Pain and the Opioid Crisis: Origins and Solutions

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DISCLAIMER

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- Medical Director, Dawn
- Past President, Mich Society of Addiction Medicine
- Consultant, USA, DEA & BCBSM
- Provider, Packard Health & St Joes (IHA)

Who Are the Players?

CURRENCY

WHO IS RESPONSIBLE FOR THE PAIN-PILL EPIDEMIC?

By Celine Gounder November 8, 2013

How did doctors, who pledge to do no harm, let the use of prescription narcotics get so out of hand?

Photograph by Roberto Machado Noa / LightRocket via Getty

4 Russell Portenoy MD


THE WALL STREET JOURNAL.

A Pain-Drug Champion Has Second Thoughts

Andrew Kolodny, MD

PAIN NEWS NETWORK HOME ABOUT US STAFF AFFILIATES PATIENT RESOURCES PNN SU

Patient Advocates Call on Brandeis to Fire Kolodny

October 03, 2017

By Pat Anson, Editor

A coalition of physicians, patient advocates and pain sufferers has written an open letter to Brandeis University asking for the dismissal of Andrew Kolodny, MD, a longtime critic of opioid prescribing who is **co-director of opioid policy research at the university's Heller School for Social Policy and Management.**

Kolodny is the founder and Executive Director of Physicians for Responsible Opioid Prescribing (PROP), an anti-opioid activist group that has lobbied politicians and regulators for years to enact stronger measures to limit prescribing of opioid pain medication.

"Dr. Kolodny has been prominent in a national campaign to deny chronic pain patients even minimal management of their pain. His actions are directed toward forcing draconian restrictions or outright withdrawal of this class of medications from medical practice," reads the letter to Brandeis President Ronald Liebowitz and other top administrators at the university.

"He calls for forced tapering of patients formerly prescribed opioids. Policy positions for which he advocates are leading to the deaths of hundreds of chronic pain patients by suicide or pain-related heart failure and medical collapse."

Investigations

Who is Joe Rannazzisi: The DEA man who fought the drug companies and lost

By Scott Higham and Lenny Bernstein
October 15, 2017

Joe Rannazzisi, seen here in September, ran the DEA's division responsible for regulating the drug industry and led a decade-long campaign of aggressive enforcement until he was forced out of the agency in 2015. (Ashi Chilwendu/The Washington Post)

Under Attack, Drug Maker Turned to Giuliani for Help

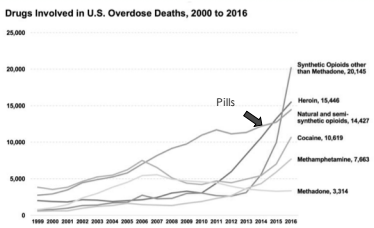
By BARRY MEIER and ERIC LIPTON DEC. 28, 2007

Giuliani Partners in 2004, with Rudolph Giuliani at top center and Bernard B. Kerik, the former New York City police commissioner, on his right. Librado Romero/The New York Times

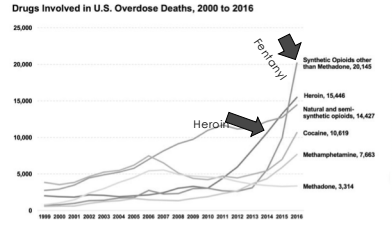
https://www.nytimes.com/2007/12/28/us/politics/28oxycontin.html

How Bad Is It?

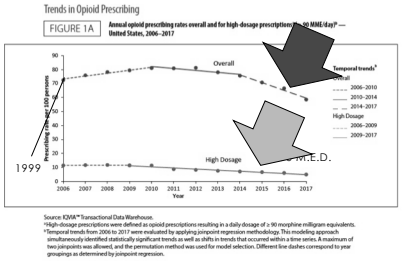
Overdose Deaths U.S. 1999-2016



Overdose Deaths U.S. 1999-2016



CDC, 2018: opioid sales 2006 - 2017

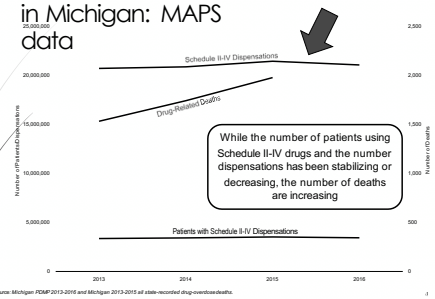


Source: IQVIA™ Transactional Data Warehouse.

*High-dosage prescriptions were defined as opioid prescriptions resulting in a daily dosage of ≥ 90 morphine milligram equivalents.

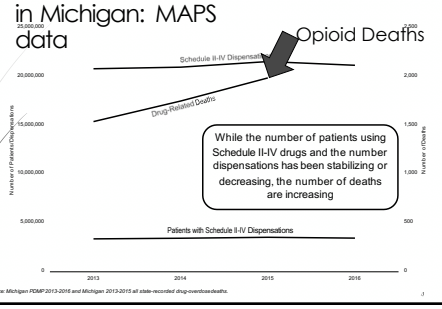
†Temporal trends from 2006 to 2017 were evaluated by applying joinpoint regression methodology. This modeling approach simultaneously identified statistically significant trends as well as shifts in trends that occurred within a time series. A maximum of two joinpoints was allowed, and the permutation method was used for model selection. Different line dashes correspond to year groupings as determined by joinpoint regression.

Prescription Drug Crisis in Michigan: MAPS data



Source: Michigan PDMP 2013-2016 and Michigan 2013-2015 all state-recorded drug-overdose deaths.

Prescription Drug Crisis in Michigan: MAPS data



Source: Michigan PDMP 2013-2016 and Michigan 2013-2015 all state-recorded drug-overdose deaths.

Conclusions:

- Prescription opioids have leveled off/decreasing.
- Despite this, OD deaths are increasing due to Fentanyl.
- Patients will routinely tell you that they "moved to heroin".
- They are being exposed to Fentanyl instead (50%+)

AJPH: no decrease in mortality expected for 5 to 10 years

AJPH
A PUBLICATION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Home Articles Authors Subscrip

Home » American Journal of Public Health (AJPH) » **October 2018**

Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic

Allison L. Pitt MS, **Keith Humphreys** PhD, and **Margaret L. Brandeau** PhD

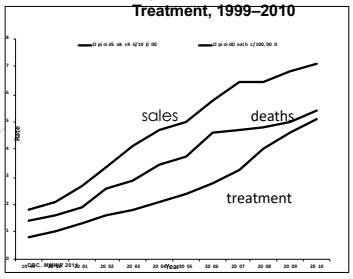
(+) Author affiliations, information, and correspondence details

Accepted: June 06, 2018 Published Online: September 12, 2018

Are Providers Behind the Opioid Epidemic?

17

Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010

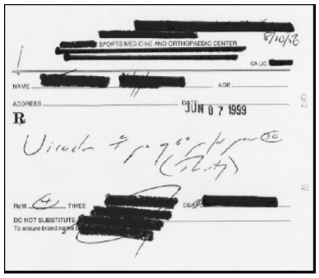


MSMS

WHERE DID THE OPIOIDS COME FROM?

- **Unless:**
- It fell off a truck, or
- Was purchased on the Internet,

It all came from this.



22

Michigan is 10th in the US:
107 prescriptions/100 people.

23

WHY do doctors over prescribe?

- The Four D's:
  - Dated
  - Dishonest
  - Duped
  - Disabled

24

The Four D's:

- Dishonest?
- Dated
- Disabled
- Duped

25

The Four D's:

- Dishonest?
- Dated
- Disabled
- Duped

CONTINUING EDUCATION REQUIREMENTS
FOR MICHIGAN MEDICAL DOCTORS

Authority: Public Act 368 of 1978, as amended

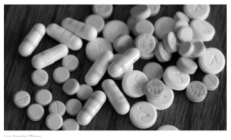
This form is for information only

26

The Four D's:

- Dishonest?
- Dated
- Disabled
- Duped

Op-Ed **Up to 15% of doctors are drug addicts. I was one of them**



Celebration of Arnold Pal

In Case You Missed It

27

The Four D's:

- Dishonest?
- Dated
- Disablec
- Duped

In closing arguments, doctors' lawyers say addicts duped their clients into writing prescriptions

NEWS By Jane Musgrave - Palm Beach Post Staff Writer

Pressure on Doctors?

Pain the 5th vital sign™ American Pain Society

Public Health & Policy

Opioid Crisis: Scrap Pain as 5th Vital Sign?

— Groups call on JC and CMS to re-evaluate policies that could lead to opioid overprescribing

Baker D. History of The Joint Commission's Pain Standards: Lessons for Today's Prescription Opioid Epidemic. JAMA, published online February 23, 2017.

"by 2004 this phrase was deleted from the accreditation standards manual".

Suing JCAHO?

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CITY OF CHARLESTON, WEST VIRGINIA, CITY OF HUNTINGTON, WEST VIRGINIA, CITY OF KENOVA, WEST VIRGINIA, and TOWN OF CEREDO, WEST VIRGINIA, municipal corporations, and other municipal corporations similarly situated,

Plaintiffs,

v.

Civil Action No.

THE JOINT COMMISSION f/k/a THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, a not-for-profit organization, and its wholly-owned affiliate, JOINT COMMISSION RESOURCES, INC. d/b/a JOINT COMMISSION INTERNATIONAL, a not-for-profit organization,

Defendants.

COMPLAINT

31

The Four D's:

- Dishonest
- Dated
- Disabled
- Duped
- The 5th D: defamation

Lembke, Anna. Why Doctors Prescribe Opioids to known Opioid Abusers. n engl j med 367;17 nejm.org october 25, 2012

Controlled Substance Act: Bottom Line

U.S. Department of Justice Drug Enforcement Administration

- The prescription must be for a legitimate medical purpose. (pain)
- It must be prescribed in the usual course of professional practice. (monitor for addiction/diversion)
- It cannot be prescribed for treatment of opioid withdrawal or maintenance (except for buprenorphine and a methadone dispensing clinic)

Consequences of the Opioid Crisis

- Restriction on dose (< 90 mg of morphine)
- Exclusion of formulations (Oxycontin, etc)
- Limits on duration (3 days without MAPS*, 7 days with)
- Limits on who can prescribe (Michigan, March 2019)
- Requirements for prescription search
- ~~Requirements for urine drug screens~~
- ~~Increased availability of addiction treatment~~
- FORCED OPIOID TAPERS/ABRUPT DISCONTINUATION

* MAPS = Michigan Automated Prescription Search

Opioid Tapers and substitution

- Your provider may CUT your dose by 10/25/50%
  - They are told to be concerned about anything close to or over 90 mg of morphine (= 9 Norco 10 mg)
- Your provider may TAPER your dose
- Your provider may REFER you to a specialist

How Fast Should Tapers Be?:

CDC MMWR March 18 2016 p 26

- The CDC recommends that tapers may need to be 10% per week OR SLOWER, especially when the patient has been taking the opioid for years.
- The taper may need to be stopped for a while and restarted and slowed down when the patient reaches a low dose.

When does the CDC recommend abrupt discontinuation?

- "If clinicians suspect their patient might be sharing or selling opioids and not taking them….opioids can be discontinued without causing withdrawal" (p30 CDC)
- Another reason: addiction = referral
- Otherwise: abrupt discontinuation is NOT recommended!

Forced Taper

Tapered to zero: In radical move, Oregon's Medicaid program weighs cutting off chronic pain patients from opioids

Forced Taper → Suicide?

- "Medicolegal Risks of Tapering opioids"
  - Risk of death by suicide can be a concern for patients with primary affective symptoms, especially in the context of a complicated pharmacotherapy regimen.
    - Tapering Long term opioid therapy in CNCP: evidence and recommendations for everyday practice. Berna C et al. Mayo Clinic Proceedings June 2015 : 90(6): 828

ABRUPT discontinuation: examples

- "I'm not prescribing opioids anymore. Here's your last prescription".
- "We got you an appointment with Dr. Christensen. Here's enough to make it to the appointment."
- "You tested positive for MJ" (The doctor signed the Medical Marijuana Card!)
- **"You tested positive for heroin. You're discharged"**
- The above can lead to complaints of…..

Patient Abandonment

- This occurs when:
  - There is an established relationship between you and the doctor
  - You still need medical treatment
  - Your care was stopped so abruptly that there is not enough time to find a replacement.
  - You must suffer an injury.

Patient Ethics

- Nonmaleficence - "do no harm"
- Beneficence – "do the best thing" for the patient
- Autonomy – allow the patient to choose the treatment (assumes informed consent).

- These principles would suggest:
  - Gradual tapers vs abrupt tapers/discontinuation
  - Referral for addiction

THE MICHIGAN OPIOID LAWS


CRAIN'S DETROIT BUSINESS

Opioid laws hit physicians, patients in unintended ways

The New Michigan Opioid Laws

- Run a MAPS before EVERY prescription.
- Get an informed consent ("Start Talking")
- Parental involvement for minors
- ~~Documented prescriber-physician relationship~~
- DRUG TESTING NOT REQUIRED
- 3 days for acute pain without a MAPS
- 7 days for acute pain with a MAPS

Why the Time Limit?
Chad Brummet, MD,et al, Univ of Mich

- 6% of patients who get opioids after surgery are "dependent" long term
  - Who does it happen to?
- NO relation to dose
- NO relation to type of surgery (minor vs major)

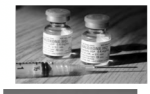
*Sekhri, Shaina, et al. "Probability of Opioid Prescription Refilling After Surgery: Does Initial Prescription Dose Matter?." *Annals of Surgery* (2017).

Effect of duration of first use
MMWR, March 17, 2017/66 (10); 265-269

- If you are opioid naiive, and get a **7 day prescription**, you have a **5 to 15%** percent chance of being on opioids 1 to 3 years later.
- If you are opioid naiive, and get a **28 day prescription**, you have a **15 to 25%** percent chance of being on opioids 1 to 3 years later.

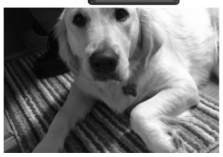
Opioid Overdose Rescue: naloxone (Narcan)

0.4 mg



0.4 mg

4 mg !!!!!



Downside of Narcan Rescue: the "White Paper"

The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime

75 Pages • Posted: 6 Mar 2018 • Last revised: 19 Apr 2018

Jennifer L. Doleac
University of Virginia - Frank Batten School of Leadership and Public Policy

Anita Mukherjee
University of Wisconsin - Madison - School of Business

Prescription Searches: why are you violating my privacy?

- The provider has to check your narcotic prescriptions every time a prescription is written!
- Exception: after surgery, if only for 3 days.
- The provider can LOSE THEIR LICENSE if they don't.

PROPUBLICA TOPICS ▾ SERIES ▾ NEWS APPS GET INVOLVED IMPACT ABOUT

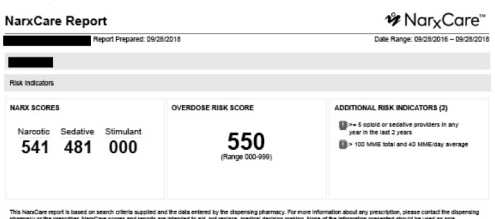
POLICING PATIENT PRIVACY

Small-Scale Violations of Medical Privacy Often Cause the Most Harm

Breaches that expose the health details of just a patient or two are proliferating nationwide. Regulators focus on larger privacy violations and rarely take action on small ones, despite the harm.

by Charles Ornstein, Dec. 10, 2015, 6 a.m. EST

NARx Score



NarxCare Report — NarxCare™

[redacted] Report Prepared: 09/28/2018 — Date Range: 09/28/2016 – 09/28/2018

[redacted]

Risk Indicators

NARX SCORES			OVERDOSE RISK SCORE	ADDITIONAL RISK INDICATORS (2)
Narcotic	Sedative	Stimulant		
541	481	000	550 (Range 000-999)	>= 5 opioid or sedative providers in any year in the last 2 years > 100 MME total and 40 MME/day average

This NarxCare report is based on search criteria supplied and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber. NarxCare scores and reports are intended to aid, not replace, medical decision making. None of the information presented should be used as sole justification for providing or refusing to provide medications. The information on this report is not warranted as accurate or complete.

Relative Risk of Fatal Overdose by NARx score
Huizenga, Breneman, Appriss, Inc

<100	1	500-599	32
100-199	8	600-700	56
200-299	10	700-800	76
300-399	10	800-900	101
400-499	16	900-999	168

https://apprisshealth.com/wp-content/uploads/sites/2/2017/02/NARxCHECK-Score-as-a-Predictor.pdf

What About Sedatives?

- Benzodiazepines: Xanax, Klonopin, Valium, Librium
- Sleepers: Ambien, Lunesta, Sonata
- **Gabapentin**
- Muscle Relaxers: Flexeril, Robaxin, Zanaflex
- SOMA

What About Benzodiazepines?

- Benzodiazepines TRIPLE the risk of opioids if your patient currently uses them.*
- They DOUBLE the risk even if they have stopped (?)*
- Benzodiazepines are associated with dementia**
- SOMA: part of the Holy Trinity (Soma, Norco, and Xanax)
- Benzodiazepines may paradoxically **increase pain**!***
- **Gabapentin** is the most common non-opioid found to be involved in opioid OD deaths (MAPS data)

*Park TW et al. BMJ 2015; 350:h2698
**Billioti de Gage S et al. BMJ 2012; 345 e 6231
***Ciccone DS et al. J Pain Symptom Manage 2000 Vol 20(3), p180.

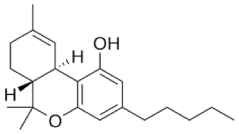
72

What is the benefit of Marijuana for Chronic Pain?

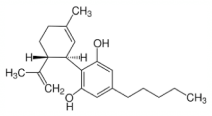
73

What Are the Phytocannibinoids?

Tetrahydrocannabinol (THC)



Cannabidiol (CBD)



74

Cannabis and Cannabinoids

- National Academy of Sciences:
  - There is conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment of chronic pain in adults. (www.nap.edu/24625)
- U of M:
  - FM patients in a MMJ clinic decreased opioids by 64% and increased QOL 45% (Bohenke et al. Subs Use Misuse 2018 Aug 24; 53(10): 1602-1607)
- MMJ and mortality:
  - **Bachhuber MA, et al**. Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010. JAMA Intern Med 2014; 174(10): 1668-1678.
  - There was a **24% decrease** in opioid OD deaths in states that implemented "Medical Marijuana" compared to states without..

But……

- Is Cannabis Addicting?
- Does Cannabis cause withdrawal?
- Is Cannabis safe during pregnancy?
- Is Cannabis safe while driving?

Finally: What Will Your Provider DO?

What Will Your Provider Do?

- Most providers will not START someone on opioids.
  - There is no good data that it works.
  - There is good data that it causes harm.
  - Your doc is painting a bullseye on their back.

What Will Your Provider Do?

- If you are ALREADY on opioids:
  - Your provider may continue them, but want to decrease/taper the dose (especially if > 90 mg of morphine)
  - Your provider may DISCONTINUE them abruptly

What Will Your Provider Do?

- If you are ALREADY on opioids:
  - Your provider may REFER you to a pain/addiction specialist
    - Even though you DON'T have addiction, most providers who specialize in detoxing/changing pain meds are addiction specialists!

What Will Your Addictionist Do?

- If you are NOT on opioids:
  - Opioids will probably NOT be started (see above).
  - You may be offered buprenorphine (Suboxone/Zubsolv/Butrans)
  - You may be offered non narcotic meds (except now, gabapentin)

What Will Your Addictionist Do?

- If you ARE on opioids:
  - Your addictionist will probably NOT continue the opioids.
    - They don't know you
    - They need to be concerned about continuing the opioids.

What Will Your Addictionist Do?

- If you ARE on opioids:
  - You may be offered the buprenorphine TABLET (Suboxone/Zubsolv)
    - Approved for addiction, used for chronic pain "off label".
  - You may be offered the buprenorphine PATCH (Butrans)
    - Much weaker, often ineffective.

What Will Your Addictionist Do?

- If you ARE on opioids:
  - If you do not want to switch over to buprenorphine, you may be offered detox meds to help with withdrawal.
  - You (may) feel better once off the meds.

Contact Information

- Carl Christensen MD
- Voice mail: 734-368-9871
- Fax: 734-212-2121