

The Opioid Epidemic:
How did we get here?
How do we begin to fight it?

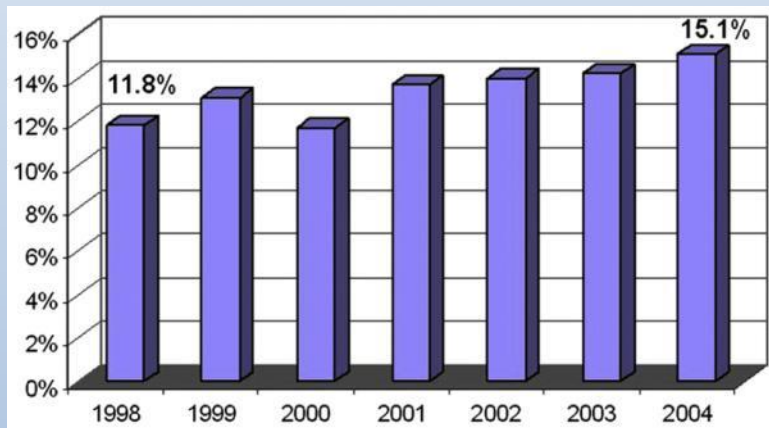
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How did we get here?

- History of DI/SSI
- History of pain as a vital sign
- ‘Science’ of narcotic pain relief
- History of pharmaceutical industry

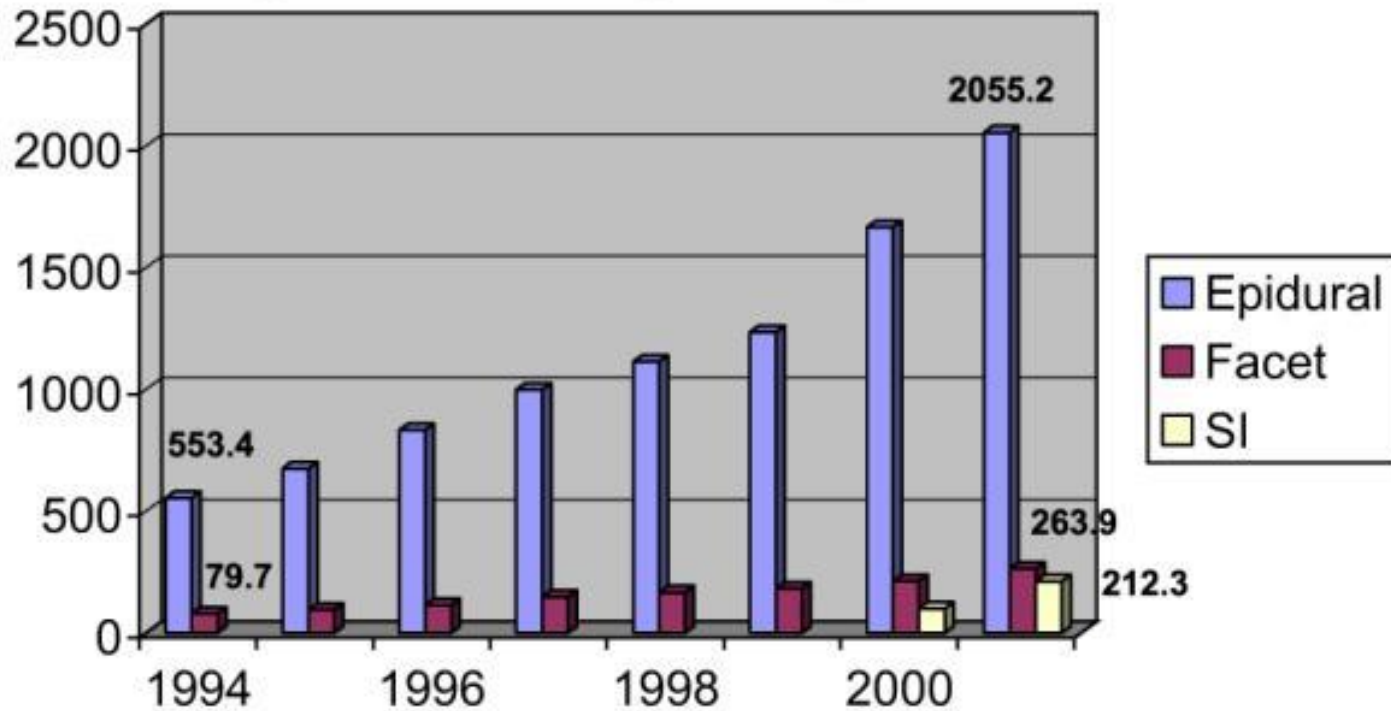
Back pain rates



- Back pain rates have not changed a lot
- Rates of opioids, ESIs, MRIs, fusions and diskectomies have
- Why?

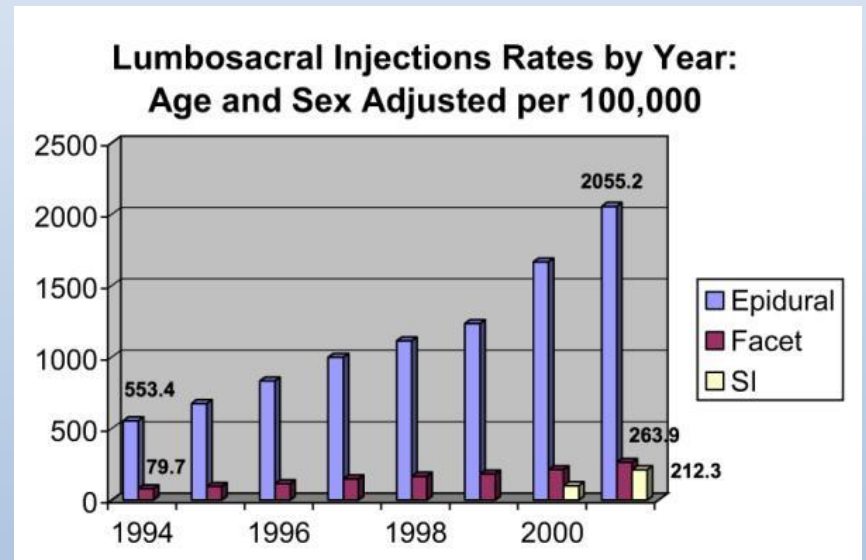
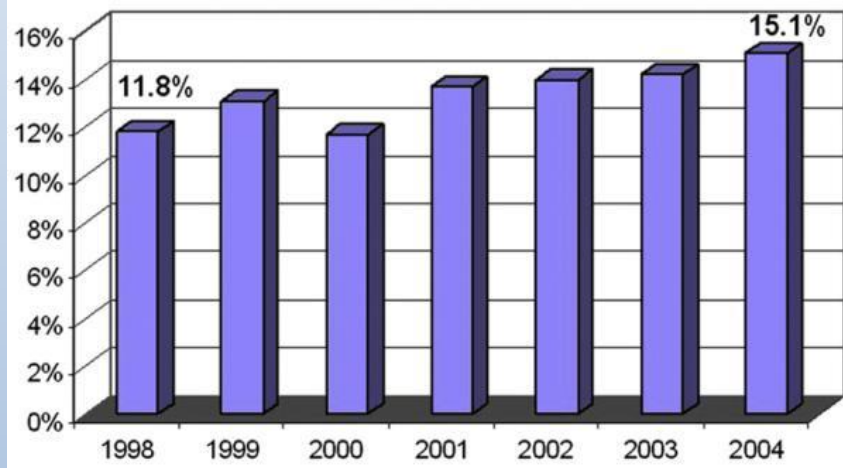
ESI rates

**Lumbosacral Injections Rates by Year:
Age and Sex Adjusted per 100,000**



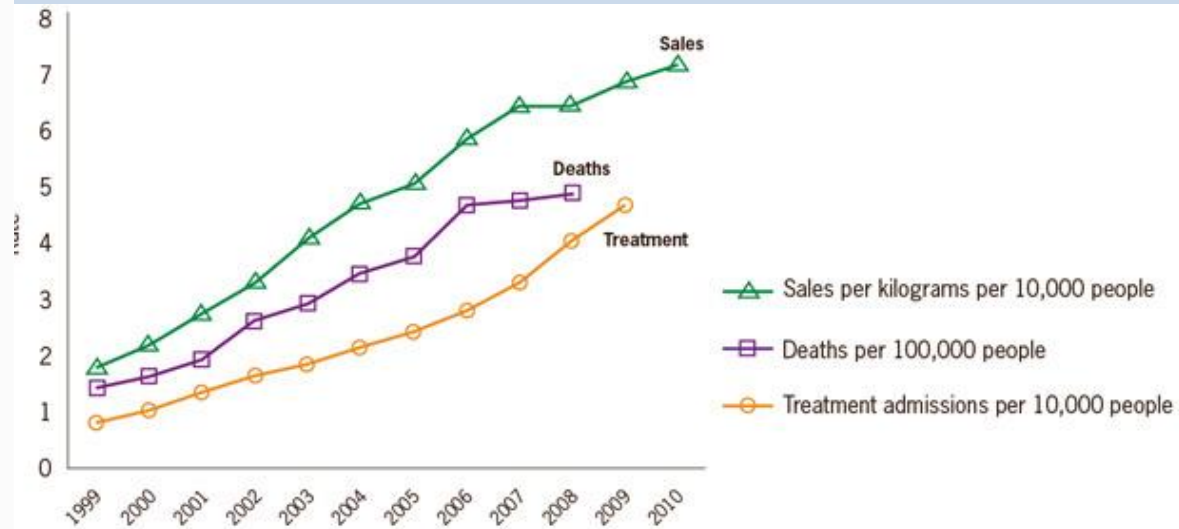
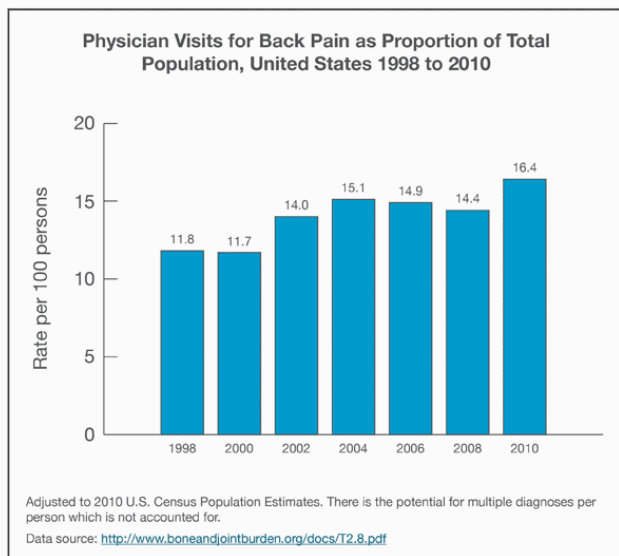
No real correlation

Outcomes not different



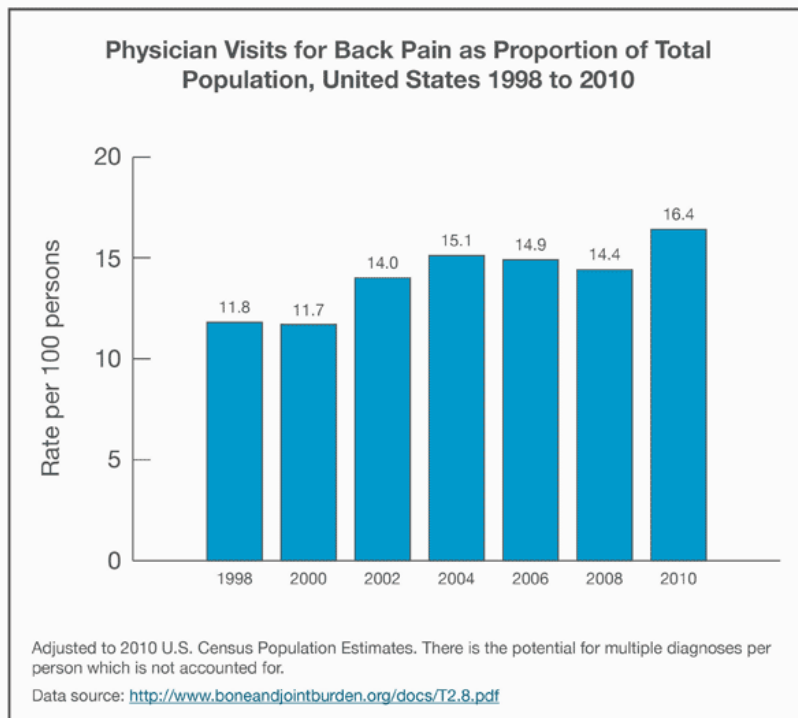
How did this happen?

- Overall rates of back pain visits is similar



Why does US now consume 80-100% opioid production worldwide?

- More dangerous jobs?
 - No, safer
- More car accidents?
 - Perhaps, but safer vehicles
- More intense pain?
 - Nothing shows that
- Less overall treatments?
 - Way more treatments actually



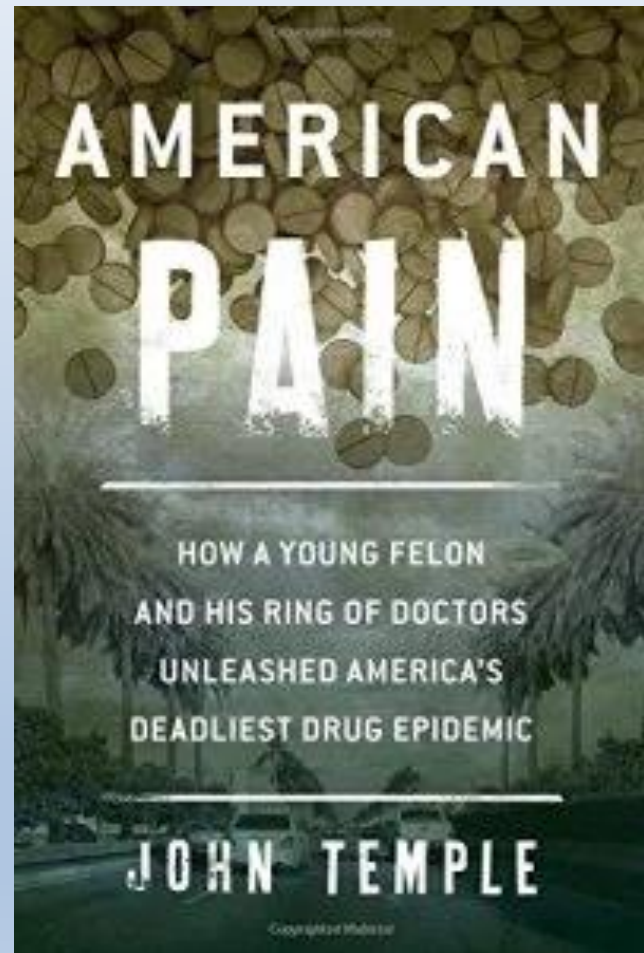
Opioid Epidemic

- We must define the problem before we can create a solution
 - Why do we take so many drugs now as a society?
 - Similar to Victorian era
 - Mary Todd Lincoln was a Laudanum addict
 - Laudanum was cheaper than gin or wine
 - Food and Drug Act of 1906 forced labelling
 - Harrison Narcotics Tax Act of 1914 regulated it finally
 - Addictive properties became known

Pain Clinic Industry

history of pain in medicine

- Dr. Bonica in WA
 - Original multi-disciplinary clinics
 - Era when palliative care began
 - Relief of suffering was primary concern
 - Very good success
 - Began era of pain education for anesthesia
 - Most clinics until the 90s did not use narcotics
 - **90s saw growth in single-specialty intervention clinics and death of multi-disciplinary**



Unintended Consequence of Government Interventions

- CPT codes in early 1980s
 - AMA; emphasized procedures
 - Multi-disciplinary clinics had routine denials of package services
 - Managed care had ‘carve outs’ that forced services to occur in different buildings
- Pain management Fellowships
 - Emphasized technique and procedures
- Procedures lucrative, multi-discipline care bankrupted you
- Today’s landscape – Pain Management is **procedure driven, single-specialty**

Pain Management Today

- SPORT trial:
 - ESI associated with less improvement in treatment of lumbar spinal stenosis

Epidural rates associated with fusion surgery rates
high rates in Southern region

Dartmouth Atlas

\$6,120
per second

Estimated cost of drug use to the U.S. society in lost productivity, health care costs, etc. (Source: NDIC)

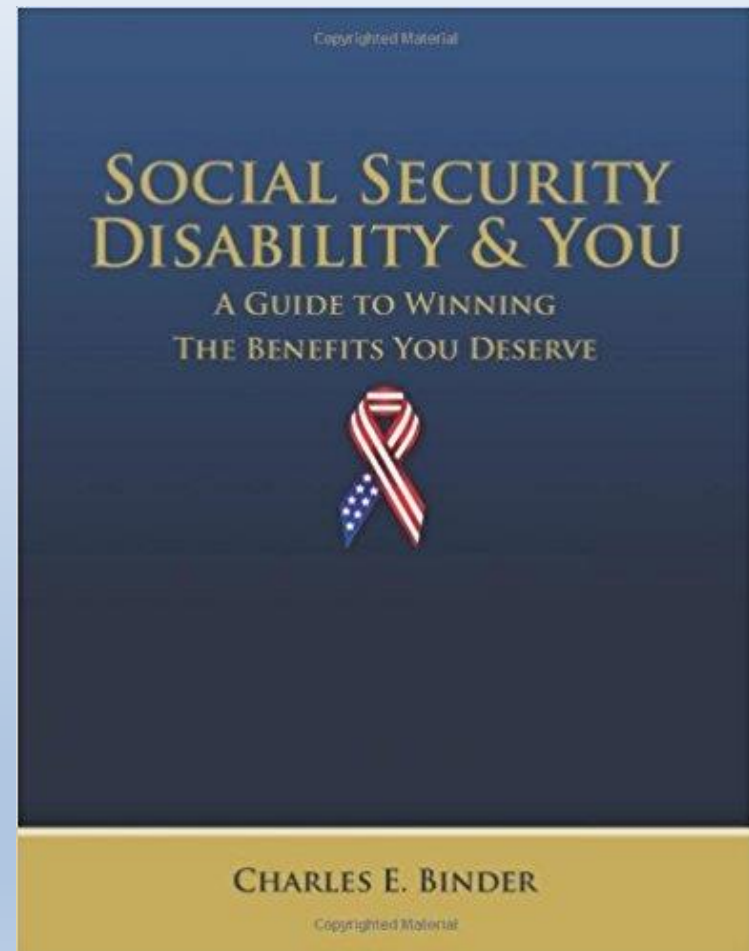
**HISTORY OF DISABILITY
INSURANCE/SOCIAL SECURITY & PAIN**

History of DI/SSI

- 1984 amendments
 - In response to reaction to 1980 reforms
 - Reforms reduced reliance on treating physician and self-reports of pain
- “established that a claimant’s statement regarding pain or other symptoms would not be conclusive evidence of disability; medically accepted findings of a medical condition were required”

Pain as a 'disabling' condition

- Listing 1.01 = back pain
 - Considered OK by Congress to support SSI/DI
- Claimant says back hurts too much to work....
- Factors to prove a subjective claim of pain became important



Self-report of pain

- Able to qualify for narcotics, disability, time off work, payments in legal settings simply by saying that you had pain
- 2000 – Pain as 5th vital
- 2001 – CA MB forces all physicians to full-day course of pain management yearly
- Self-report above question or reproach in today's medical and legal culture: began with APS push to recognize pain as a vital

Factors to support self-report SSI/DI 1984 amendments

- Location, duration and frequency (subjective)
- How it affects ADLs (subjective)
- What causes pain and aggravates it (subjective)
- Type, dosage, effectiveness and side-effects of meds
- Other treatments tried
- Other self-treatments (rest, ice, etc.) (subjective)

Objective Factor to Support pain claim

- **Medication prescriptions**
- Surgery
- Interventions

- Social security will doubt that you have severe pain if you have not sought treatment on an ongoing and continuous basis

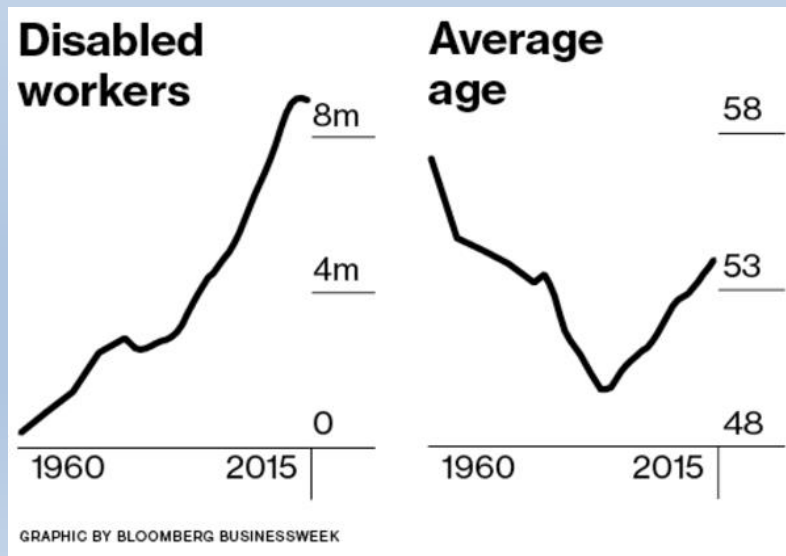
Self-report spawns an industry

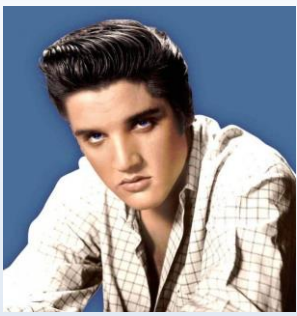


- #1 prescriber for the George brothers was #1 writer of Oxycontin in the country
- Went on trial in 2013
- Her defense (successful) was that she could not possibly know if a patient was not truthful with self-report of pain

DI/SSI and opioids

- 30.5% of disabled are under MSK group
- WV has the most disabled per capita
- WV has highest opioid death rate also
- There has been a 65% increase in overall expenditures in the USA for CLBP between 1997 and 2005
- This is far greater than the overall increase in health expenditures in general
- Ranks of the 'disabled' has grown with this spending
 - Increased spending is not improving the situation

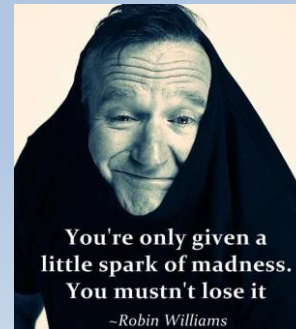




West Virginia



- Kermit, WV = 9million pills over 2 years for population 392
- Drug wholesalers put 780million pills into WV in 6 years
 - 1728 fatal ODs
 - Wholesalers blame MDs and pharmacists
- McKesson
- Cardinal Health
- AmerisourceBergen
 - Total revenues \$400B
- Tied into insurance and PBM industry now as well
- Sell their data at the same time



Pain treatment as an industry

- McKesson CEO paid \$89Million in 2015
- \$89Million = more than combined income of 2000 WV families
- DEA warned state/distributors of problem
- State law required wholesalers to report suspicious ordering
- It took a lawsuit against the 3 to start the reporting
- Board never took action

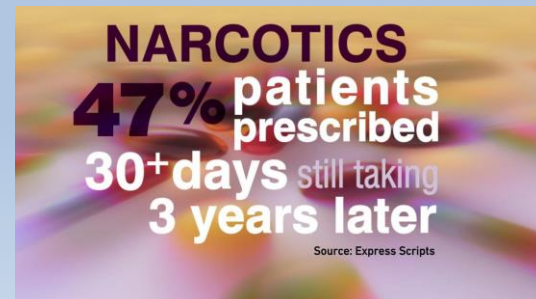
\$639 MILLION

TOTAL
COMPENSATION
OVER THE
PAST 10 YEARS
FOR MCKESSON
CEO JOHN
HAMMERGREN



Pain as vital sign

- JCAHO makes it mandatory to assess, track and treat pain
- Pain becomes integral to satisfaction scores
 - CMS finally figured this out as a bad idea; phase out starts 2018
- 1996 – Oxycontin
 - Prescriptions increase by 8million
- 1998 – Oxy video
 - Prescriptions increase by 11million
- 2001 – JCAHO makes pain 5th vital sign



Pain as vital sign

- Most narcotic studies are 6 weeks or less
- Longer studies have worse results
- Pain increases with use of narcotics
- Dependence in 25%, lifetime prevalence of dependence 36-56% of users
- Portenoy writes that he regrets his 1986 paper and wishes he never made statements



bwc19065258 Barewalls ©

Pain vs Results of Opioids....

Why do we do it at all???

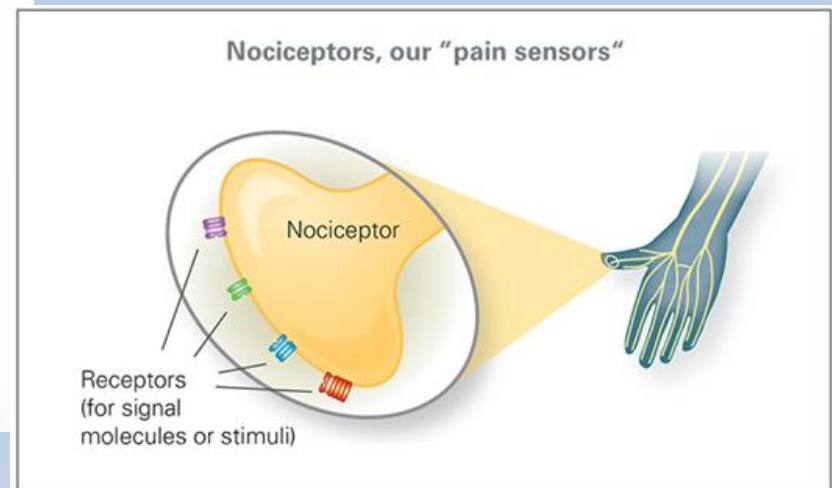


Costs of Drug Use to Society

- Deaths
- Emergency room visits
- Drugs in the workplace and lost productivity
- Broken homes, illnesses, shorter lives, etc.
- Cost of maintaining habit
- Cost of criminal behavior
- Cost of treating patients
- Fetal alcohol syndrome
- ***Others?***

The “Science” behind this

- Pain is a ‘subjective experience that does not require identifiable tissue damage to be clinically significant’
- As nociception became more understood, we began to ‘treat’ more extensively
- Chronic pain defined in 1986



'Science' of pain control

- 1980 (Porter, Jick)
 - Letter to NEJM:
 - Analysis of patients showed addiction rare in those without a history of addiction
- 1986 (Portnoy)
 - 38 patients with Non-CA pain;
 - “opioid maintenance can be a safe, salutary and more humane alternative”
 - No increase in function
 - No change in pain complaints
- 1990s American Pain Society pushes pain as the 5th vital sign
- 2000 JCAHO CME book states that “there is no evidence of addiction when opioids are used for pain control”

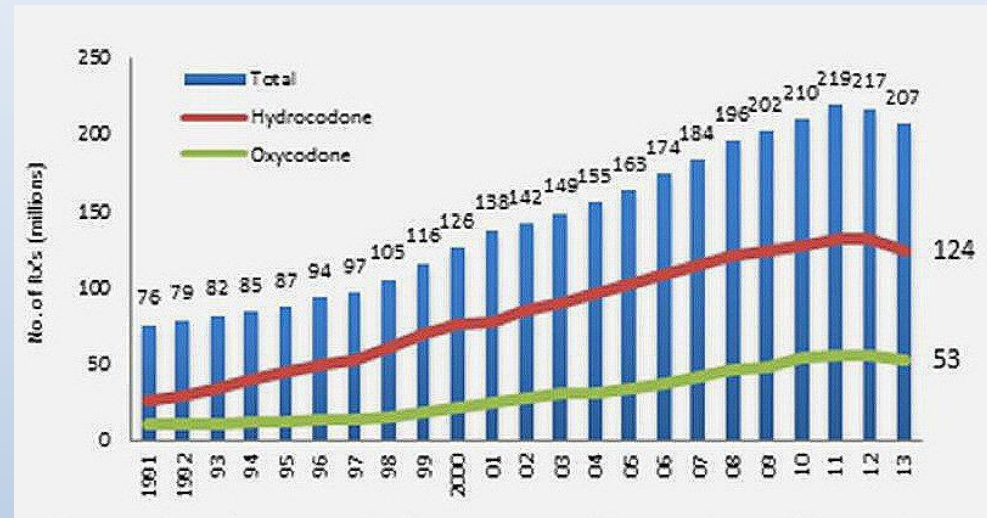


- JCAHO book for physicians in 2000 states:
 - Doctors should recognize that subjective reports of pain should be considered the gold standard upon which interventions are based
 - If patients become tolerant, the dose can be safely increased
 - Doctors have exaggerated and 'outdated' fears of addiction



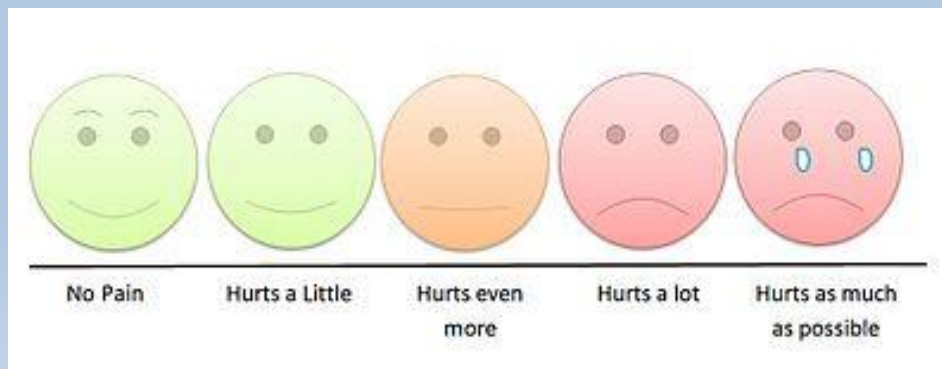
1986 Portenoy

- 38 patients with non-cancer pain
 - 2/3 on < 20 MEA per day, 4 on >40
 - 24/38 had ‘acceptable pain relief’
 - NO patients had a gain in social function
 - NO patients had a gain in employment
 - The authors essentially stated that ‘opioids are safe and humane’ for non-cancer pain



Science of Pain Relief

- Meta-analysis showed no significant difference in pain relief for those on opioid vs those off
- Large survey study showed that patients whom received narcotics at last visit were “more satisfied”



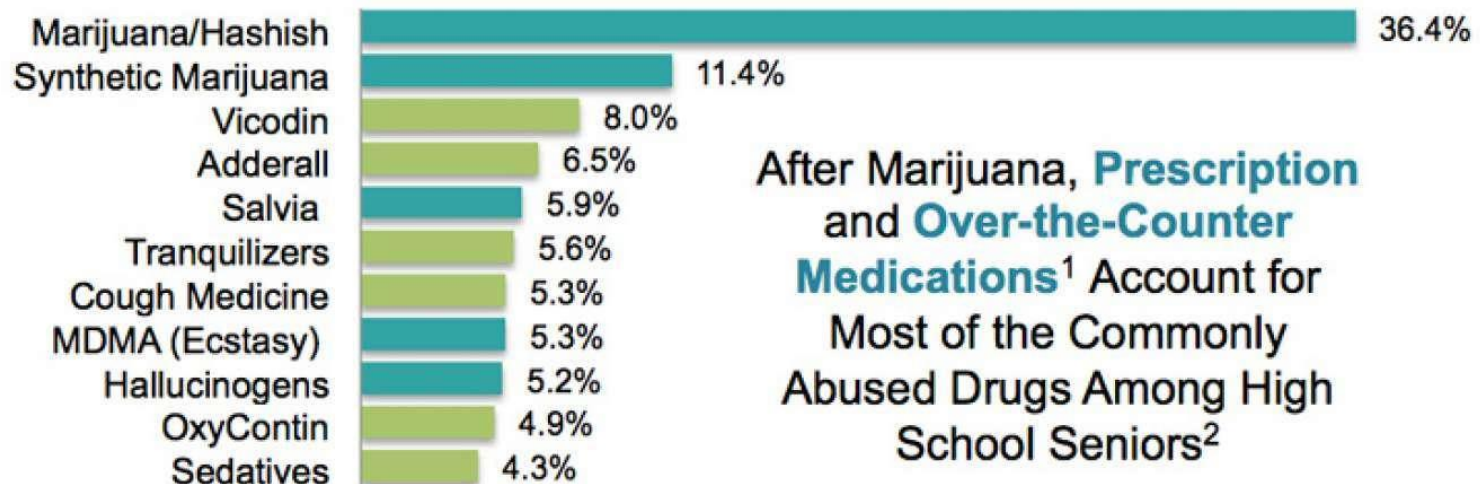
CDC 2016 guidelines

Review study

- The review concluded that there were **no well-controlled long-term studies indicating that opioid treatment for pain beyond twelve weeks effectively relieves pain or improves function** (Chou et al., 2015).
- despite the lack of controlled long-term studies >12 weeks, there is *clinical consensus from pain management practitioners* that some patients do well on chronic opioids (Chou 2009)

Evidence?

- There is no evidence to support long-term use
- But it is covered



Pollack CV: Academic Emergency Medicine; 2016

- Conclusions: Automated telephonic follow-up of ED patients prescribed short-term analgesia is feasible.
- Ketorolac-based analgesia after an ED visit for many acute pain syndromes was associated with favorable patient outcomes and higher satisfaction than opioid-based therapy.

Where Are We Now?

The Dilemma

- “I know I’m addicted to opioids, and it’s the doctors’ fault because they prescribed them. But I’ll sue them if they leave me in pain.”



Where are we now?

- 2000-2001 JSAHO, APS, etc. all recommend treat pain and that escalation is OK
- 2002; DEA states that ‘unscrupulous’ doctors will now be targeted
 - Noticed dramatic increase in prescriptions over time

US Senate Committee on Finance: 2012

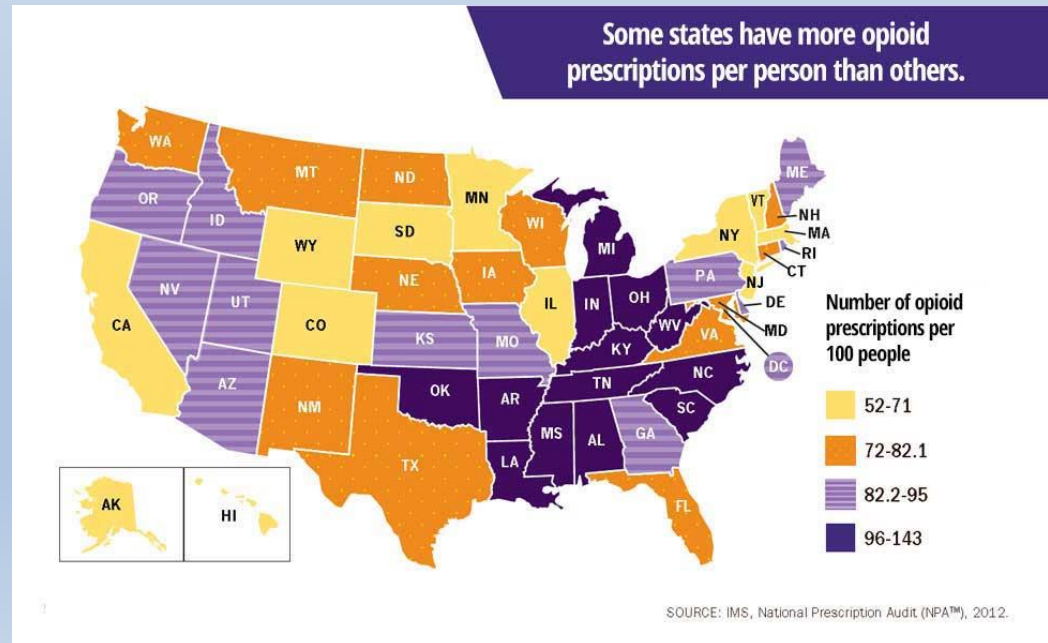
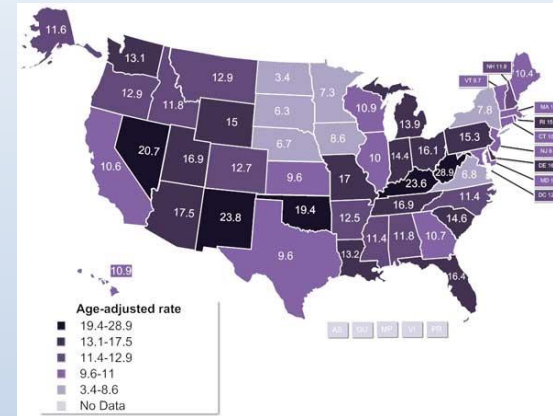
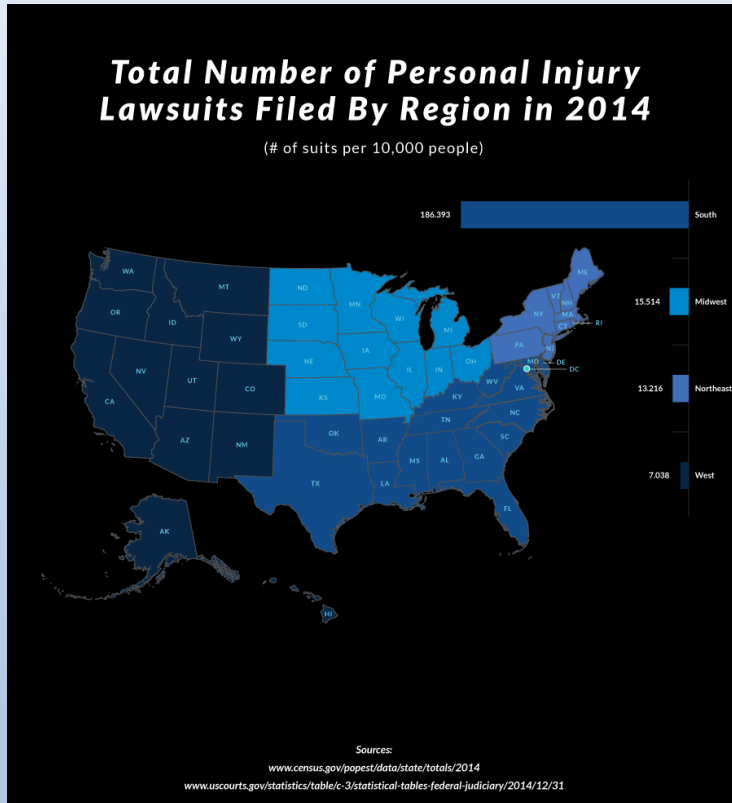
There is growing evidence pharmaceutical companies that manufacture and market opioids may be responsible, at least in part, for this epidemic by promoting misleading information about the drugs’ safety and effectiveness. Recent investigative reporting from the Milwaukee Journal Sentinel/MedPage Today and ProPublica revealed extensive ties between companies that manufacture and market opioids and non-profit organizations such as the American Pain Foundation, the American Academy of Pain Medicine, the Federation of State Medical Boards, the University of Wisconsin Pain and Policy Study Group, and the Joint Commission.



American Pain

- Any pain (physical or mental) is indicative of pathology and must be treated
 - ‘grief’ to be labeled a mental disorder
 - Rampant rise of PTSD
- Doctors that don’t prescribe are seen as withholding relief and inflicting further harm due to the psychological trauma of being in pain
- Trauma is seen as conferring a right to be compensated

Pain is rewarded





A program of the
American Cancer Society

PAIN-FREE HOSPITAL INITIATIVE

- Self-reports of pain are above question
 - Legal standard
 - Ethical standard
 - No science behind it
- Treatment of pain is ‘holy grail’ of compassionate medical care

Figure 3. Wong-Baker FACES® Pain Rating Scale

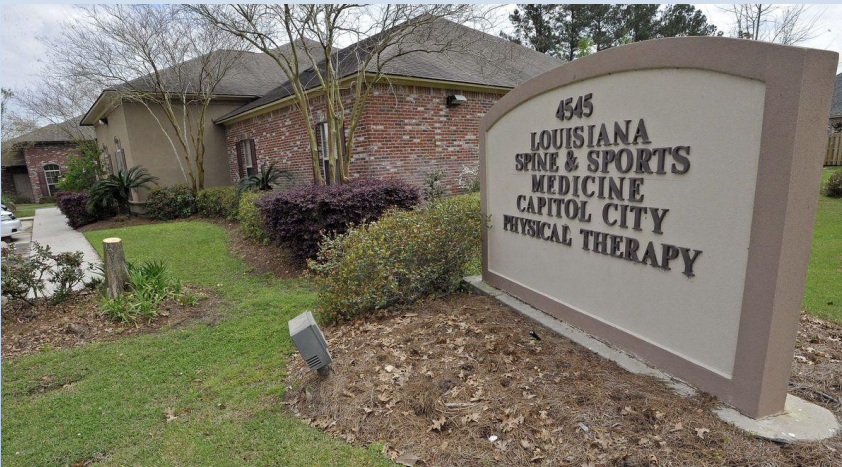


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Results of Decade of Pain

- 2.5million addicts in USA in 2014
 - 1,365,727 active duty military in 2014
- Opioids are widely diverted and misused
- Epidemic of death and addiction
- Epidemic of foster children and orphans

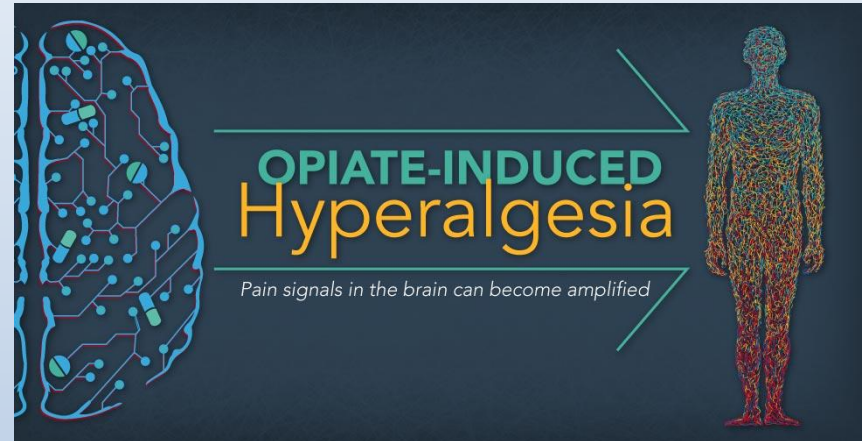


Results of 'Decade of Pain'

- 500% increase in Medicare spending for spine fusion
 - No evidence that outcomes are better
- Increased use of MRI for back pain
 - Rates of spine surgery correspond to rates of MRI
- 1200% increase in payments for ESI 95-05
- Opioid Epidemic
- Low workforce participation rate
- Low return to work rates
- More reports of pain

Decade of Pain/ Pain as 5th

- No achievement of treatment goals
 - Less pain over time
 - More happens
 - Hyperalgesia
 - Escalation
 - More function
 - Never occurs
 - Better quality of life
 - Nope
 - Return to Work
 - Nope



Decade of Pain results

Pain and Suffering Settlements

What is My Accident Claim Worth?

Is Your Settlement Worth More Than \$100,000

Find Out Now. Just Submit Our QUICK & FREE Evaluation Form Below.

1 Your Accident

2 Your Injuries

3 Contact Info

Were you injured in Car Accident? *

Yes No

Was your accident Less than 2 years ago? *

Yes No

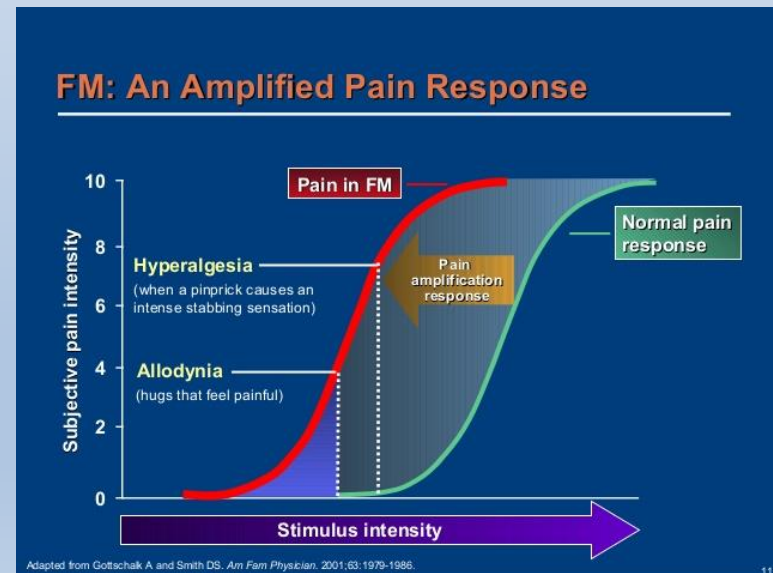
Was the accident someone else's fault? *

Yes No

[Start Free Estimate >](#)

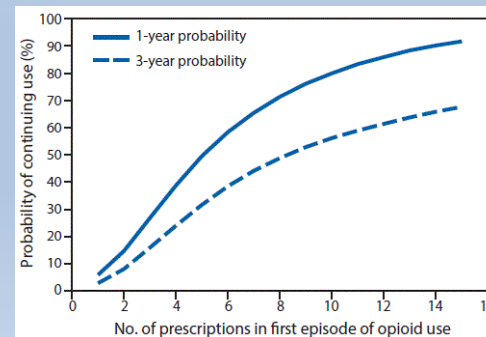
Pavlovian Response to opioids

- Learned association between receipt of drug and physiologic and perceived effects of drug
- Repeated receipt strengthens association
- Craving develops
- Conditioned urge for relief from even mild pain can lead to misuse



CDC 2017

- Literature support for long-term use of opioids is scant
- ***Each additional day of use past 2 days increases risk of chronic use***
 - Tramadol
 - Long-acting
- A 2nd prescriptions doubles the risk of use 1 year later
- Risk of long-term use
 - 1 day Rx = 6%
 - >8 days = 13.5%
 - >31 days = 29.9%



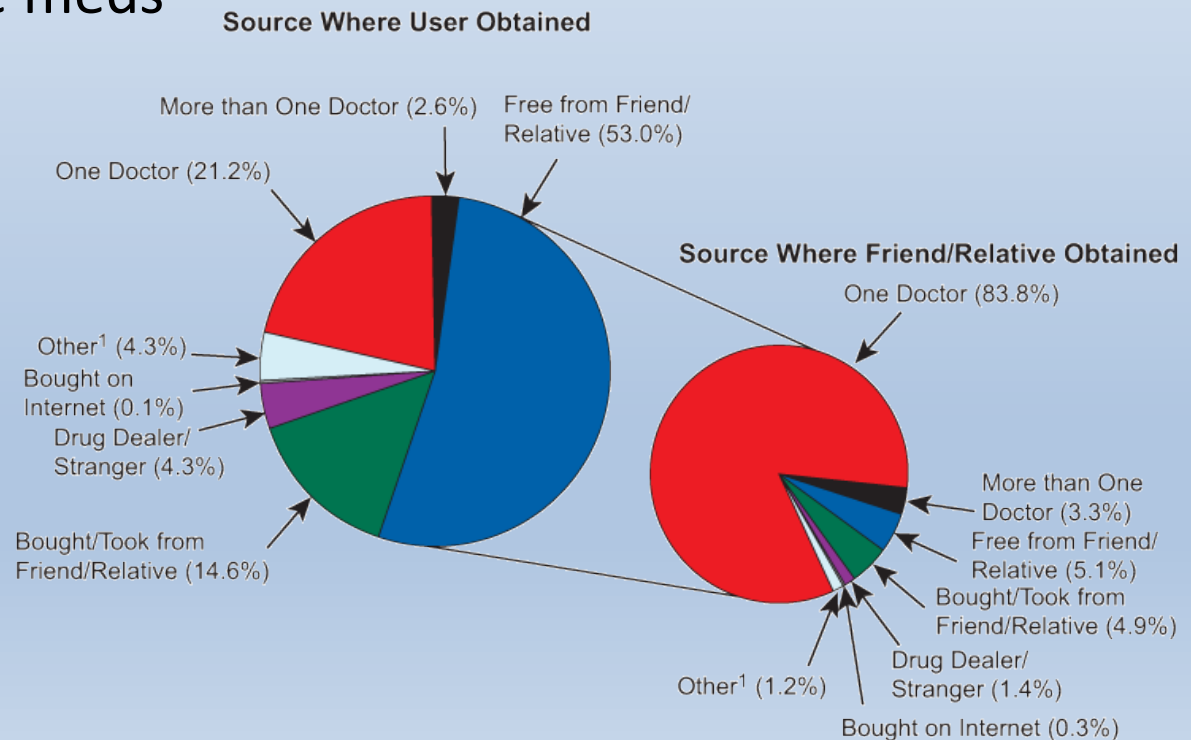
- 50 deaths a day
- Thousands of ED visits
 - Growth of Urgent care also
- 6:10 OD deaths are from prescriptions
- Average time from 1st prescription to death = 2.6 years

- Alternatives to Opioids
 - Effective
 - Proven
 - Not covered



Not really the doctors fault?

- National Survey on Drug Use and Health:
 - <20% of those that misuse receive meds from doctors



Where are we going?

- Ochsner opened a Back Pain Functional Restoration Program
- Very similar to Dr. Bonica's plan in 70s
- Similar to BOOST program in NOLA
- 5 days of therapy per week for 3 weeks
- Counseling/education
- Non-narcotic medications
- Physical therapy/OT



Cummings Motors

- Only 52% employers test for synthetic opioids in pre-employment screening
 - EE Cummings does
 - Encourages alternatives
 - Counsels
- Opioid abuse costs \$19,450 per employee annually
- Baby boomers 4x more likely to abuse than younger
- Employers bear costs of addiction
 - \$79Billion 2013
 - Per CDC
 - \$16.3B lost productivity
 - Group Health - \$14Billion
- Opened a health center for employees
 - Massage
 - Acupuncture
 - PT
 - pharmacy



Burden the doctors

- Practice audits
- Forced to look at database for every patient
- Prescription writing rules that increase time
- Prior-auths
- Bill pending to force writing for naloxone with every narcotic script
- Forced education in pain management
- Documentation rules for CPT coding of services for opioid
- Force referrals
 - No forcing of coverage



Things to think about

- Nurse Practitioners now allowed to write for Suboxone in LA
- Cost of Naloxone
- Number of personal injury lawsuits and lack of tort reform: pain pays
- Medical Marijuana
- State lawsuits against manufacturers
- FDA approval and disapprovals
 - Opana ER
- Insurance companies should probably cover non-narcotic options better

Culture of Pain

- 2007 Anesthesia & Analgesia article:
 - “the unreasonable failure to treat pain is poor medicine, unethical practice and an abrogation of a fundamental human right”



- Being 'pain free' has become a right



5 More Ways To Increase Your Pain and Suffering Compensation Settlements

1. Length of Your Recovery

It's logical to assume that the more serious your injuries, the longer it will take you to recover. The longer your injuries last, the longer will be your pain and suffering. Which means you should be settling personal injury claims for more money.

2. Long Lasting Injuries

Some injuries can last years or may be permanent. These types of injuries are referred to as residual injuries. Residual injuries include scarring, broken bones, torn ligaments, lost limbs, brain damage etc.



3. Taking Medication

If you were prescribed any medication by your doctor, emphasize this in your claim. The fact that you are taking regular medication lets the insurance company know that you're frequently experiencing pain and suffering. The stronger and longer you are taking the medication, the higher your personal injury settlement.

Make sure to emphasize the purpose of your medication. For example, are you taking it to reduce swelling, severe headaches, inflammation, relieve joint pain?

This further helps you describe the extent of your pain and suffering and settling personal injury claims for more cash.



4. Your Physical Discomfort or Emotional Pain

The type of injury you suffer can impact your life in several different ways. For example:

A strained neck may give you discomfort while trying to sleep at night.

Being in a wheel chair limits your ability to take care of your kids or elder parents.

You feel embarrassment and anxiety from a visible scar.

You should document how your injury has impacted you both physically and emotionally. You can keep a separate injury diary to note your pain and discomfort. The key points you should emphasize is how the injury has limited your experiences and created new problems.

As always, you should discuss your discomforts with the doctor so that they can be noted down in your medical report.

This helps settling personal injury claims because it pushes the psychological and physical impact of being injured.



5. Any Life Disruptions

Your injuries may have caused you to miss an important life event. This also falls under the emotional impact of your injuries and you should be compensated.

Bottom Line

Settling personal injury claims for more money will depend on how much proof you can give about your pain and suffering. The best and most credible source for your injuries is the medical report. The better you document your injuries and their impact on your life, the better your chances of getting more money from your injury settlements.

