



Dying To Ease The Pain WA State Experience with Opiate Overdoses

WA State Attorney General Summit June 15th, 2017

Stephen H. Anderson MD, FACEP



Stephen H. Anderson MD

Practicing ED Physician

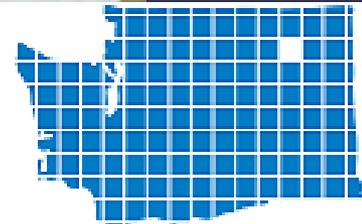
MultiCare Auburn Med Center - 30 years

Past WA State ACEP Chapter President

Co-Author WA State 7 Best Practices

National ACEP Board of Directors 2014-16

No Conflicts of Interest



American College of
Emergency Physicians
WASHINGTON CHAPTER
ADVANCING EMERGENCY CARE

Timely?

— Atlanta, GA • March 28-31, 2016 —
NATIONAL
Rx DRUG ABUSE & HEROIN
SUMMIT

PARTNERS



OPERATION
UNITE



More Timely?

- Surgeon General Issues Landmark Report on Alcohol, Drugs and Health Nov. 2016

One in seven people in the U.S. is expected to develop a substance use disorder at some point in their lives. Yet only 1 in 10 receives treatment.

Objectives



- Trace the history of opium, pain & products in America
- Review the pharmacology & presentation of overdoses
- Examine the real time problem in US 2007-2017
- Solutions with success to decreasing the pill count on the street
- Successes of rehabilitation & the role of pain clinics
- Ownership of problem by Big Pharma
- Getting past “thinning the herd” & the role of Naloxone, Buprenorphine & Naltrexone
- ALTO Programs

Historical Opium



- First used Medicinally in the Stone Age
- Sumerian, Assyrian, Egyptian, Indian, Minoan, Greek, Roman, Persian, & Arab Empires all report medicinal use.
- Fifteenth Century China first reported recreational use
- Opium Wars in 1839 & 1858
- International Opium Commission of 1914, followed by the International Narcotics Control Board
- DEA

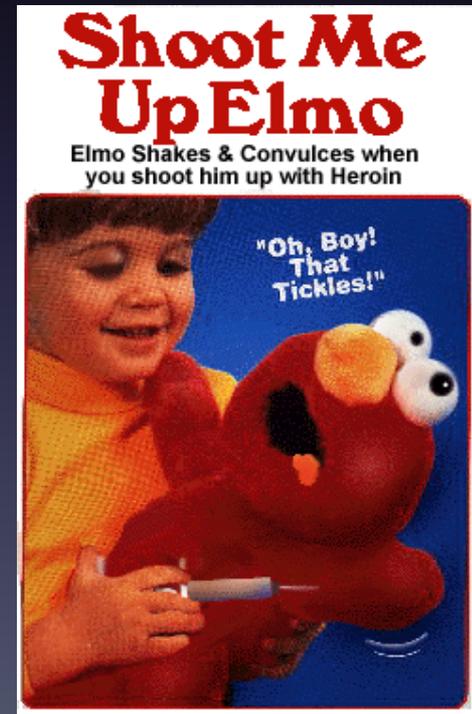
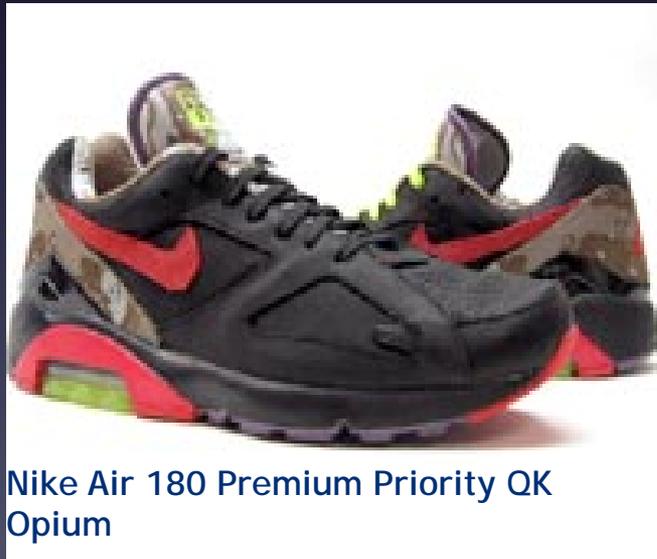
Historical Opiates

- 1804 Friedrich Serturmer isolated Morphine
- Morphine first marketed by Heinrich Merck
- Codeine isolated in 1832
- Heroin synthesized in 1874 by the Bayer Pharmaceutical Company
- 2010-16 #1 Drug written for in US:
 - Hydrocodone (combined with acetaminophen) –

131.2 million prescriptions in 2010

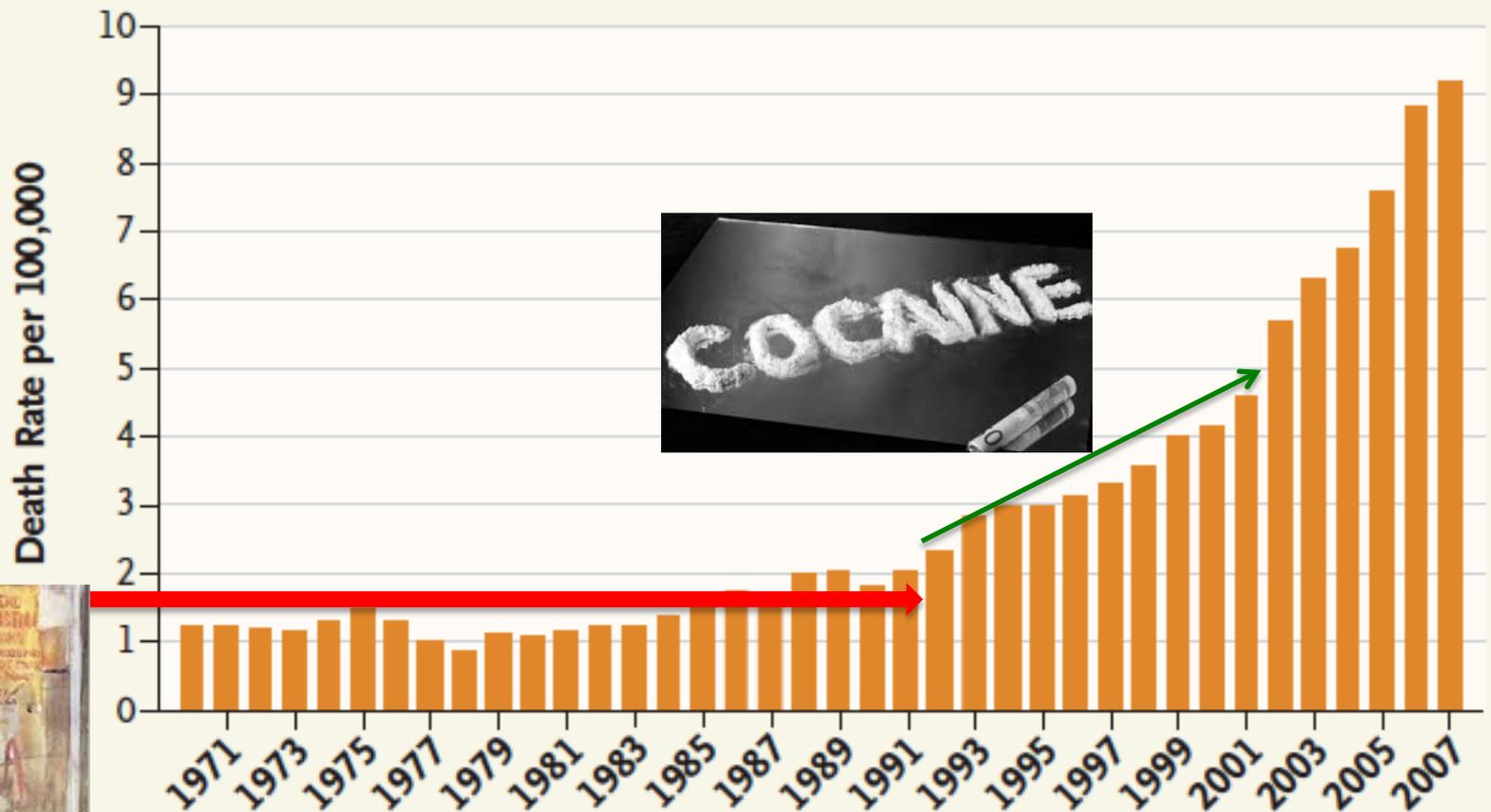


Opium in Society



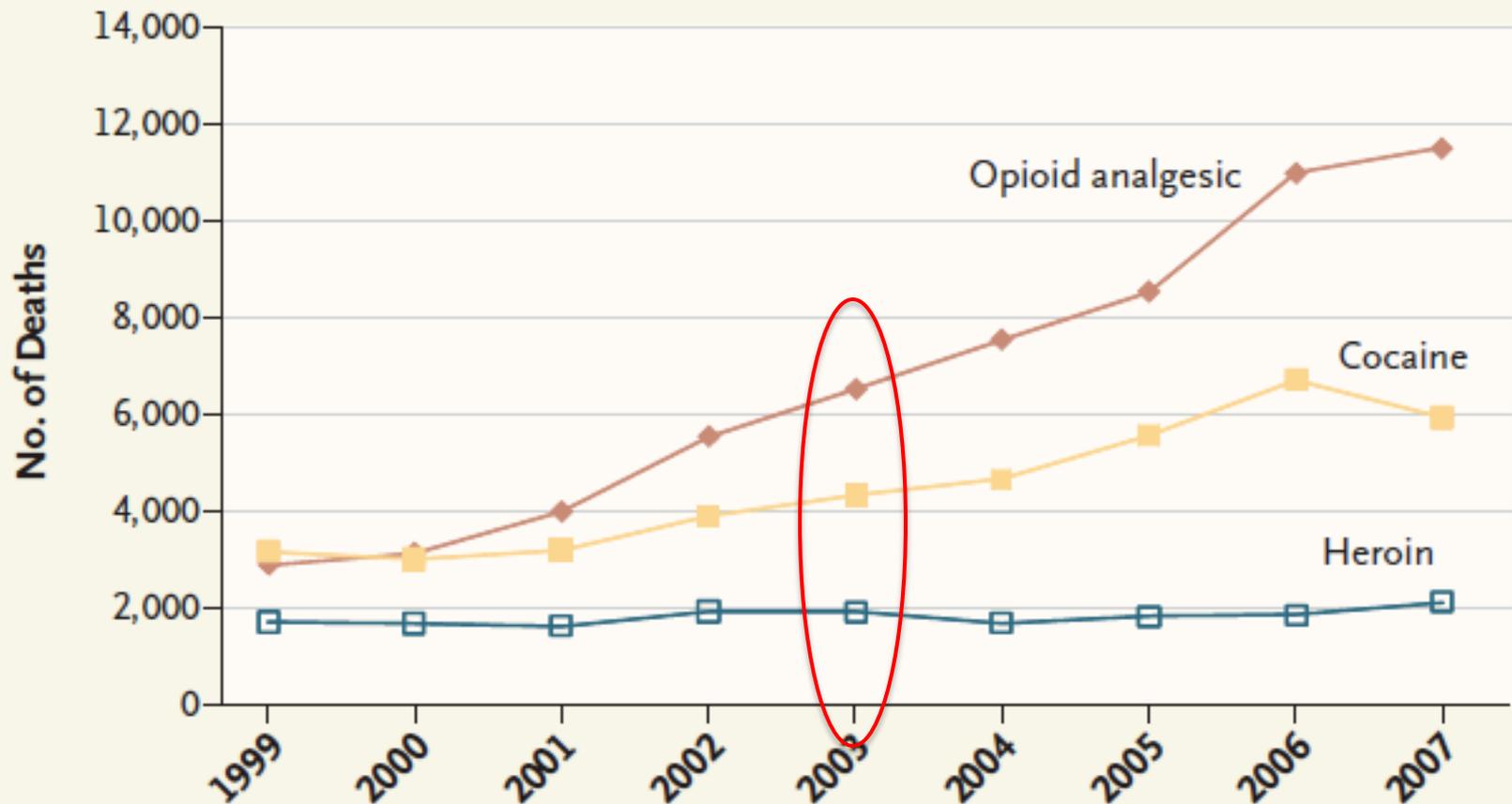
Okie, NEJM, Nov 2010

A Deaths from Unintentional Drug Overdoses in the United States, 1970–2007



Okie, NEJM, Nov 2010

B Deaths from Unintentional Drug Overdoses in the United States According to Major Type of Drug, 1999–2007



Thank-you

Joint Commission 2000 to 2005

- Joint Commission Standard - PC.01.02.07 : The hospital assesses and manages the patient's pain.

	Pre Pain Standard	Post Pain Standard
Patient satisfaction with pain control	4.13 ± 0.16	4.38 ± 0.08*
Opioid adverse drug reactions per 100,000 inpatient hospital days	11.0	24.5*

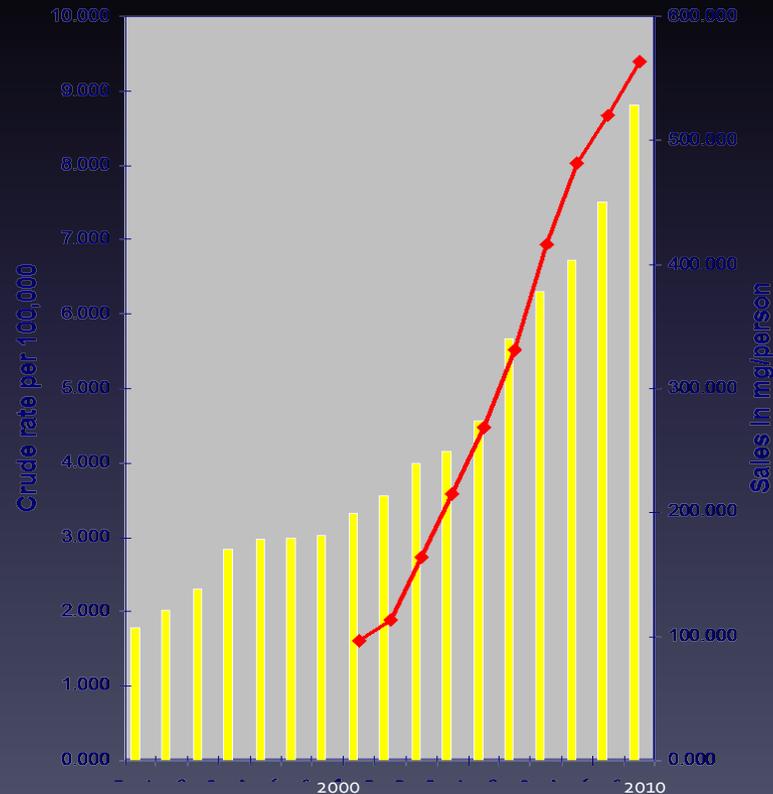
* P<0.001

Source: Vila et al., 2005

Overdose Death Rate correlates directly with Opioid sales (Prescription) rate

Unintentional drug overdose death rates & sales of Rx painkillers in US:

Deaths/100,000 North Opioid sales (mg/person)



Source: National Vital Statistics System & Drug Enforcement Administration, ARCOS

Pharmacology

Opiate Vs. Opioid



Opioid Equivalent Dose

(to morphine 10 sc)

Opioid	Approx. Equivalent Dose
Morphine	30 mg
Codeine	200 mg
Fentanyl Transdermal	12.5 mcg/hr
Hydrocodone	30 mg
Hydromorphone	7.5 mg
Methadone	20 mg
Oxycodone	20 mg

Interagency Guideline on Opioid Dosing for Non-cancer Pain

Acute Overdose Presentation

- Decreased level of consciousness
- Decreased respiration
- Pinpoint pupils
- Vomiting/ Decreased motility
- Loss of muscle tone & airway control
- Seizure
- Cardiopulmonary Arrest



Treatment of Acute Overdose

- Airway control
- Protection from harm
(rhabdomyolysis, etc)
- IV/IO access, blood pressure control
- Naloxone SQ/IM/IV 0.4- ???





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EMERGENCY
MEDICINE

APPOINTMENT CANCELLATIONS



Complications of Long-Term Opioid Therapy for Management of Chronic Pain: the Paradox of Opioid-Induced Hyperalgesia

D. Eric Brush

Opioid-induced hyperalgesia (OIH), a novel unanticipated outcome, may develop following prolonged opioid therapy. Characterized by a heightened perception of pain related to the use of opioids in the absence of disease progression or opioid withdrawal

Just A Few More Facts...

Americans, **4.6%** of the world's population, consume **80%** of the global opioid supply, and **99%** of the global hydrocodone supply.

The age-adjusted rate of death was **30.8** per 100,000 in the Medicaid-enrolled population,
compared with **4.0** per 100,000 in the non-Medicaid population

Where do they get prescription opiates that are used 'non-medically'?

- 54% from a friend or family member
- 36% from a doctor
- 5% from a drug dealer or stranger
- 5% some other way

Sources of Narcotic Analgesics

ED's write for 8% of Pills...

BUT

4%



Setting Type	% 2003 Distribution	2013
Emergency department	39%	
Primary care office	31%	>50%
Medical specialty office	13%	
Surgical specialty office	10%	
Hospital outpatient department	7%	

Source: National Center for Health Statistics. Medication therapy in ambulatory medical care: United States, 2003-04

And from 2010-2014 Emergency medicine lead all specialties in Opiate Prescribing reduction, at 8.9%

So How Do We Decrease The Pill Count On The Street?

- WA State Experience:
 - 1) State Wide Prescribing Guidelines
 - 2) Care Management Information Exchanges
 - 3) Prescription Monitoring Programs
- Legislative Solutions:
 - 1) Closing Pill Mills
 - 2) Prescription Take Back Programs



In Response To A Legislative Directive

“The public (WA state) perceived the medical community as being unresponsive and not policing themselves.”

- ACEP lead a Task force creating:
 - Guidelines for the prescribing of opioid drugs for the treatment of chronic (non-cancer) pain through the Emergency Department.

Highlights of WA State Guidelines

One prescriber, not multiple ED physician prescribers.

Avoid IV/IM opioids for the treatment of chronic pain in the ED.

→ Don't replace lost or stolen prescriptions.

Don't use OxyContin and Fentanyl patches for acute pain.

Don't give replacement doses of methadone.



Demerol usage is discouraged.

→ Contact the PMD when possible and prescribe only enough pill to last until PMD office opens.

Prescribe no more than 30 pills. **What's your default?**

Screen for previous addiction when prescribing opioids from the ED.

→ Implement screening and brief intervention programs for substance abuse.

ED care coordination programs are encouraged.

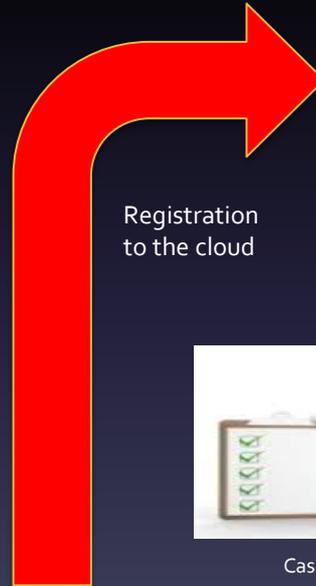
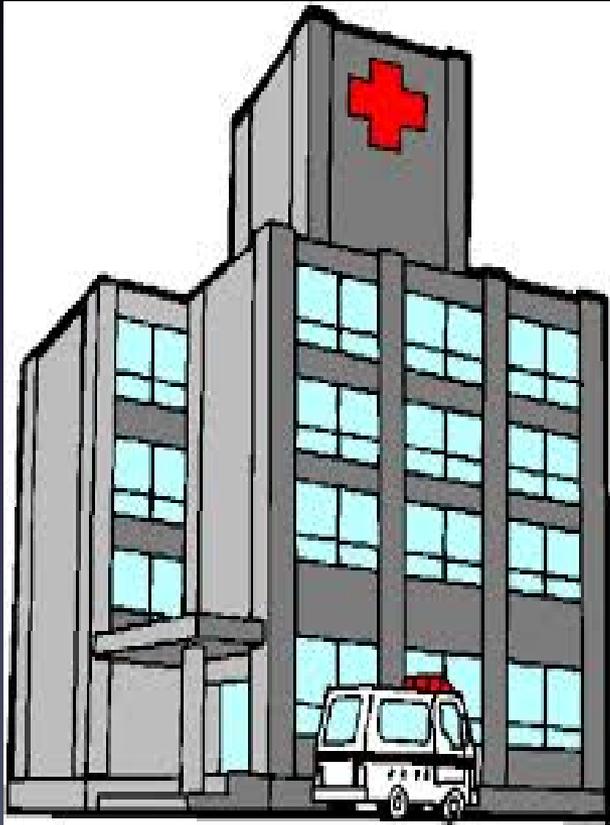
Have pain agreements accessible to ED physician.

Share ED visit information with all EDs in WA. "EDIE" (Emergency Department Information Exchange)

EMTALA does not require the treatment of pain.

New Federal CDC Guidelines in March 2016, primarily aimed at Primary Care

Emergency Department Information Exchange



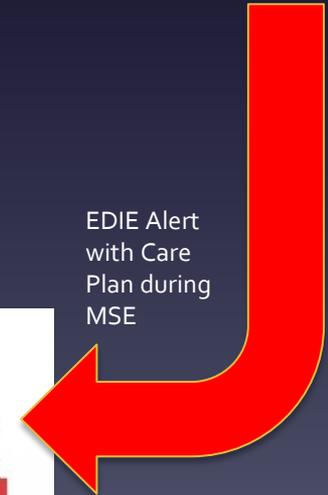
Registration
to the cloud



Case Management



EDIE Alert
with Care
Plan during
MSE



Timely #3 ?

- May 15, 2015
- Emergency Medicine
- Frequent ED Visits May Be Predictor Of Death From A Prescription Medication Overdose.
- [HealthDay \(5/15, Preidt, 16K\) reports, "Frequent visits to emergency departments appear to be a predictor of death from a prescription drug overdose," according to a study published online in the journal Annals of Epidemiology. After analyzing "data from more than 5,400 people who visited \[EDs\] in New York State between 2006 and 2010," researchers found that "people with four or more \[ED\] visits in the past year were 4.8 times more likely to die of prescription drug overdose compared to those who visited an \[ED\] once or not at all," and "with three visits a year, the risk of overdose death from a prescription drug was 17 times greater," the study found.](#)

Everyone On The Same Page

Prescribing Pain Medication in the Emergency Department

Educational Material

Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and are a major cause of accidental death. Our emergency department strives to provide pain relief options that are safe and appropriate.

Our main job is to look for and treat an emergency medical condition. Chronic pain is best managed and coordinated by primary care providers or a pain specialist outside the emergency department.

For your safety, we:

- Might not refill stolen or lost prescriptions for medication.
- Do not prescribe missed methadone doses or long-acting pain medication that has a high risk of addiction or overdose.
- Review your health and prescription history to determine the best approach to managing your pain.
- Prescribe the most appropriate pain medication, favoring those with the lowest risk of addiction or overdose, and for no longer than necessary.
- Take into consideration whether you already receive pain medication from another health care provider or emergency department, and whether you have a doctor who can follow up on your condition.
- Will help you find treatment for any pain or medication problems that you may have.



PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON



Prescription Monitoring Programs



- Game Changer
- 49 out of 50 states have this, largest network shares across 30 states
- In WA, 96% of ED providers registered
- “REGISTERED” does not equal “USES”, “3 clicks to crazy”

But imagine Push not Pull, No Bias, part of the EDIE

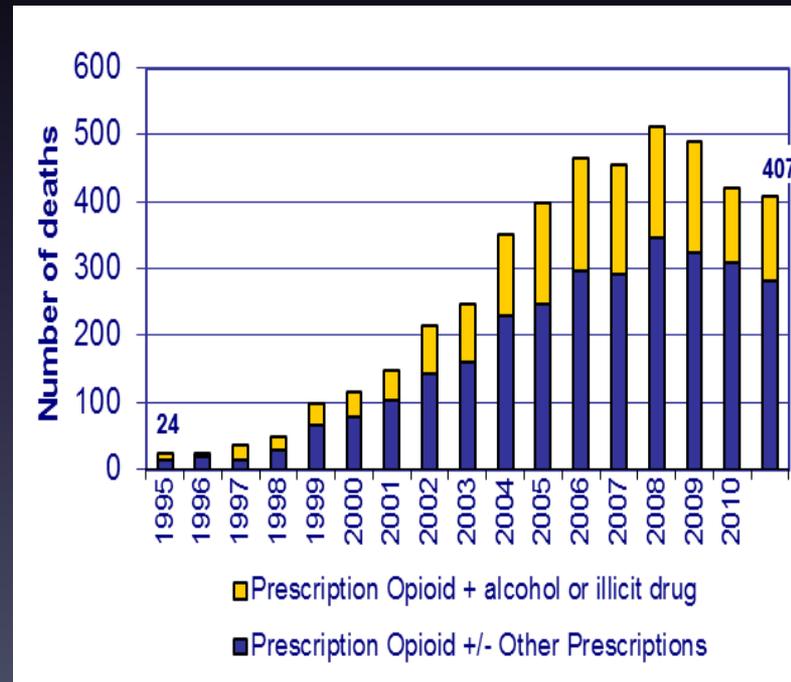
Privacy Protection

- CURES Program in California
- Proposed Legislation SB 641:
Requires a warrant for Law Enforcement
to query the PDMP

How Is WA State Doing?



- In 2012 we decreased Prescriptions for restricted medications from the ED's by **24%**



2016
continued to decrease

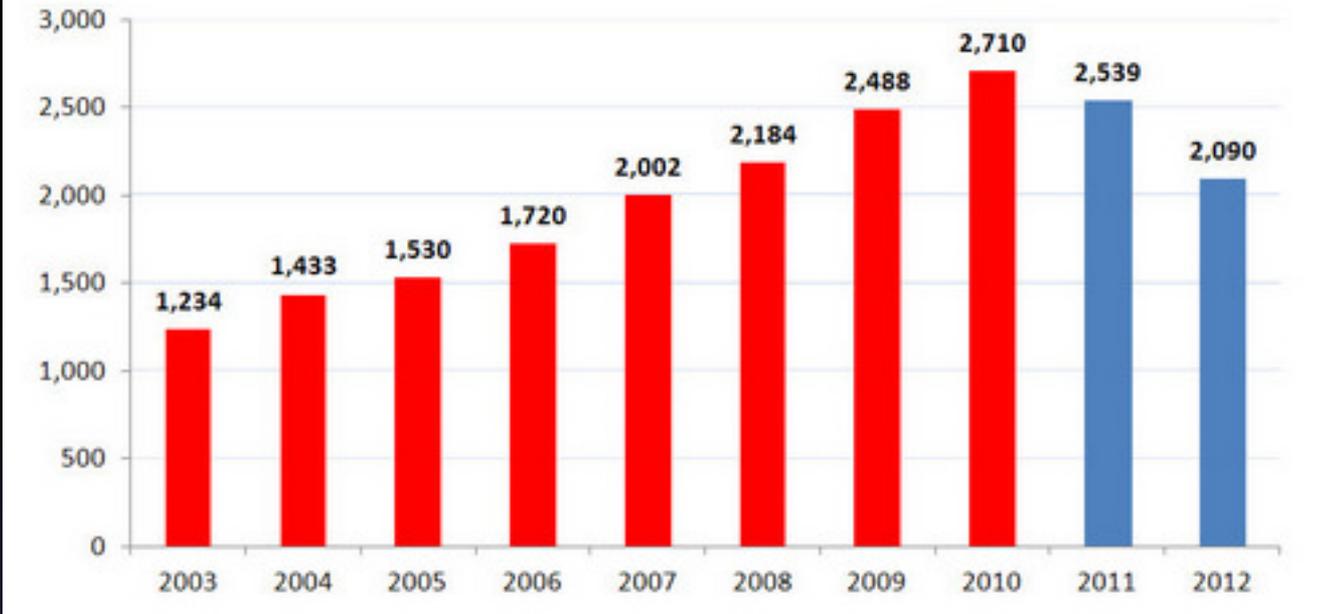
Closing The Pill Mills



- 2010, 90 of the top 100 Opiate prescribers practiced in Florida.
- 8 of the top 10 Opiate dispensing Pharmacies
& 53 of the top 100 in Florida.

Enter Florida Attorney General Pam Bondi

Rx Drug Overdose Deaths Florida 2003 - 2012



In 2012 alone, decreased Opiate overdose deaths 17%

How about 2016?

And where did the
4 newest top 10
dispensaries in 2012
open?



Community Education & Prescription Take Back Programs



Take out of pill bottle
Mix with undesirable
Seal in container
Dispose in trash



California Counties Sue Opioid Manufacturers for Deceptive Marketing

By Leon Gussow, MD

Two California counties this past May sued five pharmaceutical companies that manufacture opioid analgesics, accusing them of working to “create a sea-change in medical and public perception” about these drugs by

carrying out a “deeply deceptive marketing campaign.”

The complaint filed by attorneys for Santa Clara and Orange counties alleged that the campaign was waged over 20 years, using a multipronged initiative aimed at medical professionals and the

Continued on page 26

Big Pharma

- Zohydro (Hydrocodone ER)
- Targiniq ER (Oxycodone/naloxone) tamper proof



For patients taking immediate-release hydrocodone on a chronic basis, or those in need of another extended-release opioid option

THE FIRST AND ONLY
EXTENDED-RELEASE
HYDROCODONE

HELP YOUR CHRONIC PAIN PATIENTS FIND THEIR
ZONE OF CONTROL

The advertisement features a man in a grey hoodie and khaki pants sitting on a light-colored sofa, adjusting his bright green sneakers. The background is a plain, light-colored wall. The text is positioned to the right of the man, with the main headline in blue and green, and the tagline in green.

ER/LA OPIOID REMS:

**Achieving Safe
Use While Improving
Patient Care in the
Emergency Department**

Presented by CO*RE
Collaboration for REMS Education
www.core-rems.org



Collaborative for
REMS Education



Pain Clinics



<http://www.painmanagementlosangeles.com/pain-management.html>

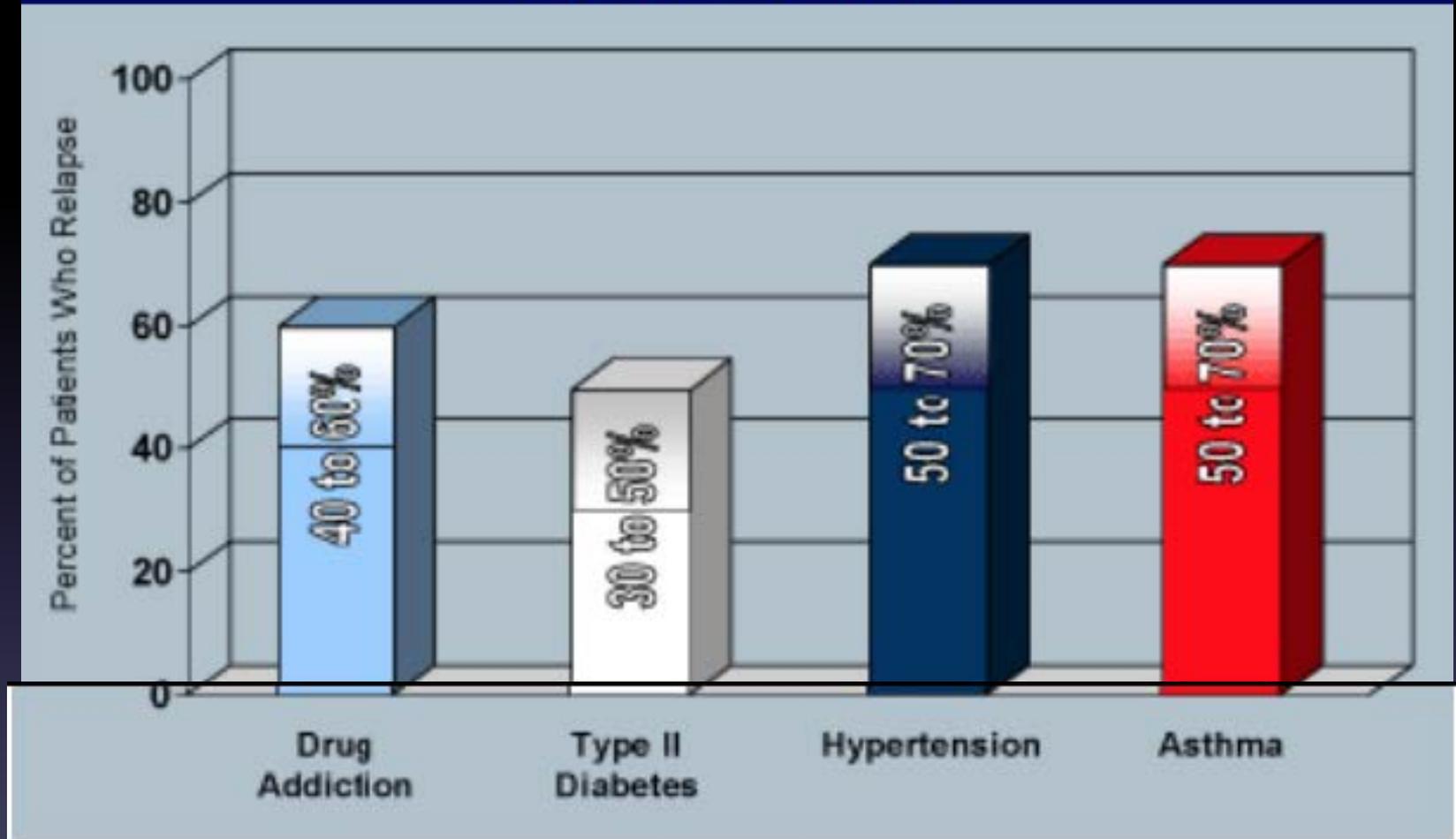
Opiate Contracts

AGREEMENT FOR OPIOID MAINTENANCE THERAPY FOR NON-CANCER/CANCER PAIN

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. **You should use one** physician to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You should use **one** pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

Relapse Rates Are Similar for Addiction and Other Chronic Illnesses



McLellan: Drug Dependence, A Chronic Medical Illness, JAMA 2000

Rehabilitation

- Inpatient treatment is more prevalent in other countries (Germany)
- 10% of substance use disorder patients in US residential treatment
- 1% have associated medical or psych resources

ASAM Principles of Addiction Medicine 2014

114th CONGRESS
2d Session

H. R. 6512

To authorize the Secretary of Health and Human Services to make loans and loan guarantees **for constructing or renovating**, or planning construction or renovation of, **qualified psychiatric and substance abuse treatment facilities**, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

December 8, 2016

Mr. Kilmer (for himself, **Ms. Herrera Beutler**, and Mr. Murphy of Pennsylvania) introduced the following bill; which was referred to the Committee on Energy and Commerce

The Danger of The Needle



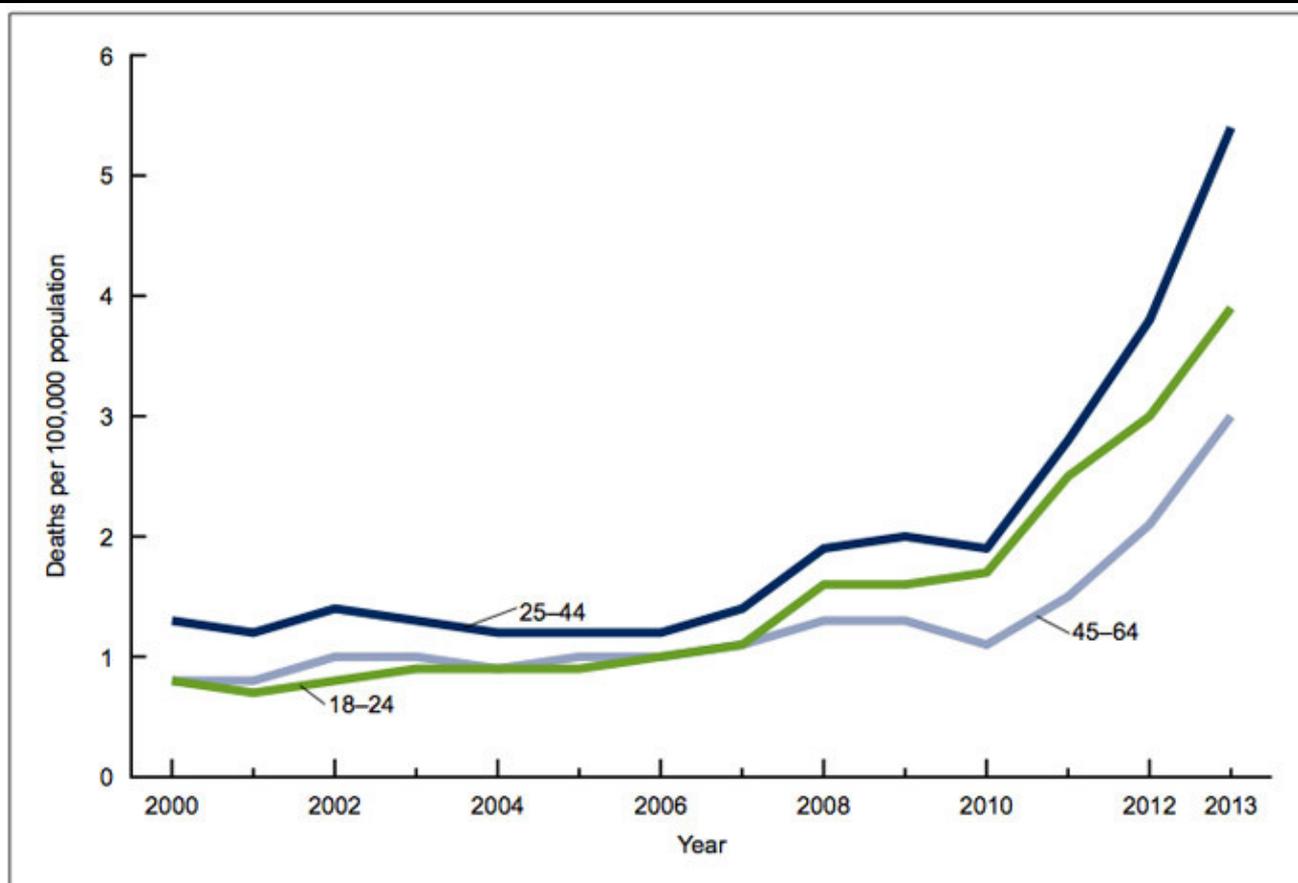
ABUSE OF PRESCRIPTION PAIN MEDICATIONS RISKS HEROIN USE

In 2010 almost 1 in 20 adolescents and adults – 12 million people – used prescription pain medication when it was not prescribed for them or only for the feeling it caused¹. While many believe these drugs are not dangerous because they can be prescribed by a doctor, abuse often leads to dependence. And eventually, for some, pain medication abuse leads to heroin.

 **1** **IN** **15** 

**PEOPLE WHO TAKE NON MEDICAL
PRESCRIPTION PAIN RELIEVERS WILL TRY
HEROIN WITHIN 10 YEARS²**

Heroin Overdose Deaths in America



NOTE: Access data table for Figure 3 at: http://www.cdc.gov/nchs/data/databriefs/db190_table.pdf#3.
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.



2014-2017
Enter
Fentanyl &
Carfentanyl

Thinning the Herd?

Missouri Alone in Resisting Prescription Drug Database

New York Times: July 20th, 2014

“If they overdose and kill themselves, it just
removes them
from the gene pool”

-Rob Schaaf, MD, State Senator

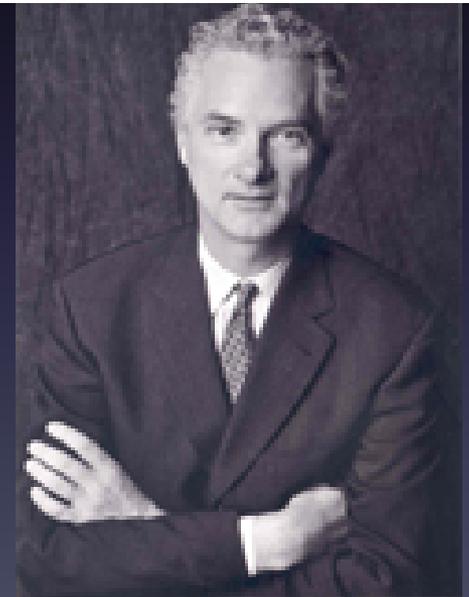
Save a life:
No brainer!

Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention

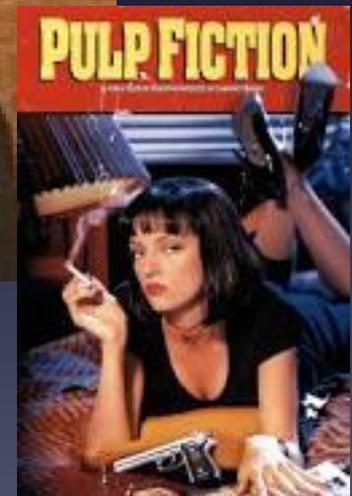
Karl A. Sporer, MD

Alex H. Kral, PhD

From the University of California, San Francisco, Department of Medicine, Section of Emergency Medicine, and the Treatment Research Center (Sporer), the Urban Health Program, RTI International and the University of California, San Francisco, Department of Family and Community Medicine (Kral), San Francisco, CA.



Not what we're talking about



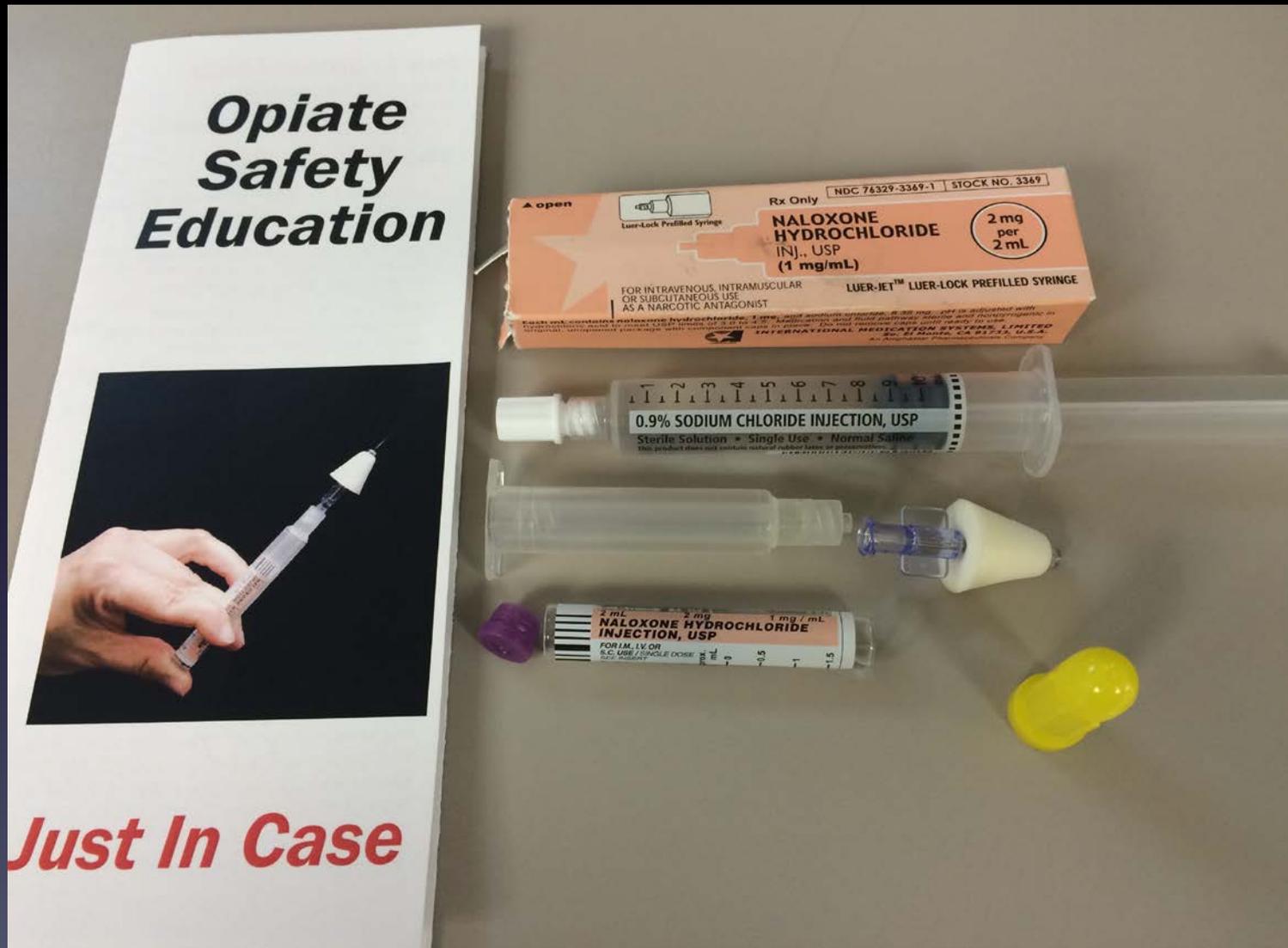
Naloxone Training Programs

- Dope (Drug Overdose Prevention and Education) Project, SF 2001
- Staying Alive, Baltimore, MD 2004
- Project Lazarus, NC 2008
- Chicago Recovery Alliance 2001
- Opioid overdose and prevention, NM 2001
- Massachusetts Overdose Education Naloxone Distribution Center, Boston, MA 2000-4 (underground)

Delivery System: Auto Injector



Delivery System: Intranasal



Nasal Naloxone



Box of 2
Each with 4mg Naloxone

Where & When





StopOverdose.org

Opioid overdoses can be prevented and reversed!

Home / Opioid OD Education

Where to Get Naloxone / FAQ

Sources for Help

Law Enforcement

Evaluation of WA Law

Pharmacy/Prescribers

Other Drugs and Overdose

Resources

News

Download & share!

Opioid Overdose Prevention Education

Learn how you can save a life:
WATCH a video, **REVIEW** the steps, then **TAKE A QUIZ**.

.....



A community health worker explains overdose prevention and demonstrates how to administer intranasal naloxone (Narcan™) in an overdose



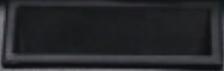
A doctor teaches patients, their families and friends, what to do in case of overdose from prescription opioids, including how to

Maintenance Training Checklist

- ✓ Verify date
- ✓ Verify volume 100-2000 while playing MP3
- ✓ Verify there is always 100% battery
- ✓ Verify people have their own computers and cables in their carts
- ✓ Verify setup 100% every time
- ✓ Verify system 100% if @ computer other time
- ✓ Verify use monitor from each loop in the
- ✓ Verify nothing, 100% use cables and setup in the
- ✓ Verify use headphones and give to someone
- ✓ Verify use headphones other each use

Questions call Mary Lou Kline at 714-749-1200
Email: maryloukline@cedars-sinai.org
Page 10/10/11 11:11 AM 11/11/11

Serene



Must be coupled with education

- Identify opioids
- Recognize an OD (opioid vs. not)
- Rouse victim
- Call 911
- Rescue breathing
- Give naloxone
- Left lateral decubitus
- Aftercare



Target Population

- Any heroin user or prescription opiate user in the Emergency Department
- Friends
- Family
- “Bystanders”



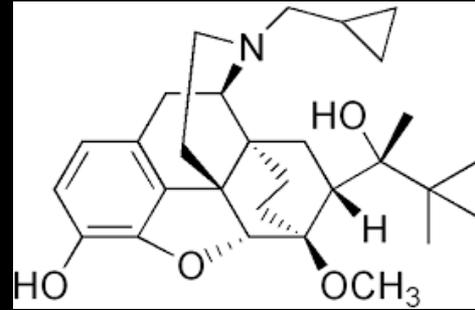
Challenges

- Prescriber concerns / Indemnification laws
- Naloxone Price
- Staff to do training vs. online training
- Prescriber incentives
- Public awareness
- Efficacy data
- **The warm handoff?**

Where Did We Fail?



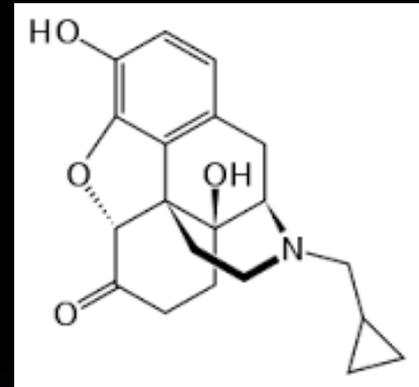
Buprenorphine



- Partial agonist/ antagonist
- Abuse potential
- Combination form with Naloxone
- Special license...
- 3-7 days to the “warm handoff”?



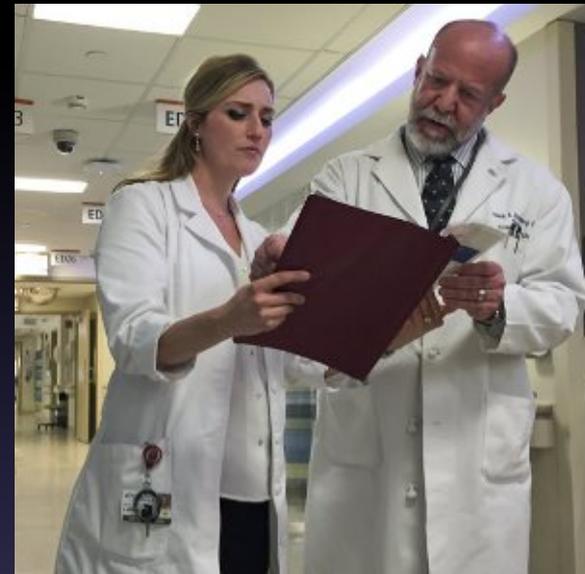
Naltrexone



- Long acting antagonist
- Can be overridden with enough opiate
- Not in setting of acute dependence / overdose



Alternatives to Opioids Programs



St. Joseph's HealthCare Center,
Paterson, NJ

Dr. Mark Rosenberg, DO, FACEP

Starting At The Left Of "The Toolbox"



Dying To Be Pain Free

It's an EPIDEMIC!

#1 Cause of accidental death in America

We must take ownership/ We can save lives

Decrease pill count on the street

Coordinate Care/ Use PMP's/ Have the tough conversations

Engage communities, leaders & legislators

Naloxone saves lives, sooner the better

\$\$\$

The "warm handoff"

Starting at the left of "The Toolbox"



“Save a life: No brainer!”



Sanderson@acep.org

