Fighting the Battle Against Opioid Misuse

EDUCATION, TREATMENT, AND COMMUNITY ACTION

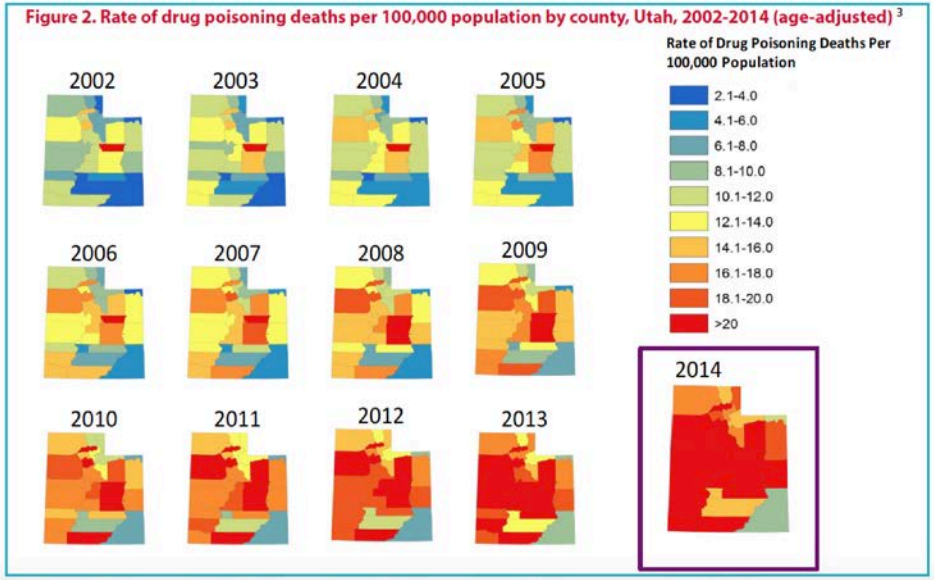
LISA NICHOLS, MSW

KRISTEN REISIG, LCSW

MICHAEL WOODRUFF, MD

The Challenge

Utah is 4th in the nation for prescription opioid overdose deaths



—National Center for Health Statistics

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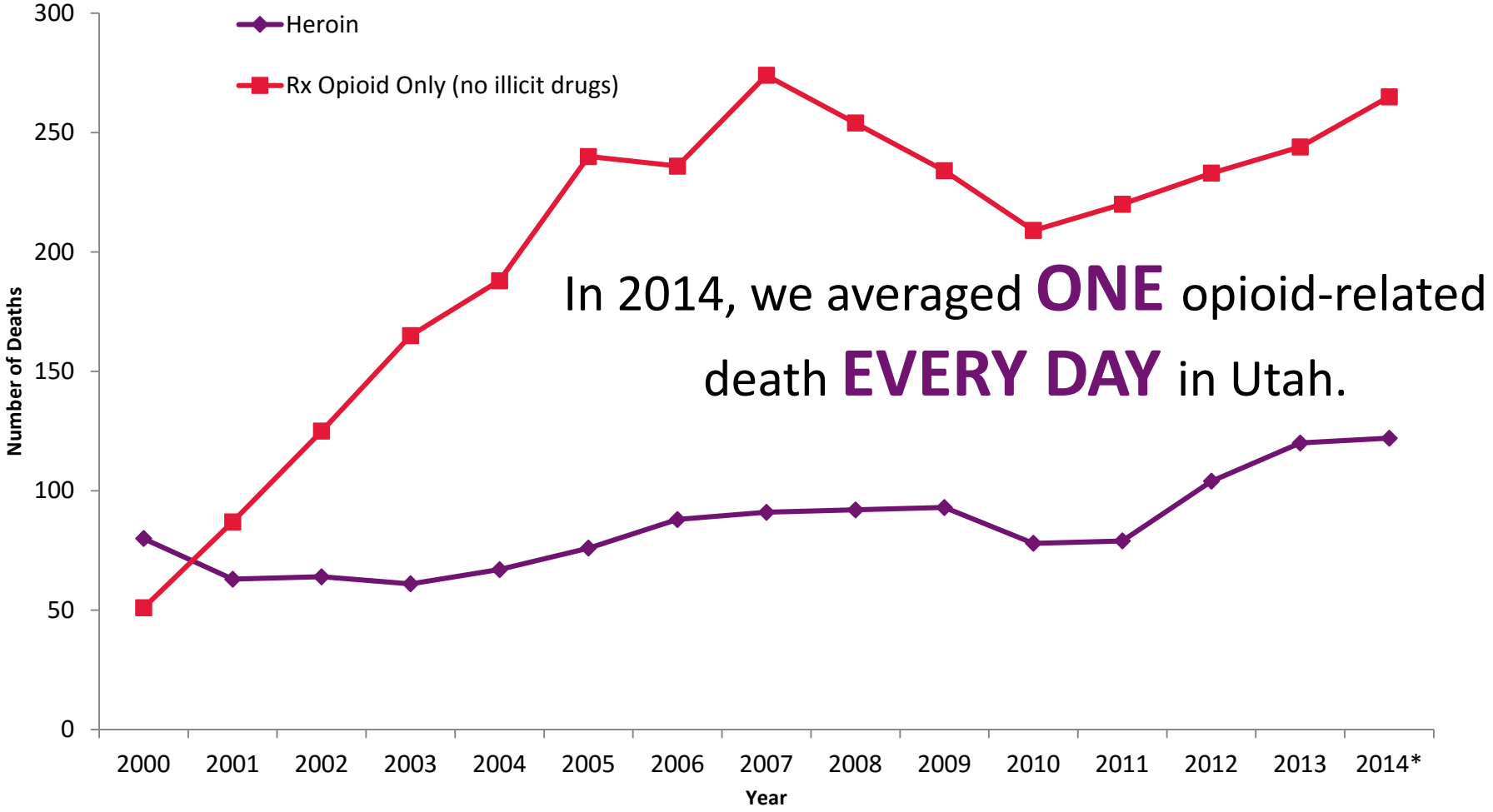
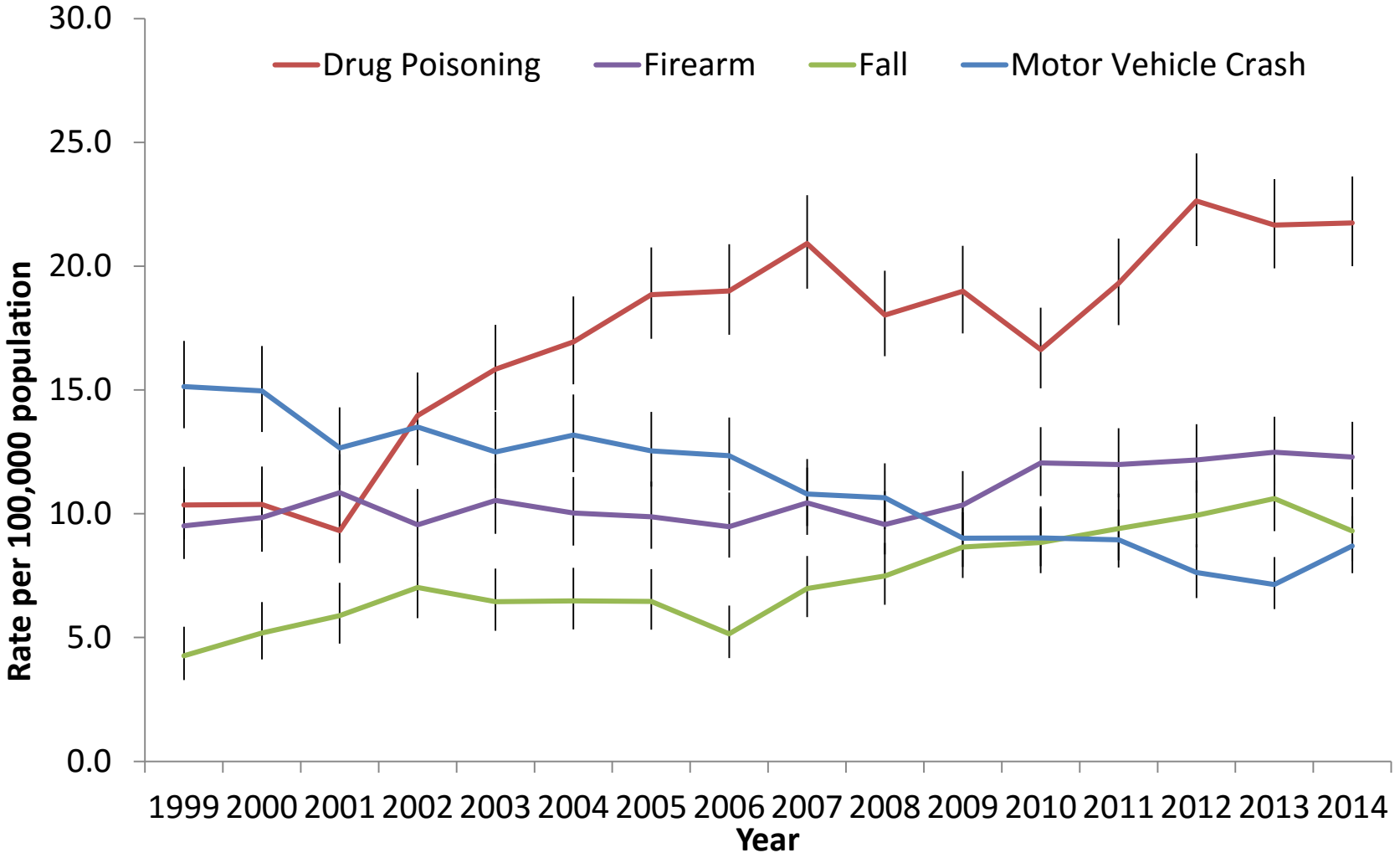
Number of Unintentional and Undetermined Opioid Deaths by Select Categories, Utah 2000-2014

UTAH DEPARTMENT OF HEALTH



*2014 data is preliminary. Data Source: Utah Violent Death Reporting System

Rate of leading causes of injury deaths by year, Utah 2000-2014

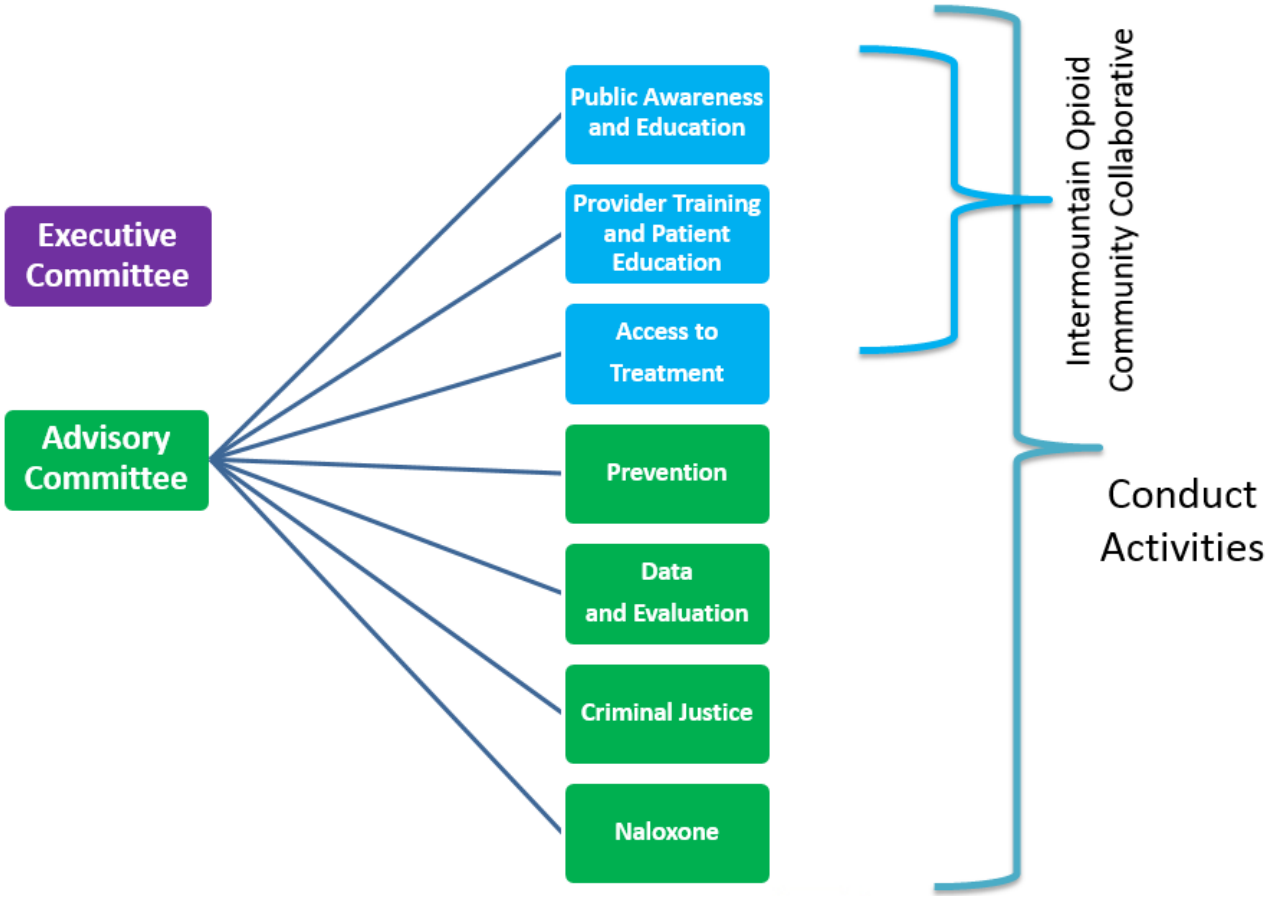


Drug poisoning is the **leading cause** of injury deaths in Utah

The Opioid Community Collaborative

The charter of the OCC is to plan and implement strategies to decrease the burden of pharmaceutical drug, misuse, abuse and overdose in the state of Utah, addressing public awareness, provider education, and access to treatment.

Utah Coalition for Opioid Overdose Prevention



Partners

- Commission on Criminal and Juvenile Justice
- Davis Behavioral Health
- Division of Substance Abuse and Mental Health
- Intermountain Healthcare
- Salt Lake Police Department
- SelectHealth
- University of Utah, Poison Control Center
- Use Only As Directed
- Utah Department of Health, Injury Prevention
- Weber Human Services

Intermountain Healthcare Support

- Contributing to Leadership
  - Intermountain staff co-chair each of the committees a community partner
  - Host meetings
- Financial Support
  - $3.5 million dollars over the course of three years to support public awareness messaging and treatment
- Training
  - Offering training to other organizations regarding prescribing practices and medication assisted treatment

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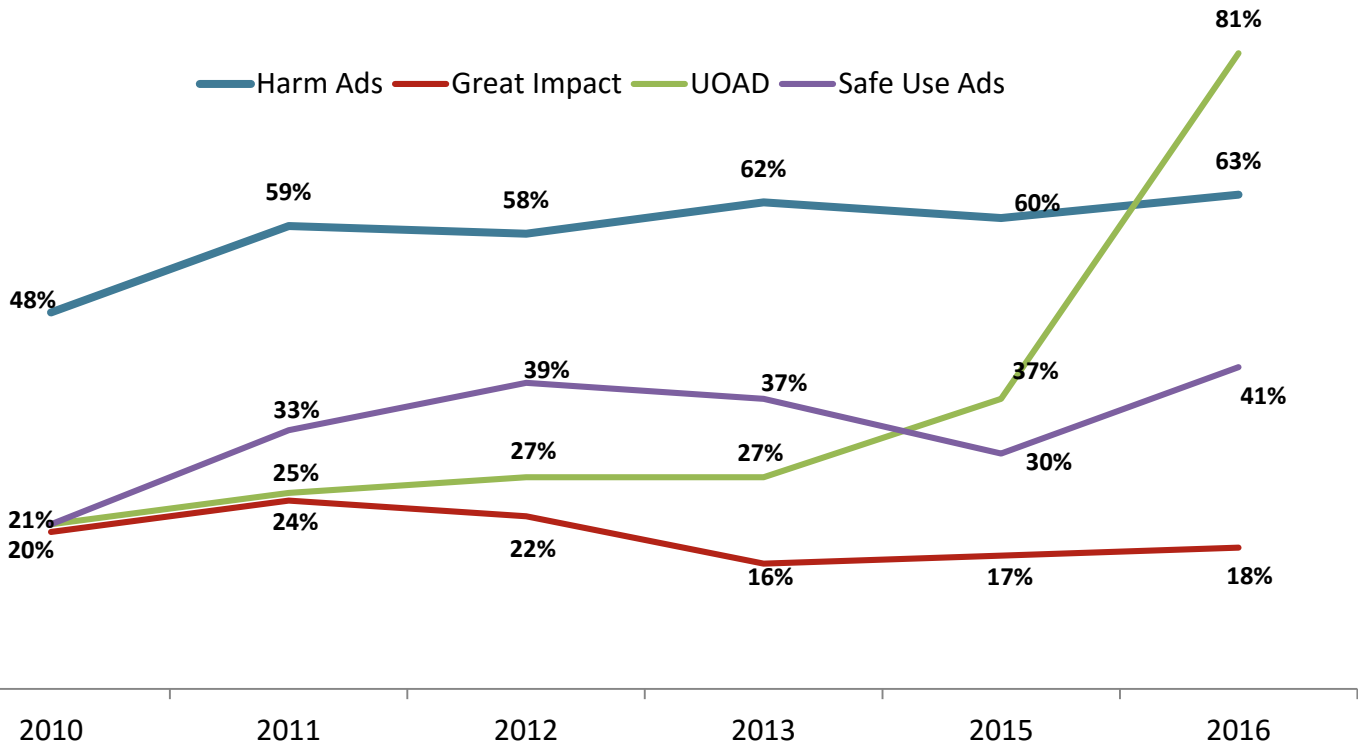
Public Awareness

Public awareness messaging around the safe use, storage, and disposal of prescription medications.

- Increase the percentage of people who believe that prescription opioids have “definite” potential for abuse or addiction
- Increase the percentage of people exposed to ads on the safe use, storage and disposal of prescription medications
- Increase the volume of medications disposed of in pharmacy drop boxes

Exposure to Use Only As Directed Messaging

The percentage of individuals who report some exposure to a UOAD message rose from 20 percent in 2010 to 81 percent in 2016.



USE ONLY AS DIRECTED

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Consumer Feedback from Focus Groups

- Consumers want to see flexibility in prescription messages that are specific to their needs, not just generalized statements
- Prescription labels can feel conflicting "…every six hours as needed…". Is that every six hours or when I'm in pain?
- Clearly state if prescription is known to be addictive
- Instructions should make it clear if the med should be consumed in its entirety (like antibiotics) or is discretionary
- Participants would appreciate simple, concise information about dangers, when and where to dispose of unused meds, and how or where to get help for misuse
- Some suggested warning labels similar to cigarettes or messages inside doctor offices with CDC guidelines

Comments taken from participants in a focus group held by Dan Jones and Associates.

Public Awareness

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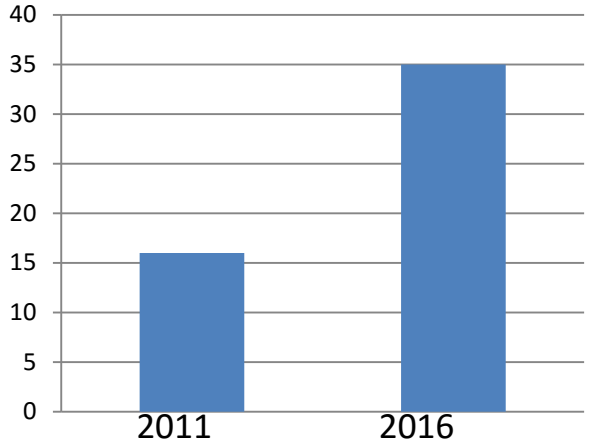
Prescription Drop Boxes

- 21 Intermountain community pharmacies have installed medsafe receptacles
- 8,348 pounds of medication have been disposed of
- Financial support for community drop boxes will be available in 2017



35% of individuals surveyed in 2016 used drop boxes as compared to 16% in 2011

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UNITED STATES SURGEON GENERAL
Vivek H. Murthy, M.D., M.B.A.

August 2016

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly two million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. **Please take the pledge at www.TurnTheTideRx.org.** Together, we will build a national movement of clinicians to do three things.

First, we will educate ourselves to treat pain safely and effectively. A good place to start is the enclosed pocket card with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Provider Education

Over 1,500 physicians have participated in continuing medical education regarding opioid prescribing

- We have raised awareness of the consequences of overprescribing
- We have provided encouragement and permission to prescribe less
- We have provided training on alternatives to prescribing opioids including over-the-counter medications and lifestyle changes

- Guidelines under development for acute pain:
  - Avoid prescribing more than 3 days or 20 pills (more than 7 days will rarely be needed)
  - Low-dose, immediate release, short acting
  - Never prescribe long-acting/extended release
  - Avoid prescribing opioid doses >50mg morphine equivalent/day

Provider Education — Care Process Models

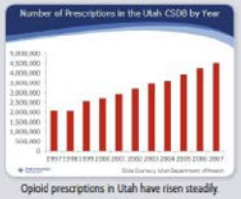
ASSESSMENT AND MANAGEMENT OF

Opioid Use in Pregnancy

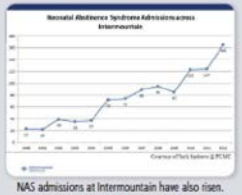
This care process model (CPM) was developed by the Neonatal Abstinence Syndrome (NAS) work group, a subgroup of the Women and Newborns Clinical Program at Intermountain Healthcare. Recommendations are based on national guidelines and regional standards of care. The CPM is intended to provide guidance and resources to help obstetric providers identify and manage opioid use in their patients. It outlines a practical approach that is appropriate for most patients, but should be adapted to meet the needs of individual patients.

Why Focus ON OPIOIDS IN PREGNANCY?

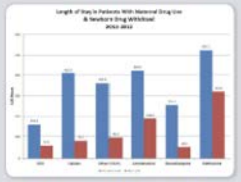
- **The rate of opioid use — and abuse — is high and rising.** The escalating use and abuse of opioids in the U.S. parallels a 300% increase since 1999 in the sale of these strong painkillers. These drugs were involved in 14,800 overdose deaths in 2008, more than cocaine and heroin combined. In 2010, the national Centers for Disease Control and Prevention characterized the problem as "a growing, deadly epidemic."
- **Opioid use may be particularly problematic for women.** Some experts believe that women become dependent on prescription pain medication more quickly than men. This is especially concerning given studies showing that, compared to men, women are more likely to have chronic pain, are more likely to be given prescription pain medication, are given higher doses, and use prescription pain medication for longer periods of time.
- **Utah is a hot spot for opioid use and abuse.** In 2008, Utah's age-adjusted overdose death rate was 18.4 per 100,000; Idaho's rate for the same year was about half that, 9.7. Between 1999 and 2007, Utah deaths attributed to poisoning by prescription pain medications increased by over 500%; the Utah Department of Health reports that "the increase was mostly due to increased numbers of deaths from prescription opioid pain medications, including methadone, oxycodone, hydrocodone, and fentanyl."
- **Data show a significant impact on the mothers and babies we care for.** In the U.S., nearly 90% of drug-abusing women are of reproductive age. Between 2000 and 2007, more than 41% of Utah women on Medicaid filled a prescription for opioids during their pregnancies. As opioid use has grown nationally and locally, Intermountain data suggest that chronic use of opioids among pregnant women has resulted in an increased length of stay (LOS) for newborns. The long-term effects of opioid exposure on the developing fetus are not well understood.



Opioid prescriptions in Utah have risen steadily.

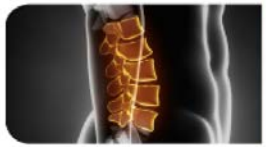


NAS admissions at Intermountain have also risen.



Drug use increases LOS for mother and infant.

GOALS AND MEASUREMENT



DIAGNOSIS AND TREATMENT OF

Low Back Pain in the ED

This care process model (CPM), created by Intermountain Healthcare's Pain Management Service, provides guid treatment of low back pain in the emergency department. **This document presents an evidence-based approach tha patients; it should be adapted to meet the needs of individual patients and situations and should not replace clinica**

Patient presents with low back pain

EVALUATION: Patient history **(a)** and physical exam **(b)**

Red flags? **(c)** — yes → Evaluate for serious pathology, refer as needed **(c)**

no

True lower motor weakness? — yes → Consider imaging and emergent surgical or neurological consultation **(c)**

no

Lumbar radiculopathy (sciatica)? — yes → Consider nonsurgical back specialist referral

no

Radiculopathy (spinal nerve root dysfunction) is rare even with leg pain. Signs include muscle weakness or pain in the distribution of the nerve root (often below the knee), sensory disturbances, and positive dural tension signs.

TREATMENT

- **Education and reassurance.** Cover the points below. (Intermountain's Patient Fact Sheet *Low Back Pain* in English or Spanish supports these points.)
  - A history and physical didn't show anything dangerous. **Imaging tests are NOT needed right now.**
  - You're likely to recover in a few weeks. Staying active will help you recover.
- **Activity.** *See notes on page 2 about recommended physical activity.*
- **Medication.** (Can use Controlled Substance Sheet to explain why opioids not prescribed.)
  - **1st line:** Acetaminophen or NSAIDs, if not contraindicated.
  - **2nd line:** Muscle relaxants, 7 days max (not in elderly).
  - **3rd line:** Short-acting opioids 2-3 days max (no better outcomes than NSAIDs). Check DOPL Database and check for medication agreement before prescribing.
- **Follow-up.** Follow-up **primary care** appointment and consider referral for **physical therapy.**

ALGORITHM NO

(a) Patient history:

- Description of onset, how pai
- Previous back
- Systemic disea infection, etc.)
- Neurological, b

Note: Subacute (>
back pain require
previous history a
suggested approa
previously diagno

(b) Physical exam:

- Motor weakne
- Sensory deficit
- Consider rectal
- Dural tension (
prone femoral
- Upper motor n
- Localized spina
- Hip examinatio

Note: If exam sho
neurologic deficits
and other appropr

(c) See TABLE 1 bel
pathology and su

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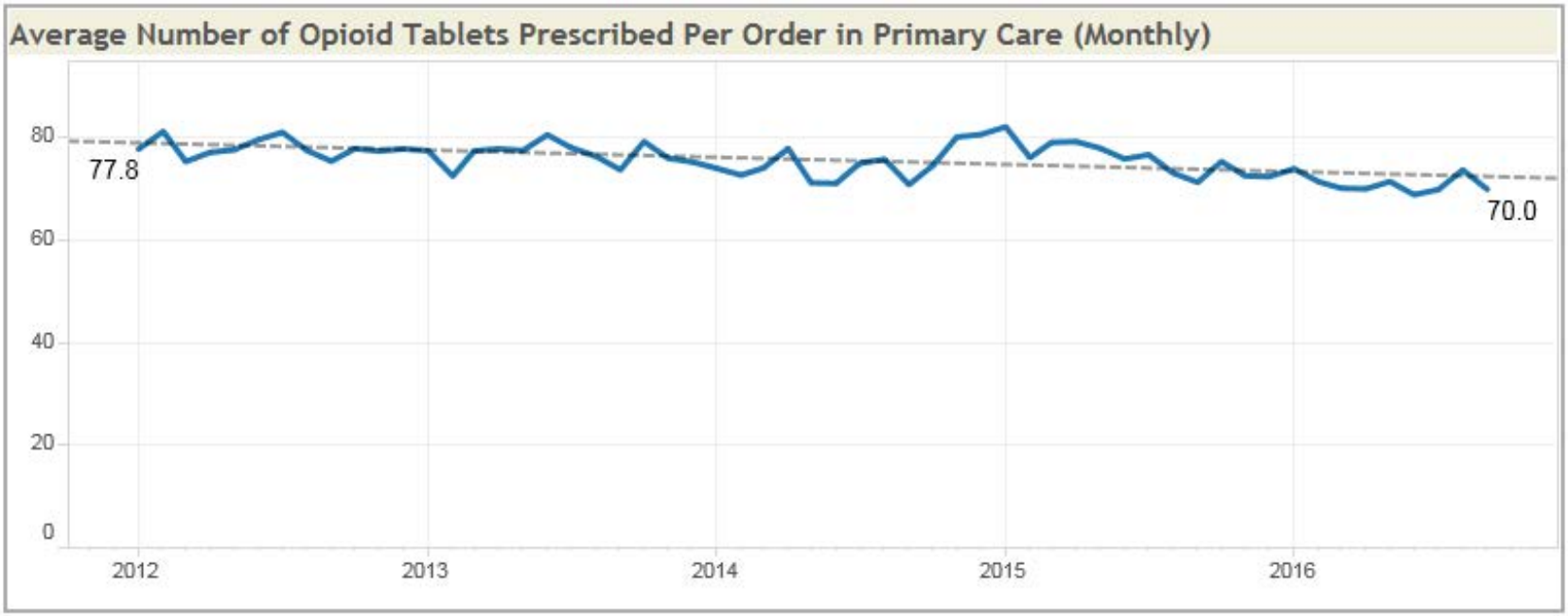
Primary Care



Since 2012 the average number of opioid tablets prescribed per order in Primary Care has **decreased 10%**.

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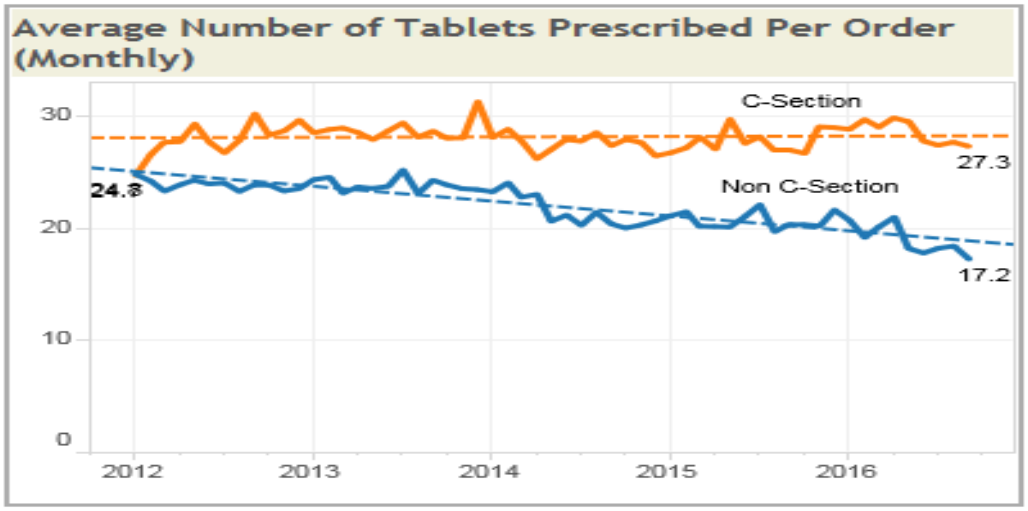
Women and Newborn



The average number of tablets prescribed per order has decreased for pregnant women without c-sections by 30 percent.

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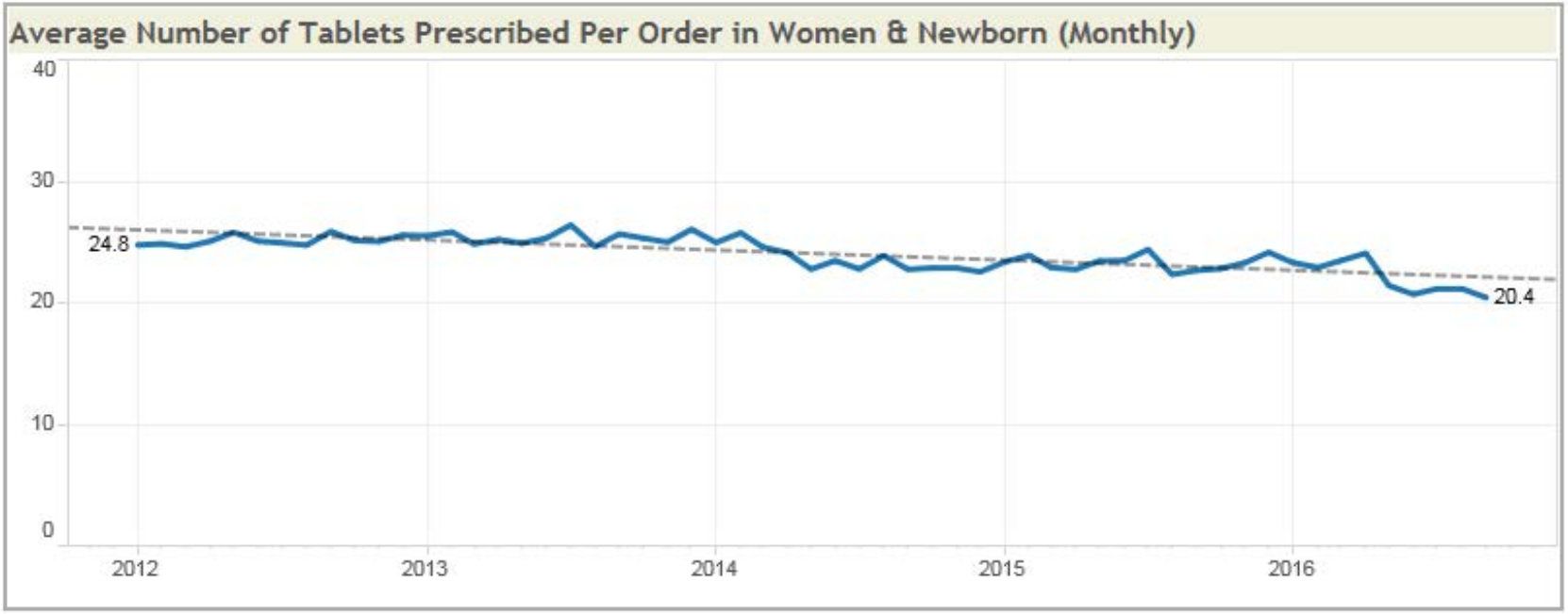
Women and Newborn



The average number of tablets prescribed per order for pregnant women has decreased by 18 percent.

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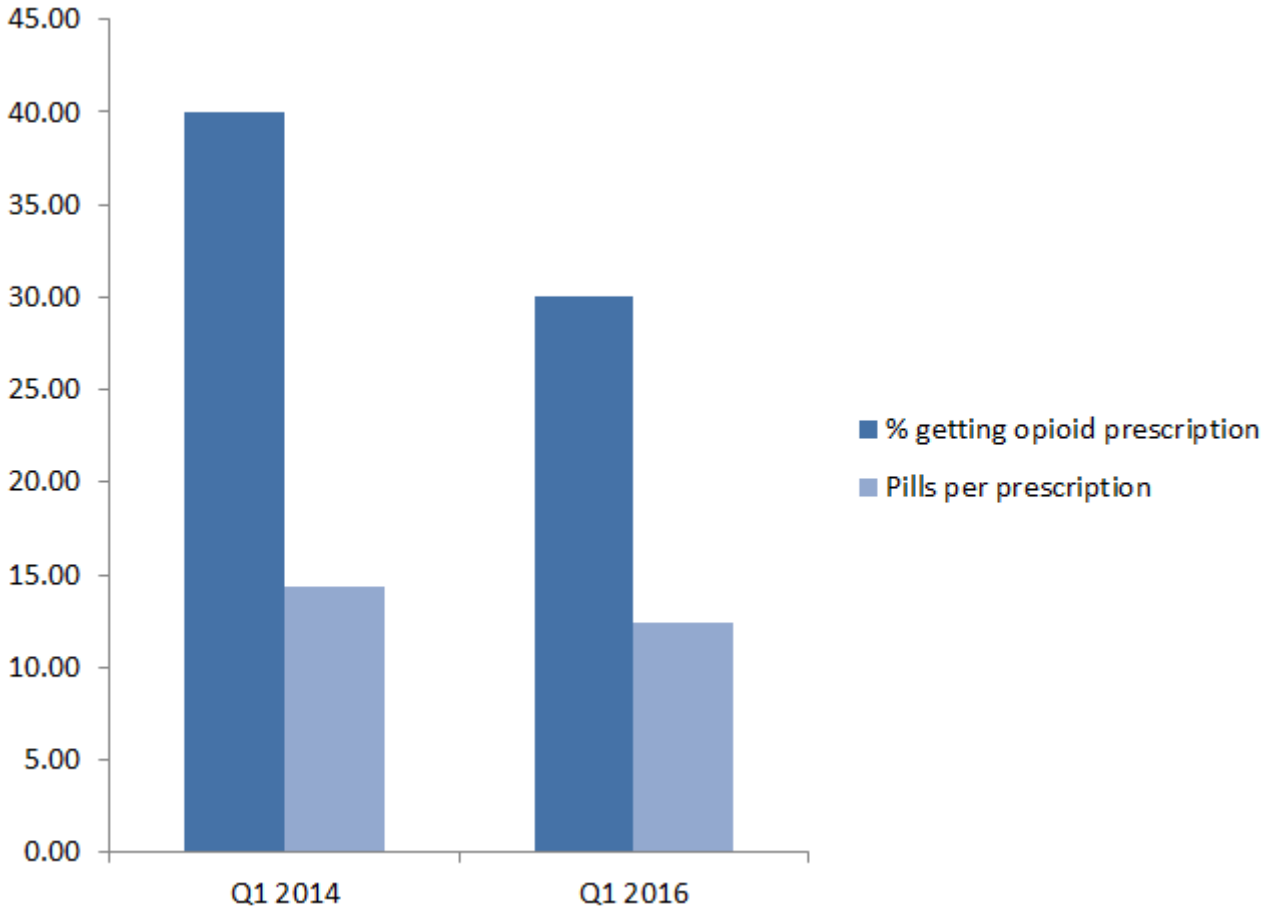
Intermountain Medical Center Emergency Department Ankle Sprain Patients



Mclellan, A. Thomas. "Have We Evaluated Addiction Treatment Correctly? Implications from a Chronic Care Perspective." *Addiction* 97.3 (2002): 249-52. Print.

Intermountain Emergency Physician Quotes

Physicians interviewed were **unanimous** that their prescribing practices had changed in recent years.

- "I don't give as many pills anymore. My standard prescription has gone from 20 to 10 to 6."
- "What I recognize more now is that children and adolescents don't need narcotics, even for fractures. I feel more comfortable telling their parents that they will be fine with ibuprofen and tylenol."
- "I feel more supported in saying no to patients who are asking for opioid medications."
- "What we need is more resources for substance abuse treatment."

Addiction & Other Chronic Illness

	Addiction	Asthma	Hypertension	Diabetes Type I	Diabetes Type II
Heritability	0.34 (heroin)	0.36-0.70	0.25-0.50	0.30-0.55	0.80
Behavioral Component	trying drug		salt sensitivity/ weight/exercise	diet	diet/weight/ Exercise
Relapsed/yr	40-60%	50-70%	50-70%	30-50%	

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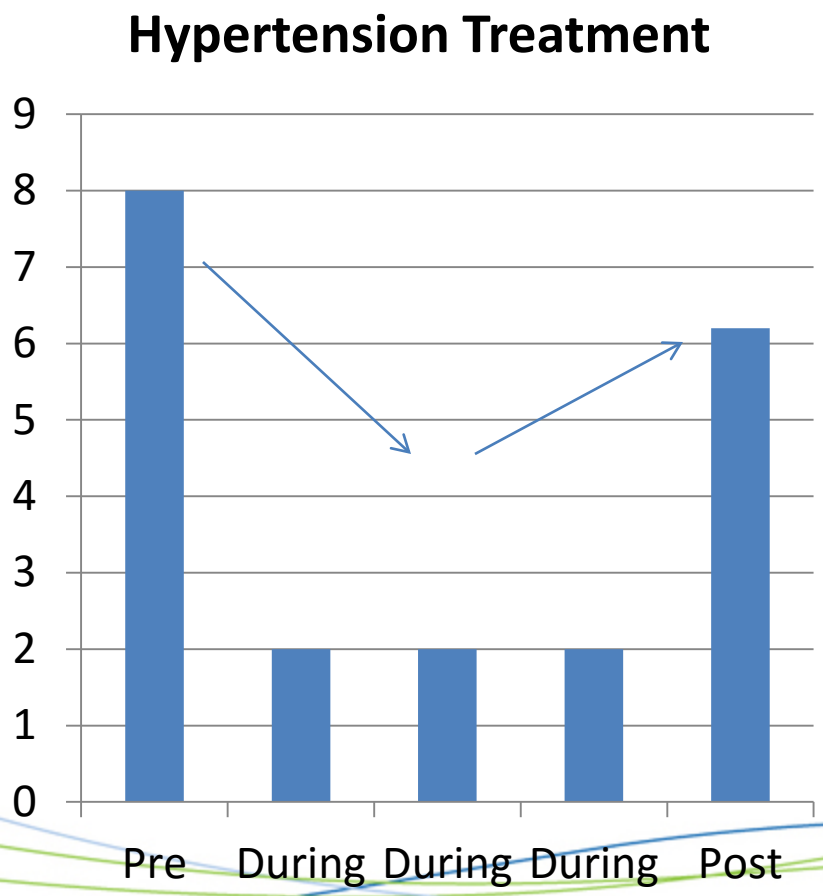
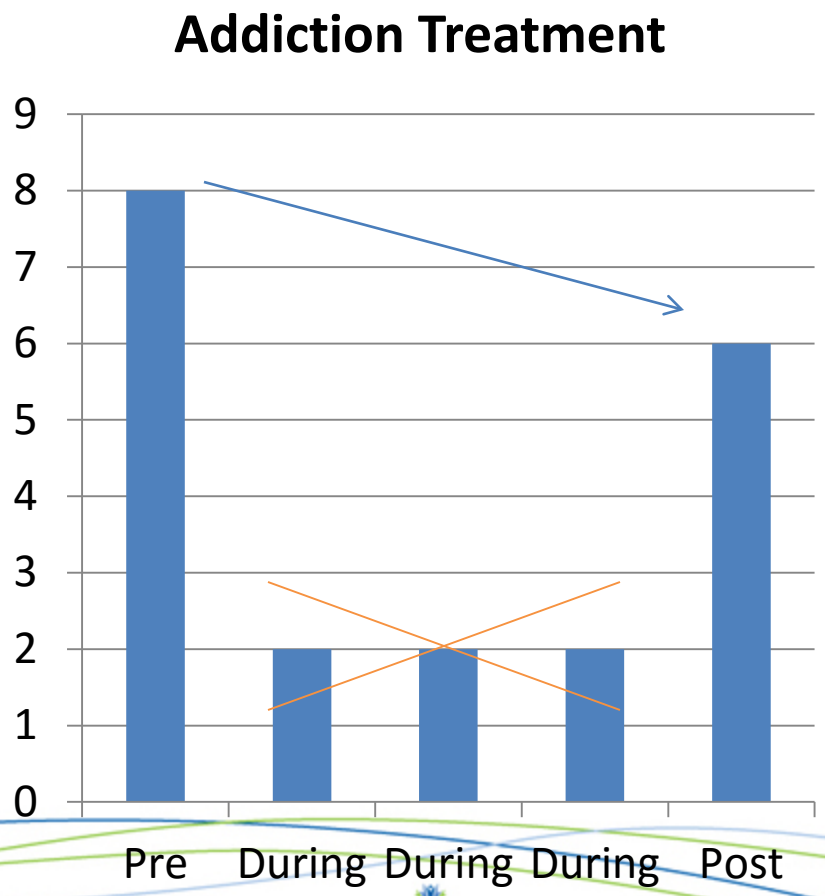
Mclellan, A. Thomas, et al. "Drug Dependence, a Chronic Medical Illness." *Jama* 284.13 (2000): 1689-695. Print.

Evaluation of a Hypothetical Treatment





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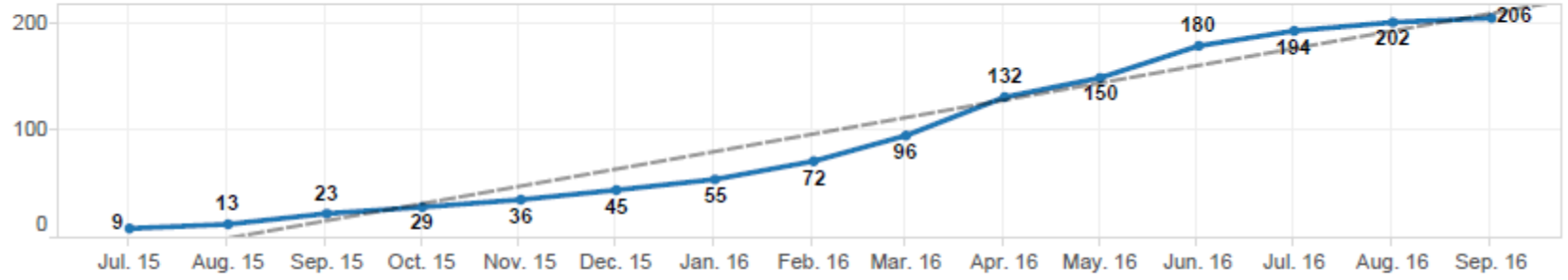
Access to Treatment

Patients Trend

Overall Growth



Monthly Admissions

Clinic	Jul. 15	Aug. 15	Sep. 15	Oct. 15	Nov. 15	Dec. 15	Jan. 16	Feb. 16	Mar. 16	Apr. 16	May. 16	Jun. 16	Jul. 16	Aug. 16	Sep. 16	Total
DBH	3	4	7	3	6	8	8	11	17	10	10	18	14	8	4	131
WHS	6		3	3	1	1	2	6	7	26	8	12				75

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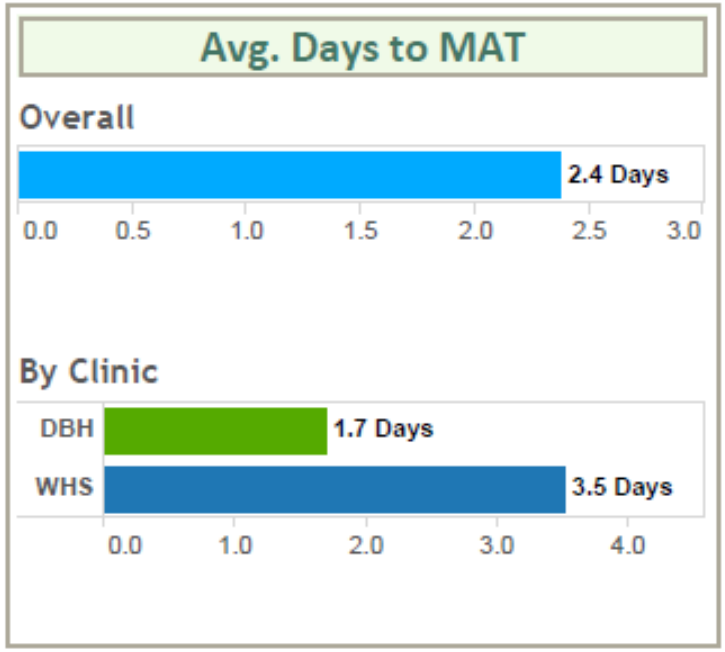
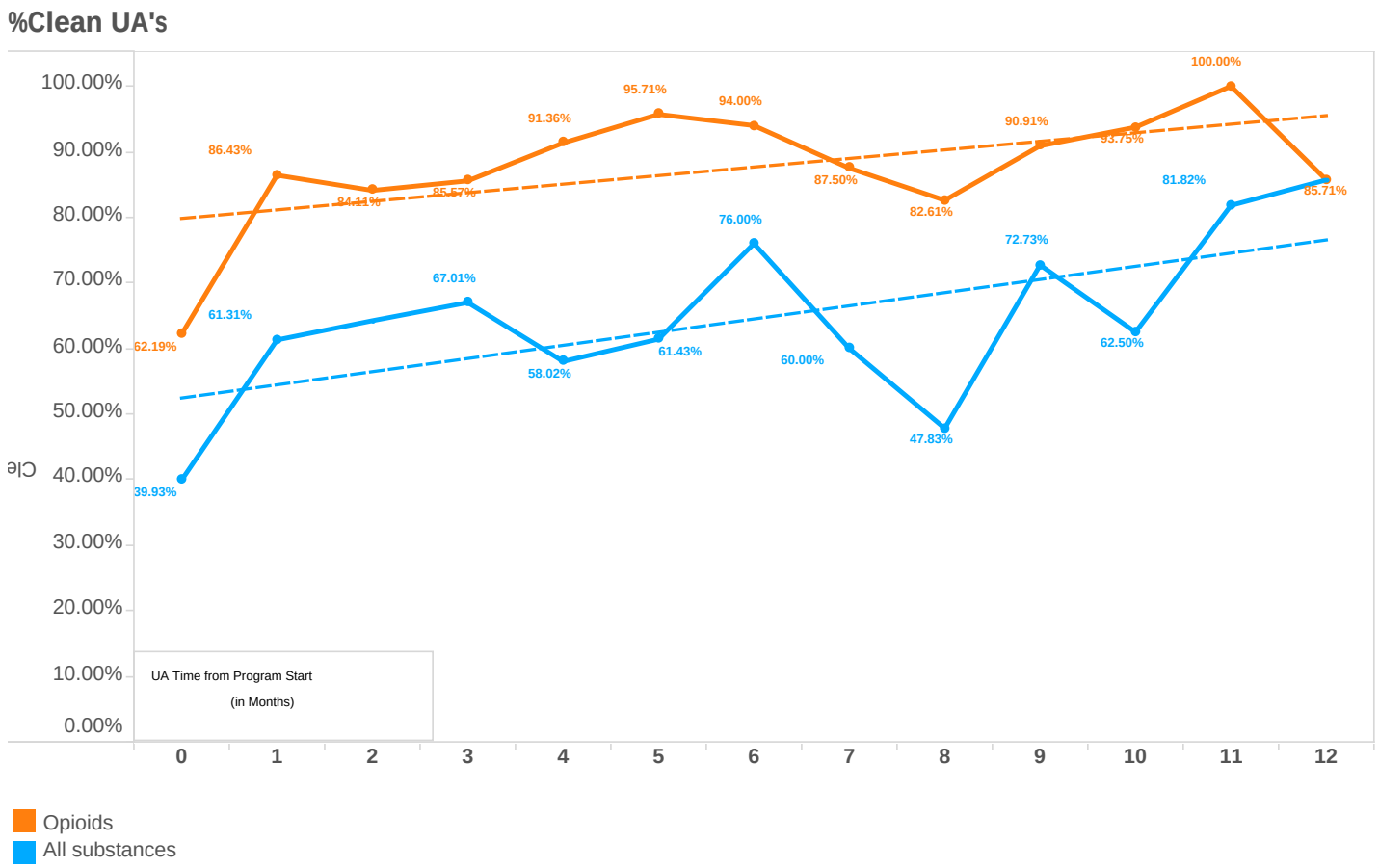
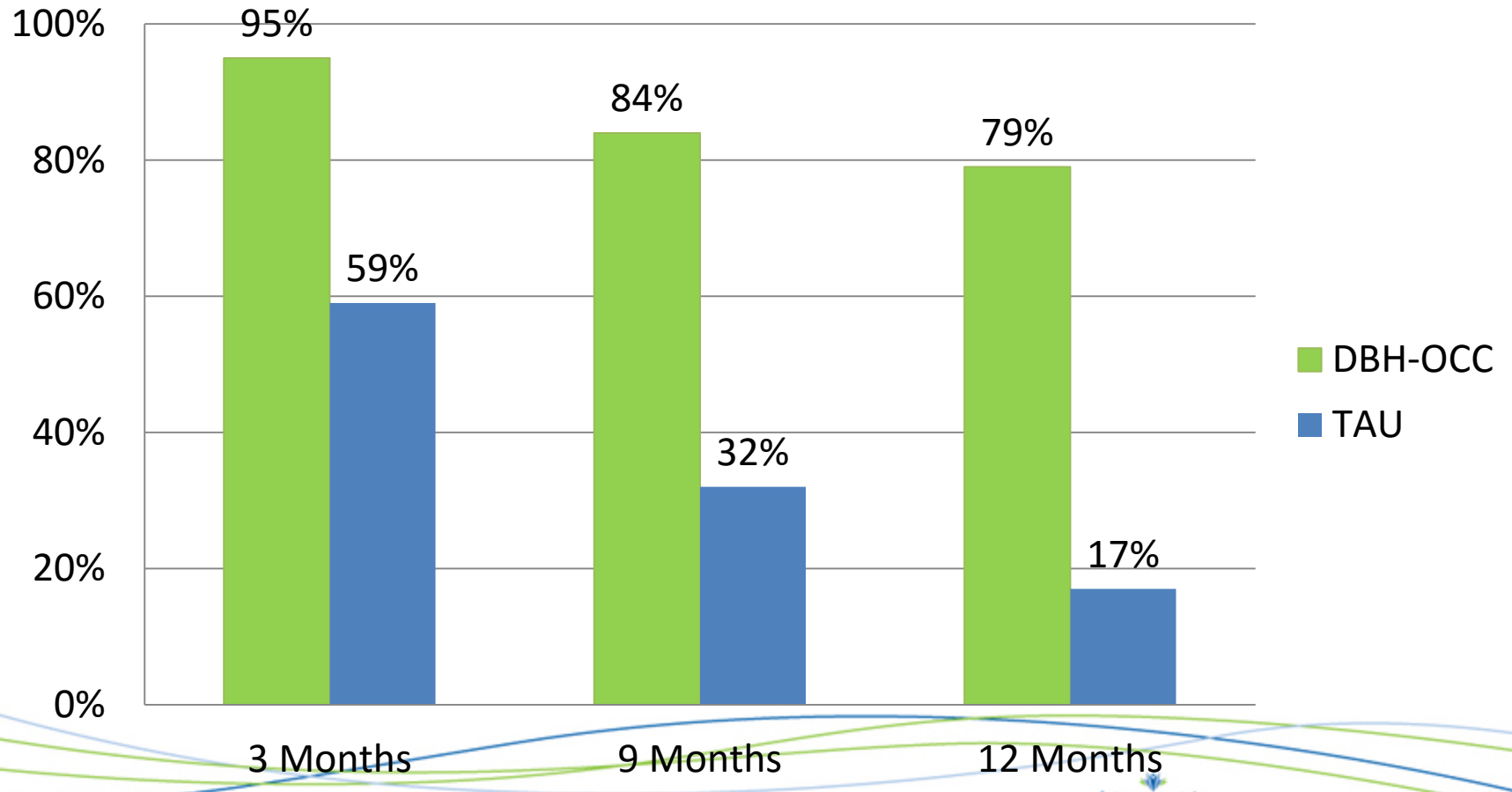
Access to Treatment



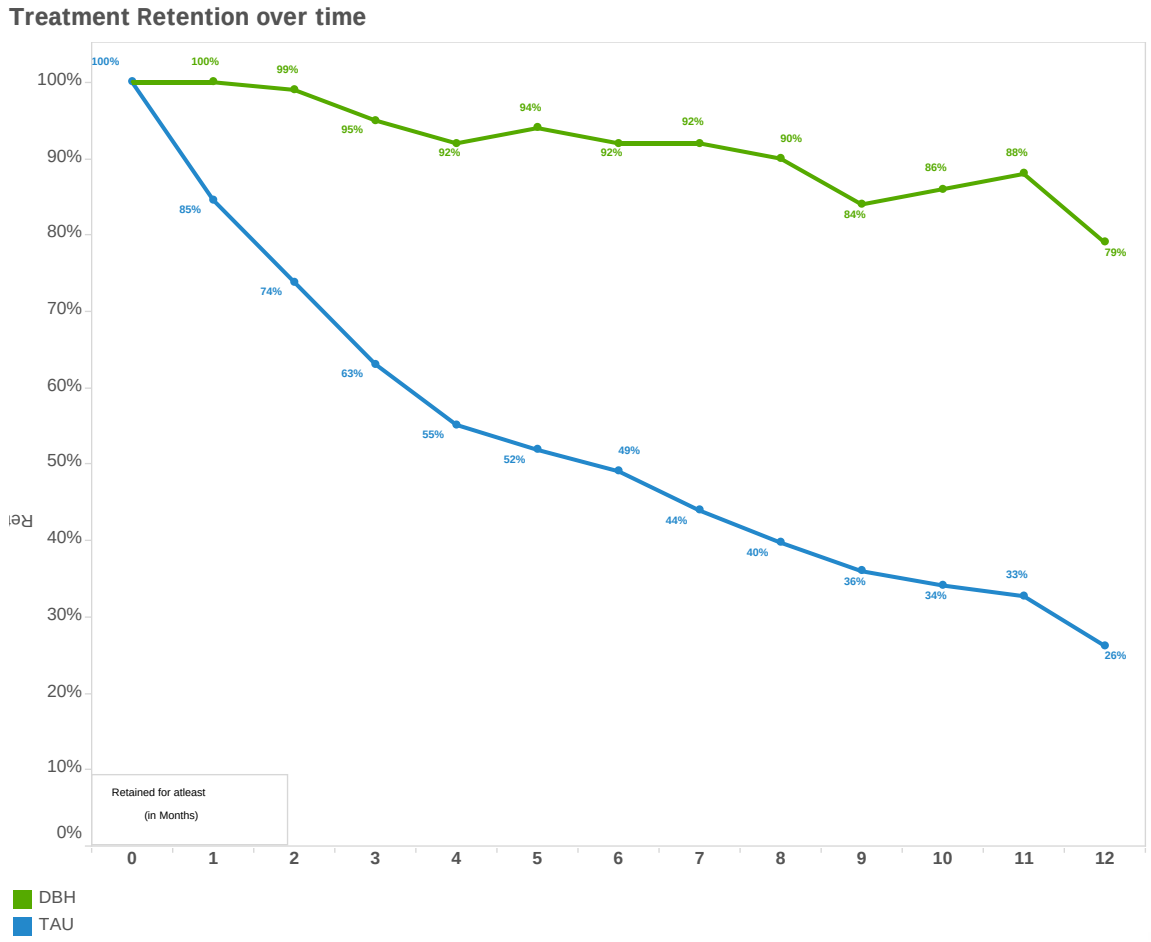
Abstinence Rates



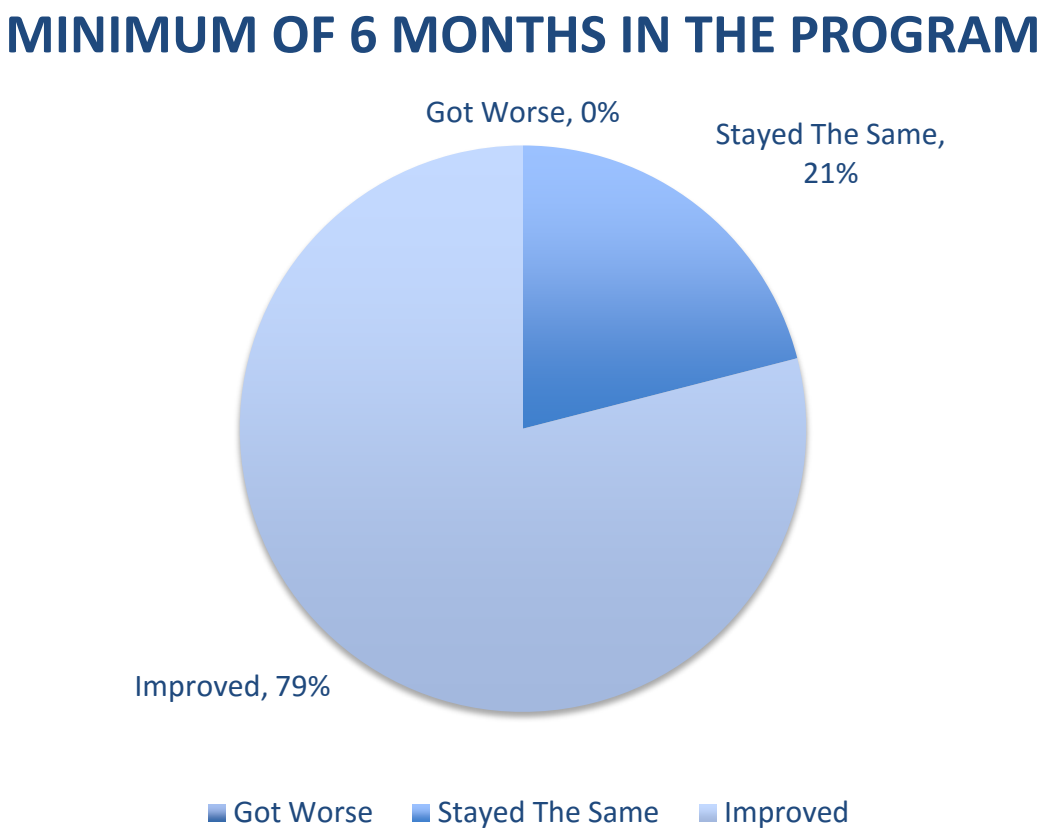
Treatment Retention



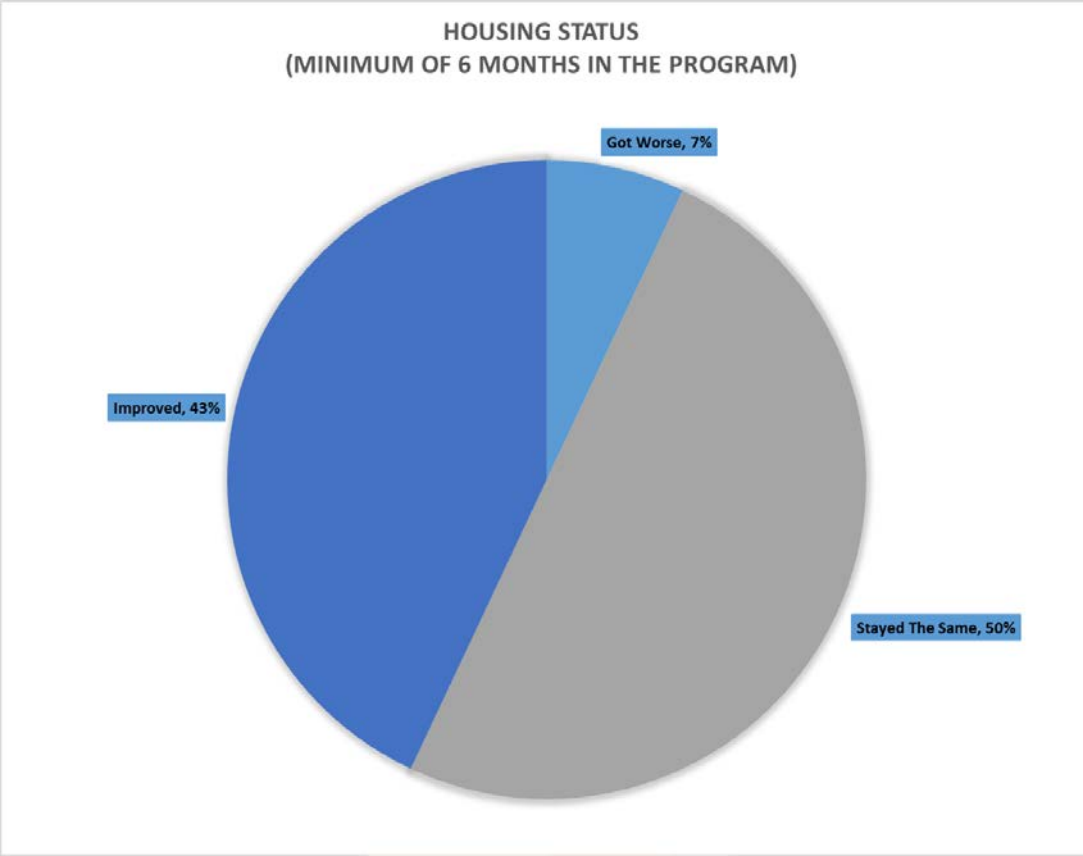
Treatment Retention



Outcomes - Employment Status

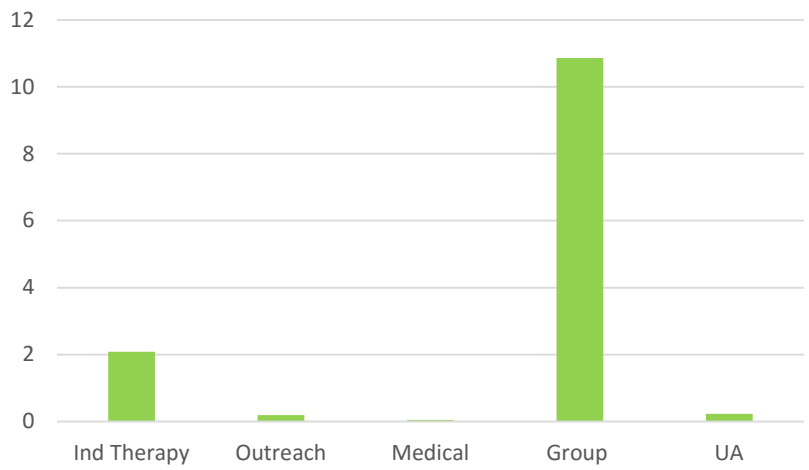


Outcomes - Housing

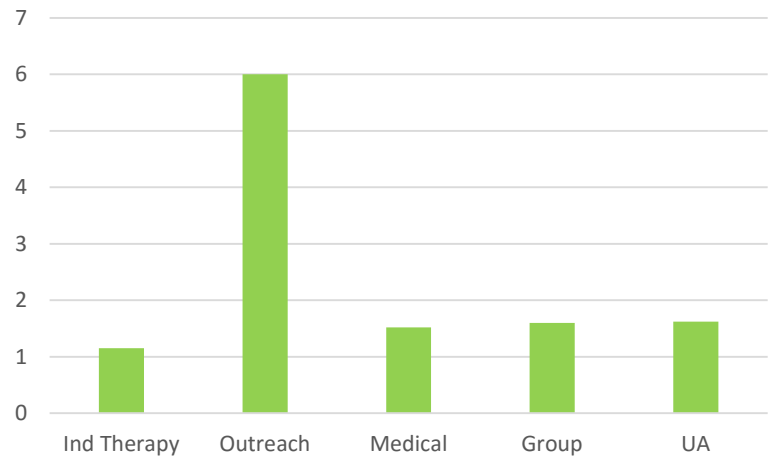


Typical Monthly Services

TREATMENT AS USUAL



OPIOID COMMUNITY COLLABORATIVE



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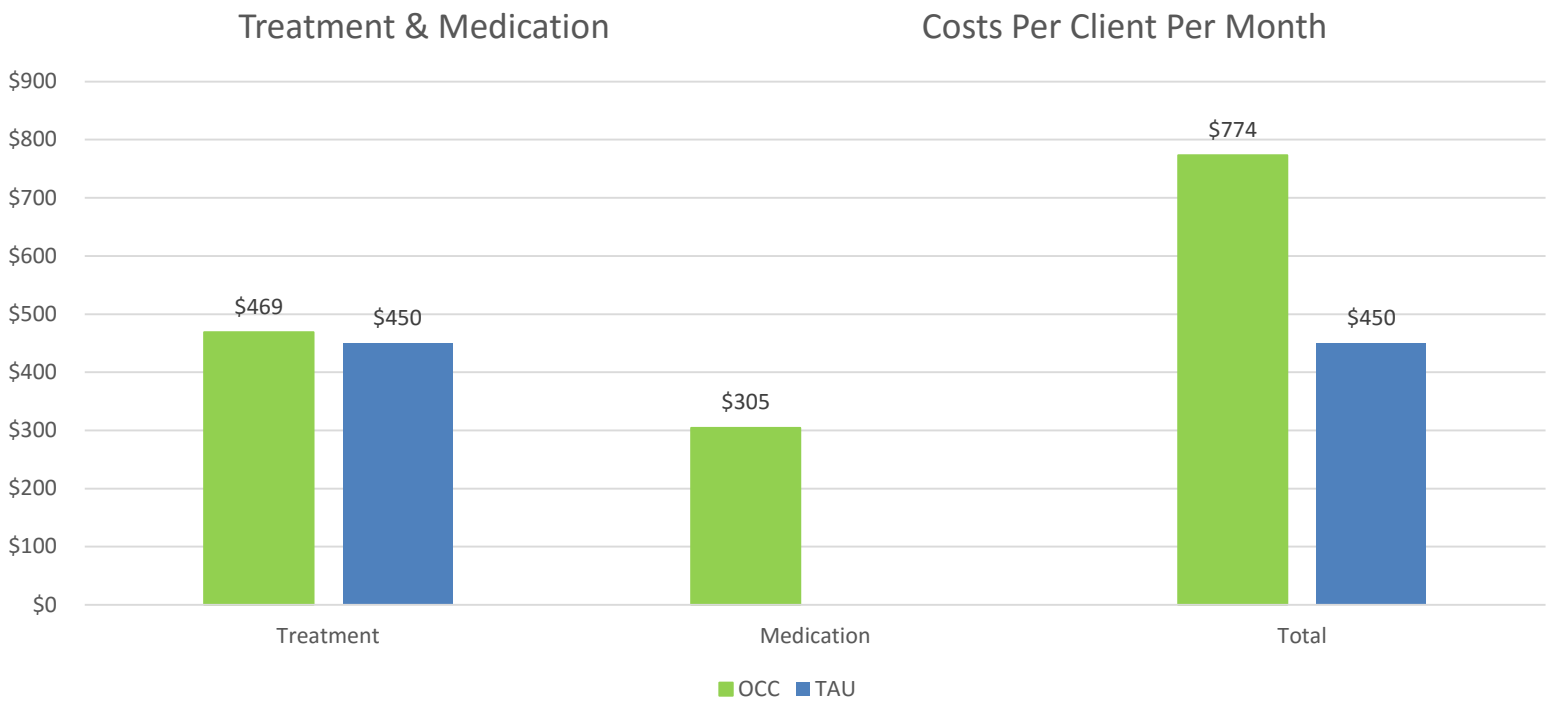
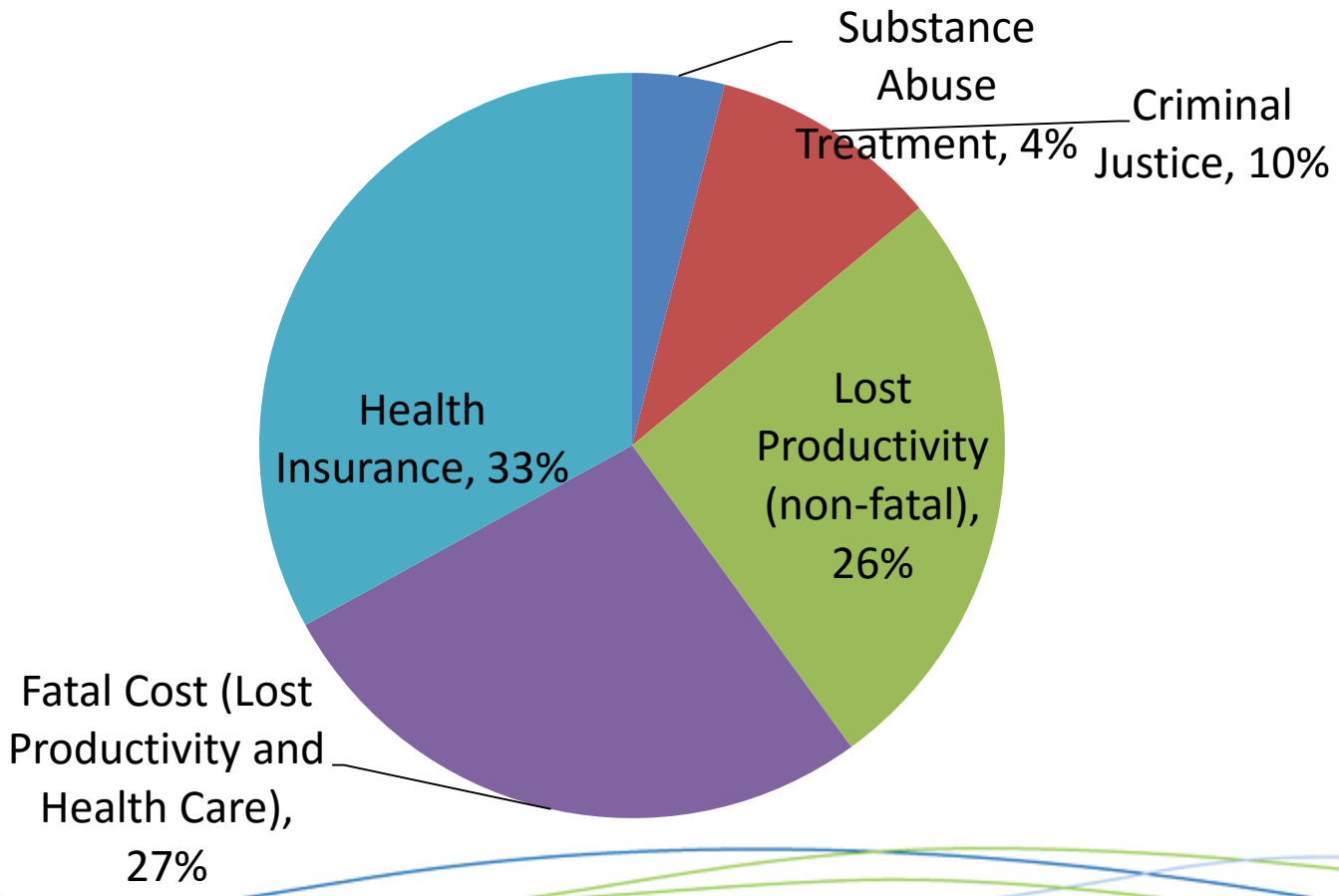
The Costs


Treatment & Medication
Costs Per Client Per Month
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
$469
$450
$305
$774
$450
Treatment
Medication
Total
OCC
TAU

The Costs

	Annual Program Costs	Annual Per Client Costs	Client Count
Medication	$255,853	$3,655	70
Treatment	$568,428	$5,628	101
Total	$824,281	$9,283	

Economic Burden - $78.5 Billion



Florence, Curtis S. et al. "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013." *Medical Care* 54.10 (2016): 901-06. Print.

Requested Support

- Support expanded access to medication assisted treatment
  - Expansion of this demonstration project to additional geographies
  - Expansion of the provision of medication assisted treatment within the public substance use and mental health system
- Financial support for public messaging similar to the anti-antibiotics campaign
- Continued legislative and financial support for the distribution of Naloxone rescue kits
- Discontinue or streamline Medicaid preauthorization for the initial dosing for medication assisted treatment
- Changes in Medicaid policy to support lifetime maintenance dosing on Suboxone

Thank you!
Questions?