Dying To Ease The Pain
WA State Experience with Opiate Overdoses
WA State Attorney General Summit June 15th, 2017

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National ACEP Board of Directors 2014-16

No Conflicts of Interest
Timely?
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 Sertturner 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

Death Rate per 100,000


COCAIN

Okie, NEJM, Nov 2010
Deaths from Unintentional Drug Overdoses in the United States According to Major Type of Drug, 1999–2007

- Opioid analgesic
- Cocaine
- Heroin

No. of Deaths vs. Year (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.

<table>
<thead>
<tr>
<th></th>
<th>Pre Pain Standard</th>
<th>Post Pain Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction with pain control</td>
<td>4.13 ± 0.16</td>
<td>4.38 ± 0.08*</td>
</tr>
<tr>
<td>Opioid adverse drug reactions per 100,000 inpatient hospital days</td>
<td>11.0</td>
<td>24.5*</td>
</tr>
</tbody>
</table>

* 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:

Source: National Vital Statistics System & Drug Enforcement Administration, ARCOS
# Opioid Equivalent Dose
*(to morphine 10 sc)*

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approx. Equivalent Dose</th>
</tr>
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<tbody>
<tr>
<td>Morphine</td>
<td>30 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200 mg</td>
</tr>
<tr>
<td>Fentanyl Transdermal</td>
<td>12.5 mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>20 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
</tr>
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*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-???
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

Source: National Survey on Drug Use & Health, 2015
Sources of Narcotic Analgesics

ED’s write for 8% of Pills…

BUT 4%

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>% 2003 Distribution</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Primary care office</td>
<td>31%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Medical specialty office</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Surgical specialty office</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient department</td>
<td>7%</td>
<td></td>
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</tbody>
</table>


And from 2010-2014 Emergency medicine lead all specialties in Opiate Prescribing reduction, at 8.9%
Overall drug overdose death rates in the United States vary more than 10 fold, by state and region.
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
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 48 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.
prescribing pain medication in the emergency department

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.

for persons with disabilities, this document is available on request in other formats. to submit a request, please call 1-800-525-0127 (tdd/tyt 711).
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%.

![Graph showing number of deaths from prescription and non-prescription drugs from 1995 to 2016.]

- 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
In 2012 alone, decreased Opiate overdose deaths 17%

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

How about 2016?
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 public.

Continued on page 26
Big Pharma

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

- Drug Addiction: 40 to 60%
- Type II Diabetes: 30 to 50%
- Hypertension: 50 to 70%
- Asthma: 50 to 70%

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
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 caused. 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 YEARS

Heroin Overdose Deaths in America

2014-2017
Enter Fentanyl & Carfentany
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
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...
Malware Training Checklist

- Install software
- Ensure software is compatible with operating system
- Update software regularly
- Keep logs of changes and updates
- Install security patches
- Monitor system for signs of infection
- Conduct regular malware scans
- Test systems for vulnerabilities
- Conduct training on malware threat

Questions: call (555) 555-5555
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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?

Prince
1958-2016
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”

Acetaminophen & Ibuprofen

Opioids & Surgery
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