Morrison County Opioid Program
The Whole Community

Minnesota Hospital Association Video
Opioid Abuse
A call to action
What caught our attention in our community

- On call narcotic refills
- Emergency room visits
- Overdoses in the community
- Police concerns
The number of emergency room visits attributable to pharmaceuticals alone increased 97% between 2004 and 2008.

SOURCE: U.S. Drug Enforcement Administration
The **number one cause of death** in 17 states is prescription drug abuse, surpassing motor vehicle accidents.

SOURCE: Centers for Disease Control and Prevention
More than 50 million Americans have admitted to abusing prescription drugs

= 1 out of 6 people

SOURCE: CBS Evening News
Approximately 30,000 Americans died from an overdose last year, with at least half of these deaths related to the improper use of legal, controlled substances.

SOURCE: CBS Evening News
1 in 7 teens admit to abusing prescription drugs to get high in the past year. Sixty percent (60%) of teens who abused prescription pain relievers did so before the age of 15.

SOURCE: U.S. Drug Enforcement Administration
About 7 million people used a prescription drug non-medically in 2009, a 13% increase over the previous year.

SOURCE: National Survey on Drug Use and Health
Opioid Abuse
The call to action.

Opioid Use
An American Epidemic

4.6% of the world’s population

Consuming 80% of the global opioid supply

Recipe for DISASTER

Opioids + Benzodiazepines
Benzodiazepines are often found in the blood of overdose victims.

50%–80% of heroin overdose deaths.
40%–80% of methadone deaths.
30%–69% of deaths due to prescription opioids were individuals who were also prescribed benzodiazepines.

SOURCE: CDC Report
Opioid Abuse
The call to action.

Opioid involvement in benzodiazepine overdose

- Total
- Benzodiazepines and Opioids
- Benzodiazepines without Opioids
Opioid Abuse
Roadmap to Disaster
HELLO CHUCK NORRIS,
THIS IS 911

WE HAVE AN EMERGENCY
Dr. Portenoy co-wrote a seminal paper arguing opioids could be used in people without cancer.
“We conclude that opioid maintenance therapy can be safe, salutary, and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse.”

Pain, 1986 May 25 (2) 171-86
“Some clinicians have inaccurate and exaggerated concerns” (about addiction, tolerance and risk of death). “This attitude prevails despite the fact there is no evidence that addiction is a significant issue when persons are given opioids for pain control.”

Guide published by JCAHO, sponsored by Purdue Pharma, 1991
The American Pain Society trademarked the slogan “Pain: The Fifth Vital Sign”.

1996
This same year (1996), Purdue Pharma released OxyContin, the most widely used narcotic pain killer today.
“If pain were accessed with the same zeal as other vital signs, it would have a much better chance of being treated properly.”

Dr. James Campbell, MD, President of the American Pain Society
The Veterans Health Administration made pain a “fifth vital sign”. The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) did the same.
Throughout the late 1990’s, groups such as the American Pain Foundation urged tackling the epidemic of untreated pain.

Physicians were falsely educated that the risk of addiction was less than 1%.
Less than 1%?

Study 1: Porter and Jick
Only four (4) of 11,882 patients became addicted.

Study 2: Perry and Heidrich
Management of pain during debridement
Zero (0) of 10,000 patients became addicted.
The problem: These studies reflect patients treated for acute pain, not daily chronic pain.
Multiple studies from 1991 to 1997 showed addiction rates from 3-43% in patients on chronic daily narcotics, research Purdue Pharma chose to ignore.
Also in 1998, the Federation of State Medical Boards reassured doctors they would not face regulatory action for prescribing even large amounts of narcotics.
The JCAHO issued new standards telling hospitals to regularly ask patients about pain and to make treating it a priority.
The Federation of Medical Boards called on state medical boards to make under-treatment of pain punishable.
“Untreated pain or undertreated pain is as serious a departure from the standard of care, and as serious a violation of the Minnesota Medical Practice Act as is excessive prescribing of controlled substances or prescribing of controlled substance for non-therapeutic purposes.”

Minnesota Board of Medical Practice controlled substance work group, November 10, 2007
Purdue Pharma and execs pleaded guilty to “misbranding” the drug as less addictive and less subject to abuse than other pain medications. Paid $645 million in fines.
Opioid Abuse
Roadmap to disaster.
259 million prescriptions for written for opioids.

Sales of opioid painkillers total more than 9 billion per year.
Opioid Abuse
Roadmap to disaster.

Opioid overdose deaths surpass car accidents as the leading cause of accidental death, a 4-time increase in deaths from 1999.
Opioid Abuse
A real solution
Community issues require community solutions.

In 2014, the Morrison County Prescription Drug Task Force formed.
Opioid Abuse
A real solution.
Prescription Drug Task Force functions:

- Community education
- Drug take-back events
- Community forums
- Coffee with a Cop
- Information sharing
In 2015, a Controlled Substance Care Team (CSCT) was formed within our primary care clinic.

SIM (State Innovation Model) grant received for $360,000 helped fund efforts.
Initial goals:

- Avoid early refills
- Encourage doctors to sign up for Prescription Drug Monitoring Program (PDMP)
- Review patient charts
- Ensure urine screens and pill counts completed
- Support providers by establishing care plans for all patients on controlled substances
Early workflow development:

- One physician
- RN
- Administrator

A social worker and Medical Home physician were added in an effort to address all the patient’s needs.
Getting into the “program”

- Provider or nurse referral
- Drug refill issues (RN reviews)
- Police information
- Pharmacy concerns
- Slowly working the “list”
Initial Evaluation

Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker.
Opioid Abuse
A real solution.

Information Gathering

- Past medication history
- Substance abuse history
- Drug-related convictions
- PMP
- Family history
- Pharmacy review (if necessary)
- Review of appropriate dosing
- Facebook
- Mental health concerns
- Medication interaction
- ER visits
- Work history
- Diagnosis for medication
Weekly meetings began to review patient cases one at a time.
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A real solution.

Entrance Form
Reviewed at weekly meetings by physicians.

Review includes:
- Previous work-ups
- Scans
- Referrals to occupational therapy, physical therapy, or pain clinics
CSCT REVIEW

Dr. ___________________________ Date: ___________________________

The CSCT has reviewed the following patient:

Patient Name: ___________________________ DOB: ___________ MRN: ___________

Diagnosis: _________________________________________________________________

Medication Agreement/Care plan signed: Y/N, Date: _____________________________

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N, _______________________

Mental Health Provider/Therapist: ____________________________________________

Current Medications of Concern:

• _________________________________________________________________
• _________________________________________________________________
• _________________________________________________________________
• _________________________________________________________________

Images Reviewed: Y/N ___________________________

Other Modalities attempted: _________________________________________________

UDAS in past year: Y/N, Date of most recent UDAS: __________________________

UDAS Findings:

• _________________________________________________________________
• _________________________________________________________________
• _________________________________________________________________

Pill Counts: ______________________________________________________________

PMP Reviewed: Y/N, Findings: ______________________________________________

Social History: ___________________________________________________________

Social Needs identified: _____________________________________________________

Recommendations: _________________________________________________________

________________________________________________________ Scanned in EMR: Y/N

Signed: _________________________________________________________________
Recommendations

- Formulated based on review.
- Reviewed with primary provider.
Components of recommendations

- Dose reductions
- Further work-up or updated work-up
- Discontinuation of other medication due to risks (benzodiazepines)
- Physical therapy or occupational therapy
- Taper if medical condition doesn’t warrant pain medication
- Discontinued if obvious diversion
CDC guidelines

“Clinicians should continue opioid therapy ONLY IF there is clinically meaningful improvement in pain and FUNCTION...”
CDC guidelines

“...increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function...”
“...and should avoid increasing dosage to >90 MME/day, or carefully justify a decision to titrate dosage to >90 MME/day.”*

* This must be documented
## Morphine Equivalents

<table>
<thead>
<tr>
<th>Opioid (mg/day except where noted)</th>
<th>Conversion Factor</th>
<th>Example Conversion to Morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
<td>200 mg codeine x 0.15 = 30 mg morphine</td>
</tr>
<tr>
<td>Fentanyl transdermal (mcg/hr)</td>
<td>2.4</td>
<td>12 mcg/hr fentanyl x 2.4 = 30 mg morphine</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
<td>30 mg hydrocodone x 1 = 30 mg morphine</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
<td>7.5 mg hydromorphone x 4 = 30 mg morphine</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
<td>20 mg methadone x 4 = 80 mg morphine</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
<td>40 mg methadone x 8 = 320 mg morphine</td>
</tr>
<tr>
<td>41-60 mg/day</td>
<td>10</td>
<td>60 mg methadone x 10 = 600 mg morphine</td>
</tr>
<tr>
<td>≥61-80 mg/day</td>
<td>12</td>
<td>80 mg methadone x 12 = 960 mg morphine</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
<td>20 mg oxycodone x 1.5 = 30 mg morphine</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
<td>10 mg oxymorphone x 3 = 30 mg morphine</td>
</tr>
</tbody>
</table>

Dose conversions are estimates that do not account for differences in genetics or pharmacokinetics.

When switching from one opioid to another, remember to consider incomplete cross-tolerance. Decreasing the dose of the new opioid can help avoid unintentional overdose.

Reference
Opioid Abuse
A real solution.

CDC guidelines

“Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.”
Outcomes
Outcomes

In 2014, the #1 Emergency Department diagnosis was therapeutic drug monitoring.

As of Nov. 2015, Emergency Department diagnosis for therapeutic drug monitoring is no longer on the Top 20 list.
Outcomes

324 patients had opioids, benzodiazepines, or stimulants discontinued by a Controlled Substance Care Team Intervention.

These patient tapers account for 370,000 fewer pills/units prescribed in a year.
Outcomes

- 324 Total Tapered Patients (narcotics, stimulants or Benzo.)
  Average decrease = 30,869 units/month no longer prescribed
  Approx $7/pill = $2.6 million per year
- Reasons for Tapers:
  Dose too high
  Diverting
  No Diagnosis/Reason for medications
  “other” – Urine drug screen results, self medicating, etc.
- Patient Needs/Support Referrals
  2016: 146
  So far in 2017: 210
Opioid Abuse
A real solution.

Change in physician culture is slow and ongoing.

- Unexpected urine testing
- Overdoses and overdose deaths
- Police information
- CDC guideline information
- Pending state guidelines
- State Board interest in this issue
MN Board of Medical Practice Policy for use of controlled substances for the treatment of pain:

- Evaluate patient history and physical
- Document treatment plan
- Check the PDMP
- Informed consent and medication agreement
MN Board of Medical Practice Policy for use of controlled substances for the treatment of pain (continued):

- Periodic review-functional improvement?
- Consultation/referral if appropriate
- Medications-attempt to decrease and pill counts, drug screens
MN Board of Medical Practice Policy for use of controlled substances for the treatment of pain (continued):

- Medical records-if not in the record, it did not occur.
Our Story: MN-DHS Commissioner’s Circle Of Excellence
Community Partnerships
Our Story: Rural Health Team of the Year Award
Community Partnerships
Our Story: Minnesota Hospital Association
Innovation in Patient Care
Our Story: American Hospital Association NOVA award
Awards do not save lives, but… they draw attention to the issue.
A real solution.

- Community presentations
- Legislation to clone the program
- ECHO program
Opioid Abuse
MAT
Buprenorphine—Why did we start?

2016 National Prescription Drug and Heroin Summit
Physician Training/Preparation:

8 hour course
www.buppractice.com
SAMHSA
www.samhsa.gov
XDEA
Suboxone

What is it?
- Buprenorphine/naloxone
- Agonist/antagonist
- Pills or films form

Vs. Methadone
- Agonist only
- Ability to get high

Diversion differences
In 2016, there were approximately 100 buprenorphine providers in Minnesota, concentrated mostly in the metro areas.

We wanted a comprehensive program (not just handing out medication).
Barriers to a Rural Buprenorphine program

- No mentors
- Lack education
- High rate of uninsured/Medical Assistance
- Lack of treatment facilities
- No addiction medicine specialists
Our Buprenorphine Program

Program requirements

- Rule 25 assessment (in clinic availability)
- Inpatient or Outpatient treatment
- Medication counts
- Urine testing (many witnessed)
- Release of records:
  - Clinics
  - Mental health facilities
  - Probation officer
  - Drug court
Phone Intake- Screening Criteria

- Where do you live?
- What is the drug or medication abused?
- Have you been prescribed Suboxone in the past or currently? If so, dose? And why changing providers?
- Who is your doctor now? If none, who in the past?
- Have You had any previous treatment?
- Are you currently in counseling?
- What medications are you currently taking? (Including herbals/OTC).
- Review substance use
Our Buprenorphine Program

Intake

- Review intake form
- Interview and physical by physician and assessment of appropriateness for buprenorphine treatment.
- RN and social worker meet with patients to assess other needs, fill out consent forms, and referrals.
Induction

- Same day if withdrawing and appropriate.
- Return following day when in withdrawal.
Our Buprenorphine Program

Follow up visits

RN:
- Urine (witnessed)
- PDMP

Care Coordinator:
- Social Worker assessment
- Meetings (AA, NA)
- Support
- Cravings/triggers

Side effects

Exam:
- Arms, pupils, weight, tremors
Prior Authorization for prescriptions:

- South Country Health Alliance partnership (Brad Johnson)
- Minimal # of private insurance patients thus far
Our Buprenorphine Program

Why witness/observe a UDAS?
Advantage of a Rural Buprenorphine Program

- Law enforcement
- Patients “rat” on each other
- Relationship with pharmacy
- We know the family and friends of patients.
Our Buprenorphine Program

Success thus far:
- Total considered for program = 52
- Total enrolled = 50
- Currently Active = 26
- Inactive = 24
Buprenorphine Program
Defining success

- Time
- Employment
- Repaired relationships
The issue: interrupted buprenorphine treatment

The solution: collaboration
- Assembling a team
- Developing protocols to continue buprenorphine
- Considering new starts
Emergency Room Initiative

Goal: Point of care intervention

- Interact with overdose patients or patients in withdrawal.
- Flyer with control substance care team number.
- Referral process for buprenorphine treatment.
Acute MI
Opioid Overdose
THANK YOU!
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