WHA Member Forum:

Wisconsin Best Practices in Tackling the Opioid Abuse Issue

Thursday, March 17, 2016
10:00 am – 11:30 am CST
Opioid Use in the Emergency Department

Julie Doniere, MD
Wheaton Franciscan Healthcare
What is the problem?

• There were 259 million prescriptions written for painkillers in 2015.

• This would enable every single person in the U.S. to have their own bottle.

• The number of deaths in the U.S. from overdose of opioids is skyrocketing.
What is the problem?

• The most commonly prescribed opiates are hydrocodone and oxycodone.
• The U.S. makes up only 4.6% of the world’s population, but consumes 80% of its opioids.
• The U.S. consumes 99% of the world’s Vicodin.
• In 2014, the U.S. saw its highest rate of mortality resulting from drug abuse in history.
• 61% of these deaths included some kind of opioid.
State Variability in Prescribing

Map showing state variability in prescribing painkillers per 100 people. States are color-coded as follows:
- Yellow: 52-71
- Orange: 72-82.1
- Light Purple: 82.2-95
- Dark Purple: 96-143

Source: U.S. National Prescription Audit (2011-2013)

A Valued Voice
What is the problem?

• Drug misuse was the cause of 2.5 million emergency department visits in 2011.

• It is causing a strain on hospitals and first responders.
Where are people getting their opiates?

A Valued Voice

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Where are people getting their opiates?

![Bar chart showing sources of opiates by number of days of use.]

- **Given by a friend or relative for free**
- **Prescribed by ≥1 physicians**
- **Stolen from a friend or relative**
- **Bought from a friend or relative**
- **Bought from a drug dealer or other stranger**
- **Other**

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*Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.*

*Estimate is statistically significantly different from that for highest-frequency users (200-365 days) (P<.05).*

*Includes written fake prescriptions and those opioids stolen from a physician’s office, clinic, hospital, or*
Financial Toll

• It is estimated that the cost of prescription drug abuse is $55.7 billion.
• This is thought to be due to lost productivity, increasing health care costs and criminal justice costs.
Why do people abuse opioids?
Currently, what is going on in Wisconsin?

• The Heroin, Opiate, Prevention and Education Agenda.
  – A.B. 445: Requires that anyone picking up a prescription for narcotics must show identification.
  – A.B. 446: Ensures that all first responders will be trained in the use of the opiate antagonist naloxone.
HOPE Agenda

• A.B. 447: Provides protection from prosecution for those seeking assistance for a person who has overdosed.
• A.B. 448: Encourages better and more regulated disposal programs.
• A.B. 668: Increases funding for treatment of drug and alcohol abuse.
HOPE Agenda

• A.B.701: Creates regional pilot programs to address opiate addiction in underserved areas. The treatment programs will assess individuals to determine treatment needs, provide counseling, and medical or abstinence-based treatment.
HOPE Agenda

• A.B. 702: Relates to the “swiftness and certainness “ of punishment related to narcotic related crimes.
• A.B. 472: Makes it possible for pharmacies to dispense Naloxone without a prescription.
• B. 365: Makes it the duty of law enforcement to report misconduct or related deaths to the PDMP.
HOPE Agenda

• A.B. 365: Pain clinics must submit an application to the Department of Health Services and have a physician medical director.

• A.B. 366: Requires that methadone clinics report annually to the Department of Health Services and also ensures that prior to prescribing methadone a review must be done to ensure that the person is not being prescribed Methadone or any other narcotic pain medication from another source.
Emergency Department Tactics

- Prescription Drug Monitoring Program
  - Established in 2009
  - The PDMP is a statewide program that collects information about monitored prescriptions drugs that are dispensed to patients in Wisconsin.
  - Its primary purpose is to reduce the abuse and diversion of prescription drugs in Wisconsin.
  - The information can be accessed by pharmacists, physicians and physician delegates.
Emergency Department Tactics

• Oxy Free ED
  – Milwaukee Healthcare Partnership EDCC.
  – An agreement between the medical directors of all the ED’s in Milwaukee.
  – Guidelines to providers to support them in the decreased prescribing of opiates.
Oxy Free ED

Treatment of chronic pain
in this Emergency Department

Chronic narcotic pain medications will not be refilled in this Emergency Department.

The use of IV or IM injection of narcotic pain medication or chronic pain is discouraged.

If you have questions about these guidelines, please ask.
Barriers to Appropriate Opiate Prescriptions

- Maintaining flow in the Emergency Department
- Patient satisfaction/Physician/Hospital Compensation
- It’s just easier to say yes.
CDC Guidelines

- Non-opioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- When opioids are used, the lowest possible effective dose should be prescribed to reduce risks of opioid use disorder and overdose.
- Providers should always exercise caution when prescribing opioids and monitor all patients closely.
The Prescription Opioid and Heroin Epidemic: A Systems Approach

Michael McNett, MD
Medical Director for Chronic Pain – Aurora GMS PSM
WMS Opioid Education Subcommittee
The Dilemma

- Patient Rights Groups:
- JCAHO:
- Press-Ganey:
- Attorneys:

  **Treat Pain Aggressively!**

- State Licensing Boards:
- DEA/Law Enforcement:
- The Press:
- Attorneys:

  **Don’t Feed Addiction!**
Some Historical Background

- 1995: OxyContin approved by FDA
  - Claimed “non-addictive” due to extended release
  - Advocated use in chronic non-cancer pain
- 1998: JCAHO and CMS accept pain as the “5th Vital Sign”
  - Not fully enforced until ~2001
- 2010: More deaths from prescription opioids than motor vehicle accidents
Question #1

Should we be using chronic opioid therapy at all??
What are the consequences?

Prescription Painkiller Sales and Deaths

Figure 2. Number of drug-poi...
More consequences

Rx opioid abuse is rampant in our society

- Approximately 7% of people in the US have a substance use disorder
- The prevalence of troublesome opioid/alcohol use in PCP pts. is 11%
- Rx OD deaths exceed 39,000/year in US, greater than MVA fatalities
- Rx opioids have now caught up to marijuana as most abused drugs
- Rx opioid OD deaths exceed those from heroin and cocaine combined
- Drug overdose death rate 4X greater in 2008 than 1999
- 75% of fatal OD’s in 2008 involved prescription drugs
- Middle-aged whites were at highest risk of prescription opioid OD death
- 85% of misused narcotics are physician prescriptions
- 27% of addicts were first exposed to narcotics by prescription from MD

Since the worst ADRs from opioids are overdose and addiction, prescribers must have high index of suspicion
Opioid prescribing is out of control

80% of all prescription opioids in the world are consumed in the US
95% of all hydrocodone
All these deaths for nothing

“From 1999 to 2013, the amount of prescription painkillers prescribed and sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report.”

CDC website
The Cause of the Problem

The prescription opioid addiction epidemic is a multifactorial disease based in part on numerous provider misconceptions:

“Opioids are the best drugs for pain”
“There’s an infinite dose-response curve”
“Though possibly addictive, the benefits of opioids usually outweigh the risks.”
“Addiction is a moral failing”
“It’s impossible to ID a potential abuser”
The Reality - Physiological

This is the basis for opioid tolerance and hyperalgesia. Initially, opioids help pain; later, they tend to worsen it.

Unbound State → Initially Bound State → Eventual State

↓ cAMP

↑ cAMP
The Reality - Clinical

Multiple meta-analyses on opioids in chronic pain have been done:

<table>
<thead>
<tr>
<th>Mo.</th>
<th>Evidence of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Good</td>
</tr>
<tr>
<td>2-6</td>
<td>Weak; ~15%, less than patients consider effective</td>
</tr>
<tr>
<td>&gt; 6</td>
<td>None</td>
</tr>
</tbody>
</table>

No decent studies > 6 mo
Longer studies < 6 mo tend to have less benefit
Linear dose-response curve?

Multiple studies have shown this not to be true for chronic pain

- Canadian meta-analysis:
  - Weak to 120 MEs/d, very weak to 200/d
  - No benefit >200, with linear ↑ ADRs, death
- Other studies indicate max 60-80 ME/d
- ↑↑ Mortality
  - At 100 MEs 8 x normal
  - At 200 MEs 24 x normal
  - And these are TRIPLED if also on a benzo!
And opioids aren’t even that effective in Acute Pain (Cochrane)

NNT to get 50% postop pain relief from 1 dose:

<table>
<thead>
<tr>
<th>Medication</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone 15 mg</td>
<td>4.6</td>
</tr>
<tr>
<td>Percocet 5/325</td>
<td>2.7</td>
</tr>
<tr>
<td>Naproxen</td>
<td>2.7</td>
</tr>
<tr>
<td>Ibuprofen 200/APAP 500</td>
<td>1.6</td>
</tr>
</tbody>
</table>

So 1 Advil + 1 Tylenol ES is 3 times as likely to give 50% pain relief as OxyIR 15 mg!
So why do patients say they work?

AmeriTox data: 12 mo: 400,000 tests

61% showed aberrant behavior:

- 38% Prescribed drug not present
- 31% Non-prescribed controlled substances
- 13% Illicit drugs
- 17% Levels > 2 std. dev. from expected

And these tests were done when patients knew they could be tested!

Opioids reward taking them; interpreted as pain relief
Linus’ blanket, reverse placebo effect
Some patients may genuinely benefit
Reward is its own reward.

Opioids directly stimulate the dopaminergic reward circuits
With chronic use, changes in these structures can be ID’ed on MRI
This occurs whether they are taken for abuse or for pain
This causes the brain to confuse the primal drive to take more with pain relief
The Roots of Addiction

The patient – addictive propensity
- Genetic
- Psychological
- Learned behaviors
- Situational

The drug – euphoric quality
- Delivery system (IV vs. po)
- Onset of action
- Rate of metabolism (rapid loss increases craving)
- Long-acting (constant) vs. short (rewards pill-taking)

The more addiction-prone the patient, and the more euphoric the opiate, the greater the risk of addictive behavior.
Approximate Scale of Opiate Euphoria
(anecdotal)

**Low**
- buprenorphine, tapentadol (Nucynta), tramadol
- nalbuphine (Nubain), butorphanol (Stadol)
- methadone
- fentanyl (transdermal)
- codeine, hydrocodone, morphine
- fentanyl (sublingual)
- oxycodone, hydromorphone (po), oxymorphone (Opana)
- meperidine, heroin

**High**

Wisconsin Medical Society
So what is the answer?
What Aurora has done

1. Created a set of strict opioid prescribing guidelines; distributed to all providers.
2. In process of developing a mandatory policy on how to handle patients showing signs of addiction to their opioids (the Drug-Seeking Policy).
3. Developed on-line and in-person education programs for prescribers on appropriate opioid prescribing and how to identify signs of abuse in patients taking them.
4. Developed a comprehensive program for training internal medicine and family practice residents in effective pain medicine, with an emphasis on non-narcotic treatments.
5. Developed an “Oxy-free ED” program
6. Started a program to maximize non-narcotic treatments for patients who have surgery (at W. Allis) which has dramatically reduced and in many cases eliminated the need for narcotics in these patients.
What Aurora has done (cont.)

7. Developed a Chronic Pain Program pilot incorporating principles of psychology and addiction medicine and focusing on minimizing narcotics while maximizing non-narcotic treatments.
8. Have a program for treating pregnant women with drug abuse.
10. Developing programs for keeping patients in narcotic addiction treatment programs and making their programs more effective.
11. Developed a documentation tool to help busy practitioners quickly and effectively document that patients are in compliance with their Opioid Agreements when they come in for rechecks. It also prompts the prescriber to make sure they are doing Best Practices.
12. Aurora pharmacies are checking IDs on all patients bringing in opioid prescriptions and picking them up.
13. Aurora pharmacies allow standing orders for naloxone (for OD)
3 Aspects to Addressing the Problem

1. Avoid exposing people to addictive meds as much as possible
2. Identify patient in early stages of “dysfunctional relationship” to opioids and switch to other treatments
3. Identify patients with opioid use disorder and have services available to treat them
Education

- It is essential to properly educate prescribers
- MEB plans to mandate 2 hrs. “approved” CME for license renewal starting 2017
- PI/MOC Pts. II and IV CME being developed by WMS
- Practice-specific pain/opioid education highly desirable, not yet developed. (ED, ortho, etc.)
- Consider developing CME and strongly promoting it
  - Non-narcotic Tx
  - Dangers of opioids; addiction risk stratification
  - Proper documentation
  - Identifying/treating substance abuse
CDC Guidelines for Chronic Opioid Therapy (COT): Summary

1. Opioids should be the last resort in treating chronic pain.
2. Before starting COT, set Sx and functional goals: D/C if goals not met
3. Risks/benefits should be discussed before and reassessed during COT
4. Initially use IR opioids, may include ER once daily dose established
5. Use lowest possible dose. If >50 MEs,↑ precautions. Avoid >120 MEs.
6. For acute pain, Rx lowest dose and # pills necessary, pref. ≤ 3 days.
7. If starting COT, recheck in 1-4 wks., then ≤ q 3 mo.
   1. Wean or d/c if risks > benefits
9. Review PDMP at least q 3 mo, preferably w/ each Rx.
10. Check UDS at initiation of COT and at least yearly, more if ↑ risks.
11. Avoid use of both opioids and benzodiazepines. (triples risk of fatal OD)
12. If opioid use disorder (addiction) develops, arrange for evidence-based Tx. (Don’t just terminate them from your practice.)
Common Alternatives to Opioids

- Acetaminophen
- NSAIDs (acute, inflammatory)
- SNRIs: venlafaxine, duloxetine, milnacipran
- TCAs: desipramine, amitriptyline, nortriptyline
- Anticonvulsants: gabapentin, pregabalin, topiramate, carbamazepam, etc.
- Topicals: lidocaine, NSAID, capsaicin
- Procedures: blocks, epidurals, facet block
- PT, OT, braces, stimulators
- CBT, hypnosis, meditation, acupuncture
Consider mandatory education on PDMP

- **HOPE law:** by 4/1/2017, all prescribers *must* check PDMP before writing a “monitored prescription”
- Opioids, benzodiazepines, amphetamines, other stimulants, hypnotics, barbiturates, carisoprodol
- Consider recorded “hard stops” on Rx’s in EMR
  - “I affirm that I have checked the WI PDMP and that it shows no evidence of behavior suggesting a medication use disorder.”
- **New PDMP after 1/1/2017** will be much easier to access from or integrate into EMR
What about Press-Ganey??

Keys:
- Build appropriate expectations
  - Time horizon for opioid Tx
  - ↑ opioids in acute pain not assoc. w/ ↑ satisfaction
  - Low euphoria opioid makes for easy weaning

Pleasing a drug-seeker = feeding addiction

As expectations standardized, all doctors will have to deal with some dissatisfaction; percentiles should remain relatively constant
Opioids fall short in creating patient satisfaction

- Multiple studies have shown that inpatients receiving the most opioids have:
  - Worse satisfaction scores
  - Worse pain scores
  - Longer stays
  - More complications

While there is selection bias, these studies clearly show that opioids are not doing their job.
Developing operative protocols

Pre-emptive analgesia (PEA)

• PEA associated with lower pain, higher satisfaction, shorter LOS, lower costs
• Different surgeries respond differently:
  • [www.postoppain.org](http://www.postoppain.org)
• Among treatment modalities:
  • Gabapentin
  • NSAIDs
  • IV acetaminophen
  • Ketamine
  • Lido/bupivacaine
  • Clonidine
Look closely at postop order sets and ED practices

• Avoid LA opioids
• Avoid IV hydromorphone (Dilaudid), po oxycodone
  • Heroin addicts prefer IV hydromorphone to heroin!
  • Oxycodone the most addictive oral agent
  • If patient addiction-prone, will claim ↑ pain to get more
• Alternatives
  • IV: nalbuphine (Nubain), butorphanol (Stadol), morphine, fentanyl
  • PO: tapentadol (Nucynta), morphine, hydrocodone
  • Remember the Cochrane non-narcotic slide!
Develop a system-wide EMR documentation tool. Example:

1. Has the patient's condition changed significantly since their last visit?
2. Has the patient been compliant with treatments, inc. non-opioid treatments?
3. Has there been any aberrant opioid behavior since the last visit?
4. Is the total opioid dose less than 120 morphine equivalents?
5. Is there reasonable progress toward meeting established functional goals?
6. Was the last drug test consistent with prescribed medications?
   Is another drug test due on this visit?
7. Does the PDMP show the patient is in compliance?
8. Is the patient complying with their signed Opioid Agreement?
9. Based on the above, is the patient still a candidate for chronic opioid therapy?
Identifying Outliers: QA, Compliance

• NOT a witch-hunt.
• All prescribers are presumably well-intentioned, but outliers are misinformed
  • Practicing 1999 medicine in 2016
  • Don’t understand addiction
  • Believe in infinite dose-response
  • Not trained to properly screen
• Identified through EMR prescription reports
• Build proper practices through remedial education
• Monitor response to intervention
• If poor response, consider disciplinary action
Opioid Use Disorder (OUD)

- Current data indicate that the incidence of significant OUD is 0.8%
- Most PCPs have ~2000 patients
- That means every PCP has, on average, 16 patients with OUD severe enough to warrant treatment

- Suboxone training takes 8 hr. online and costs $200
- The maximum roster in 1st year is 30 patients (thereafter 100)
- Legislation pending to allow 100/300 and APP Rx’ers
Addressing Opioid Use Disorder

• Treatment programs desperately needed
  • Suboxone in primary care for mild-moderate cases
  • Inpatient & IOP for severe cases
• Strongly recommend developing/expanding programs
  • Federal and state funds available for assistance
  • System-supported IP/IOP addiction treatment centers
  • Educate, recommend, and incentivize PCPs to become Suboxone providers
Hurdles to PCPs Rx’ing Suboxone

• Belief that *they* don’t have drug-addicted patients
  • Almost certainly not true
• Belief that patients with OUD are very bad patients
  • These are their and their partners’ patients
• Concerns about payment
  • E&M codes just like other patients
• Already over-burdened
  • Understanding the potentially fatal nature of OUD is critical
• Lack of comfort with learning something so absent from their training.
  • Interestingly, the “Chronic Disease Model” applies
Naloxone rescue for OD

- Making naloxone available to opioid users has been shown to ↓↓ OD deaths
- Typically 0.4 mg IM
- WI law allows prescribing practitioners to authorize pharmacists to dispense to their patients/family members and educate on use
- Currently recommended to provide Rx to all patients on chronic opioid therapy
Thank you for your time and attention

• Thank you for attending!
Upcoming Webinars

Drug Diversion from the Health Care Workplace: A Multiple Victim Crime
Presented by: Dr. Keith Berge, Mayo Clinic
Tuesday, April 5 *** 1:00-2:00 pm

Navigating Wisconsin’s Prescription Drug Monitoring Program and Controlled Substances Board
Presented by: Chad Zadrazil, Dept of Safety & Professional Services
Wednesday, April 27 *** 10:00-11:30 am

Visit www.wha.org for more information and to register.
Questions?

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