at Mather Hospital. We are a nurse practitioner-led integrative are a nurse practitioner-led integrative pain management service which is um I pain management service which is um I think probably a little bit different think probably a little bit different than what you may see at many of the than what you may see at many of the Northwell facilities and across the Northwell facilities and across the country. Northshore LIJ has a similar country. Northshore LIJ has a similar program. Uh we are so fortunate though program. Uh we are so fortunate though that because early on you know when we that because early on you know when we started seeing um the challenge of started seeing um the challenge of caring for people with opioid medication caring for people with opioid medication only or only pharmacologic only or only pharmacologic um approaches to pain. We quickly um approaches to pain. We quickly realized that that was not enough and we realized that that was not enough and we are very grateful for a lot of the are very grateful for a lot of the guidelines that actually support the guidelines that actually support the care that we are so passionate about care that we are so passionate about which includes non-farmacologic which includes non-farmacologic interventions and the role of the nurse interventions and the role of the nurse or advanced practice providers to or advanced practice providers to support individuals who are suffering support individuals who are suffering with pain. So we are in a hospital with pain. So we are in a hospital setting and we care for patients ranging setting and we care for patients ranging from surgical pain, sickle cell pain, from surgical pain, sickle cell pain, chronic low back pain exacerbated coming chronic low back pain exacerbated coming to the hospital and then because we are to the hospital and then because we are not fortunate to have an addiction not fortunate to have an addiction medicine specialty in our hospital when medicine specialty in our hospital when there is a patient who is suffering um there is a patient who is suffering um with pain and substance use disorder or with pain and substance use disorder or perhaps patients who are on medications perhaps patients who are on medications for opioid use disorder. and there's for opioid use disorder. and there's maybe a lot of confusion or um chaos maybe a lot of confusion or um chaos around how to approach these patients.

around how to approach these patients. We are the closest thing so to speak to We are the closest thing so to speak to the addiction medicine service. So we're the addiction medicine service. So we're called in quite often and it's our called in quite often and it's our toolbox of non-farmacologic toolbox of non-farmacologic interventions that really um drive the interventions that really um drive the work that we do. So really incredible um work that we do. So really incredible um clinical experience and clinical insight clinical experience and clinical insight and certainly for an issue and a and certainly for an issue and a challenge that is incredibly common and challenge that is incredibly common and compounded by substance use disorders.

compounded by substance use disorders. You know there are you know estimates You know there are you know estimates that roughly one out of four of our that roughly one out of four of our patients who are initially diagnosed patients who are initially diagnosed with a substance use disorder have with a substance use disorder have chronic pain. And that's on the low end, chronic pain. And that's on the low end, right? For our patients who suffer with right? For our patients who suffer with an opioid use disorder, it's closer to an opioid use disorder, it's closer to about half. So, you know, we see this in about half. So, you know, we see this in all different environments all different environments and can we start to better understand and can we start to better understand some of the some of the kind of principles in understanding kind of principles in understanding pain, understanding chronic pain versus pain, understanding chronic pain versus acute pain, the type of pain from acute pain, the type of pain from trauma, from physical trauma as compared trauma, from physical trauma as compared to neuropathic pain. Right? Not all pain to neuropathic pain. Right? Not all pain is the same.

is the same. Um, Javier, can I ask you what might you Um, Javier, can I ask you what might you suggest in terms of a way of of thinking suggest in terms of a way of of thinking about pain both comprehensively but about pain both comprehensively but understanding all these differences as understanding all these differences as well?

well? well?

Pain Neuroscience and Patient Education

Yeah, it's a it's a great point and I Yeah, it's a it's a great point and I think actually that's where we need to think

actually that's where we need to start because not all pain is the same start because not all pain is the same and we probably don't have enough time and we probably don't have enough time to do a robust treatment of the topic to do a robust treatment of the topic but briefly but briefly the way that I organize it and I and I the way that I organize it and I and I try to instill this in other colleagues try to instill this in other colleagues who may not be pain medicine experience who may not be pain medicine experience etc or trainees and even patients I talk etc or trainees and even patients I talk to them about this is first you really to them about this is first you really want to understand temporally what are want to understand temporally what are you dealing with right a lot of our our you dealing with right a lot of our our medical instincts are to think well is medical instincts are to think well is this neuropathic versus this versus that this neuropathic versus this versus that and that's very important. We'll get to and that's very important. We'll get to that know susceptive etc. But it's that know susceptive etc. But it's really important to differentiate acute really important to differentiate acute from chronic pain very different from chronic pain very different phenomena in terms of what is happening phenomena in terms of what is happening biologically, psychologically and biologically, psychologically and socially socially socially um I won't emphasize too much on acute um I won't emphasize too much on acute pain but with chronic pain very briefly pain but with chronic pain very briefly we know that a number of processes take we know that a number of processes take a foot and kind of potentiate over time.

a foot and kind of potentiate over time. central sensitization, changes in the central sensitization, changes in the central nervous system, hyperalesia, central nervous system, hyperalesia, aladenia, all this jargon, all this, all aladenia, all this jargon, all this, all of these findings that we know of these findings that we know biologically occur psychologically. We biologically occur psychologically. We also see unfortunate ramifications of also see unfortunate ramifications of this. Living with chronic pain is this. Living with chronic pain is obviously not a walk in the park. Huge obviously not a walk in the park. Huge toll, depression, anxiety, insomnia, um toll, depression, anxiety, insomnia, um fear of of of the future. Um people's fear of of of the future. Um people's worlds get smaller if you will which worlds get smaller if you will which gets into the social bucket. The social gets into the social bucket. The social dimensions of chronic pain are dimensions of chronic pain are debilitating as well. U people will debilitating as well. U people will pajoritize individuals with chronic pain pajoritize individuals with chronic pain automatically assume a number of things automatically assume a number of things uh might keep their distance from them.

uh might keep their distance from them. Patients with chronic pain keep their Patients with chronic pain keep their distance as well from others. So it distance as well from others. So it becomes really this complex morass that becomes really this complex morass that isn't necessarily the case with acute isn't necessarily the case with acute pain. So I think it's very important to pain. So I think it's very important to distance ourselves from lumping them all distance ourselves from lumping them all in medical education. There is very in medical education. There is very little attention to chronic pain itself.

little attention to chronic pain itself. A lot of what we do in chronic pain is A lot of what we do in chronic pain is an extrapolation from acute pain. You an extrapolation from acute pain. You know if we if we really take care of know if we if we really take care of that nerve or if we use an analesic all that nerve or if we use an analesic all will be fine. Well it's actually become will be fine. Well it's actually become a very complex syndrome over time. So I a very complex syndrome over time. So I think the temporal nature is very think the temporal nature is very important. And then we get into the important. And then we get into the qualities of is this no susceptive qualities of is this no susceptive neuropathic nosiplastic which is another neuropathic nosiplastic which is another classification etc. and then get more classification etc. and then get more into the specifics of the individual into the specifics of the individual you're working with to add complexity.

you're working with to add complexity. There's medical coorbidities. There are There's medical coorbidities. There are conditions that are acute on chronic.

conditions that are acute on chronic. You mentioned cickle cell for instance You mentioned cickle cell for instance is a classic one that's very difficult is a classic one that's very difficult to approach. So it gets complex but I to approach. So it gets complex but I think the first order of business is to think the first order of business is to differentiate acute and chronic by differentiate acute and chronic by definition and to understand that it's definition and to understand that it's not just this sensor neuro kind of not just this sensor neuro kind of phenomenon you hurt

because you had an phenomenon you hurt because you had an operation or a surgery or medical operation or a surgery or medical injury. It's much more complex than that injury. It's much more complex than that and just doing that I think is half the and just doing that I think is half the battle because you open patients and battle because you open patients and families and other physicians brains to families and other physicians brains to thinking okay we got to do more than thinking okay we got to do more than just analesia for instance. Thank you just analesia for instance. Thank you Javier for just kind of outlining the Javier for just kind of outlining the complexity right and it's a complexity complexity right and it's a complexity that I'm hearing and as a physician I'm that I'm hearing and as a physician I'm thinking oh my goodness like that is a thinking oh my goodness like that is a lot that we are thinking about that we lot that we are thinking about that we are aware of pain is different how do we are aware of pain is different how do we address it um and that's the address it um and that's the conversation that we may have with um conversation that we may have with um you know other physicians um other you know other physicians um other treatment team members and I wonder treatment team members and I wonder Marie from your perspective right how do Marie from your perspective right how do we or how do Do you think about we or how do Do you think about translating that understanding translating that understanding to our patient right to the person that to our patient right to the person that you're providing care to? What what kind you're providing care to? What what kind of principles do you have in mind? What of principles do you have in mind? What type of can you talk a little bit about type of can you talk a little bit about that conversation that you might have?

that conversation that you might have? >> Absolutely. That is a great question and >> Absolutely. That is a great question and such a great perspective. Um to the core such a great perspective. Um to the core of that is the foundation and philosophy of that is the foundation and philosophy of pain neuroscience education. You of pain neuroscience education. You know, we heard Penny and Diane talk this know, we heard Penny and Diane talk this morning about, you know, not being able morning about, you know, not being able to have a relationship with their to have a relationship with their provider and being told, "I'm the provider and being told, "I'm the provider. You're the patient. This is provider. You're the patient. This is what I'm giving you. This is my what I'm giving you. This is my prescription, and do this or else you're prescription, and do this or else you're non-compliant." You know, and that is non-compliant." You know, and that is what so many of our patients hear when what so many of our patients hear when really what they need to hear and truly really what they need to hear and truly understand is that there is a reason, understand is that there is a reason, especially with chronic pain. There's a especially with chronic pain. There's a reason that they have pain and more reason that they have pain and more importantly suffering for such a long importantly suffering for such a long period of time. And it's that foundation period of time. And it's that foundation of why pain is being perpetuated, of why pain is being perpetuated, what pain is, which is your what pain is, which is your fightor-flight response working with the fightor-flight response working with the body. So that your body is telling your body. So that your body is telling your brain you're in danger. And when we brain you're in danger. And when we utilize non-farmacologic interventions, utilize non-farmacologic interventions, if they don't understand the connection if they don't understand the connection between the fight orflight response, between the fight orflight response, their sympathetic and parasympathetic their sympathetic and parasympathetic nervous system in a scaled down nervous system in a scaled down non-clinical so to speak way, they're non-clinical so to speak way, they're not going to buy in to the idea that not going to buy in to the idea that something as simple as aromatherapy, something as simple as aromatherapy, guided imagery, mindful breathing, yoga, guided imagery, mindful breathing, yoga, all the nonfarm interventions that are all the nonfarm interventions that are at the foundation of every diet body for at the foundation of every diet body for the management of chronic pain. They're the management of chronic pain. They're just going to think they're being just going to think they're being brushed off and that we're trying to, brushed off and that we're trying to, you know, give them to escape giving you know, give them to escape giving them a medication. when in fact if they them a medication.

Non-Pharmacologic Pain Management Strategies

when in fact if they truly understand the neuroscience that truly understand the neuroscience that we're trying to calm their nervous we're trying to calm their nervous system and then have a positive impact system and then have a positive impact on their overall level of comfort then on their overall level of comfort then we can get their buy in and at least we can get their buy in and at least have them try and then see for have them try and then see for themselves that they themselves have the themselves that they themselves have the self-efficacy and the autonomy to make self-efficacy and the autonomy to make an impact on the function. Thank you, an impact on the function. Thank you, Marie. That that's wonderful. And I'm, Marie. That that's wonderful. And I'm, you know, I I was

struck just when you you know, I I was struck just when you mentioned specifically the issue of mentioned specifically the issue of buyin, right? And that piece of that buyin, right? And that piece of that education and um you know, in thinking education and um you know, in thinking about how does pain overlap with about how does pain overlap with substance use, right? And as we, you substance use, right? And as we, you know, for all of those in the audience know, for all of those in the audience that are, you know, spend a lot of time that are, you know, spend a lot of time thinking and providing care for thinking and providing care for substance use disorders, right? We're substance use disorders, right? We're all familiar with the, you know, 11 all familiar with the, you know, 11 criteria and we think about, you know, a criteria and we think about, you know, a couple four related to impulse control couple four related to impulse control and the social impact and high-risisk and the social impact and high-risisk use and the the physiologic effects as use and the the physiologic effects as well. And, you know, sometimes we kind well. And, you know, sometimes we kind of group that into kind of different of group that into kind of different ways as we think about a a cognitive ways as we think about a a cognitive impact of a substance use disorder, the impact of a substance use disorder, the behavioral impact, and then the the behavioral impact, and then the the physiologic impact.

physiologic impact. And right there's overlap right that I'm And right there's overlap right that I'm hearing with with pain. And you know a hearing with with pain. And you know a term that was I think a kind of a little term that was I think a kind of a little bit more popular roughly 20 years ago bit more popular roughly 20 years ago this concept of pseudo addiction.

this concept of pseudo addiction. this idea of this idea of some of what we see that we sometimes some of what we see that we sometimes would diagnose or consider with a would diagnose or consider with a substance use disorder substance use disorder are are are very clear effects from a medication very clear effects from a medication that may be prescribed. Right? How we that may be prescribed. Right? How we talk about and how we assess withdrawal talk about and how we assess withdrawal symptoms? Well, we know if somebody is symptoms? Well, we know if somebody is prescribed opioids chronically, they prescribed opioids chronically, they will will will experience withdrawal. Taking that experience withdrawal. Taking that medication appropriately every single medication appropriately every single time they will experience withdrawal if time they will experience withdrawal if it's suddenly discontinued. In the same it's suddenly discontinued. In the same context, tolerance develops. We know context, tolerance develops. We know this for many medications. It is a this for many medications. It is a pharmacologic effect of the medication pharmacologic effect of the medication that as providers we may prescribe for that as providers we may prescribe for patients. And so we also know that when patients. And so we also know that when you know pain is not being addressed, you know pain is not being addressed, it is clearly incredibly distressing and it is clearly incredibly distressing and there is going to be behavioral impacts there is going to be behavioral impacts to it. And how does that evolve, you to it. And how does that evolve, you know, over time? What may initially know, over time? What may initially be more of a pseudo addiction, more be more of a pseudo addiction, more may evolve six months later, a year may evolve six months later, a year later, two years later into an opiate later, two years later into an opiate use disorder, into another substance use use disorder, into another substance use disorder. And so there isn't this kind disorder. And so there isn't this kind of clear, you know, a person has pseudo of clear, you know, a person has pseudo addiction or a person has substance use addiction or a person has substance use disorder. uh it would be great if it was disorder. uh it would be great if it was always clear or if there was a checklist always clear or if there was a checklist that we could review but there is so that we could review but there is so much overlap and in some ways you know much overlap and in some ways you know the system that we are all part of the system that we are all part of struggles with that and there's tension struggles with that and there's tension there sometimes there sometimes um and so as we think about treatments um and so as we think about treatments maybe if we can go to the maybe if we can go to the non-farmacologic treatments first I non-farmacologic treatments first I think a lot of us have kind of spent a think a lot of us have kind of spent a lot of time thinking about what lot of time thinking about what medications are prescribed kind and so medications are prescribed kind and so forth. Um, and I wonder, Marie, maybe if forth. Um, and I wonder, Marie, maybe if you can speak a little bit more on those you can speak a little bit more on those non-farmacologic interventions non-farmacologic interventions that you know you utilize. Um, and maybe that you know you utilize. Um, and maybe just for everyone if you can help us just for everyone if you can help us understand really what those understand really what those interventions are and what do you see in interventions are and what do you see in your patients that are engaged in those your patients that are engaged in those interventions.

interventions. interventions. >> Oh, that's a great question and you know >> Oh, that's a great question and you know it varies based on the person. So it varies based on the person. So patients will always say to myself or a patients will always say to myself or a member of my team, what's the best member of my team, what's the best non-med thing that I can do for myself?

non-med thing that I can do for myself? And just like anything, it's what what And just like anything, it's what what you're going to use and what resonates you're going to use and what resonates with you. So just as if we have so many with you. So just as if we have so many different medications in a certain different medications in a certain category, there are many different category, there are many different non-farmacologic interventions available non-farmacologic interventions available to help with pain. These can range from to help with pain. These can range from something as simple as aromatherapy, something as simple as aromatherapy, which we use in the hospital. So, we use which we use in the hospital. So, we use a simple aromatherapy inhaler that the a simple aromatherapy inhaler that the patient can keep at their bedside, keep patient can keep at their bedside, keep in their pocket, and when they feel in their pocket, and when they feel anxious or they need a way to tell their anxious or they need a way to tell their nervous system that they're safe, they nervous system that they're safe, they can take this out. It's a tool they can can take this out. It's a tool they can use. We educate them to find just a use. We educate them to find just a moment or two to take a few slow, deep moment or two to take a few slow, deep breaths. That again calms the nervous breaths. That again calms the nervous system, you know, and that is point of system, you know, and that is point of pe your nervous system in hyperdrive.

pe your nervous system in hyperdrive. And between utilizing that and the deep And between utilizing that and the deep breaths and maybe some positive guided breaths and maybe some positive guided imagery, patients can experience a imagery, patients can experience a significant reduction in a sense of significant reduction in a sense of calm, a sense of comfort. It doesn't fix calm, a sense of comfort. It doesn't fix the reason that they're having pain, but the reason that they're having pain, but it can help them with the suffering it can help them with the suffering aspect of pain. And so that's something aspect of pain. And so that's something simple in the hospital. And then outside simple in the hospital. And then outside of that, things like acupuncture, of that, things like acupuncture, um even uricular ear seeds, which is um even uricular ear seeds, which is something that we're trying to help move something that we're trying to help move forward in our organization. Um but I forward in our organization. Um but I think sometimes from a system approach, think sometimes from a system approach, things that we don't understand, there things that we don't understand, there are barriers go up. So there's barriers are barriers go up. So there's barriers to acupuncture in the hospital. There's to acupuncture in the hospital. There's barriers to nurses doing something as barriers to nurses doing something as simple as ear seeds or aromatherapy or simple as ear seeds or aromatherapy or clinical hypnosis. So I think in trying clinical hypnosis. So I think in trying to support our patients, anything we can to support our patients, anything we can do to remove the barriers to things that do to remove the barriers to things that can promote self-efficacy will go a long can promote self-efficacy will go a long way in empowering our patients when they way in empowering our patients when they leave the hospital to happy schools.

leave the hospital to happy schools.

Integrated Care and Addiction Treatment Access

I mean so that's really helpful and I I mean so that's really helpful and I and you know so many times we see um and you know so many times we see um this challenge this challenge beyond prescribing a medication right we beyond prescribing a medication right we can prescribe medications but the other can prescribe medications but the other services the comprehensive care that we services the comprehensive care that we can really provide um that does have can really provide um that does have evidence supporting its use um how are evidence supporting its use um how are we able to adapt to those models um we able to adapt to those models um Javier in in terms of thinking about Javier in in terms of thinking about that distress that Marie you mentioned, that distress that Marie you mentioned, you know, these other factors that come you know, these other factors that come into play when someone is experiencing into play when someone is experiencing pain day after day, month after month, pain day after day, month after month, the kind of impact that you may be the kind of impact that you may be called to assess um or to provide some called to assess um or to provide some care for. Can you help us just get a care for. Can you help us just get a sense of that when we think sense of that when we think comprehensively about a

person, the comprehensively about a person, the behavioral impact that you tend to see behavioral impact that you tend to see and maybe some thoughts about what kind and maybe some thoughts about what kind of interventions do you do, you know, of interventions do you do, you know, kind of come to mind to you?

kind of come to mind to you? >> Yeah, it's a great it's a great point. >> Yeah, it's a great it's a great point. Uh, first off, I want to say that we Uh, first off, I want to say that we need to be able to, need to be able to, you know, walk and chew gum at the same you know, walk and chew gum at the same time. We got to do a lot of things with time. We got to do a lot of things with complex patients, whether it's this complex patients, whether it's this discussion or others, right? And so I discussion or others, right? And so I think we need to try our best to help think we need to try our best to help with the pain of course and not only with the pain of course and not only focus on distress or psycho behavioral focus on distress or psycho behavioral features, right? We got to do both.

features, right? We got to do both. When individuals live with chronic pain When individuals live with chronic pain for significant amounts of time, you for significant amounts of time, you know, months, years, they tend to have, know, months, years, they tend to have, you know, this has been validated you know, this has been validated through studies. They tend to have through studies. They tend to have higher rates of catastrophizing and higher rates of catastrophizing and certain cognitive patterns, behavioral certain cognitive patterns, behavioral patterns like you know avoidance patterns like you know avoidance patterns, deconditioning that's physical patterns, deconditioning that's physical but also mental deconditioning in terms but also mental deconditioning in terms of um less ability to really process of um less ability to really process stress. And and so all of these factors stress. And and so all of these factors come into play when I see somebody who's come into play when I see somebody who's had chronic unrelenting pain. And to get had chronic unrelenting pain. And to get to your question, I think about totality to your question, I think about totality of what I'm seeing. And I'm seeing of what I'm seeing. And I'm seeing neurobiology that extends beyond where neurobiology that extends beyond where the what part of the body is hurting, the what part of the body is hurting, right? I I sort of go beyond the right? I I sort of go beyond the peripheralist, that's my word that I peripheralist, that's my word that I use, perspective of the knee or the back use, perspective of the knee or the back or the belly or the ankle or whatever or the belly or the ankle or whatever hurts and think about the entirety of hurts and think about the entirety of the pain neuroscircuit. Right? Once you the pain neuroscircuit. Right? Once you start to really consider all of it, not start to really consider all of it, not just that thing that is hurting, but just that thing that is hurting, but also the spinal cord, the brain, certain also the spinal cord, the brain, certain pathways that are coming back down from pathways that are coming back down from the brain importantly to modulate pain.

the brain importantly to modulate pain. When you really consider all of that and When you really consider all of that and bring this to the patients attention, bring this to the patients attention, which by the way is rarely part of their which by the way is rarely part of their care, unfortunately, as as medicine is care, unfortunately, as as medicine is built, then you start to really identify built, then you start to really identify a number of targets. Some of them may be a number of targets. Some of them may be psycho behavioral but some of them might psycho behavioral but some of them might be purely neurobiological. So an example be purely neurobiological. So an example I I see a number of patients who have I I see a number of patients who have been physically deconditioned who um been physically deconditioned who um really can't tolerate much pain over really can't tolerate much pain over time and I introduce the concept of time and I introduce the concept of their own endogenous pain relieving you their own endogenous pain relieving you know system uh goes by numerous names know system uh goes by numerous names the descending pain pathway etc. I the descending pain pathway etc. I sometimes use cartoons to show them the sometimes use cartoons to show them the anatomy. This can be very powerful. I anatomy. This can be very powerful. I explained that this is actually explained that this is actually something that we should kind of work something that we should kind of work on. We should beef this thing up. It's on. We should beef this thing up. It's inside of you. And for years, not not, inside of you. And for years, not not, you know, not to your fault, of course, you know, not to your fault, of course, nobody's really attended to that. So, we nobody's really attended to that. So, we need to calm the nervous system. We need need to calm the nervous system. We need to remove barriers that are clouding to remove barriers that are clouding your sensorium. Unfortunately, some your sensorium. Unfortunately, some individuals are in polyarm pharmacy. We individuals are in polyarm pharmacy. We need to think about physical need to think about physical reconditioning to activate those reconditioning to activate those endorphins and encapsulins and endorphins and encapsulins and everything and uh and other everything and uh and other psychotherrapeutic principles like psychotherrapeutic principles like mindfulness based stress reduction

and mindfulness based stress reduction and CBT to assist with beefing that part of CBT to assist with beefing that part of you up. when you when it's couched in you up. when you when it's couched in those medically validating terms that those medically validating terms that there's a little part of your anatomy there's a little part of your anatomy that I actually want to manipulate, it's that I actually want to manipulate, it's very different than saying I only want very different than saying I only want to reduce your stress or I only want to to reduce your stress or I only want to adjust your depression etc.

adjust your depression etc. This segus nicely into then to answer This segus nicely into then to answer the second part of your question, what the second part of your question, what are the interventions? Half the are the interventions? Half the intervention is that education. Uh but intervention is that education. Uh but next is thinking about medications.

next is thinking about medications. Assuming we're not using opioids for a Assuming we're not using opioids for a second, which by the way is is an second, which by the way is is an assumption. We'll talk about that later.

assumption. We'll talk about that later. In some patients, they do need opioids. In some patients, they do need opioids. But assuming we're not, there's a whole But assuming we're not, there's a whole host of nonopioid strategies that are, host of nonopioid strategies that are, you know, neuropathic agents, uh you know, neuropathic agents, uh psychopharmarmacologic agents, um you psychopharmarmacologic agents, um you know, alpha generic agents. We heard the know, alpha generic agents. We heard the talk earlier about how sadly those are talk earlier about how sadly those are in adulterance, etc., etc. plus of in adulterance, etc., etc. plus of course the non-farmacologic agents that course the non-farmacologic agents that that Marie was referring to. So it's a that Marie was referring to. So it's a complex complex complex dance if you will. There's a method to dance if you will. There's a method to the madness. If you do it enough, it the madness. If you do it enough, it starts to become actually quite starts to become actually quite effective and efficient. But I think it effective and efficient. But I think it has to combine that neurobiology, the has to combine that neurobiology, the medical validation, education, and then medical validation, education, and then some actual tangible strategies to offer some actual tangible strategies to offer to the patient with confidence. Um, that to the patient with confidence. Um, that I'm going to help you not just with your I'm going to help you not just with your pain, but with your distress.

pain, but with your distress. So, I'm hearing similarity So, I'm hearing similarity even in thinking about actively even in thinking about actively addressing substance use disorders. I addressing substance use disorders. I don't know if everyone in the audience don't know if everyone in the audience is kind of hearing this this overlap of is kind of hearing this this overlap of you know the neurobiology you know the neurobiology the the the [snorts] comprehensive effects on the [snorts] comprehensive effects on the patient patient patient how we are not only directing our care how we are not only directing our care and our thoughts around risk benefits of and our thoughts around risk benefits of medications and exposure and so forth um medications and exposure and so forth um but patient education right as well and but patient education right as well and that in many ways that in many ways gets tied into a challenge that so many gets tied into a challenge that so many And so, you know, I wonder And so, you know, I wonder um recognizing that there are, you know, um recognizing that there are, you know, so many challenges that we probably all so many challenges that we probably all experience with this complex experience with this complex clinical challenge.

clinical challenge. Are there Are there is there a vision of an of an ideal is there a vision of an of an ideal integrated practice or an ideal integrated practice or an ideal way to collaborate way to collaborate with or for your patients who do have um with or for your patients who do have um a substance use disorder and how do you a substance use disorder and how do you think about that or what's been your think about that or what's been your experience?

there is a such a lack of a program such there is a such a lack of a program such as such as that. You know, just like as such as that. You know, just like we've seen with um co-occurring mental we've seen with um co-occurring mental health challenges and substance use health challenges and substance use disorder, there's an even greater der of disorder, there's an even greater der of resources available for patients who resources available for patients who suffer from chronic pain and mental suffer from chronic pain and mental health disorders or chronic pain and health disorders or chronic pain and substance use disorder. And heaven substance use disorder. And heaven forbid they have all three, then there's forbid they have all three, then there's really such a lack of

resources. And really such a lack of resources. And often from our experience it comes down often from our experience it comes down to this perception that maybe it's not a to this perception that maybe it's not a financially viable financially viable program you know for patients for us to program you know for patients for us to care for people holistically who have care for people holistically who have chronic pain. So ideally collaboration chronic pain. So ideally collaboration between mental health, addiction between mental health, addiction medicine, pain management, um medicine, pain management, um community-based holistic care community-based holistic care practitioners that can help with the practitioners that can help with the non-farmacologic interventions and non-farmacologic interventions and having them accessible for our patients having them accessible for our patients in a way that they feel like they are in a way that they feel like they are cared for. And um you know, we're not cared for. And um you know, we're not just saying to them it's either just saying to them it's either medications or nothing.

medications or nothing. I think it's an important question, but I think it's an important question, but I agree. There's really not enough in I agree. There's really not enough in this space for this these triad, if you this space for this these triad, if you will, of problems, chronic pain, will, of problems, chronic pain, mental health needs, and substance use.

mental health needs, and substance use. Two or three of those combined. But I Two or three of those combined. But I will say that I I had the distinct honor will say that I I had the distinct honor and pleasure of working in an and pleasure of working in an interdisciplinary space that did that, interdisciplinary space that did that, the program I mentioned before at the the program I mentioned before at the Cleveland Clinic. And I think uh for Cleveland Clinic. And I think uh for operational reasons, financial reasons, operational reasons, financial reasons, um there are very few of those around.

um there are very few of those around. Um it it takes a herculean kind of Um it it takes a herculean kind of effort to get that kind of thing going effort to get that kind of thing going and to maintain it. Um but I applaud you and to maintain it. Um but I applaud you know places like Welbridge that clearly know places like Welbridge that clearly I was even looking at the programming I was even looking at the programming there for instance on the on the screen there for instance on the on the screen try to emulate that that try to emulate that that interdisciplinary nature is not the same interdisciplinary nature is not the same >> as multidisciplinary nature or >> as multidisciplinary nature or community-based connected dots care community-based connected dots care which is really the standard of care which is really the standard of care multi-disiplinary is better but multi-disiplinary is better but interdisciplinary is pretty rare I think interdisciplinary is pretty rare I think that's what's needed and I think within that's what's needed and I think within the interdisciplinary care model you the interdisciplinary care model you need to be guided by a ton of education need to be guided by a ton of education to miss sort of dispel stigma, to miss sort of dispel stigma, misconceptions, all of that. A ton of misconceptions, all of that. A ton of validation and that I think most validation and that I think most importantly needs to come from importantly needs to come from physicians or representatives of health physicians or representatives of health care as well as peers. The peer part is care as well as peers. The peer part is critical in my opinion. Um and and then critical in my opinion. Um and and then thirdly is the actual clinical part of thirdly is the actual clinical part of it. So notice the hierarchy that I just it. So notice the hierarchy that I just offered. This is my opinion at least.

offered. This is my opinion at least. Education is king. Validation is an you Education is king. Validation is an you know, sort of next second and then the know, sort of next second and then the clinical care. The clinical care is clinical care. The clinical care is critical. We need to obviously have critical. We need to obviously have clinical care that's state-of-the-art clinical care that's state-of-the-art and and has multimodality to it. But I and and has multimodality to it. But I think the first two actually are half think the first two actually are half the battle.

the battle. >> You know, I'll share some of um you >> You know, I'll share some of um you know, my own clinical experience and know, my own clinical experience and sort of opportunities to to partner sort of opportunities to to partner particularly with sometimes pain particularly with sometimes pain management. um maybe from a little bit management. um maybe from a little bit more of a perspective of a substance use more of a perspective of a substance use disorder specialty program and you know disorder specialty program and you know for patients who receive methadone in an for patients who receive methadone in an opioid treatment program. you know, the opioid treatment program. you know, the the opportunity now to partner with the opportunity now to partner with inpatient programs with inpatient inpatient programs with inpatient services and adapt care is services and adapt care is

frankly speaking frankly speaking so different now than really since the so different now than really since the initiation of a licensed opiate initiation of a licensed opiate treatment program in the early '7s. So treatment program in the early '7s. So as many people may familiar as many people may familiar just about a year ago, just about a year ago, the entire kind of regulatory framework the entire kind of regulatory framework of opioid treatment programs, meaning of opioid treatment programs, meaning attendance to receive methodone was attendance to receive methodone was dramatically changed. And I'll just dramatically changed. And I'll just highlight for the sake of time two highlight for the sake of time two items.

items. items. One is that near daily attendance for One is that near daily attendance for someone new to treatment is gone. someone new to treatment is gone.

Right? So the ability to match what a Right? So the ability to match what a person needs in terms of their treatment person needs in terms of their treatment with a medication that is only one of with a medication that is only one of two that has a very clear direct impact two that has a very clear direct impact in reducing fatal overdoses for someone in reducing fatal overdoses for someone with an opioid use disorder. as well as with an opioid use disorder. as well as a host of other clinical improvements a host of other clinical improvements has been changed for much more um a has been changed for much more um a decision on attendance to a program that decision on attendance to a program that may vary to once a week to once a month may vary to once a week to once a month over just the first few weeks of care over just the first few weeks of care dramatically different than daily dramatically different than daily attendance. The other major in terms of attendance. The other major in terms of partnership is the ability for opioid partnership is the ability for opioid treatment programs to be able to partner treatment programs to be able to partner with inpatient any inpatient environment with inpatient any inpatient environment to directly admit patients in a way that to directly admit patients in a way that you know clinical practice had made it you know clinical practice had made it very difficult to provide a person who very difficult to provide a person who is newly identified with opioid use is newly identified with opioid use disorder or newly open to engaging in disorder or newly open to engaging in methadone treatment who may be in the methadone treatment who may be in the hospital to be directly admitted to no hospital to be directly admitted to no obia treatment program and we have a few obia treatment program and we have a few minutes. We we definitely want to leave minutes. We we definitely want to leave some time for questions, but I wonder if some time for questions, but I wonder if um Marie Javier um Marie Javier any kind of just in just initial any kind of just in just initial thoughts on the other let's at least thoughts on the other let's at least touch on the FDA approved medications touch on the FDA approved medications for opioid use disorder, right? Thoughts for opioid use disorder, right? Thoughts on managing your patients on on managing your patients on bupinorphine or thoughts on managing bupinorphine or thoughts on managing your patients on extended release your patients on extended release nrexone and then we'll just we'll move nrexone and then we'll just we'll move to questions.

to questions. >> Awesome. force. So, um in the hospital >> Awesome. force. So, um in the hospital just um a incident that we had or um an just um a incident that we had or um an opportunity that we had maybe a few opportunity that we had maybe a few months ago, an individual who came into months ago, an individual who came into the hospital with a very painful the hospital with a very painful condition, large painful wound, abscess condition, large painful wound, abscess to the spine, needing hospital care for to the spine, needing hospital care for extended period of time, and also extended period of time, and also admitting to having substance use admitting to having substance use disorder and really wanting treatment.

disorder and really wanting treatment. wanting methadone and the initial um wanting methadone and the initial um reaction from say hospital medicine who reaction from say hospital medicine who is not familiar not comfortable with is not familiar not comfortable with methadone and treatment for medications methadone and treatment for medications for opioid use disorder was that's not for opioid use disorder was that's not something we can start here you need to something we can start here you need to wait until you're discharged. So for wait until you're discharged. So for more than two days, this individual had more than two days, this individual had to endure withdrawal anxiety very close to endure withdrawal anxiety very close to signing out of the hospital. I'm sure to signing out of the hospital. I'm sure we've all experienced patients like we've all experienced patients like that. And we were so fortunate to be that. And we were so fortunate to be called in right before the patient was called in right before the patient was going to sign out AMA. And we were able going to sign out AMA. And we were able to navigate collaboration with experts to navigate collaboration with experts from Northwell. I was able to, you know,

from Northwell. I was able to, you know, call a friend, receive guidance, and call a friend, receive guidance, and we're able to start this individual on we're able to start this individual on methadone in the hospital, titrate the methadone in the hospital, titrate the dose up, and we were able to allow this dose up, and we were able to allow this person to endure their treatment and person to endure their treatment and then get connected with resources on then get connected with resources on discharge, which you think is so discharge, which you think is so important.

important. important. >> I I tend to not secure permission as >> I I tend to not secure permission as Right. Right. I hope [snorts] for Right. Right. I hope [snorts] for forgiveness. Um, so prior to any changes forgiveness. Um, so prior to any changes like this, I've I've, you know, played like this, I've I've, you know, played with the rules I think that was with the rules I think that was mentioned earlier. You have to in this mentioned earlier. You have to in this space and have always advocated for space and have always advocated for whether it's methadone or suboxone or whether it's methadone or suboxone or nrexone or whatever we're talking about nrexone or whatever we're talking about getting it done. That doesn't mean I getting it done. That doesn't mean I have a 100% hit rate by any any stretch have a 100% hit rate by any any stretch because I have to work with others and because I have to work with others and there's a lot of moving parts. But I there's a lot of moving parts. But I agree that where where there's a will, agree that where where there's a will, there's a way. It may be time consuming.

there's a way. It may be time consuming. It may require extra steps but there are It may require extra steps but there are ways to uh start method on to use your ways to uh start method on to use your example denovo in the medical hospital.

example denovo in the medical hospital. Suboxone make sure the person gets a Suboxone make sure the person gets a script make sure the person connects to script make sure the person connects to the next step or comes to my clinic the next step or comes to my clinic where I I might you know bridge them where I I might you know bridge them until they get to another another you until they get to another another you know long-term plan. So I think that know long-term plan. So I think that problem solving this this is the problem solving this this is the probably less scientific part of this is probably less scientific part of this is is really critical. It's a case by case is really critical. It's a case by case advocacy that has to happen and um and I advocacy that has to happen and um and I think I think we all should be think I think we all should be unapologetic about it. It's wonderful unapologetic about it. It's wonderful perspective. Um perspective. Um >> thank you. Um, so I just want to say >> thank you. Um, so I just want to say first of all, um, I really liked how you first of all, um, I really liked how you used that, um, that phrase walk and used that, um, that phrase walk and chewing gum at the same time. I'm really chewing gum at the same time. I'm really going to try and work that into my going to try and work that into my professional language like in my emails professional language like in my emails and meetings and stuff.

and meetings and stuff. >> Add a third thing in there and now >> Add a third thing in there and now you're really juggling. you're really juggling. >> There you go. [laughter] >> There you go. [laughter] Um, so you know, I have a really good Um, so you know, I have a really good working relationship with our CL team at working relationship with our CL team at my hospital, which is crazy that we my hospital, which is crazy that we ended up striking up a conversation ended up striking up a conversation during lunch.

during lunch. >> Yeah. >> Yeah. >> Yeah. >> And, um, I was wondering if maybe you >> And, um, I was wondering if maybe you could expand a little more on, you know, could expand a little more on, you know, how you might approach that patient that how you might approach that patient that I was kind of, you know, um, talking to I was kind of, you know, um, talking to you about right like towards the end of you about right like towards the end of lunch. If you want I can you know um lunch. If you want I can you know um explain a little more explain a little more >> very briefly for the group. Uh he was >> very briefly for the group. Uh he was sharing that sadly an individual sharing that sadly an individual sustained a horrible injury and now is a sustained a horrible injury and now is a double ampute lower extremities has been double ampute lower extremities has been in the hospital for a month and not in the hospital for a month and not getting correct me if I'm wrong getting correct me if I'm wrong appropriate pain control.

appropriate pain control. >> Yeah. So they they've been medicating >> Yeah. So they they've been medicating him, you know, they've been giving him him, you know, they've been giving him opioids and they had reached out to the

opioids and they had reached out to the addiction consult service because they addiction consult service because they were concerned that, you know, as we get were concerned that, you know, as we get closer to discharge that there might be closer to discharge that there might be a concern for, you know, an opioid use a concern for, you know, an opioid use disorder because he's had a history of disorder because he's had a history of substance use disorder in the past.

substance use disorder in the past. >> Yeah. >> Yeah. >> So they wanted us to >> So they wanted us to >> Yeah. >> Yeah. >> Yeah. >> Yeah. >> Yeah.

>> Yeah. >> So a couple of reactions to that >> So a couple of reactions to that situation. Number one, I tend to be situation. Number one, I tend to be forgiving of primary teams who maybe forgiving of primary teams who maybe don't know what they're saying or doing.

don't know what they're saying or doing. Couched in there, I want to give them Couched in there, I want to give them the benefit of the doubt that there's a the benefit of the doubt that there's a good intent. They're watching out for good intent. They're watching out for the patient, don't want to cause another the patient, don't want to cause another problem, all of that. But we could problem, all of that. But we could quickly quickly quickly say, gosh, these people are really not say, gosh, these people are really not advocating proper proper pain and advocating proper proper pain and they're stigmatizing him because of his they're stigmatizing him because of his addiction and all of that. So, it can go addiction and all of that. So, it can go both ways. Uh but back to my original both ways. Uh but back to my original first question, this is acute pain. I first question, this is acute pain. I hate to make it, you know, terribly hate to make it, you know, terribly simple in that way, but it is it's acute simple in that way, but it is it's acute pain in somebody with a history of pain in somebody with a history of addiction. Sure. But this is somebody addiction. Sure. But this is somebody who's had a terrible injury. It's one who's had a terrible injury. It's one month fresh. The definition is at least month fresh. The definition is at least 3 months to 6 months, right? Um and the 3 months to 6 months, right? Um and the qualities of the injury double qualities of the injury double amputation, you know, are really amputation, you know, are really important to manage acutely because it important to manage acutely because it can transition more so into chronic pain can transition more so into chronic pain and greater risk for addiction and and greater risk for addiction and substance use if you don't do things now substance use if you don't do things now like appropriate pain control. You know, like appropriate pain control. You know, phantom limb pain and all that other phantom limb pain and all that other stuff can develop if at higher rates if stuff can develop if at higher rates if you don't do something about it now.

you don't do something about it now. Furthermore, the argument about Furthermore, the argument about substance use raises in many minds this substance use raises in many minds this idea of risk, right? there's a greater idea of risk, right? there's a greater risk of abuse, but also from a pain risk of abuse, but also from a pain management standpoint, there may also be management standpoint, there may also be a pain threshold difference in that a pain threshold difference in that individual, right? Very likely to your individual, right? Very likely to your point about opioids and and and point about opioids and and and individuals who have pain. So, it may be individuals who have pain. So, it may be that we need to be more aggressive with that we need to be more aggressive with this individual, right? But a lot of of, this individual, right? But a lot of of, you know, good intentioned, you know, good intentioned, well-intentioned minds are out there well-intentioned minds are out there thinking the opposite. We need to spare thinking the opposite. We need to spare this person of risk of addiction. And this person of risk of addiction. And yet maybe yet maybe every case is different. Maybe the way every case is different. Maybe the way to do that is actually with aggressive to do that is actually with aggressive pain control. Now, pain control. Now, and I'll just add one small piece of and I'll just add one small piece of this. It is this. It is sadly uh you know I've received a number sadly uh you know I've received a number of calls where sometimes the team again of calls where sometimes the team again uh concerned about how best to manage a uh concerned about how best to manage a person uh pain who may be on methadone person uh pain who may be on methadone or bupinorphine thinking that the or bupinorphine thinking that the methadone or the bupinorphine in which methadone or the bupinorphine in which they're receiving for their opioid use they're receiving for their opioid use disorder covers pain.

disorder covers pain. >> Yeah. >> Yeah. >> Yeah. >> Right. Well, they're on methadone. they >> Right. Well, they're on methadone. they receive 120 milligrams a day. Therefore, receive 120 milligrams a day. Therefore,

they're good. They they're already on they're good. They they're already on pain medication. Similarly for for pain medication. Similarly for for bupinorphine and just to say uh without bupinorphine and just to say uh without any question that is not the case, any question that is not the case, right? We really need to consider pain right? We really need to consider pain and address pain uh when it's clinically and address pain uh when it's clinically indicated in every person that we indicated in every person that we manage. Um and and that's something manage. Um and and that's something that's important. Um do we have time for that's important. Um do we have time for one more? So, thank you everyone. Great one more? So, thank you everyone. Great pleasure. Um, pleasure. Um, >> thank you so much >> thank you so much for our panel. Give it up for them.

for our panel. Give it up for them.