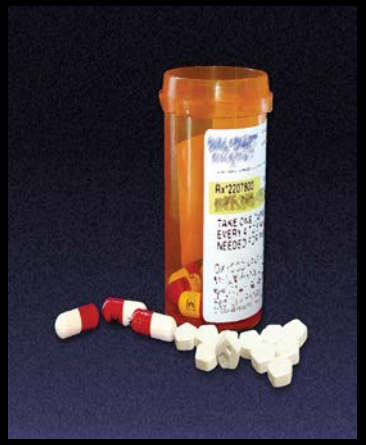
The Opioid Crisis



David Schultz, MD
Nima Adimi, MD, MS

MAPS Medical Pain Clinics

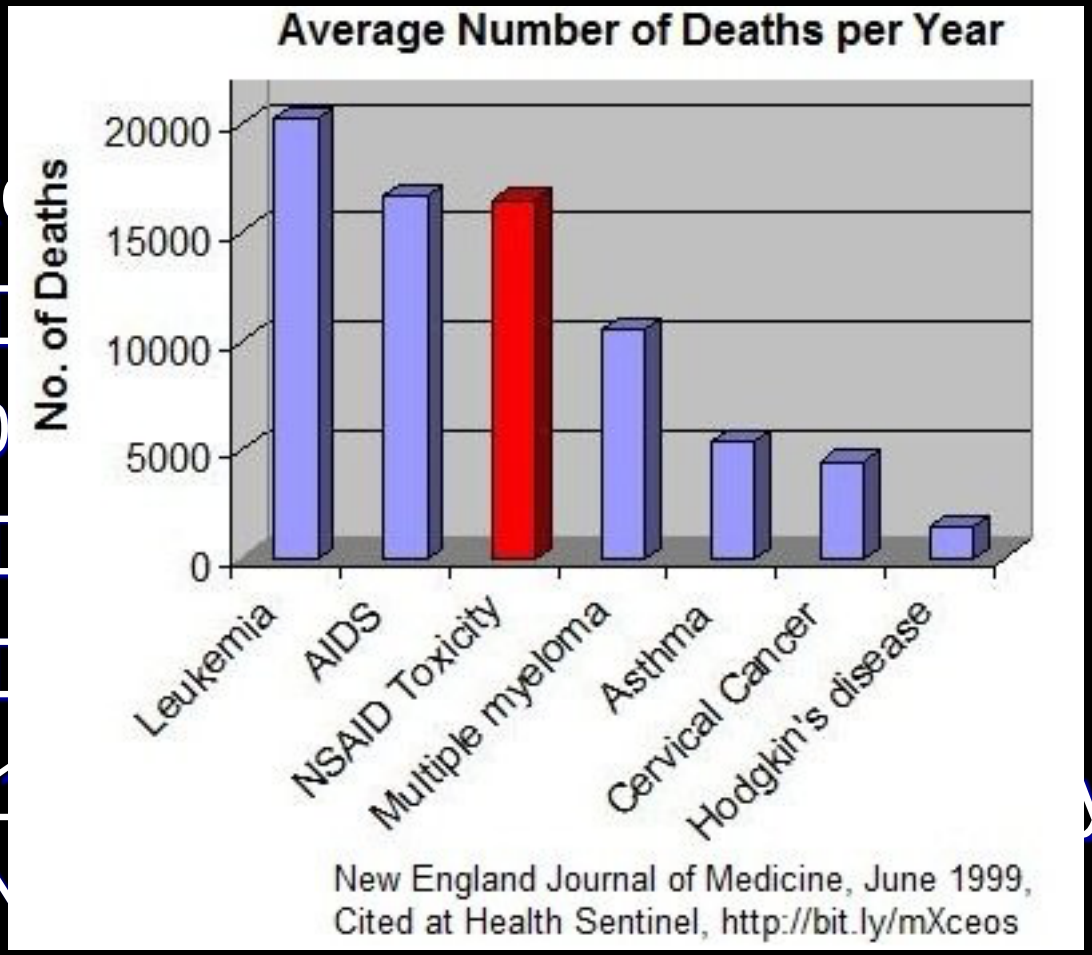
Moderator:
Carol Falkowski
Drug Abuse Dialogues, LLC

Opioids: the good

- Powerful analgesics
- Easy to prescribe
- Patients tend to like them
- Do not cause damage to kidneys, liver, stomach, heart, lungs or any other bodily organ even at extremely high doses

NSAID risk

- Weak
- NSAID
  - 4,00
- NSAID
- NSAID
- Over 1 year from N



Acetaminophen risk

- Less analgesic than opioids
- Aceta sible for:
  - 50%
  - 20%
- 78,0 bital admissions per year in the US for acetaminophen-induced liver injury

1990s: Prominent physicians promote liberal use of opioid analgesics

Dr. Kathleen Foley

Dr. Russell Portenoy

Journal of Pain and Symptom Management

Volume 11, Issue 4, April 1996, Pages 203–217

Opioid therapy for chronic nonmalignant pain: a review of the critical issues

Russell K. Portenoy, MD

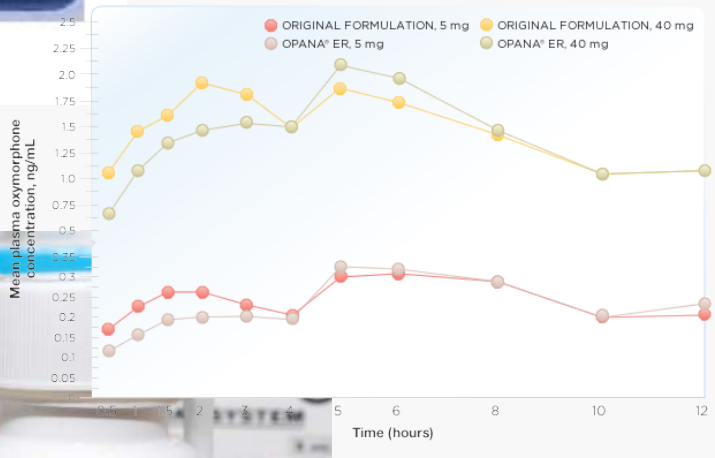
Pain Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, Nevi York, New York, USA

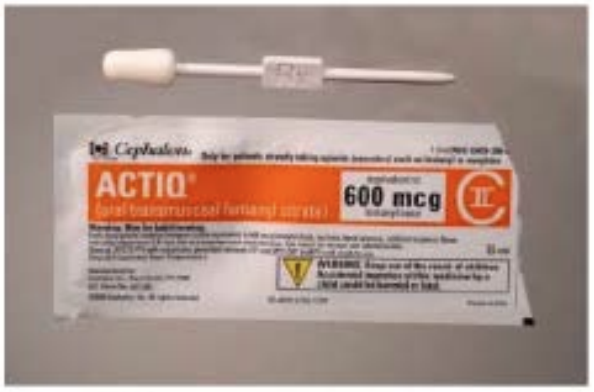
Abstract

The controversy surrounding the, long term use of opioid drugs in patients with nonmalignant pain has intensified in recent years. This debate is driven by a new willingness to consider the potential -benefits of an approach that has been traditionally rejected as invariably, ineffective and unsafe. The published literature continues to be very limited, but a growing clinical experience, combined with a critical reevaluation of issues related to efficacy, safety, and addiction or abuse, suggests that there is a subpopulation of patients with chronic pain that can achieve sustained partial analgesia from opioid therapy without the occurrence of intolerable side effects or the development of aberrant drug-related behaviors. Future research must confirm this impression, through controlled clinical trials and clarify those factors that may predict therapeutic success or failure. For the present, the clinician who contemplates this approach must have a clear grasp of the relevant issues and an understanding of the guidelines for treatment and monitoring that have proved useful in practice.

1990s: Drugmakers create new, powerful opioid medications

Samples of Oxycontin tablets.





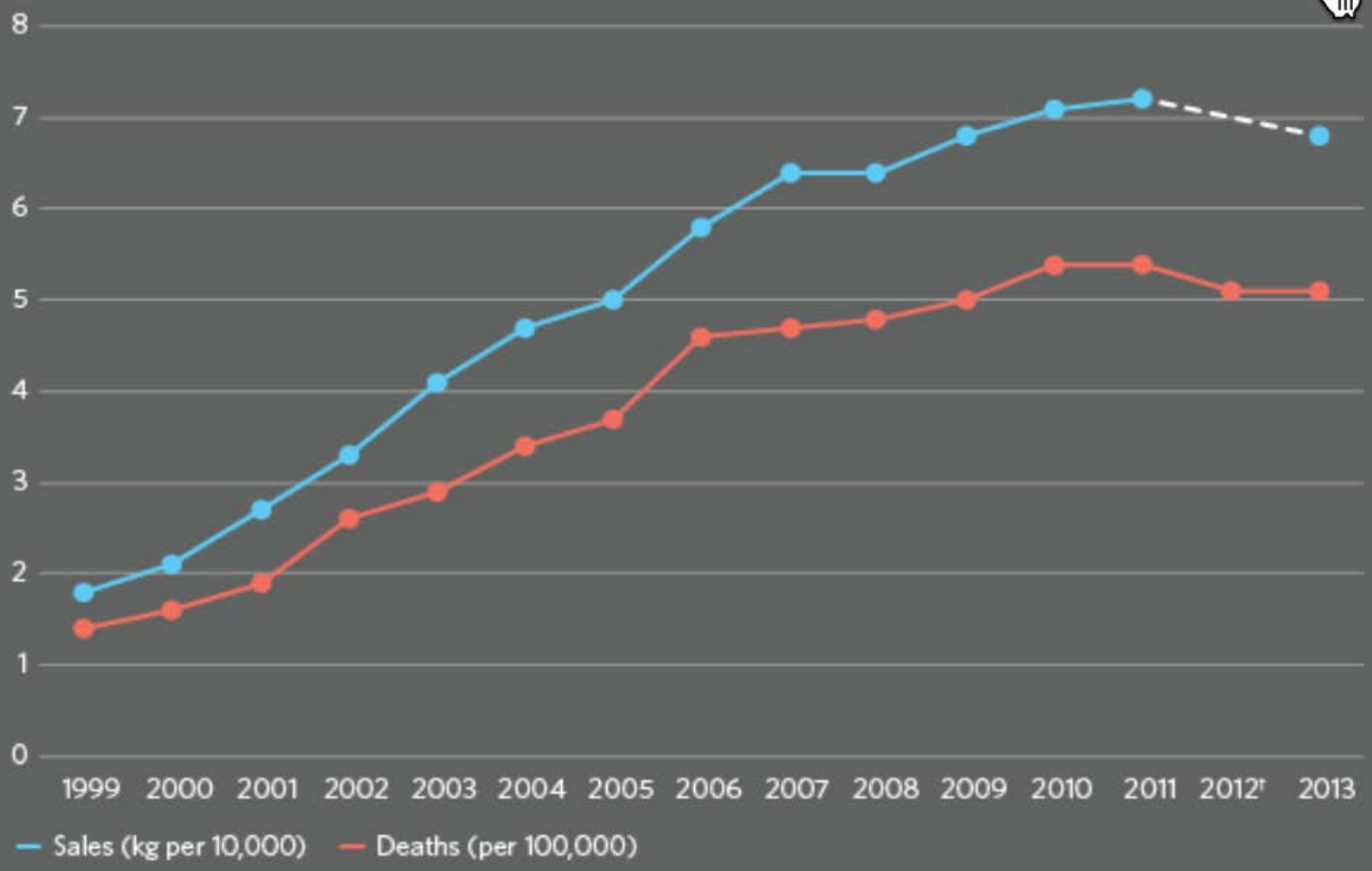
Fentanyl 600mcg

Painkiller Sales and Overdose Deaths

The nation's rising overdose death rate from painkillers such as Vicodin, Percocet and OxyContin closely parallels an increase in opioid prescription sales over the past 15 years.

Oxycontin introduced

1996



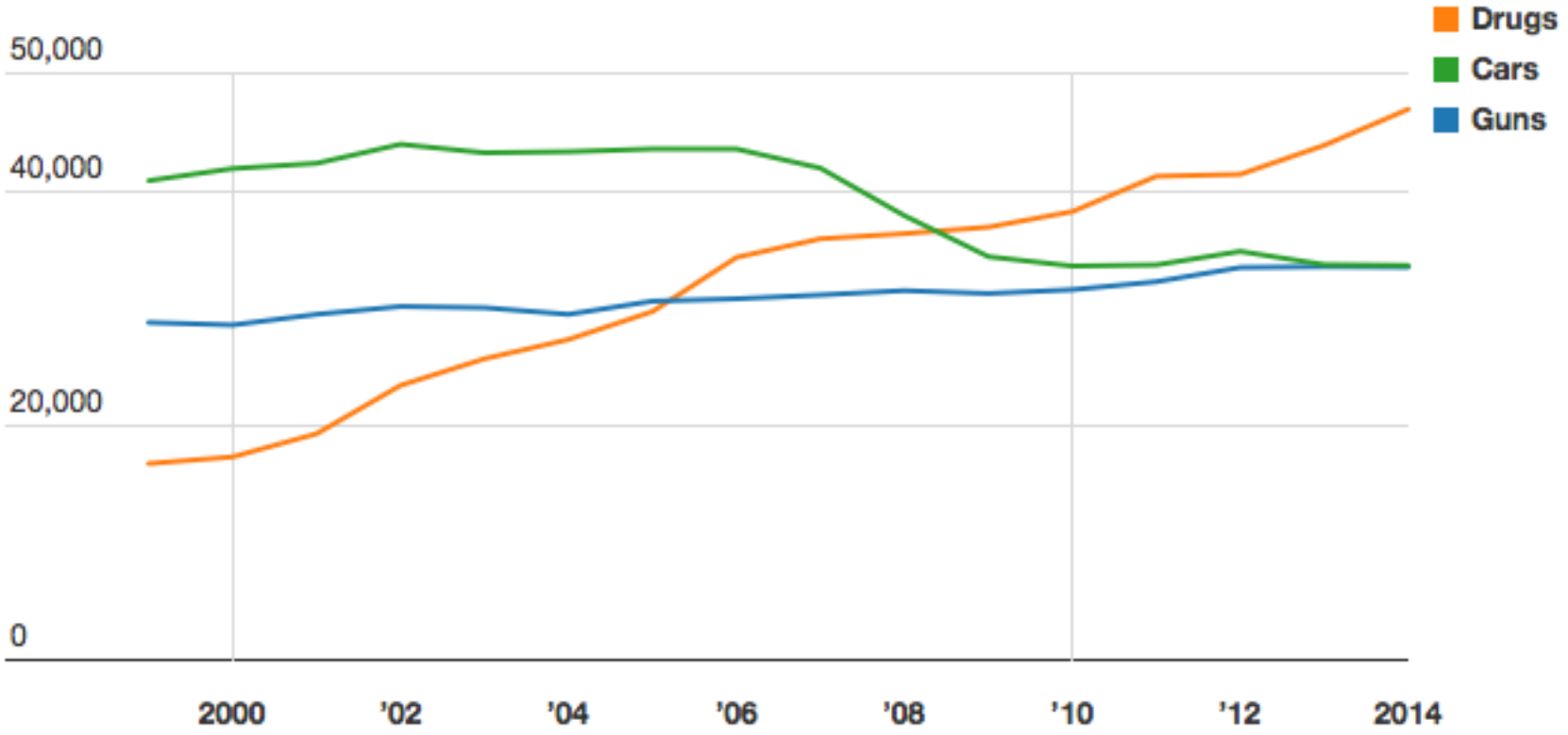
† Sales data is unavailable for 2012.

Source: U.S. Drug Enforcement Administration and Centers for Disease Control and Prevention

2000s: America is in the midst of an epidemic of prescription opioid abuse, diversion and overdose death

Deaths From Drug Overdoses, Car Accidents, and Gun Violence

From 1999 to 2014



Source: Centers for Disease Control and Prevention Get the data

Opioids: the bad

- Overdose can cause fatal respiratory depression
- Opioids can impair function
- Side effects may include somnolence, nausea, constipation, hormonal imbalance, sexual dysfunction, urinary retention

- Opioids can be abused and diverted
- Opioids can cause addiction in certain individuals

Opioids: the ugly

- Can destroy individuals
- Can devastate communities

- Can create liability for healthcare providers

Opioid statistics

2015 data:

- 39 million patients suffer from chronic pain
- 230 million opioid prescriptions written
- 2 million patients considered addicted to opioids
- 18,000 deaths from prescription opioids

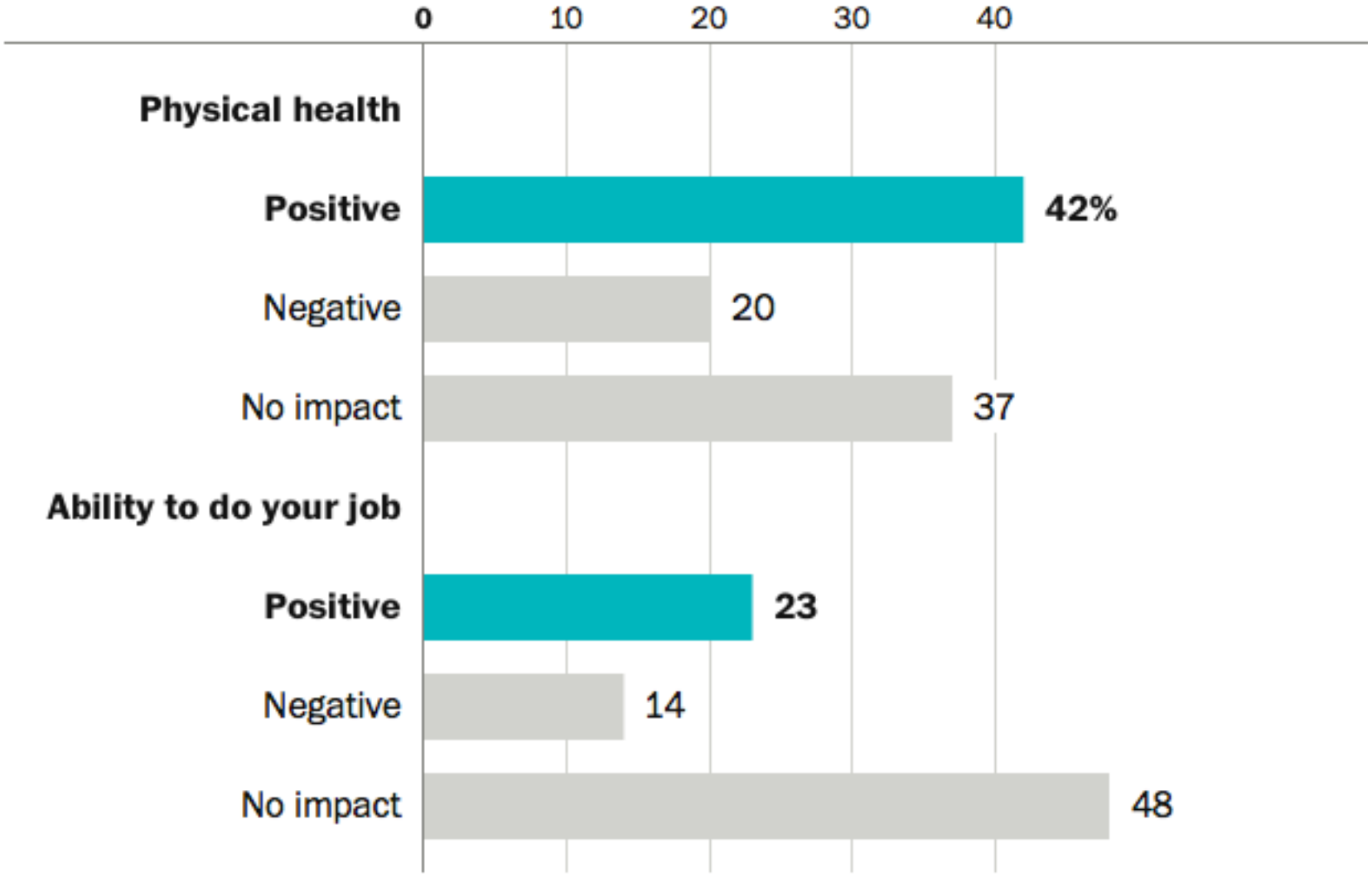
- Many patients on opioids are not addicted, not overdosing and not dying

Some chronic pain patients
do well on long-term opioids

For some patients, opioids may be the safest and most effective treatment option among a number of imperfect options

Opioids' impact on physical health and work

Percentage of long-term opioid users on how drugs impact their lives

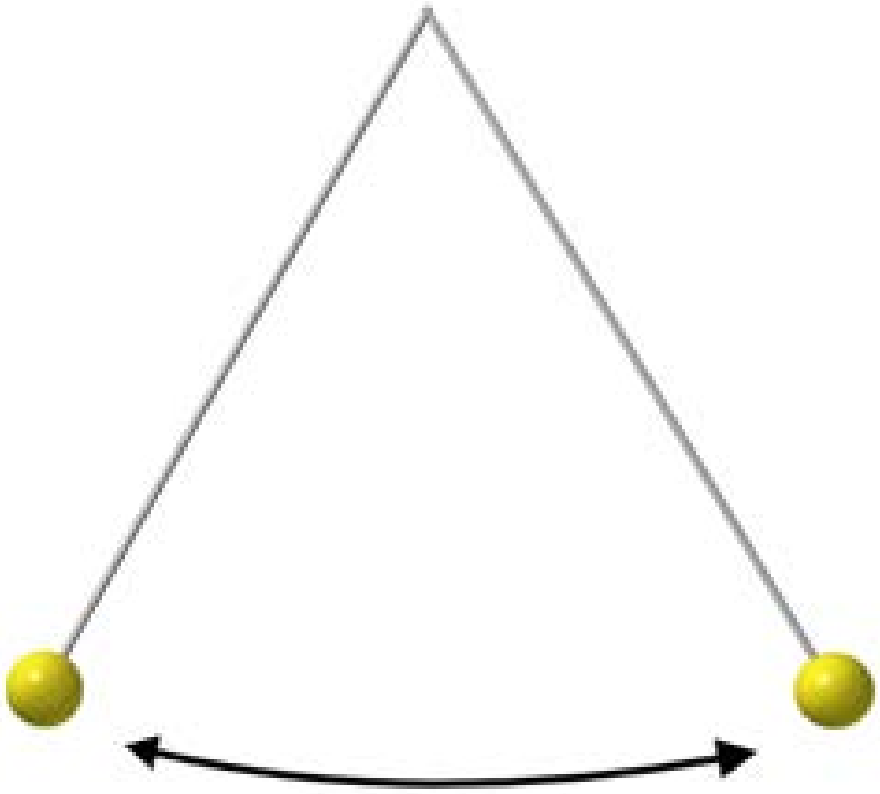


Source: Washington Post-Kaiser Family Foundation survey of 622 long-term opioid users with a sampling error of +/- 5 points

Chronic pain and long-term opioids

- Most long-term users report positive effects
- 92% say opioids have relieved their pain at least somewhat well
- 57% say opioids have improved the overall quality of their lives
- 16% say opioids have made their quality of life worse

The Opioid Prescribing Pendulum



Liberal opioid prescribing

1997

FUTURE DIRECTION

Rational opioid prescribing for well-selected patients in a controlled environment

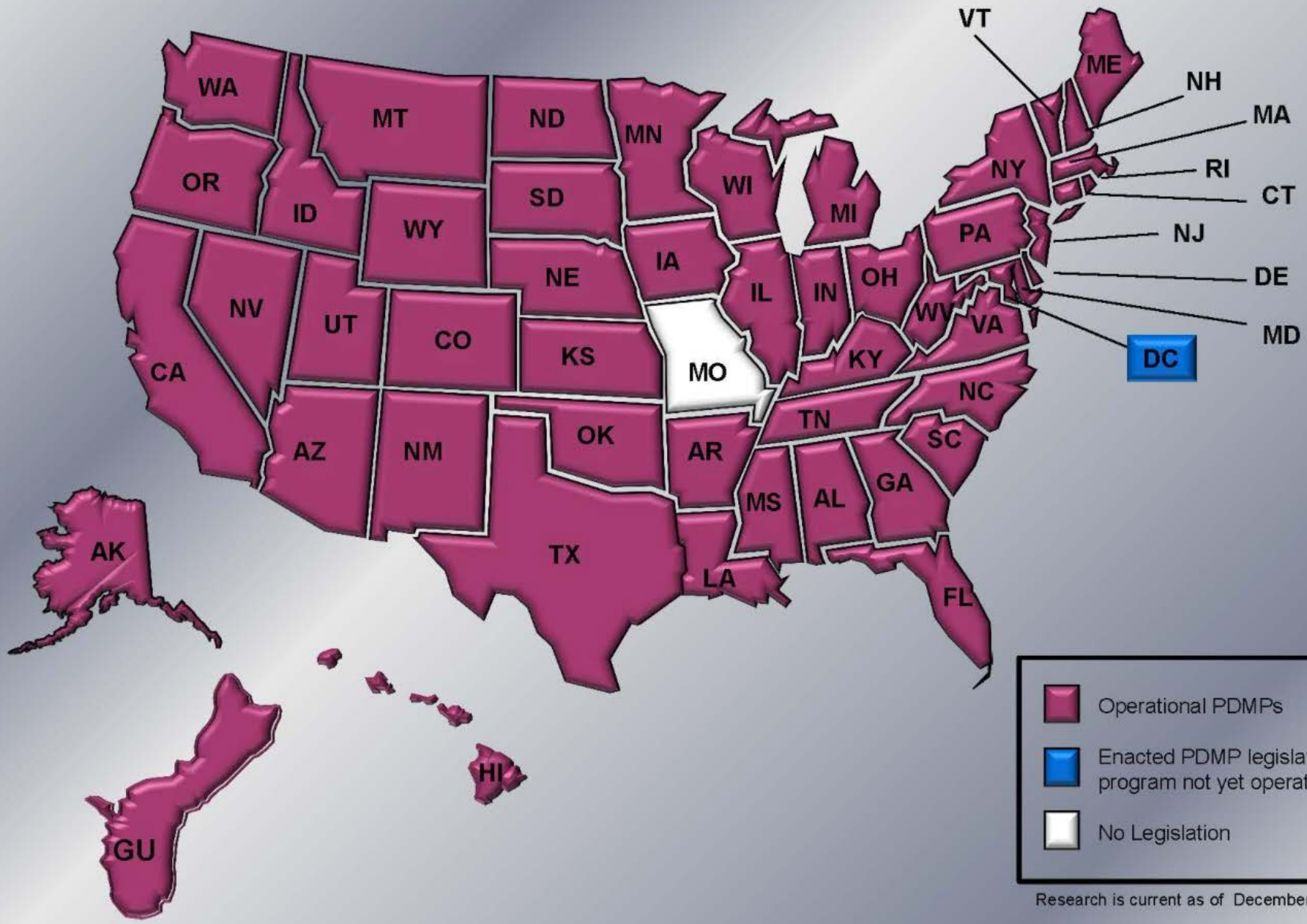
No Opioids!

2017

Recent Developments

Status of Prescription Drug Monitoring Programs (PDMPs)

** To view PDMP Contact information, hover your cursor over the state abbreviation*



Research is current as of December 19, 2014

MINNESOTA MEDICAL ASSOCIATION

2017

Mandate PMP use

Use PMP to track prescribing

No opioids for chronic pain

Prescription Opioid Management Advisory Task Force – Phase II

At the July 18th meeting of the MMA Board of Trustees, the MMA Public Health Committee presented a list of recommendations for next steps the MMA should take to address the addiction, abuse and diversion of prescription opioids. At the meeting, one of the recommendations approved by the Board was to reconvene the MMA Prescription Opioid Management Advisory Task Force. Per the Board's decision, the task force reconvened on September 13, 2016.

The task force is charged with developing recommendations for consideration by the MMA Board of Trustees on the following topics:

1. The potential circumstances for when mandatory use of the Minnesota Prescription Monitoring Program may be appropriate.
2. The potential circumstances for when required education/additional training with respect to opioid prescribing may be appropriate.
3. Strategies for expanding the number of buprenorphine providers.
4. The task force is also charged with reviewing the recommendations from the DHS Opioid Prescribing Work Group to help guide MMA response.

Task Force Members

- Alfred Anderson, MD (Pain Medicine)
- Beth Baker, MD, MPH, Chair (Occupational Medicine)
- Paul Biewen, MD (Physical Medicine and Rehabilitation)
- Elisabeth Bilden, MD (Emergency Medicine/Toxicology)
- Michelle Cowling, MD (Obstetrics/Gynecology)
- William Dicks, MD (Family Medicine/Pain Medicine)
- Mark Eggen, MD (Anesthesia)
- Tom Flynn, MD (Oncology)
- Christopher Johnson, MD (Emergency Medicine)
- Charles Reznikoff, MD (Addiction Medicine/Internal Medicine)
- David Schultz, MD (Anesthesia/Pain Medicine)
- Pamela Shultz, MD (Addiction Medicine)
- Keith Stelter, MD (Family Medicine)
- Lindsey Thomas, MD (Forensic Pathology)
- Joseph Westermeyer, MD (Addiction/Substance Abuse)

The New York Times

HEALTH

Opioid Prescriptions Drop for First Time in Two Decades

By ABBY GOODNOUGH and SABRINA TAVERNISE MAY 20, 2016

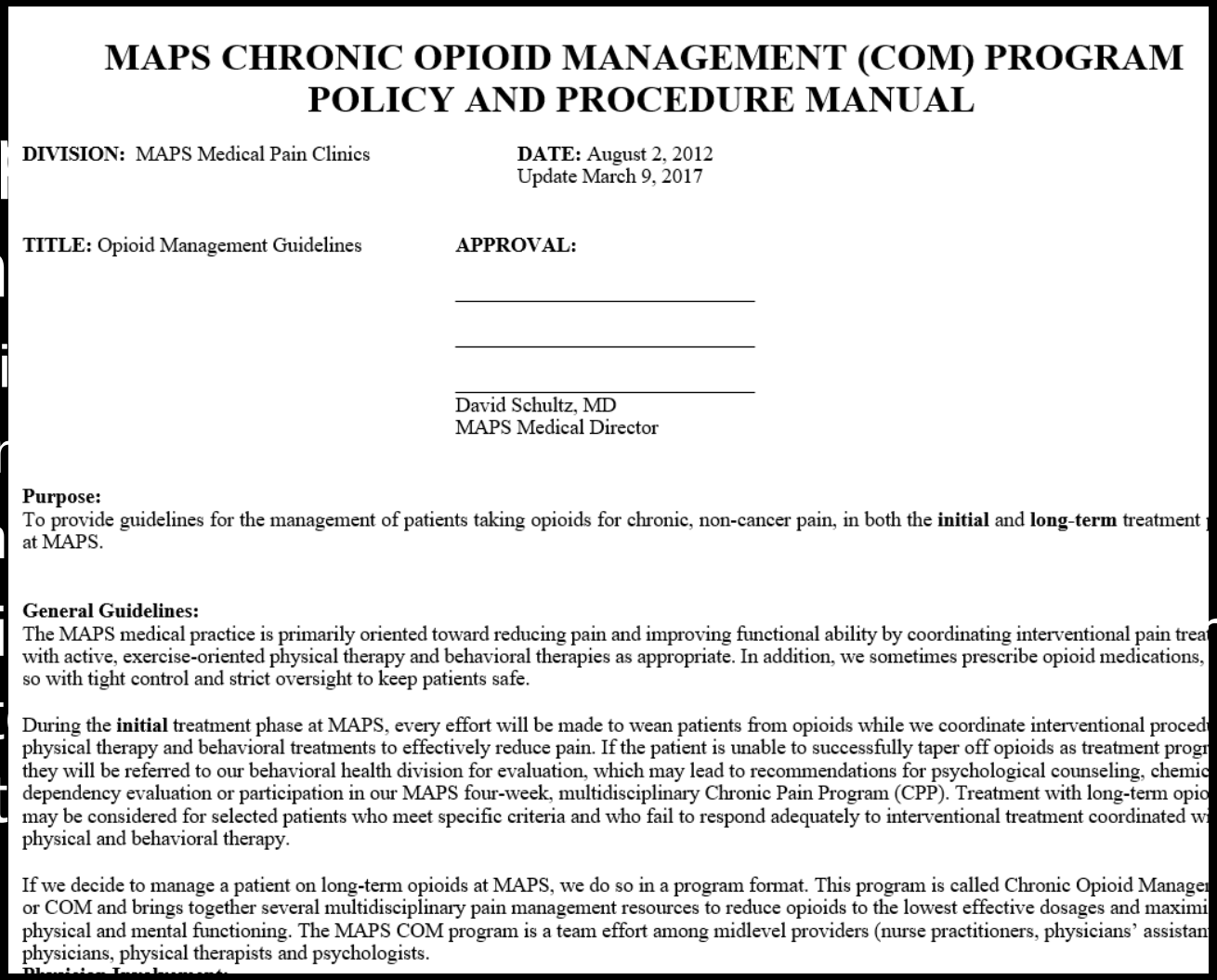
Dr. Mitchell Stark, an oral surgeon in Maryland, advised Ronda Person on Friday to take ibuprofen after surgery. Dr. Stark said he tells all of his patients to try prescription-strength ibuprofen first, before considering opioid painkillers. Chad Bartlett for The New York Times

WASHINGTON — After years of relentless growth, the number of opioid prescriptions in the United States is finally falling, the first sustained drop since OxyContin hit the market in 1996.

MAPS approach to opioid management

MAPS approach to opioids

- Careful p
- Close m
  - Pain reli
  - Function
  - Aberran
- Use opioi n coordinat physical t



MAPS CHRONIC OPIOID MANAGEMENT (COM) PROGRAM POLICY AND PROCEDURE MANUAL

DIVISION: MAPS Medical Pain Clinics

DATE: August 2, 2012
Update March 9, 2017

TITLE: Opioid Management Guidelines

APPROVAL:

_____

_____

_____
David Schultz, MD
MAPS Medical Director

Purpose:
To provide guidelines for the management of patients taking opioids for chronic, non-cancer pain, in both the **initial** and **long-term** treatment p at MAPS.

General Guidelines:
The MAPS medical practice is primarily oriented toward reducing pain and improving functional ability by coordinating interventional pain treat with active, exercise-oriented physical therapy and behavioral therapies as appropriate. In addition, we sometimes prescribe opioid medications, so with tight control and strict oversight to keep patients safe.

During the **initial** treatment phase at MAPS, every effort will be made to wean patients from opioids while we coordinate interventional proced physical therapy and behavioral treatments to effectively reduce pain. If the patient is unable to successfully taper off opioids as treatment progr they will be referred to our behavioral health division for evaluation, which may lead to recommendations for psychological counseling, chemic dependency evaluation or participation in our MAPS four-week, multidisciplinary Chronic Pain Program (CPP). Treatment with long-term opio may be considered for selected patients who meet specific criteria and who fail to respond adequately to interventional treatment coordinated w physical and behavioral therapy.

If we decide to manage a patient on long-term opioids at MAPS, we do so in a program format. This program is called Chronic Opioid Manage or COM and brings together several multidisciplinary pain management resources to reduce opioids to the lowest effective dosages and maximi physical and mental functioning. The MAPS COM program is a team effort among midlevel providers (nurse practitioners, physicians' assistan physicians, physical therapists and psychologists.

Assess risk for abuse and addiction

- Opioid risk screening tests
- Review records, talk to previous providers
- Prescription monitoring program
- Urine drug tests
- Criminal record database
- Provider experience is important

Assess risk for overdose

- Comorbidities
- Age
- Other medications
  - Benzodiazepenes
- Alcohol use
- Sleep apnea

Patient Education

Medical Pain Clinics

Medical Advanced Pain Specialists (MAPS)

David M. Schultz, M.D., D.A.B.P.M.
Medical Director

2104 Northdale Blvd. NW
Suite 220
Minneapolis, MN 55433

(763) 537-6000
(763) 537-6666 Fax
(800) 775-PAIN Toll-free
www.painphysicians.com

MAPS Philosophy on Using Controlled Substances for Pain Management:

A Patient Education Sheet

At MAPS, we specialize in the management of pain. Our main goals are to reduce pain and improve function through the use of injection procedures, physical therapy and psychological intervention when appropriate. This document will explain our philosophy regarding the use of controlled substances (sometimes called "narcotics" or "pain medicines") to treat pain.

We are primarily an injection-type pain clinic and we specialize in the use of X-ray guided injection procedures to treat pain. We also offer various non-invasive treatments including specialized physical therapy, psychology services and our multidisciplinary chronic pain program.

Like many pain clinics, we sometimes prescribe controlled substances to assist patients in their treatment program, based on individual needs and a legitimate medical purpose for these medications. While we recognize controlled substances play a role in managing chronic pain conditions, we believe that we can usually find more effective alternatives for our patients. Consequently, we believe that a patient's use of controlled substances on a long-term basis is a treatment of last resort and only for those patients who have failed all other treatments. If we believe you are a candidate for the long-term use of controlled substances, we will only prescribe them to you within our Chronic Opioid Management Program (COMP). This program provides a fairly rigid structure which includes:

- **monthly medical evaluations, including appropriate physical examinations and diagnostic screenings**
- **requirements to participate in physical therapy and/or psychological counseling if we prescribe them; and, among other requirements**
- **Adherence to a medication contract which includes agreeing to random urine drug screens.**

When you arrive at MAPS, we will take a thorough patient history, perform a complete physical examination, and then make recommendations for treatment. If you are not interested in exploring alternatives to controlled substances for pain management, we may recommend that you seek medical care elsewhere. Even if you have tried various treatments including injections at other pain clinics, we usually recommend trying again in our clinic with MAPS specialists using MAPS specialized techniques and equipment. Prior treatments may have been ineffective for a variety of reasons and similar treatments provided by our expert practitioners may prove helpful and allow you to reduce or discontinue your reliance on controlled substances.

MAPS providers may or may not agree to prescribe controlled substances to you during your first visit. If we choose to continue prescribing some or all of your reported medications, we will only do so on a limited basis for a short period, while we provide further evaluation by our psychologists and physical therapists and try to reduce your pain with other non-drug treatment interventions. If you do not follow through with our recommended treatment plan, we may decide to stop prescribing your controlled substances.

Please understand that as medical professionals we have an ethical responsibility to provide you with what we consider to be appropriate medical care in keeping with the philosophy and principles we have established for our medical practice. If you do not agree with our philosophy or our approach to pain management, please let us know and we will try to help you find another pain clinic to treat your pain.

MAPS Philosophy on Using Controlled Substances for Pain Management:

An Explanation for Referring Physicians and other Health Professionals

Medical Pain Clinics

Medical Advanced Pain Specialists (MAPS)

David M. Schultz, M.D., D.A.B.P.M.
Medical Director

2104 Northdale Blvd. NW
Suite 220
Minneapolis, MN 55433

(763) 537-6000
(763) 537-6666 Fax
(800) 775-PAIN Toll-free
www.painphysicians.com

At MAPS, we specialize in the management of acute and chronic pain. Our primary goals are to:

- **Provide high quality, appropriate pain management for our patients.**
- **Meet the needs of our referring physicians and health care providers.**
- **Reduce pain management burdens on an already strained healthcare system by reducing pain-related emergency room visits and hospitalizations.**
- **Improve the overall health of the community by effective pain management.**

We are primarily an interventional pain clinic and we specialize in the use of minimally-invasive fluoroscopic procedures to diagnose and treat persistent pain. We typically coordinate various types of non-invasive treatments with our invasive interventions. Non-invasive treatments offered at MAPS include specialized physical therapy, psychological intervention and our multidisciplinary chronic pain program.

Like many pain clinics, we sometimes prescribe opioids for pain management although we understand the potential risk of addiction in some patients. We believe that we can usually find more effective and less drastic alternatives for our patients and that long-term controlled substances should only be considered when all other reasonable treatments have been tried and failed. At MAPS, long-term opioids are prescribed within our Chronic Opioid Management Program (COMP). This program provides a fairly rigid structure which includes monthly medical evaluations, requirements to participate in physical therapy and/or psychological counseling if indicated, and random urine drug screens performed at our discretion.

If you refer a patient to us for opioid management, we will start with a thorough evaluation of the patient. We explain our pain management philosophy and our team approach and describe alternatives to the use of controlled substances.

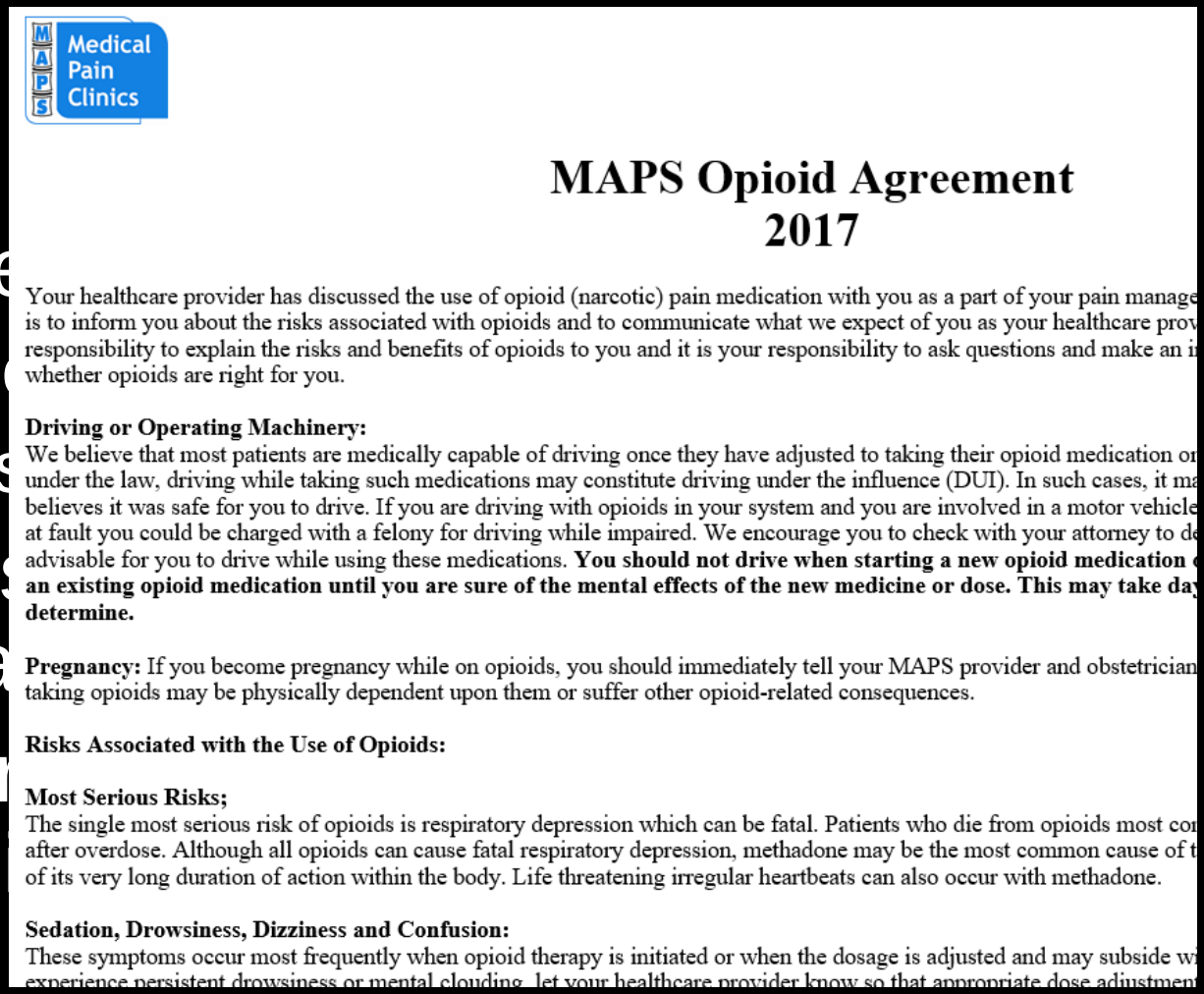
If the patient is not interested in exploring alternatives to controlled substances for pain management, we may recommend that the patient seek medical care elsewhere. Even if the patient has tried various treatments including injections at other pain clinics, we usually recommend trying again in our clinic with MAPS specialized techniques and equipment. Prior treatments may have been ineffective for a variety of reasons and similar treatments provided by our expert practitioners may prove helpful and allow the patient to reduce or discontinue their use of controlled substances.

MAPS providers may or may not agree to prescribe controlled substances to patients at the first visit. If, in our opinion, the patient has active chemical dependency or is at high risk for drug diversion or abuse, we will probably not prescribe controlled substances. Instead, we may recommend immediate referral to a chemical dependency treatment unit. If we are unsure of the patient's potential for chemical dependency, we may agree to take over prescribing of the patient's current medications on a limited basis during a transitional period while we further evaluate the patient. During this period we may prescribe controlled substances for a short time, subject to the patient keeping their scheduled appointments for psychological and physical therapy evaluations and following through with injection-type treatments, if any are recommended. Our goals during this transitional period are to avoid acute opioid withdrawal as we gain further insight into the patient's pain problem and determine response to interventional pain management.

As pain specialists, we understand how demanding patients with chronic pain can be. We also understand that many referring physicians do not have the resources for pain medication management in patients with difficult circumstances. Please understand that as a pain clinic we must try to address the needs of the patient, as well as the requests of the referring physician, while always remaining true to our practice philosophy and principles.

Formal Opioid Agreement

- Spell out in
  between the
  - Intentions
  - Obligations
- Outline risks
  minimize lia
- Allow for ter
  agreement



Medical Pain Clinics

MAPS Opioid Agreement 2017

Your healthcare provider has discussed the use of opioid (narcotic) pain medication with you as a part of your pain manage
is to inform you about the risks associated with opioids and to communicate what we expect of you as your healthcare prov
responsibility to explain the risks and benefits of opioids to you and it is your responsibility to ask questions and make an i
whether opioids are right for you.

Driving or Operating Machinery:
We believe that most patients are medically capable of driving once they have adjusted to taking their opioid medication or
under the law, driving while taking such medications may constitute driving under the influence (DUI). In such cases, it ma
believes it was safe for you to drive. If you are driving with opioids in your system and you are involved in a motor vehicle
at fault you could be charged with a felony for driving while impaired. We encourage you to check with your attorney to de
advisable for you to drive while using these medications. **You should not drive when starting a new opioid medication o
an existing opioid medication until you are sure of the mental effects of the new medicine or dose. This may take day
determine.**

Pregnancy: If you become pregnancy while on opioids, you should immediately tell your MAPS provider and obstetrician
taking opioids may be physically dependent upon them or suffer other opioid-related consequences.

Risks Associated with the Use of Opioids:

Most Serious Risks;
The single most serious risk of opioids is respiratory depression which can be fatal. Patients who die from opioids most co
after overdose. Although all opioids can cause fatal respiratory depression, methadone may be the most common cause of t
of its very long duration of action within the body. Life threatening irregular heartbeats can also occur with methadone.

Sedation, Drowsiness, Dizziness and Confusion:
These symptoms occur most frequently when opioid therapy is initiated or when the dosage is adjusted and may subside wi
experience persistent drowsiness or mental clouding, let your healthcare provider know so that appropriate dose adjustment

Monitor and manage the patient over time

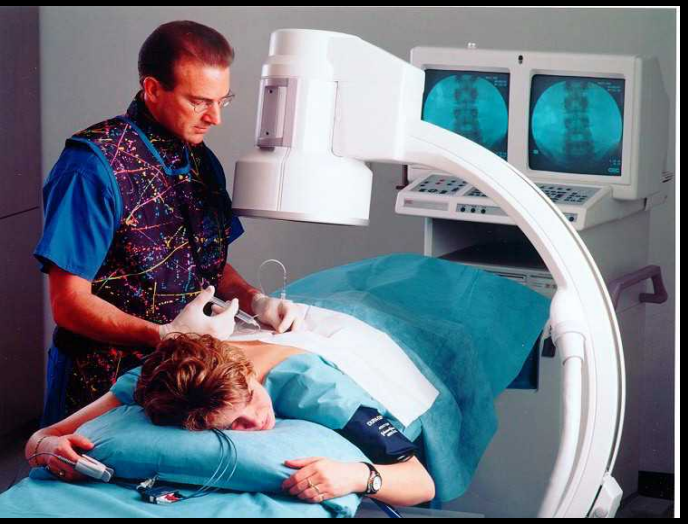
- Pain scores
- Physical functioning and quality of life (LifeTest)
- Periodic checks of PMP
- Random urine drug screens
- Pill counts
- Monitor for aberrant drug-seeking behaviors
  - Lost prescriptions
  - Early refills

Minnesota Prescription Monitoring Program

152.126 SCHEDULE II AND III CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM.

MAPS is a
multidisciplinary pain clinic

Utilize our multidisciplinary
pain management options



MAPS COM program

- Opioids are prescribed as part of a **program**
- Patient education
- Patient contract
- Monthly visits
- Multidisciplinary internal referrals
- PMP checks
- Urine drug testing
- Case Review

Addressing a drug epidemic:

- **Law enforcement**/curtail supply
- **Prevention**
- **Treatment:** Access to evidence-based, quality addiction treatment services

Addressing the *OPIOID* epidemic:

Changes medical practice:

- Education re: addiction & treatment
- Screening for SUD in primary care settings
- Integrated SBIRT models (Screening, Brief Intervention, Referral to Treatment)
- Ongoing use of Rx monitoring programs
- New, emerging pain management tools