The Current Status of the Opioid Epidemic in 2019 and What We Can Do About It

David R. Neff, DO
Assistant Clinical Professor
Department of Family and Community Medicine
Michigan State University College of Osteopathic Medicine
Objectives

This presentation will assist the provider to –

1. Understand the Magnitude of the Opioid Epidemic in 2019
   • When the Prescription Opioid is the Problem
   • When Diversion of the Prescription Opioid is the Problem
   • When Heroin is the Problem
   • When Illicitly Manufactured Fentanyl (IMF) is the Problem
   • When Multiple Substances are the Problem
2. Use Current Data to Modify Strategy on How to Combat the Epidemic Across the State – Using a Data to Care Model
3. Develop an improved Opioid Management Documentation System to Modify Practice Patterns and Mitigate Risk
4. Identify Illicit Opioid Use Beyond the Prescription and What to Do About It
The Current Status of the Opioid Epidemic As It Exists Today
Addiction Is A Neurodegenerative and Neurocognitive Disorder From Prolonged Exposure of External Chemicals on the Brain

Biological and Social Consequences of Ongoing Addiction

- Prolonged exposure leading to downregulated structure and function (decreased neurotransmitters, receptors and structural proteins)
- Loss of self control and executive function, ie, judgement
- Inability to calculate risk versus benefit
- Severe uncontrollable drug seeking to satisfy craving and avert withdrawal symptoms
- Loss of Family, Job and Shelter
- Petty Theft Leading to Larger Crimes, Arrest and Incarceration
- Accidental overdose, cardiorespiratory arrest, brain injury and death
12 Month-ending Provisional Number of Overdose Deaths
Based on data ending 10/31/18 and available for analysis on 5/5/2019

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

- 12 month ending period: December 2017
  - Reported number of deaths: 70,699
  - Predicted number of deaths: 72,224
  (↑ 9.5% US)

- 12 month ending period: December 2016
  - Reported number of deaths: 63,938
  - Predicted number of deaths: 65,530
  (↑ 24.7% US)

- 12 month ending period: October 2018
  - Reported number of deaths: 66,824
  - Predicted number of deaths: 69,394
  (↓ -4.0% US)

12 Month-ending Provisional Number of Overdose Deaths
Based on data ending 10/31/18 and available for analysis on 5/5/2019

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Michigan

12 Month-ending Provisional Number of Overdose Deaths by Drug or Drug Class
Based on data ending 10/31/18 and available for analysis on 5/5/2019

United States, Oct 2018,
Opioids (T40.0-T40.4,T40.6)
Reported number of deaths: 46,118
Predicted number of deaths: 47,959

Synthetic opioids, excl. methadone (T40.4)
Reported number of deaths: 30,511
Predicted number of deaths: 31,960

Cocaine (T40.5)
Reported number of deaths: 14,490
Predicted number of deaths: 15,458

Heroin (T40.1)
Reported number of deaths: 14,759
Predicted number of deaths: 15,305

Natural & semi-synthetic opioids (T40.2)
Reported number of deaths: 12,562
Predicted number of deaths: 13,103

Psychostimulants with abuse potential (T43.6)
Reported number of deaths: 12,092
Predicted number of deaths: 12,664

Methadone (T40.3)
Reported number of deaths: 3,048
Predicted number of deaths: 3,158

Legend for Drug or Drug Class

- Opioids (T40.0-T40.4,T40.6)
- Heroin (T40.1)
- Natural & semi-synthetic opioids (T40.2)
- Methadone (T40.3)
- Synthetic opioids, excl. methadone (T40.4)
- Cocaine (T40.5)
- Psychostimulants with abuse potential (T43.6)

Fentanyl, Cocaine and Heroin are Outpacing Prescription Opioids at Death

12 Month-ending Provisional Number of Overdose Deaths by Drug or Drug Class
Based on data ending 10/31/18 and available for analysis on 5/5/2019

12 Month-ending Provisional Number of Overdose Deaths by Drug or Drug Class
Based on data available for analysis on: 3/3/2019

Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: October 2017 to October 2018

Michigan
Predicted cases, October 2018: 2,338
Predicted cases, October 2017: 2,734
Percent change: -14.5

Percent Change for United States
-4.0

Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

National Opioid Prescription Rates are Continuing to Shrink
Grey Death in GA, FL, OH and WV

May 4, 2017 - Gray Death is a combination of several powerful substances such as Heroin, Fentanyl, Carfentanil and a synthetic opioid called U-47700

The drug has the appearance of a concrete rock. It is chunky and solid, created from compressed and cooked powder

At least 50 people have reportedly overdosed, some dying after their first dose of the drug
MI 2017 Overdose Deaths - Bay County Health Department
The Value of Linking Toxicology Screens to MAPS/NarxCare

When Fentanyl Analogues Were Found

30 deaths that were overdose of any kind
• 28 had an opioid
• 17 of 28 (60%) opioids were fentanyl or fentanyl family
• 14 of 17 (80%) fentanyl deaths were bootleg non pharmaceutical fentanyl
• No fentanyl was identified 4 years ago

Courtesy of William Morrone, DO, Bay County Medical Examiner
MI Swift Toxicology of Opioid-Related Mortalities (STORM)
Data Through April, 2019 is Revealing Similar and Consistent Patterns Regarding Polysubstance Misuse
Five Primary Root Causes for The Epidemic in 2019

• When the Opioid Prescription is the Problem
  • Too much opioid being prescribed for acute and chronic pain over the last 20 years
    • Unintended consequence of treating “Pain as the 5th Vital Sign” and HCAPS Surveys
    • The Good News -- Prescription Rates are Going Down Nationally, in Michigan and in Medicaid by Double Digits in the last two years

• When Diversion of the Prescription Opioid is the Problem – National Drug Threat Assessment Survey
  • 2/3– 3/4 of Prescribed Opioids are Bought, Stolen or Given Away
  • Leakage in the Distribution System - Lost in Transit, Armed Robbery, Night-time Break-ins and Employee Pilferage
  • Illegal Backdoor Sales and Distribution – Informal Networks and Organized Crime

• When Heroin is the Problem
  • Largely distributed by 6 Mexican Cartels of Which Two are in Michigan
  • $300 Billion Dollar Global Business Where Revenues Are Only Outpaced by Walmart Global Sales

• When Illicitly Manufactured Fentanyl (IMF) is the Problem
  • Mostly made in China and sold in the US over the internet
  • Some brought across the border from Mexico or Canada
  • Reassembled by smuggled reassembled pill presses
  • Prepared for inhalation (including vaping devices) or IV injection

• When Multiple Substances are the Problem
  • Mixtures of Fentanyl Analogues, Heroin, Prescription Opioids, Cocaine, Methamphetamine, Amphetamine, Benzodiazepines -> Grey Death
This is Mostly Good News...However Have We Swung Too Far The Other Way?
Health Professionals for Patients in Pain

Professionals Call on the CDC to Address Misapplication of its Guideline on Opioids for Chronic Pain through Public Clarification and Impact Evaluation

Authors: Health Professionals for Patients in Pain (HP3)
Date: March 6, 2019

I. In 2016, the Centers for Disease Control and Prevention, CDC, issued a Guideline for Prescribing Opioids for Chronic Pain for primary care physicians. Its laudable goals were to improve communication between clinicians 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. The Guideline reflected the work of appointed experts who achieved consensus on the matter of opioid use in chronic pain.

Among its recommendations are that opioids should rarely be a first option for chronic pain, that clinicians must carefully weigh the risks and benefits of maintaining opioids in patients already on them, and that established or transferring patients should be offered the opportunity to re-evaluate their continued use at high dosages (i.e., > 90 MME, morphine milligram equivalents).

In light of evidence that prescribed dose may pose risks for adverse patient events, clinicians and patients may choose to consider dose reductions, when they can be accomplished without adverse effect, and with possible benefit, according to some trial data.

Nonetheless, it is imperative that healthcare professionals and administrators realize that the Guideline does not endorse mandated involuntary dose reduction or discontinuation, as data to support the efficacy and safety of this practice are lacking.

II. Within a year of Guideline publication, there was evidence of widespread misapplication of some of the Guideline recommendations. Notably, many doctors and regulators incorrectly believed that the CDC established a threshold of 90 MME as a de facto daily dose limit. Soon, clinicians prescribing higher doses, pharmacists dispensing them, and patients taking them came under suspicion.

Actions that followed included payer-imposed payment barriers, pharmacy chain demands for the medical chart, or explicit taper plans as a precondition for filling prescriptions, high-stakes matrices imposed by quality agencies, and legal or professional risks for physicians, often based on innovation of the CDC’s authority. Taken in combination, these actions have led many health care providers to perceive a significant category of vulnerable patients as institutional and professional liabilities to be contained or eliminated, rather than as people needing care.

III. Adverse experiences for these patients are documented predominantly in anecdotal form, but they are concerning. Patients with chronic pain, who are stable and, arguably, benefiting from long-term opioids, face draconian and often rapid involuntary dose reductions. Often, alternative pain care options are not offered, not covered by insurers, or not accessible. Patients are pushed to undergo addiction treatment or invasive procedures (such as spinal injections), regardless of whether clinically appropriate.

Consequently, patients have endured not only unnecessary suffering, but some have turned to suicide or illicit substance use. Others have experienced preventable hospitalizations or medical deterioration in part because insurers, regulators, and other parties have deployed the 90 MME threshold as a both a professional standard and a threshold for professional suspicion. Under such pressure, care decisions are not always based on the best interests of the patient.

IV. Action is Required: The 2016 Guideline specifically states, “the CDC is committed to evaluating the guideline to identify the impact of the recommendations on clinician and patient outcomes, both intended and unintended, and revising the recommendations in future updates when warranted”. The CDC has a moral imperative to uphold its avowed goals and to protect patients.

Therefore, we call upon the CDC to take action:

- We urge the CDC to follow through with its commitment to evaluate the impact by consulting directly with a wide range of patients and caregivers, and by engaging epidemiologic experts to investigate reported suicides, increases in illicit opioid use and, to the extent possible, expressions of suicidal ideation following involuntary opioid taper or discontinuation.
- We urge the CDC to issue a bold clarification about the 2016 Guideline—what it says and what it does not say, particularly on the matters of opioid taper and discontinuation.

Signatories here represent their own views, and do not purport to reflect formal positions of their employing agencies, governmental or otherwise. For questions please contact: healthprof.org.
FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

Safety Announcement

[4-9-2019] The U.S. Food and Drug Administration (FDA) has received reports of serious harm in patients who are physically dependent on opioid pain medicines suddenly having these medicines discontinued or the dose rapidly decreased. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide.

While we continue to track this safety concern as part of our ongoing monitoring of risks associated with opioid pain medicines, we are requiring changes to the prescribing information for these medicines that are intended for use in the outpatient setting. These changes will provide expanded guidance to health care professionals on how to safely decrease the dose in patients who are physically dependent on opioid pain medicines when the dose is to be decreased or the medicine is to be discontinued.
No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.
Misapplication of the 2016 CDC Chronic Pain Guidelines

- Efforts to implement prescribing recommendations to reduce opioid-related harms are laudable
- Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations
- A consensus panel has highlighted these inconsistencies, which include
  - inflexible application of recommended dosage and duration thresholds
  - policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician’s practice.
- The panel also noted the potential for misapplication of the recommendations to populations outside the scope of the guideline
- Such misapplication has been reported for patients with pain associated with cancer, surgical procedures, or acute sickle cell crises
- There have also been reports of misapplication of the guideline’s dosage thresholds to opioid agonists for treatment of opioid use disorder
- Such actions are likely to result in harm to patients
Misapplication of the 2016 CDC Chronic Pain Guidelines (Continued)

- We need better evidence in order to evaluate the benefits and harms of clinical decisions regarding opioid prescribing, including when and how to reduce high-dose opioids in patients receiving them long term.
- However, we know little about the benefits and harms of reducing high dosages of opioids in patients who are physically dependent on them.
- In situations for which the evidence is limited, it is particularly important not to extend implementation beyond the guideline’s statements and intent.
- And yet in some cases, the guideline has been misimplemented in this way –
  - For example, the guideline states that “Clinicians should, . . . avoid increasing dosage to ≥90 MME [morphine milligram equivalents]/day or carefully justify a decision to titrate dosage to ≥90 MME/day.”
  - This statement does not address or suggest discontinuation of opioids already prescribed at higher dosages, yet it has been used to justify abruptly stopping opioid prescriptions or coverage.
- This recommendation also does not apply to dosing for medication-assisted treatment for opioid use disorder.
Misapplication of the 2016 CDC Chronic Pain Guidelines (Continued)

• Patients who are able to successfully taper their opioid use are likely to have a lower risk of overdose, and evidence is accumulating that they might experience reduced pain

• Other patients may find tapering challenging; could face risks related to withdrawal symptoms, increased pain, (suicidal ideation) or unrecognized opioid use disorder
Even Guideline-concordant Care Can Be Challenging and Lead to Restricted Care

• Implementing recommendations with individual patients takes time and effort
• An unintended consequence of expecting clinicians to mitigate risks of high-dose opioids is that rather than caring for patients receiving high dosages or engaging and supporting patients in efforts to taper their dosage
  • some clinicians may find it easier to refer or dismiss patients from care
• Clinicians might universally stop prescribing opioids, even in situations in which the benefits might outweigh their risks
• Such actions disregard messages emphasized in the guideline that clinicians should not dismiss patients from care,
  • can adversely affect patient safety
  • could represent patient abandonment
  • can result in missed opportunities to provide potentially lifesaving information and treatment
There Are No Shortcuts to Safer Opioid Prescribing

• Requires assessment of benefits and risks, patient education, and risk mitigation or to appropriate and safe reduction or discontinuation of opioid use.

• Starting fewer patients on opioid treatment and not escalating to high dosages in the first place will reduce the numbers of patients prescribed high dosages in the long term.

• In the meantime, clinicians can
  • maximize use of nonopioid treatments
  • review with patients the benefits and risks of continuing opioid treatment
  • provide interested and motivated patients with support to slowly taper opioid dosages, closely monitor and mitigate overdose risk for patients who continue to take high-dose opioids, and offer or arrange medication-assisted treatment when opioid use disorder is identified.
Taking Data to Care – Part I

Developing a Systematic Strategic Approach to Limiting Prescription Opioid Overutilization & Illicit Use – A Health System Perspective
Leveraging the MDHHS Public Health Approach to the Opioid Crisis

Data Drives Decisions

1° PREVENTION:
- Promote awareness
- Reduce supply & demand
- Improve IT analytics & surveillance

2° EARLY INTERVENTION:
- Identify co-occurring conditions
- Identify risk of addiction & overdose
- Screening, brief intervention, referral to treatment
- Informed consent & treatment contracts
- Care coordination, collaboration, and continuity
- Monitor & adjust dosing
- Coping skills

3° TREATMENT:
- Increase treatment services
- Increase emergency services
- Rescue with Naloxone
- Medication-assisted treatment
- Recovery

MDHHS
Michigan Department of Health & Human Services
Creating a Learning Health System* to Improve Quality of Care and Create Teachable Moments

*Embraced by AHRQ, the National Academy of Medicine and CMS

The Opioid Mortality Crisis Is Two Epidemics Within One (An Evolving Model)

**Medical Pathway**
- Disease/Injury
- Person Reports Pain
- Opioid Rx
- Tolerance -> Dependence
- Addiction – Uncontrollable Craving and Withdrawal Symptoms
- Cardiopulmonary Arrest
  - Brain Injury
  - Death

**Illicit Pathway**
- Negative Cultural Influences
- Person Misuses
  - Illicit Opioid Rx
  - Heroin
  - Fentanyl Analogues
- Experimentation
- Escapism
Focus on 4 Key Objectives

1° Prevention

Medical Pathway
- Disease/Trauma
- Person Reports Pain
- Opioid Rx
- Tolerance -> Dependence
- Addiction – Uncontrollable Craving and Withdrawal Symptoms
- Chronic Pain Opioid Management
  - Cancer
  - Palliative Care
  - Hospice
- Cardiopulmonary Arrest
- Brain Injury
- Death

Illicit Pathway
- Negative Cultural Influences
- Person Misuses
  - Illicit Opioid Rx
  - Heroin
  - Fentanyl Analogues
- Cardiopulmonary Arrest
- Brain Injury
- Death

2° Early Intervention

1. Prescribe Less
2. Decrease Demand & Get Illicit Opioids Off the Street
3. Improve Access to Care
4. Do Not Abandon the Chronic Pain Patient

3° Treatment

Physical Pain

Disease/Trauma
- Person Reports Pain
- Opioid Rx
- Tolerance -> Dependence
- Addiction – Uncontrollable Craving and Withdrawal Symptoms
- Chronic Pain Opioid Management
  - Cancer
  - Palliative Care
  - Hospice
- Cardiopulmonary Arrest
- Brain Injury
- Death

Negative Cultural Influences
- Person Misuses
  - Illicit Opioid Rx
  - Heroin
  - Fentanyl Analogues
- Cardiopulmonary Arrest
- Brain Injury
- Death

Experimentation

Prevention

Early Intervention

Treatment
Solution – Optimize Care

1° Prevention
- Disease/Trauma
  - Prevent
    - Disease – Malnutrition, Immobility (Deconditioning), Smoking, Substance Abuse, Infectious Disease, Cancer
    - Trauma - Seatbelts, Fall Avoidance, Safe Equipment

2° Early Intervention
- Person Reports Pain
  - Opioid Rx
    - Acute Treatment
      - Take a Team Based Approach
      - Scrutinize Opioid Need
      - Carefully Justify Decisions
      - Use Non-Opioid Therapies 1st
      - Rx Opioids Cautiously
      - Taper ASAP
      - Provide Informed Consent
      - Utilize Patient Contracts
      - Evaluate with MAPS/NarxRx
      - Secure Storage & Dispose Safely
      - Minimize Diversion
  - Tolerance -> Dependence
    - Addiction – Uncontrollable Craving and Withdrawal Symptoms

3° Treatment
- Person Misuses
  - Illicit Opioid Rx
    - Heroin
    - Fentanyl Analogues
  - Early Intervention
    - Screen Risk Regularly
    - Monitor with PDMP/UDS
    - Identify Misuse & Treat Early

Chronic Treatment
- Chronic Pain Opioid Management
  - Cancer
  - Palliative Care
  - Hospice

- Cardiopulmonary Arrest
  - Brain Injury
  - Death

Evidence-based Care
- Naloxone
- MAT (buprenorphine, methadone, naltrexone)
- Behavioral Therapy

Improve Access and Eliminate Barriers to Care
- ↑ Highly Qualified Workforce
- Simplify Pathways to Care
- ↑ Appointment Times
- ↑ Care Coordination
- ↑ MAPS/NarxRx
- ↑ UDS (w/ and w/o Fentanyl Analogues)
- ↑ Naloxone
- ↑ MAT
- ↑ Counselling

Prevent
- Disease – Malnutrition, Immobility (Deconditioning), Smoking, Substance Abuse, Infectious Disease, Cancer
- Trauma - Seatbelts, Fall Avoidance, Safe Equipment

Negative Cultural Influences
- Prevent
  - Early Alcohol Use
  - Early Nicotine Use
  - Early Cannabis Use
  - Early Drug Experimentation
  - Traumatic Experiences

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Prevent
- Disease – Malnutrition, Immobility (Deconditioning), Smoking, Substance Abuse, Infectious Disease, Cancer
- Trauma - Seatbelts, Fall Avoidance, Safe Equipment
Best Approach to Evaluate for Appropriate Care Along With Addictive and Other Aberrant Behaviors

**Individual Case Consideration**

- **MAPS/NarxCare**: Tells us what they are supposed to be taking.
- **Drug Screens**: Tells us what they are actually taking.
- **Clinical Information**: Provides clinical context as to why they are taking.
- **MQIC Guidelines (CDC Pain & ASAM Addiction Guidelines)**: Tells us how they can be better managed (MI Specific Synthesis of CDC Pain & ASAM Addiction Guidelines).
A Systematic Approach to Reducing Unnecessary Opioid Prescription Use for Prescribers

- Person Reports Pain
- Opioid Rx
- Acute Use - Opioid Naïve ≥180 days
- Chronic Use - Taking Opioids > 30 days &/or ≥ 90 MEDD

Acute (7 days and < 90 mg MEDD)

- Continue up to 26-30 Days
- Re-evaluate & Document
  - Pain Status
  - PDMP
  - Drug Screen
  - Consultation

Resolved → Limit Opioid Use to ≤ 28-30 Days for Extended Pain
Not Resolved → Continue (3-12 Months) & Re-evaluate

Chronic Use w/ or w/o High Dose

- Not Justifiable
- Justifiable

Limit Opioid Use to ≤ 7 Days for Acute Pain

Resolved → Refer
Not Resolved → Initiate Taper Process (Patient Centered)

- Manage with Mentoring (EHCO, MPRO)
- Taper to Less Risky Dose
- Taper Then Switch to MAT

Reevaluate Pain, Justify and Document Continued Use Beyond 28-30 Days

Limit Opioid Use to ≤ 7 Days for Acute Pain

Limit Opioid Use to ≤ 28-30 Days for Extended Pain

≤ 180 days

Continue up to 28-30 Days

Managing Opioid Prescribing

Initiate Taper Process (Patient Centered)

Refer

Limit Opioid Use to ≤ 7 Days for Acute Pain

Limit Opioid Use to ≤ 28-30 Days for Extended Pain
All Things Considered

- We cannot totally legislate, regulate, arrest or spend our way out of this dilemma
- We need to increase social and individual resilience
- We need to shrink cultural mores and expectations that support recreational drug use
- **We must decrease prescription opioid use**
- **We must get heroin and fentanyl analogues off the street**
- We cannot abandon the patient with life altering pain
- We cannot send anyone to the street by saying no
- We need to improve access to addiction care regardless of what caused it and before we clamp down on supplies
- We need to bolster work force and infrastructure to manage those who suffer from opioid tolerance and addiction
- We need to support the providers taking care of the patient and family
- We need to support families and social networks