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Disclosure
None of the above speakers or planners have any conflicts of interest to report
The Opioid Epidemic: How We Got Here, Where We Are Now, and How to Get Out

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Disclosures

I have no conflicts to disclose.
How did we get here?
Pre- 1980’s
Late 1990’s
Link between opioid prescribing and opioid deaths
Pill mill doctors?
We’re *all* prescribing too many opioids

Big Pharma co-opts Big Medicine
3 Myths of opioids

● Myth #1: Opioids work for chronic pain

● Myth #2: No dose is too high

● Myth #3: Less than 1% get addicted if Rx’d by a doctor
Keypoint: Key opinion leaders

Continuing medical education
Professional medical societies and patient advocacy organizations

Recent investigative reporting from the Milwaukee Journal Sentinel/MedPage Today and ProPublica revealed extensive ties between companies that manufacture and market opioids and non-profit organizations such as the American Pain Society.

According to the Milwaukee Journal Sentinel/MedPage Today, a “network of national organizations and researchers with makers of narcotic painkillers...”
<table>
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<tr>
<th>Vital Signs</th>
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The Federation of State Medical Boards

Federation of State Medical Boards

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Distributed by 21 state medical boards to over 150,000 clinicians.

The book’s sponsors include:

- Abbott Laboratories
- Alpharma Pharmaceuticals LLC
- Cephalon, Inc.
- Endo Pharmaceuticals
- King Pharmaceuticals
- Purdue Pharma L.P.

Where are we now?
The second wave of the epidemic
12 Month-ending Provisional Number of Drug Overdose Deaths

Based on data available for analysis on: 9/5/2018

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States
Figure 1b. Percent Change in Reported 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: February 2017 to February 2018
The hidden epidemic – benzodiazepines: 7-fold increase in overdose deaths

We’re still prescribing too many opioids
The U.S. continues to consume a disproportionate amount of the world’s Rx opioids
U.S. outstrips other rich nations in opioid Rx’ing
CDC data opioid prescriptions/100 persons

- U.S. average in 2012 = 81 opioid Rx’s/100 persons (255 million total)
- U.S. average in 2016 = 66 opioid Rx’s/100 persons (214 million total)
- Highest state average in 2016 = Alabama at 121 opioid Rx’s/100 persons
- Some counties with rates 7x the national average
CDC data opioid prescriptions/100 persons (2016 state)
CDC data opioid prescriptions/100 persons (2016 county)
Opioid misuse (NSDUH 2016)

- 11.5 Million People with Past Year Pain Reliever Misuse (97.4% of Opioid Misusers)
- 641,000 People with Past Year Pain Reliever Misuse and Heroin Use (5.4% of Opioid Misusers)
- 948,000 People with Past Year Heroin Use (8.0% of Opioid Misusers)
- 10.9 Million People with Pain Reliever Misuse Only (92.0% of Opioid Misusers)
- 307,000 People with Heroin Use Only (2.6% of Opioid Misusers)

11.8 Million People Aged 12 or Older with Past Year Opioid Misuse
How Rx opioids obtained (NSDUH 2016)

- Prescription from One Doctor (35.4%)
- Got through Prescription(s) or Stole from a Health Care Provider (37.5%)
- From Friend or Relative for Free (40.4%)
- Bought from Friend or Relative (8.9%)
- Bought from Drug Dealer or Other Stranger (6.0%)
- Some Other Way (3.4%)
- Stole from Doctor’s Office, Clinic, Hospital, or Pharmacy (0.7%)
- Given by, Bought from, or Took from a Friend or Relative (53.0%)

11.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year
September 2017

- 28 year old male with chronic pain
  - 40 mg Opana BID
  - 30 mg Dilaudid qD
  - 60 mg Oxycodone qD
  - 20 mg Valium qD
  - 65 mg Phenobarb qD
  - 30 mg Temazepam qD
  - 8 mg Xanax qD

- MED = 470
A deeper look
The canary in the coal mine...
Opioids the solution . . .?
What motivates the compassionate doctor?
A pleaser
Responding to a ‘higher calling’
Socialized to empathize and believe patients

Put yourself in their shoes
Motivated by mutually affectionate relationships
What motivates the drug-seeking patient?

Neuroadaptation
The Senator
The Sycophant
The Exhibitionist
The Dynamic Duo
The City Mouse and the Country Mouse
The Loser
The Weekender
The Twin
The Bully
Invisible forces continue to drive overprescribing
#1 The Toyota-ization of medicine
Doctors leaving private practice

The P-Paradigm

● Palliate Pain
● Prescribe Pills
● Perform Procedures
● Protect Privacy
● Please Patients

Dr. Anna Lembke MD

3.0 Add your rating: ★★★★★ ★★★☆☆☆ 7/4
2 reviews

Psychiatrist
15 years of experience
Video profile
✓ Accepting new patients

401 Quarry Rd
Palo Alto, CA 94304
Phone number & directions

Patient Reviews

Overall Rating: 3.0 ★★★★★
Total Ratings: 7
Total Reviews: 2

Ease of Appointment: ★★★★★
Bedside Manner: ★★★★★
Promptness: ★★★★★
Spends Time with Me: ★★★★★
Courteous Staff: ★★★★★
Follows Up After Visit: ★★★★★
Accurate Diagnosis: ★★★★★
Average Wait: 5 minutes

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Certified FM Experts
Respiratory Medicine
Medical Billing Coding
Pediatric concierge MDs
Plaza Medical Centers
1 Trick to Fibromyalgia
KUBI Telemedicine Robot

★ ★ ★ ★ ★ | Care that worsens your condition | show details
by Corey on Jun 25th, 2013
Really wish I had seen this site's reviews before making an appointment with this physician. She provides the kind of care that will make you wish you had never sought help in the first place. Wrong diagnosis, wrong medication. In some cases this can be terrible. Seek help from someone else.
The Cost of Satisfaction
A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Joshua J. Fenton, MD, MPH; Anthony F. Jemant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N = 51,946) to the 2000 through 2007 National Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2003 subsample (n = 36,428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.0 years.

ease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit (adjusted odds ratio [aOR], 0.92; 95% CI, 0.84-1.00), higher odds of any inpatient admission (aOR, 1.12; 95% CI, 1.02-1.23), 8.8% (95% CI, 1.6%-16.6%) greater total expenditures, 9.1% (95% CI, 2.3%-16.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.
#2 Medicalization of poverty
The poor treated differently (2010)

- People receiving Medicaid are prescribed opioid painkillers
  - at **2x** rate of non-Medicaid patients
  - and die from prescription overdoses at **6x** the rate.

Medicaid opioid overprescribing continues

**Figure 4**: Average Number of Incidences of Indicators for Potential Inappropriate Prescriptions of Opioids per Patient by Insurance Type, Age, Gender, Race/Ethnicity, and Year

- Red: Age 55-64, 2.71
- Blue: Age 45-54, 2.60
- Purple: Missing race, 2.20
- Green: FFS, 2.06
- Black: Male, 1.69
- Pink: White, 1.68
- Brown: Age 35-44, 1.41
- Green: Female, 1.12
- Light Green: Hispanic, 1.02
- Orange: Other, 0.67
- Blue: MC, 0.63
- Cyan: Black, 0.62
- Teal: Age 18-34, 0.41

FFS = fee-for-service; MC = managed care.
Opioid and benzo co-prescribing

APPENDIX A
Indicators of Potential Inappropriate Prescribing by Number of Individuals

- Red: Opioid/opioid
- Green: Opioid/benzos
- Blue: Opioid/buprenorphine/haloxone
- Orange: LA/ER for acute pain
- Brown: High daily dose

benzos = benzodiazepines; LA/ER = long acting/extended release

Journal of Managed Care & Specialty Pharmacy JMCP September 2018 Vol. 24, No. 9
www.jmcp.org
2016 opioid prescriptions per 100 persons (county)
U.S. unemployment by county
Figure 11. Deaths of Despair for White Non-Hispanics Age 50–54, by Level of Education, 1998–2015

Deaths per 100,000

Sources: National Vital Statistics System; authors’ calculations.
a. Deaths of despair refer to deaths by drugs, alcohol, or suicide.

Case and Deaton (2017) Brookings Papers on Economic Activity
Medical disability = safety net for poor/undereducated

SSDI 1957
- 150,000
- #1 reasons cancer and cardiac disease

SSDI 2016
- 8 million
- #1 reasons mental illness and musculoskeletal disorders

Religion is the opium of the masses.

(Karl Marx)
#3 Cultural narratives
Pain is dangerous
Thomas Sydenham 1624-1689

“I look upon every ... effort calculated totally to subdue that pain and inflammation dangerous in the extreme .... for certainty a moderate degree of pain and inflammation in the extremities are the instruments which nature makes use of for the wisest purposes.”
The body cannot heal itself
Doctors have superhuman abilities to heal
Victimhood is a right to be compensated
Doctors (and patients) caught between a prescription and a hard place
Defense mechanisms to the rescue!
How defense mechanisms work

Anxiety ➔
Defense Mechanisms ➔
DECREASED ANXIETY
Denial
Projection
Splitting
Passive aggression
What happens when the compassionate doctor and the drug-seeking patient get a room?
Doctor meets patient Take 1

Video Not Available
In other words . . .

A Kerfuffle that perpetuates the problem . . .
What happens when primitive defenses no longer work?

- For example when the Prescription Drug Monitoring Database shows undeniable doctor-shopping

- Doctor is fully unmasked as a de facto drug dealer
A narcissistic injury
Healthy narcissism

Heinz Kohut, *The Kohut Seminars*, 1987
Narcissistic rage and retaliation
Doctor meets patient Take 2

Video Not Available
How can we do better?

Enabling

Retaliation
What has been done so far?

- Pill Mills shut down
- Pain guidelines revised
- Hydrocodone products rescheduled/ Tramadol scheduled
- Naloxone distributed
- PDMPs re-invigorated
- Pharmacy lock-in programs implemented
- Opioid addiction treatment subsidized (CARA and 21st Century Cures Act)
- Abuse-deterrent formulations promoted (sketchy)
#1 Primary prevention
Avoid new opioids starts
1 in 7 opioid naïve patients who refills an opioid Rx will become a persistent opioid user

1 in 7 patients who receive a refill or second opioid prescription were on opioids 1 year later. *Morbidity and Mortality Weekly Report (MMWR)* March 17, 2017/66(10); 265-269.
1 in 10 opioid naïve surgery patients will become a persistent opioid user

Following surgery, patients receive an average of 85 opioid pills, whether they need them or not.

Percent of Newly Persistent Opioid Patients
- Rotator Cuff: 10.2%
- Colectomy: 17.6%
- Hysterectomy: 7.5%
- Sleeve Gastrectomy: 8.5%
- Hernia: 7.2%
- Total Hip: 9.9%
- Total Knee: 16.7%
- Overall: 9.5%

Share of Opioid Prescriptions by Gender
- 65% for women
- 35% for men

Newly persistent is defined as patients using an opioid far beyond (3-6 months) the postsurgical recovery period.

Simple policy nudges make a difference

Figure 1. Quantity of Oxy/Paracetamol tablets dispensed before and after implementation of ED EMR discharge order default of 10 tablets.

M. Kit Delgado, Frances S. Shofer, Mitesh S. Patel, Scott Halpern, Christopher Edwards, Zachary F. Meisel, Jeanmarie Perrone
Journal of General Internal Medicine – first online January 16, 2018
#2 Secondary Prevention:
Taper at risk patients down or off of opioids

http://stan.md/taper-off-opioids
Risks

- Depression
- Pseudo-dementia
- Constipation
- Hormonal imbalance
- Addiction
- Death

- Tolerance
- Dependence
- Withdrawal
- Hyperalgesia
Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain
The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravel, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth Delronne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorballeachi, PhD

**IMPORTANCE**: Limited evidence is available regarding long-term outcomes of opioids compared with nonopioid medications for chronic pain.

**OBJECTIVE**: To compare opioid vs nonopioid medications over 12 months on pain-related function, pain intensity, and adverse effects.

**DESIGN**, **SETTING**, **AND PARTICIPANTS**: Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.
Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial

Mark D. Sullivan, Judith A. Turner, Cory DiLodovico, Angela D’Appolonia, Kari Stephens, and Ya-Fen Chan

Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington.

Abstract: Patients receiving long-term opioid therapy for chronic pain and interested in tapering their opioid dose were randomly assigned to a 22-week taper support intervention (psychiatric consultation, opioid dose tapering, and 18 weekly meetings with a physician assistant to explore motivation for tapering and learn pain self-management skills) or usual care (N = 35). Assessments were conducted at baseline and 22 and 34 weeks after randomization. Using an intention to treat approach, we constructed linear regression models to compare groups at each follow-up. At 22 weeks, adjusted mean daily morphine-equivalent opioid dose in the past week (primary outcome) was lower in the taper support group, but this difference was not statistically significant (adjusted mean difference = 42.9 mg; 95% confidence interval, –92.42 to 6.62; P = .09). Pain severity ratings (0–10 numeric rating scale) decreased in both groups at 22 weeks, with no significant difference between groups (adjusted mean difference = –.68; 95% confidence interval, –2.01 to .64; P = .30). The taper support group improved significantly more than the usual care group in self-reported pain interference, pain self-efficacy, and prescription opioid problems at 22 weeks (all P-values < .05). This taper support intervention is feasible and shows promise in reducing opioid dose while not increasing pain severity or interference.

Perspective: In a pilot randomized trial comparing a prescription opioid taper support intervention to usual care, lower opioid doses and pain severity ratings were observed at 22 weeks in both groups. The groups did not differ significantly at 22 weeks in opioid dose or pain severity, but the taper support group improved significantly more in pain interference, pain self-efficacy, and perceived opioid problems. These results support the feasibility and promise of this opioid taper support intervention.

© 2016 by the American Pain Society

Key words: Chronic opioid therapy, opioid dose taper, pain intensity, pain interference, pain self-management.
HOW TO TAPER PATIENTS OFF OF CHRONIC OPIOID THERAPY

ONLINE CME COURSE

Internet Enduring Material Sponsored by the Stanford University School of Medicine. Presented by the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine

COURSE DETAILS

Original Release Date: 08/02/18
Expiration Date: 08/02/21
Figure 14-4: Discussing Prescription Opioid Dependence with Patients in the Primary Care Setting

- Broaching the Subject
  - Schedule enough time with your patient to have a discussion on this difficult topic
  - Anticipate the patient’s strong emotional reaction
  - Identify the feelings, normalize those feelings, and express empathy with the concerns the patient may have

- Risk-Benefit Calculator
  - When assessing benefits, weigh the patient’s pain relief against their functionality
  - Involve family members for more objective views on a patient’s opioid use
  - Track common risks such as tolerance and opioid-induced hyperalgesia
  - Include all of these factors when discussing reasons for tapering off opioids

- Addiction Happens
  - Addiction is defined by the “Four C’s”: out-of-Control use, Compulsive use, Craving, and Continued use despite consequences
  - Dependence happens when the body relies on a drug to function normally
  - Dependence and Addiction are not equivalent

- Velocity Matters - and So Does Validation
  - Go slowly, take the necessary time to ease your patients down on their doses
  - Let the patient be involved when deciding how much to decrease and at what time
  - It is OK to take breaks in lowering the dosage
  - Never go backwards; your patient’s tolerance will increase and progress will be lost

- Other Strategies for Coping with Pain – teach patients these 3 Dialectical Behavioral Therapy (DBT) practices:
  - STOP: Stop, Take a breath, Observe internal and external experiences, and Proceed mindfully
  - Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values goals
  - Radical Acceptance: accepting reality as it is and not as we wish it to be

http://stan.md/taper-off-opioids
V = Velocity

- Go slowly
- Start wherever the patient is willing to start
- Let the patient drive (within reason)
- Keep dosing schedule (BID, TID, etc)
- Take breaks
- Never go backwards
#3 Treatment

Think of addiction ... 

... as a chronic relapsing and remitting disease (even if you don’t believe it is one)
“Over a median follow-up of 299 days, opioids were dispensed to 91% of patients after an overdose. … Our finding that almost all patients continue to be prescribed opioids after overdose is highly concerning.” Larochelle, et al., “Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose,” *Ann Intern Med* 2016; 164:1-9, at 1, 6.
Build an infrastructure inside the house of medicine to treat addiction
Treating addiction as a disease works

Drug Dependence, a Chronic Medical Illness
Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O’Brien, MD, PhD
Herbert D. Kleber, MD

Many expensive and disturbing social problems can be traced directly to drug dependence. Recent studies estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems. These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.
Biological interventions
#4 Change the perverse incentives inside healthcare driving overprescribing
Eliminate patient satisfaction surveys
Reimburse providers for educating and spending time with patients, not just for pills and procedures.
Provide insurance coverage for non-medication alternatives for chronic pain
#5 Reform disability
#6 Limit influence of special interest groups
#7 Provide alternative sources of dopamine

Dopamine $\text{C}_8\text{H}_{11}\text{NO}_2$
Reinhold Niebuhr (1892-1971)

“Ultimately evil is done not so much by evil people, but by good people who do not know themselves and who do not probe deeply.”
Videos available free online

- Stanford University Online CME Courses
  https://med.stanford.edu/cme/learning-opportunities/online.html

- Youtube: Compassionate Doctor Meets Drug Seeking Patient:
  https://www.youtube.com/watch?v=SIJiMLxorkc

- Youtube: Drug Seeking Patient and Physician Interaction - Narcissistic Injury:
  https://www.youtube.com/watch?v=X9efr-5WAPc
Thanks for listening!