Westchester Academy of Medicine

Office of Continuing Medical Education
333 Westchester Ave., Suite LN01, White Plains, NY 10604

Accreditation and Disclosure Statements

Hospital/Organization: Westchester Medical Center
Name of Activity: Pain and Palliative Care Grand Rounds Series:

The Opioid Epidemic: How We Got Here, and How We Can Get Out

Date and Time: Tuesday, November 7, 2017 – 12:30 pm-1:30 pm
Location of Activity: Taylor Care Pavilion Media Room, Westchester Medical Center, Valhalla, NY

Course Director(s) and Speakers:
Anna Lembke, MD; Michael Frankenthaler, MD; Garrett Weber, MD; Kathleen Carlisle

Accreditation Statement

This activity has been planned and implemented in accordance with the Accreditation Requirements and Polices of the Medical Society of the State of New York (MSSNY) through the joint providership of the **Westchester Academy of Medicine and Westchester Medical Center**. The Westchester Academy of Medicine is accredited by the Medical Society of New York (MSSNY) to provide Continuing Medical Education for physicians.

The Westchester Academy of Medicine designates this live activity for a maximum of ***1 AMA PRA Category I Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement

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The Opioid Epidemic
How We Got Here
How We Can Get Out

Anna Lembke, MD
Medical Director, Stanford Addiction Medicine
Associate Professor, Stanford University School of Medicine
alembke@stanford.edu

Disclosures/Conflicts of Interest

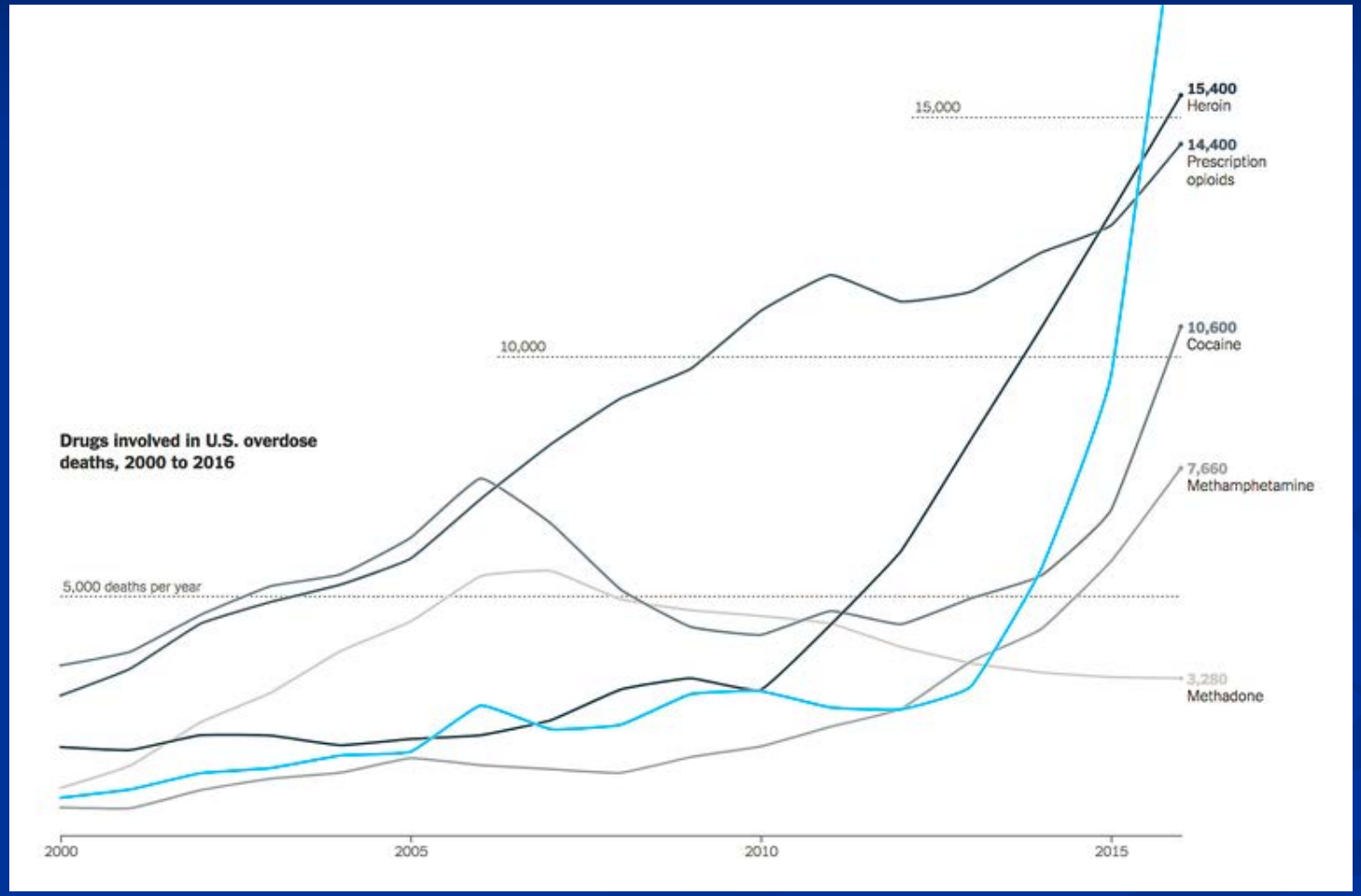
- I have no conflicts to disclose.

Pre- 1980's

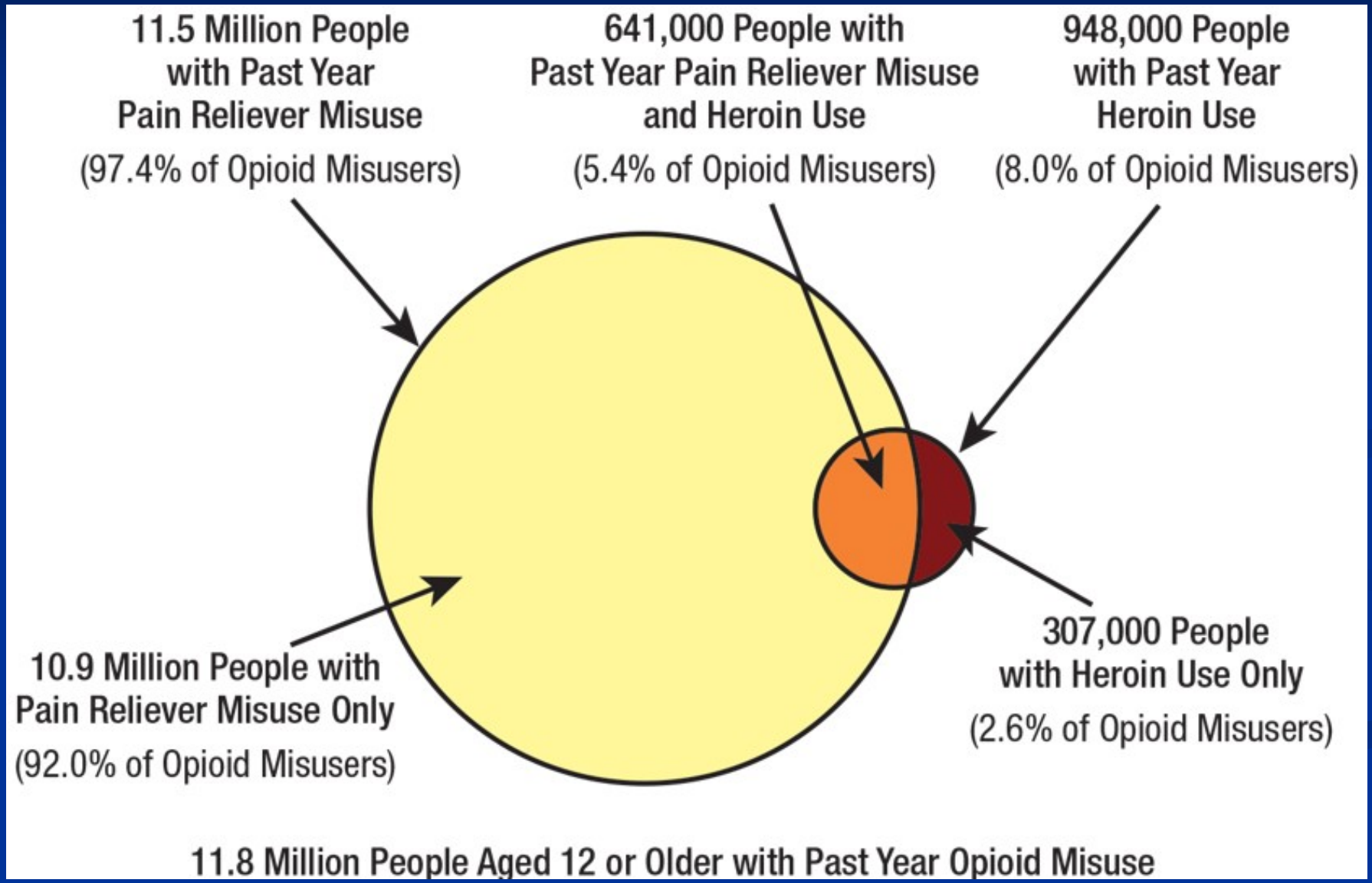
Late 1990's

September 2016

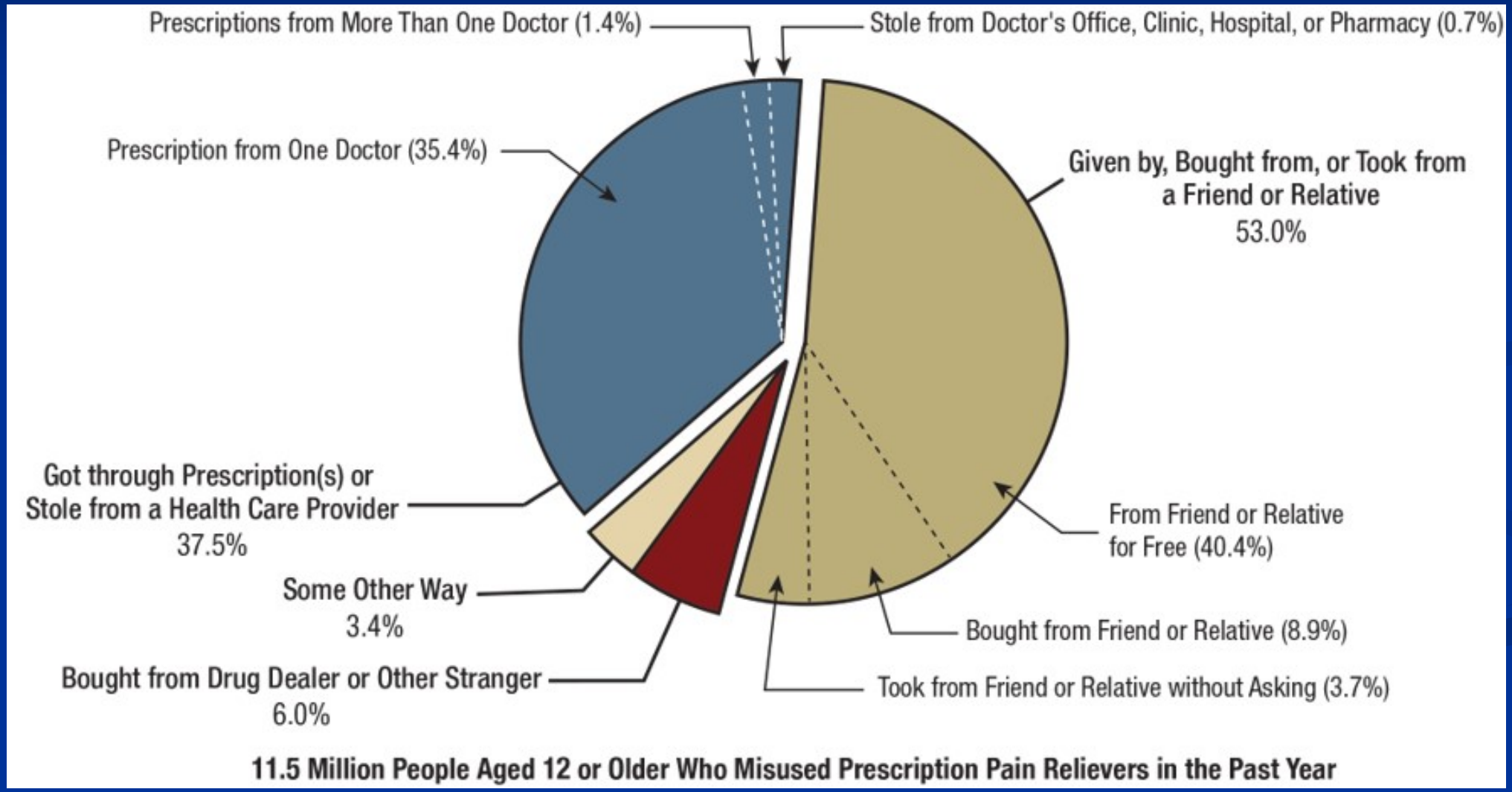
Drug overdoses 2000-2016



NSDUH 2016 Opioid misuse



NSDUH 2016
How opioids obtained?



How did we get here?

- Big Pharma?

- Pill Mill Docs?


Today's web bonus » See our staff's latest news and sports videos.

DAILY TIMES

Tuesday, September 22, 2015 delcotimes.com

'PILL MILL' TRIAL STARTS

NETHER PROV DOC FACES BOGUS PRESCRIPTION CHARGES: PAGE 3

FOLLOW US ON TWITTER

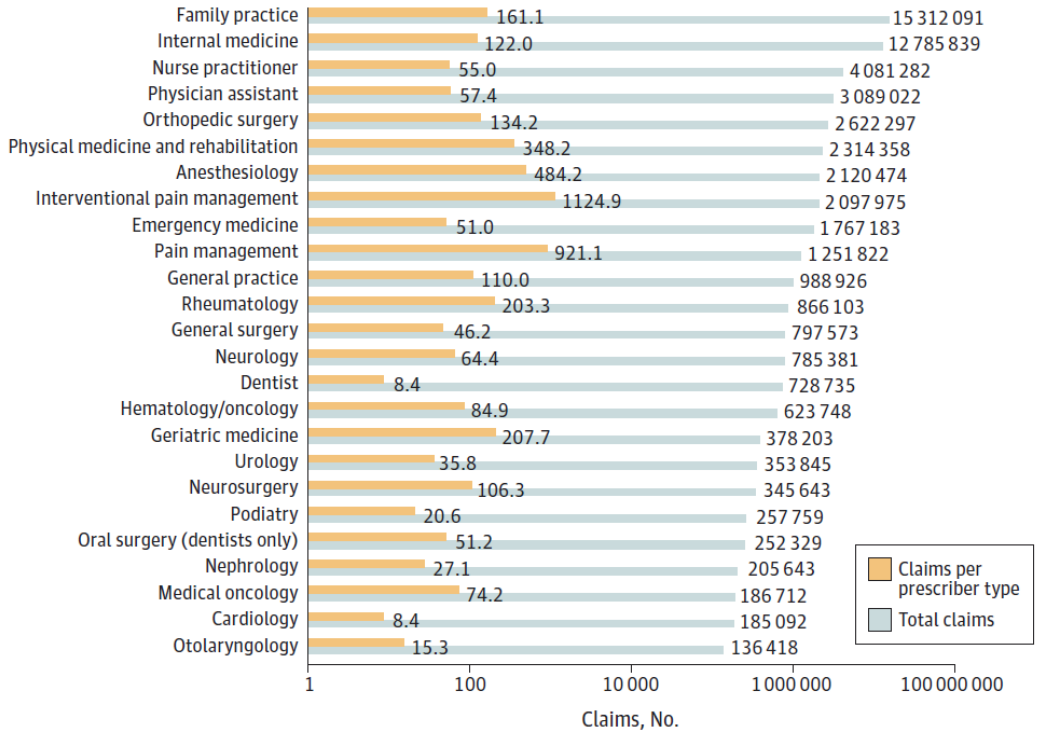
Chester Upland rallies for support at state Capitol

'Embarrassed' Kelly vows the Birds will learn from their loss

Here comes Francis: Roads start closing for the pope's visit

We're ALL prescribing too many opioids

Figure 1. Top 25 Prescriber Specialties by Total Medicare Part D Claims for Schedule II Opioids in 2013



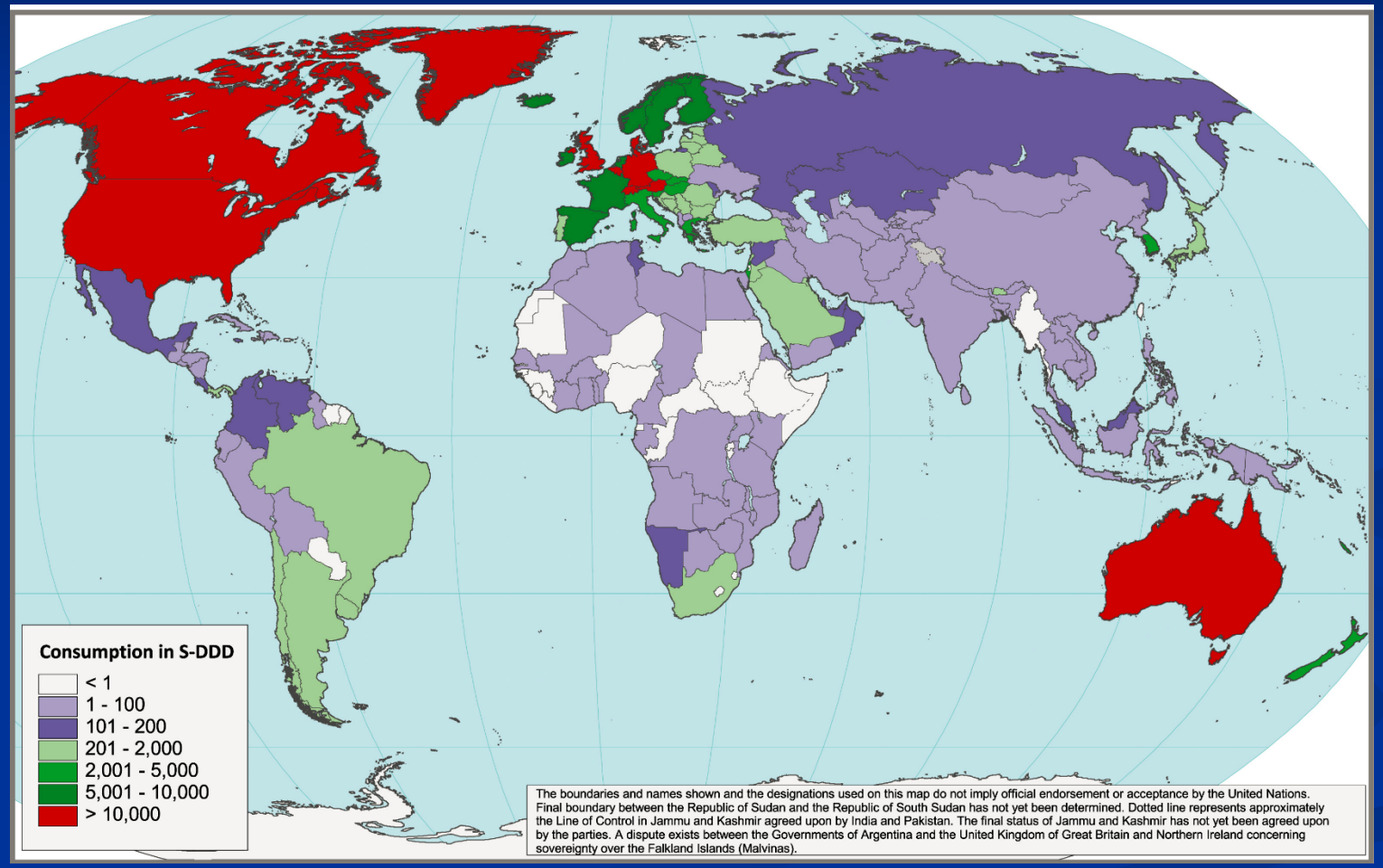
Values are reported on logarithmic scale.

jamainternalmedicine.com

JAMA Internal Medicine Published online December 14, 2015

Chen, J., Humphreys, K., Shah, N.H., Lembke, A. Distribution of Opioids by Different Types of Medicare Prescribers, *JAMA Internal Medicine*, December 14, 2015

The U.S. consumes 80% of the world's Rx opioids



https://www.incb.org/incb/en/narcotic-drugs/Availability/availability.html

September 2017

- 28 year old male with no organic pathology
  - 40 Opana BID
  - 30 Dilaudid qD
  - 60 Oxycodone qD
  - 20 Valium qD
  - 65 Phenobarb qD
  - 30 Temazepam qD
  - 8 Xanax qD
- MED= 470

A deeper look

The canary in the coal mine…

Opioids the solution …

What motivates the compassionate doctor?

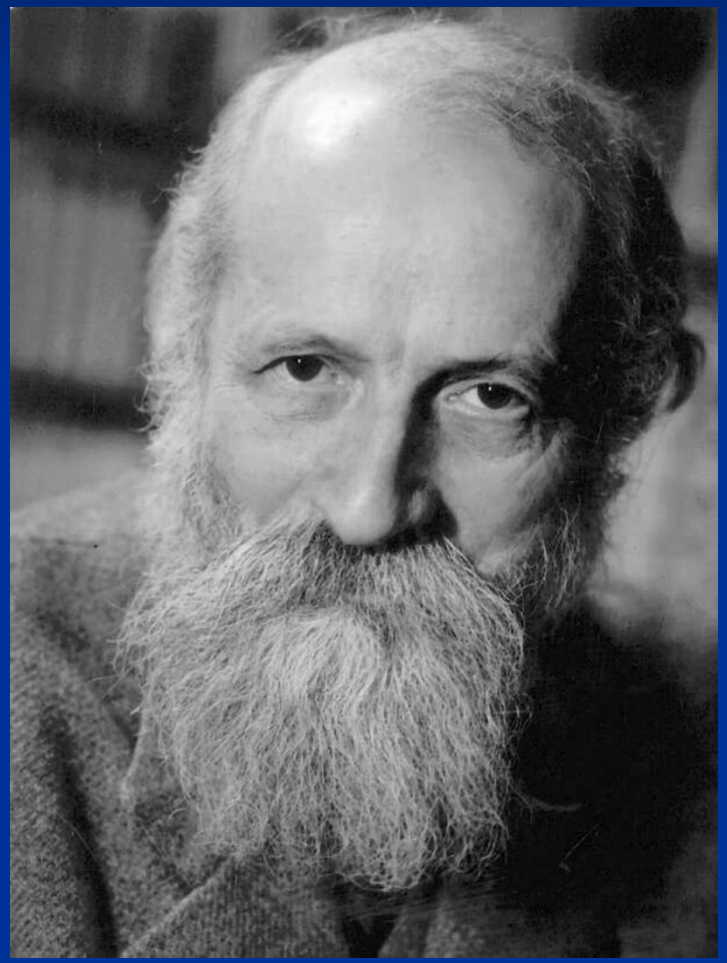
A pleaser

Responding to a ‘higher calling’

Socialized to empathize and believe patients

Motivated by mutually affectionate relationships

Martin Buber (1878-1965)

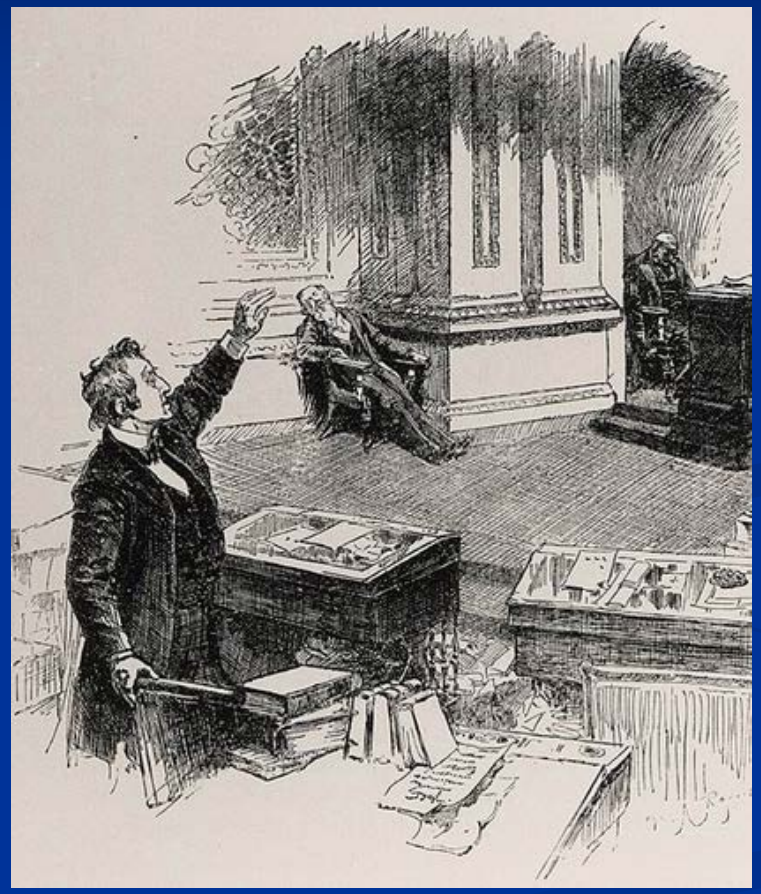


- "Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other…. Secretly and bashfully he watches for a YES which allows him to be and which can come to him only from one human person to another."

What motivates the drug-seeking patient?

Neuroadaptation

Filibustering

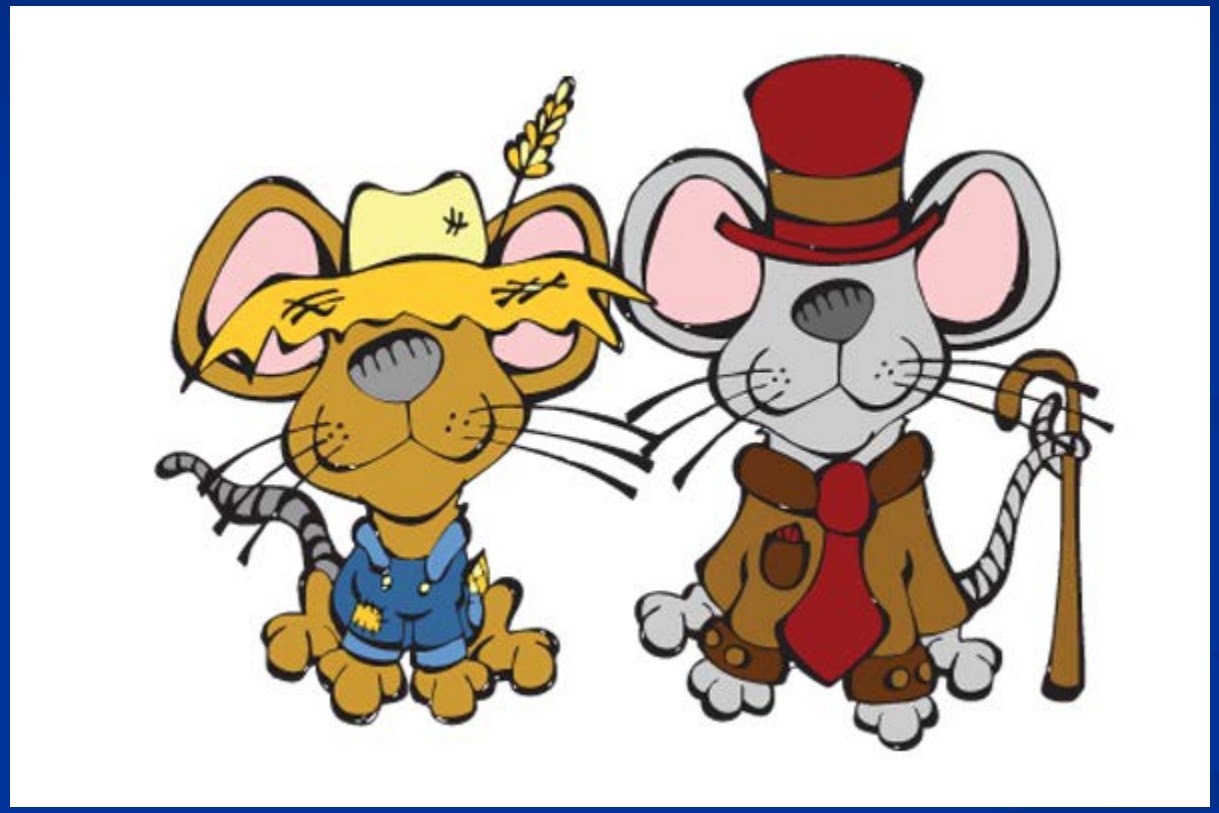


Flattering

Demonstrating

Teaming Up

Being City Savvy or Country Naïve



Losing Meds

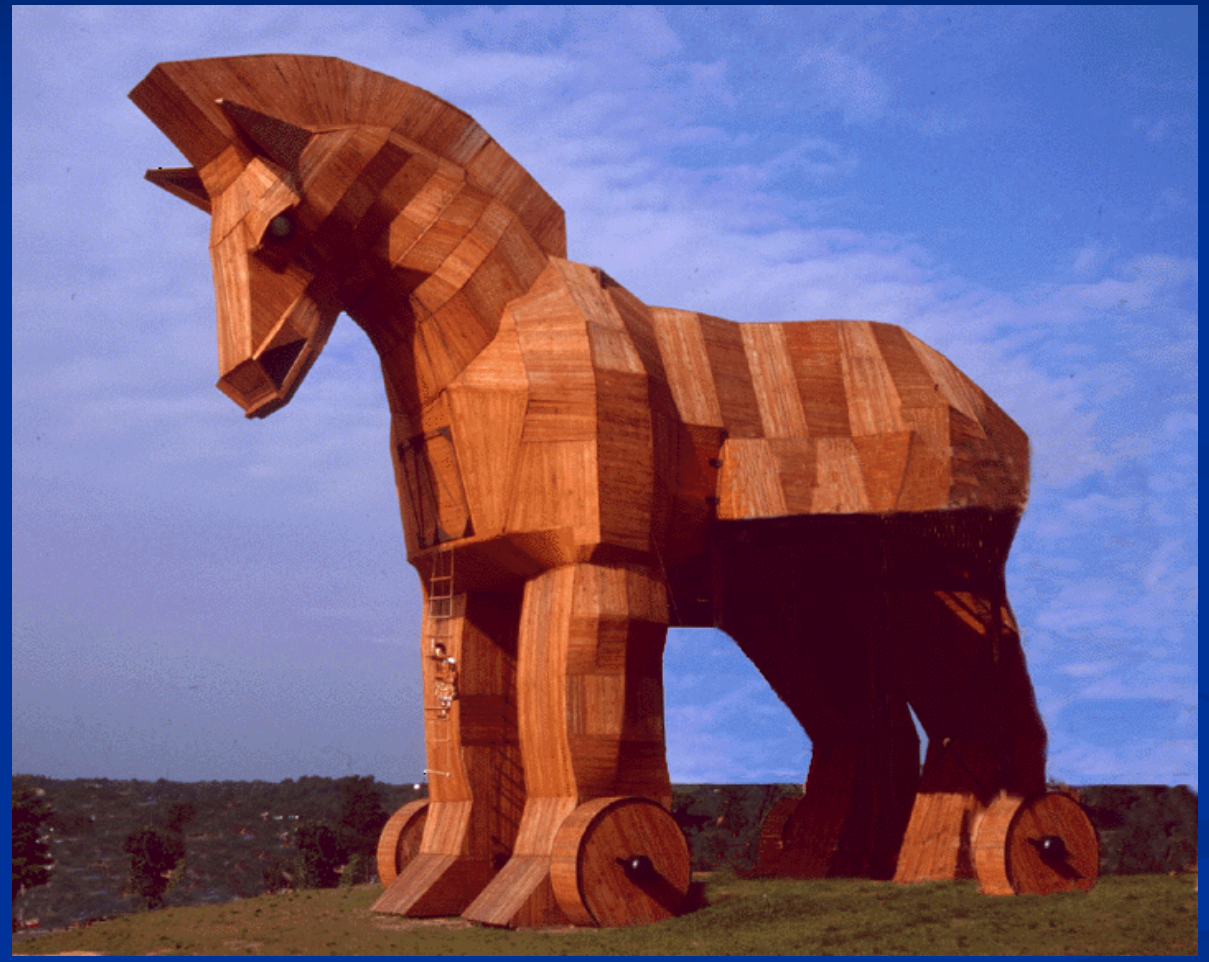
Calling Weekends and Evenings

Seeing a Mirror-Image

Doctor Shopping

Bullying

#1 Big Pharma Co-Opts Big Medicine



4 Myths of opioid prescribing

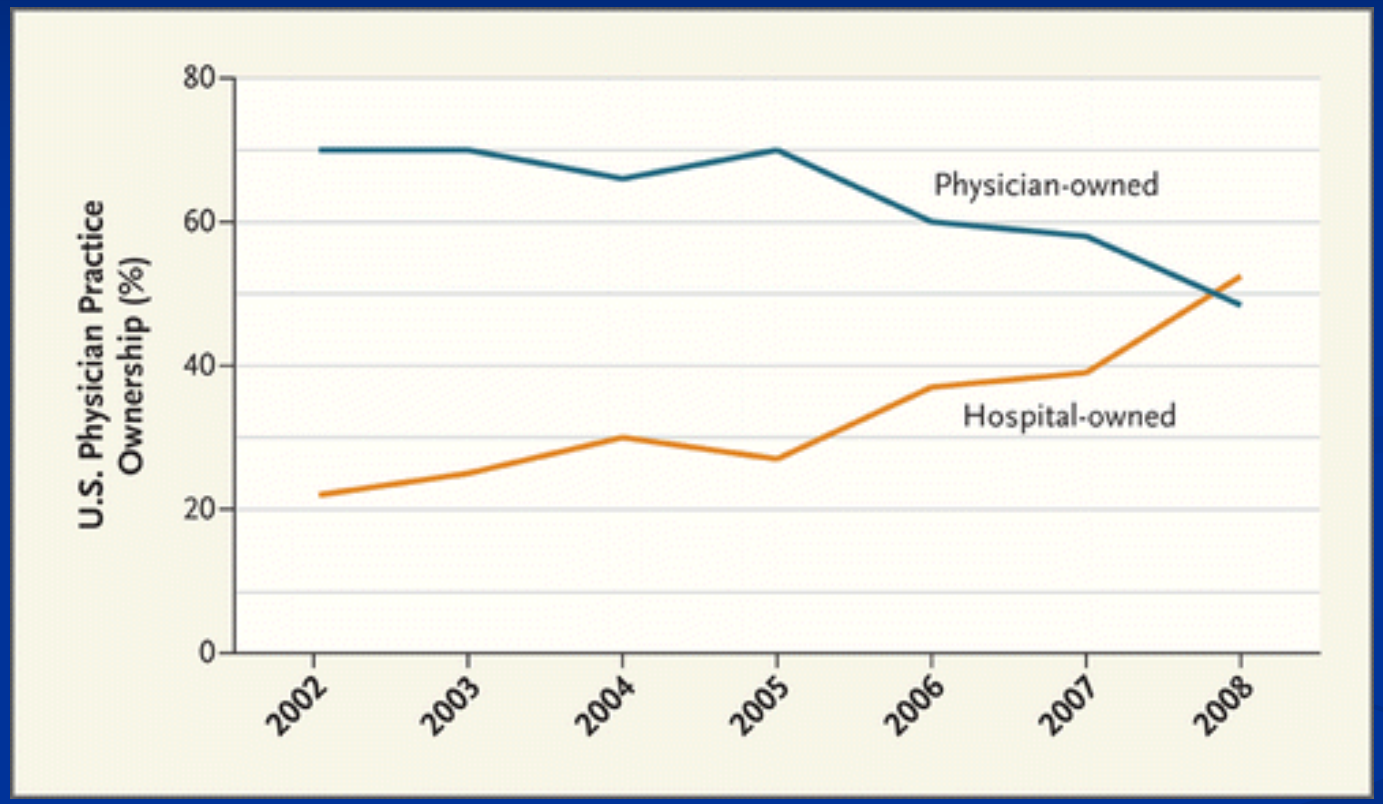
- Myth #1: Opioids work for chronic pain
- Myth #2: No dose is too high
- Myth #3: Less than 1% get addicted if Rx'd
- Myth #4: Pseudo-addiction

“Not everything that counts can be counted …”
-William Bruce Cameron

- Clinical judgment
- Clinical experience
- Intuition

#2 The Toyota-ization of Medicine

Doctors leaving private practice



"Hospitals' Race to Employ Physicians — The Logic behind a Money-Losing Proposition", Robert Kocher, M.D., and Nikhil R. Sahni, B.S., N Engl J Med 2011

The P-Paradigm

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

Lembke, A., *Why Doctors Prescribe Opioids to Known Opioid Abusers,* NEJM, 2012

Dr. Anna Lembke MD

3.0 Add your rating: ★★★★ ? / 4

2 reviews

Psychiatrist
15 years of experience
Video profile
✔ Accepting new patients

401 Quarry Rd
Palo Alto, CA 94304

Phone number & directions

Read Reviews | Check Insurance Plans

Summary | **Patient Reviews** | Credentials | Locations & Availability | Accepted Insurance | Schizophrenia

Patient Reviews

Write a Review

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

Ratings

4 stars
3 stars
2 stars
1 star

Ease of Appointment:	★★½★	Bedside Manner:	★★½★
Promptness:	★★½★	Spends Time with Me:	★★½★
Courteous Staff:	★★½★	Follows Up After Visit:	★★½★
Accurate Diagnosis:	★★½★	Average Wait:	5 minutes

Most recent

★★★★ | **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.

Archives of Internal Medicine 2012

ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Scan for Author Audio Interview

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, 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 2005 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 3.9 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.

Opioids as a proxy for the doctor patient relationship

=

#3 Medicalization of Poverty

The Poor Treated Differently

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

Mack K, Zhang K, Paulozzi L, Jones C. Prescription practices involving opioid analgesics among Americans with Medicaid, 2010. *J Health Care Poor Underserved.* 2015;26(1):182–198

Medical disability the new safety net for poor and undereducated

- SSDI 1957 → 2016
  - 150,000 → 8 million
  - #1 cancer and cardiac → #1 mental illness and musculoskeletal

Autor DH, Duggan MG. The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding. J Econ Perspect. 2006;20(3):71-96.

Addiction not recognized as a disability … or a disease

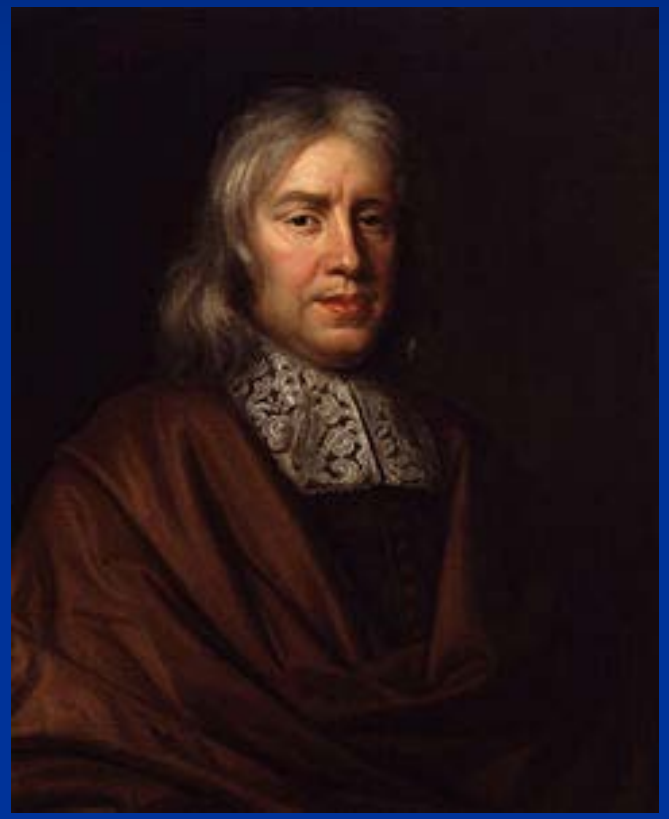
Opioids as a poor substitute for a social safety net

=

#4 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."

People are fragile

The body cannot heal itself

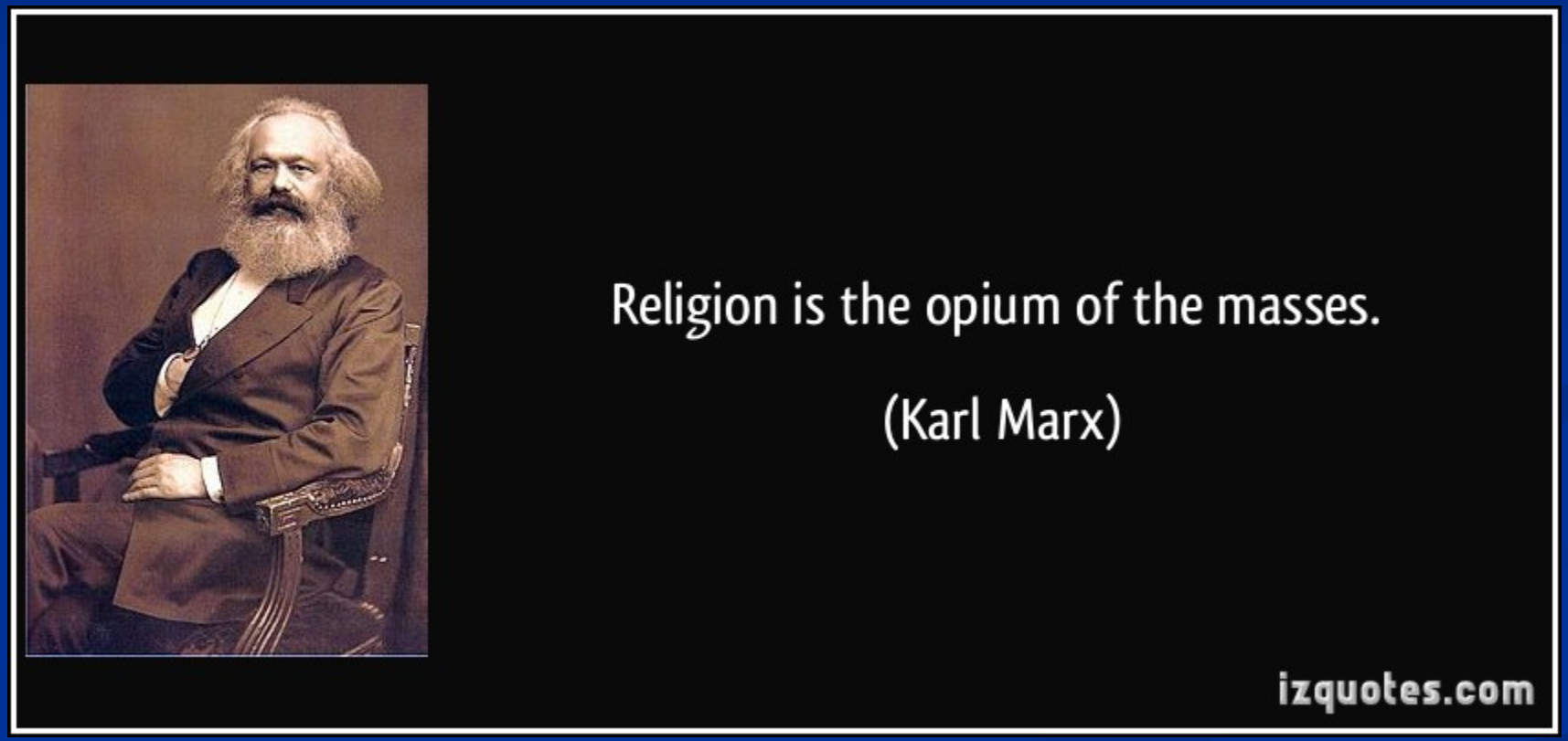
Doctors have superhuman abilities to heal

Victimhood is a right to be compensated

Opioids as a way to find meaning and identity

=

Karl Marx (1818-1883)



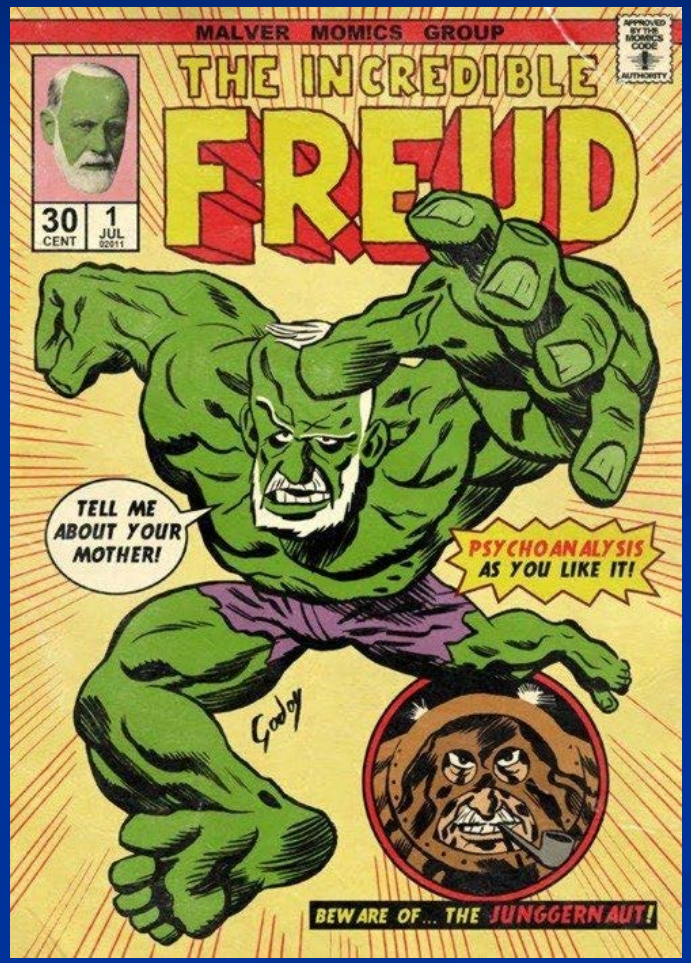
Where does that leave the compassionate doctor?

- WITHHOLDING OPIOIDS is AT ODDS WITH the compassionate doctor's IDENTITY AS A HEALER
- BUT OVERPRESCRIBING OPIOIDS threatens to make the compassionate doctor A DRUG DEALER

Doctors (and patients) caught between a prescription and a hard place


scared
chest
tense
panic
ANXIETY
headache
stress
fear
sweating
feelings
worry
emotional
trembling
tension
angst
jumpy

Defense mechanisms to the rescue!



How defense mechanisms work

Anxiety →

Defense Mechanisms →

DECREASED ANXIETY

Denial

Projection

Splitting

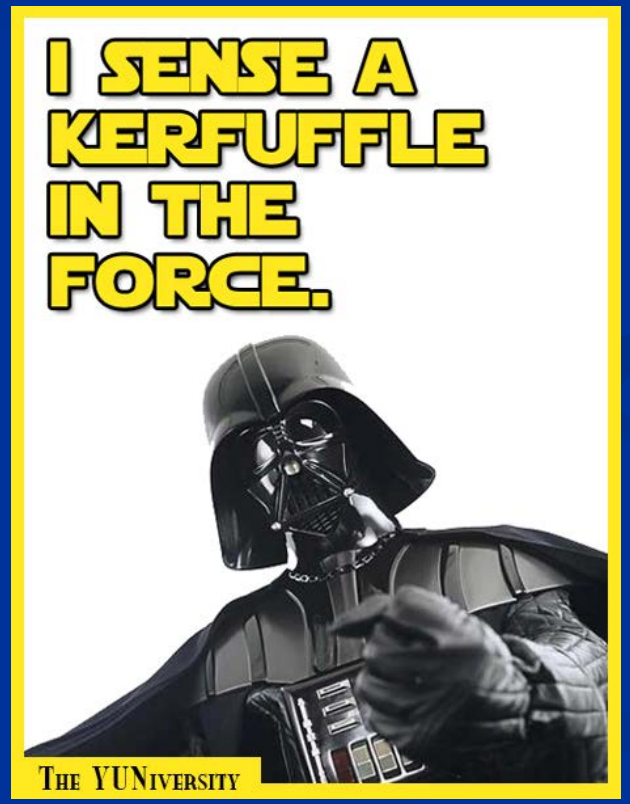
Passive aggression

What happens when the compassionate doctor and the drug-seeking patient get a room?

Doctor meets patient Take 1

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

How can we do better?

Prevention

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose.

The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

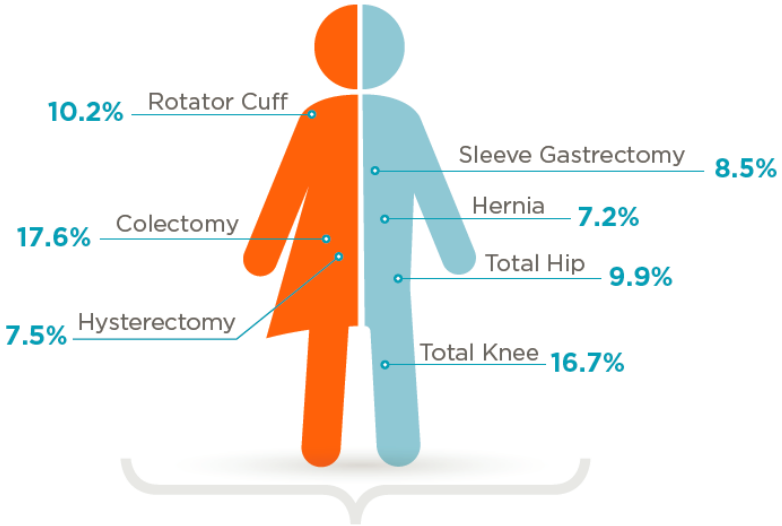
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Prevention

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

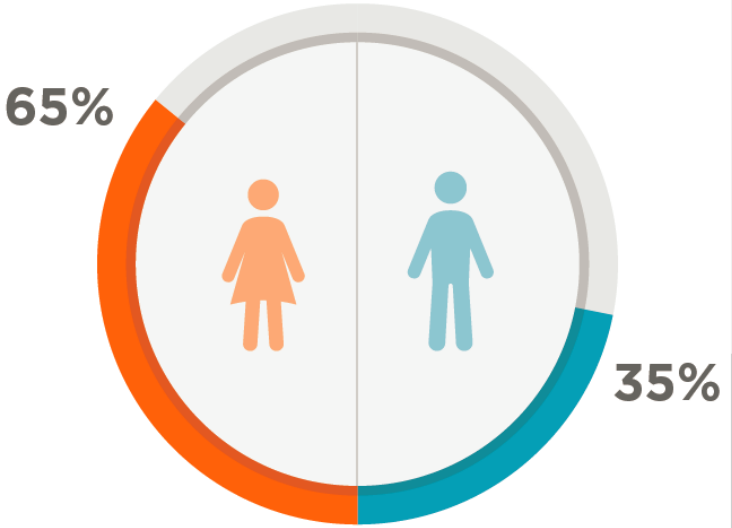
Percent of Newly Persistent Opioid Patients



Overall 9.5%

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

Share of Opioid Prescriptions by Gender

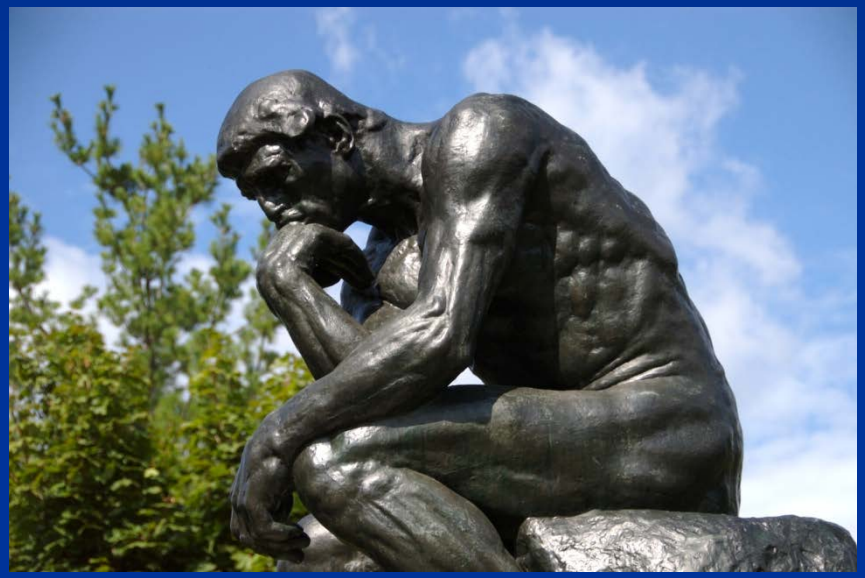


To download the *United States for Non-Dependence* Report please visit **www.PlanAgainstPain.com**.

We need de-prescribing clinics

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

Think of addiction …



…as a *chronic relapsing and remitting disease,*

EVEN IF YOU DON'T BELIEVE IT IS ONE

Biologizing problems is how we solve them

The disease model enhances compassion and reduces stigma

By ignoring addiction, we'll perpetuate the problem

- 28 year old male with no organic pathology 2017
  - 40 Opana BID
  - 30 Dilaudid qD
  - 60 Oxycodone qD
  - 20 Valium qD
  - 65 Phenobarb qD
  - 30 Temazepam qD
  - 8 Xanax qD
- MED= 470

Co-locate addiction treatment in the House of Medicine

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

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.

JAMA. 2000;284:1689-1695 www.jama.com

MANY EXPENSIVE AND DISturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] 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

Opioid agonist treatment works

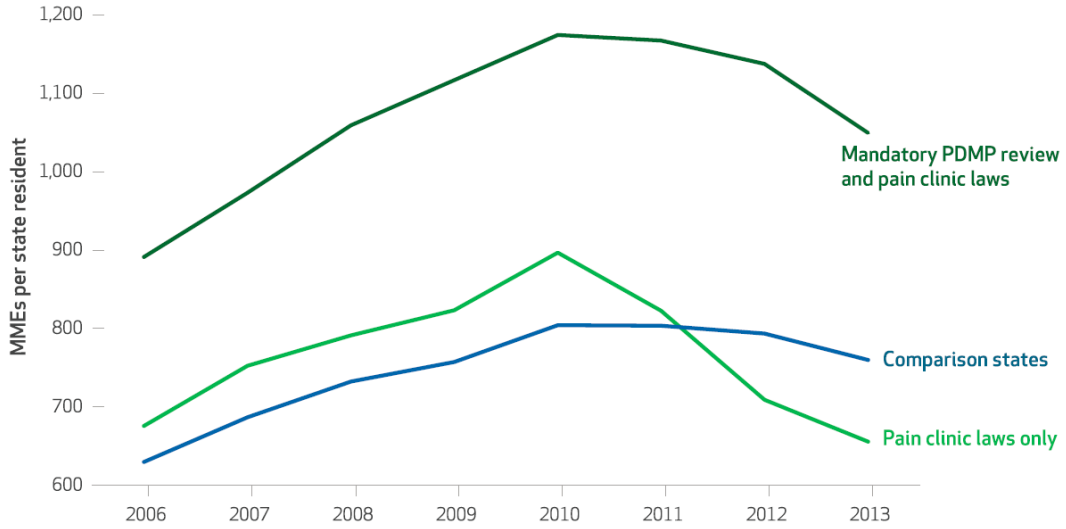
Contingency management works

- Punishment certainty > punishment severity
- Immediate punishment > delayed punishment
- Punishment = transgression
- Rewards for good behavior

Check your PDMP!

EXHIBIT 1

Opioid prescribing rates by state policy category



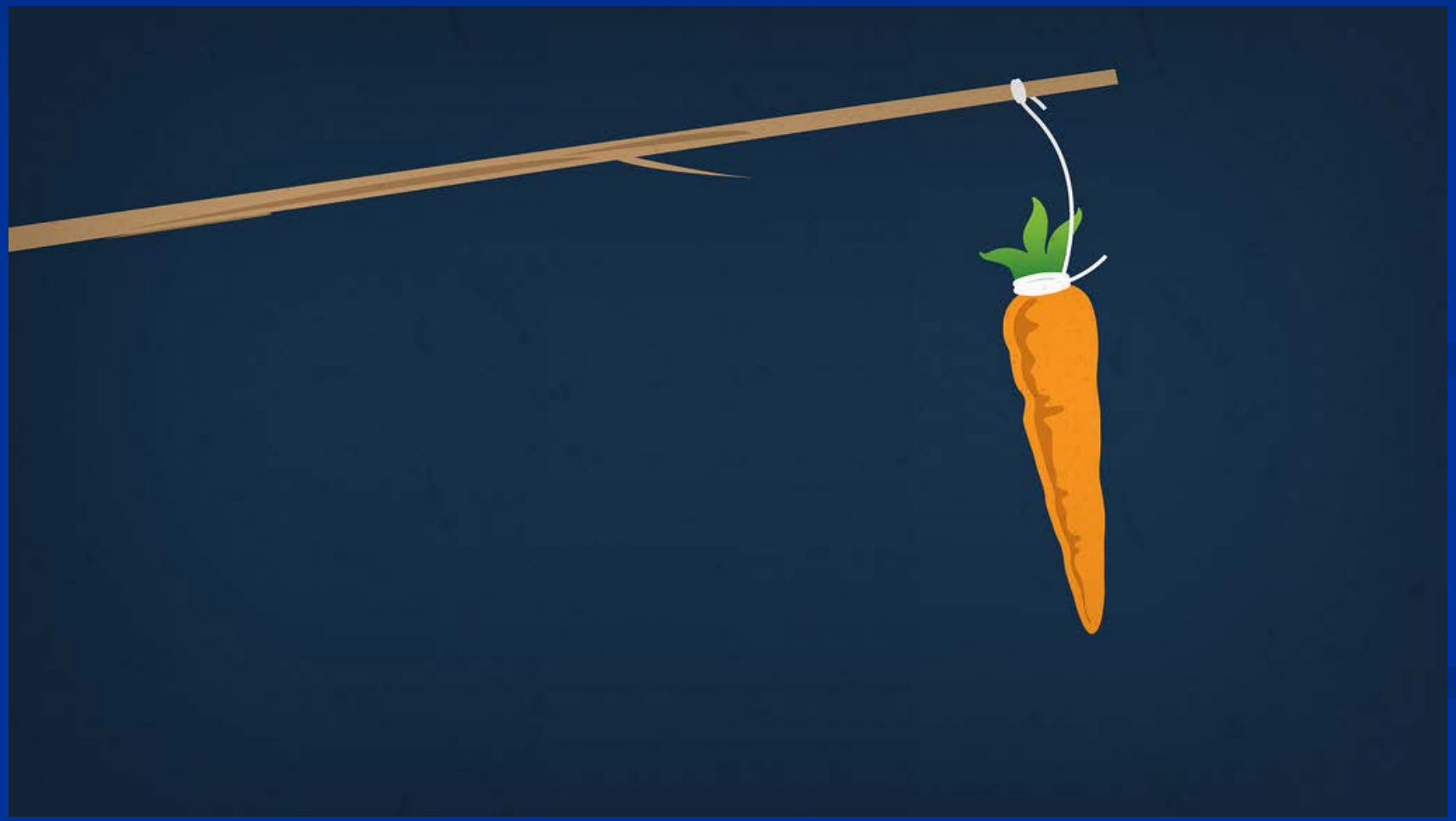
SOURCES IMS Health's National Prescription Audit, 2006–13; state populations obtained from CDC WONDER (Wide-ranging Online Data for Epidemiologic Research), 2006–13. **NOTES** MME is morphine milligram equivalent. PDMP is prescription drug monitoring program.

Deborah Dowell, Kun Zhang, Rita K. Noonan and Jason M. Hockenberry; Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates; Health Affairs 35, no.10 (2016):1876-1883 10.1377/hlthaff.2016.0448

Train doctors from the first day of medical school to detect and intervene for substance use problems

Two target populations …

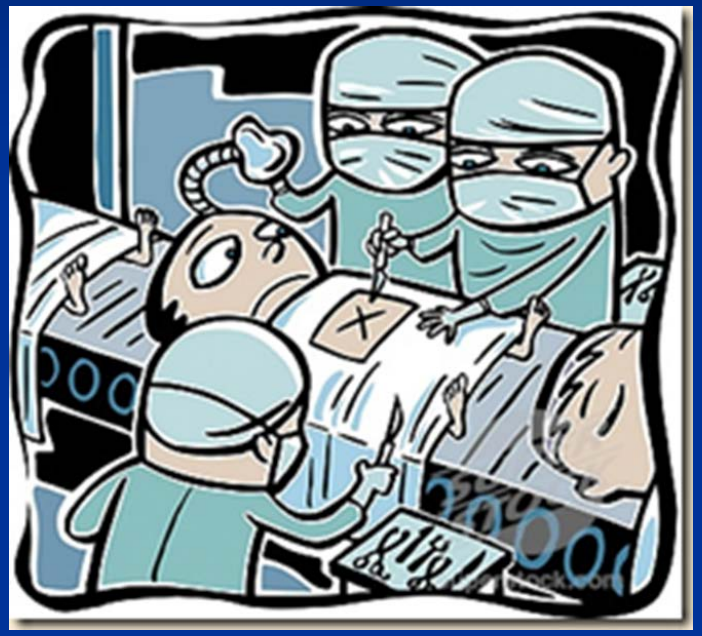
Incentivize doctors to stop overprescribing pain pills, and start treating addiction



The carrot: $$$$$$$$$$$$$

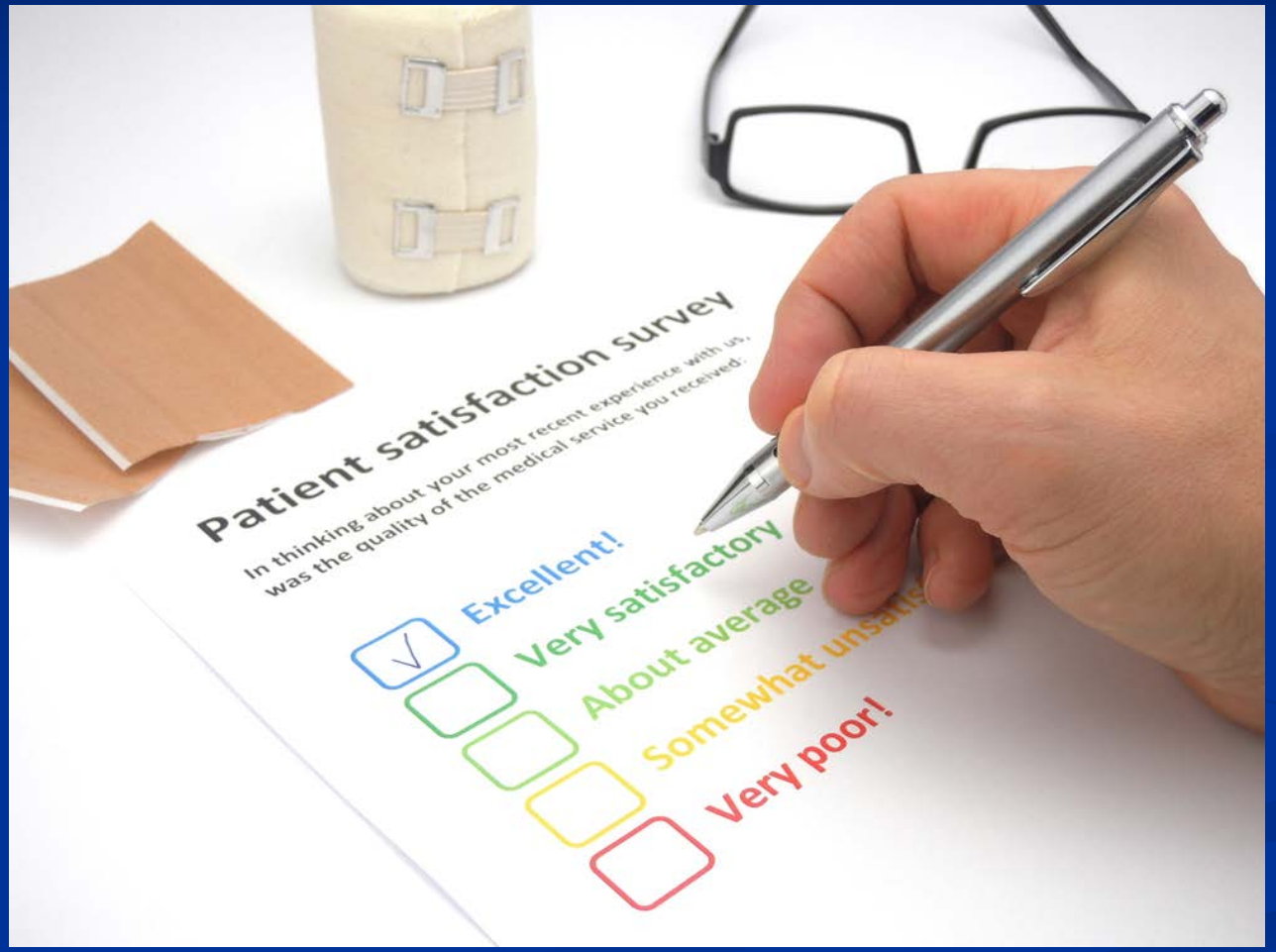

Governmental & Military
MHPAEA
means
Mental Health Parity and
Addiction Equity Act of 2008
by acronymsandslang.com

The carrot: A relationship



We need a chronic care model which re-asserts the primacy of the doctor-patient relationship as vital to healing

Get rid of patient satisfaction surveys

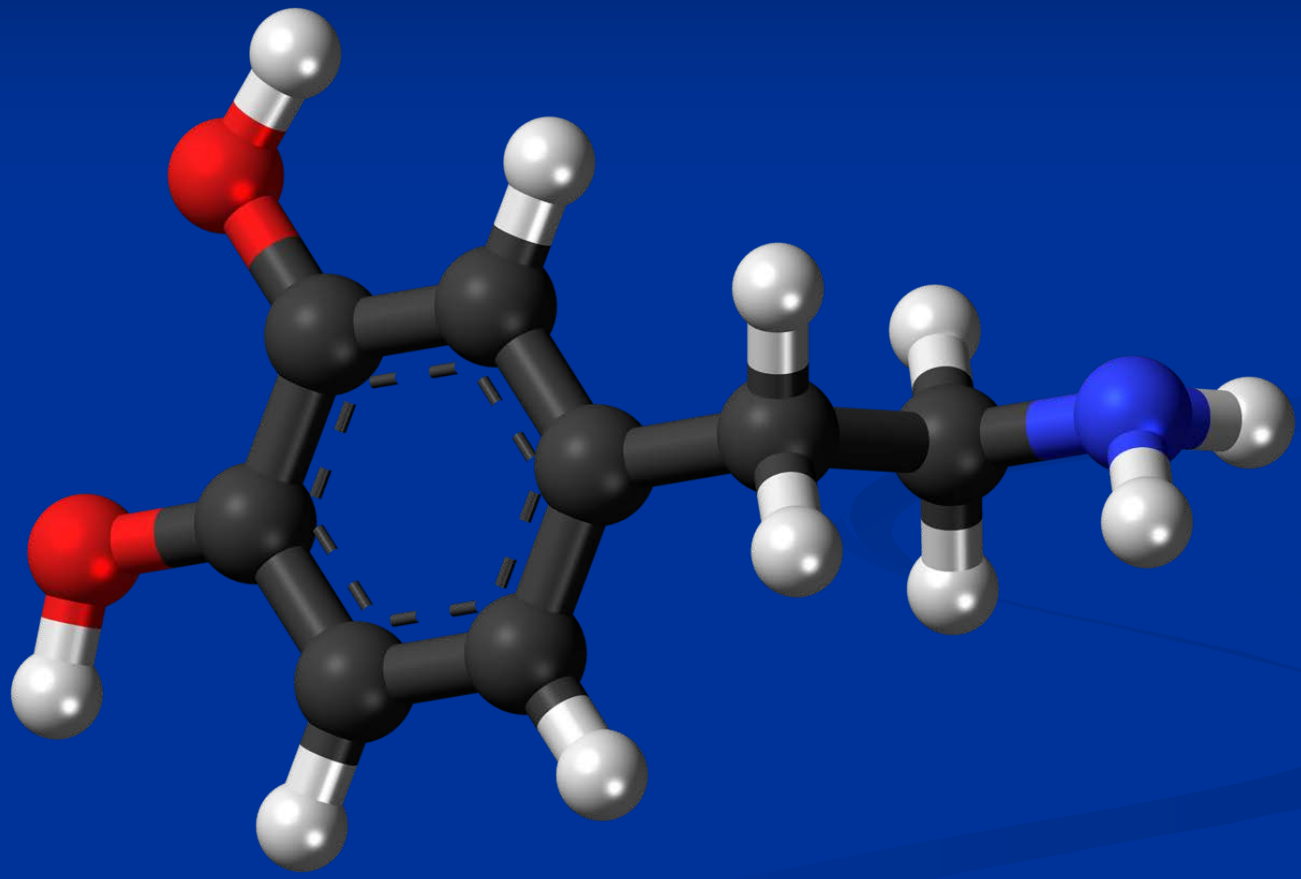


The stick


CVS
pharmacy
DRIVE-THRU PHARMACY


CONSTRICT
DISAPPEAR
SHRINK
WITHDRAW
CONTRACT
DROOP
HIDE
SAG
SLUMP
LOOK DOWN
ESCAPE

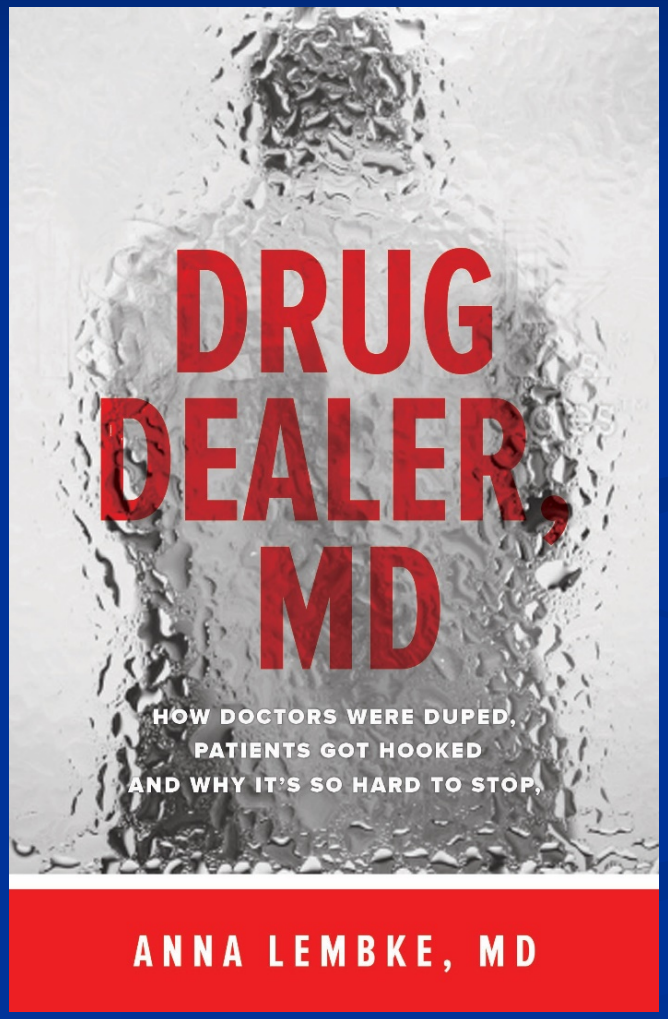
Alternative sources of dopamine



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."

Additional References



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!