Opiate Prescribing: Addressing the Crisis Collaboratively

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Our Mission

We are called to make a healthy difference in people’s lives.
Our Values

Quality       Justice
Hospitality   Stewardship
Respect       Teamwork
Integrated Health System

- Home Health Services
- 7 Long Term Care
- 14,000 Employees
- Research Institute
- Student Education
- 5 Ambulance Services
- Pharmacies
- Telemedicine
- 66 Clinics
- 15 Hospitals
- 6 Assisted/Independent Living
- 900 Physicians
- 900 Advanced Practitioners
- Electronic Health Record
- Medical Equipment and Supply
- Rehabilitation Centers

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Our Employees

14,200+ Total Employees
- 900 Physicians
- 900 Advanced Practitioners
- 2,800 Registered Nurses

Serving 500,000+ patients in Minnesota, Wisconsin, North Dakota and Idaho
Our Service Area

Idaho

North Dakota

Minnesota

Wisconsin
Opioids: A trip through time
460 B.C. Hippocrates, the "father of medicine," acknowledges opium's usefulness as a narcotic and styptic in treating disease.

3400 B.C. The earliest reference to opium growth and use is in 3400 B.C. when the opium poppy was cultivated in lower Mesopotamia.

330 B.C. Alexander the Great introduces opium to India. The Arabs, Greeks and Romans use it as a sedative.

Source: www.TheAtlantic.com; www.opioids.com
In 1527, Swiss-German alchemist Paracelsus discovers a tincture of opium that helped reduce pain. He calls this preparation laudanum.

Opium becomes a taboo subject during the Inquisition. References to opium disappear for 200 years from European historical record.

In 1806, German chemist Friedrich Wilhelm Adam Sertürner isolates morphine from opium. He names it after the god of dreams, Morpheus.
A brief history of opioids

Heroin is synthesized as a derivative of morphine by a German company in 1898. It is offered as a cough suppressant and a non-addictive alternative.

Spurred by growing addiction rates, Congress outlaws the importation, manufacture, sale, and use of heroin in 1924.

The FDA approves Oxycodone in 1950, making it widely available in the U.S., a precursor to growing abuse of prescription opioids.

Source: www.TheAtlantic.com; www.opioids.com
1983
Vicodin® becomes available in a generic version. Yet doctors are reluctant to prescribe opioids in general.

1990s
Concern about the under treatment of pain prompts increased use of opioids for all pain types, including non-cancer pain.

1999
Following a surge in opioid marketing by drug manufacturers, an estimated 4 million people are using prescription opioids non-medically.

Source: www.TheAtlantic.com; www.opioids.com
Opioids: An exploding problem
A change in prescribing habits and a decade of aggressive marketing of prescription opioids to American physicians has led to increased use:

- Hydrocodone: 198%
- Fentanyl: 423%
- Oxycodone: 588%
- Methadone: 933%

Source: Manchikanti, Laxmaiah, MD Pain Physician 2007; 10:399-424 • ISSN 1533-3159
A growing problem

Primary non-heroin opiates/synthetics admission rates
(per 100,000 population aged 12 and over)

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS); Andrew Kolodny, MD; Physicians for Responsible Opioid Prescribing, Oct. 2012
An American issue

80% of the world’s prescription opioid supply is consumed in the U.S.

Source: Manchikanti, Laxmaiah, MD Pain Physician 2007; 10:399-424• ISSN 1533-3159
Opioid use at least once during past year

Per capita opioid use

2005

Map shows grams per 10,000 people of prescriptions for painkiller opioids, such as oxycodone, hydrocodone, codeine, morphine.

Source: Drug Enforcement Administration; Pioneer Press, *Prescription opiates and heroin in Minnesota*
Sobering statistics

78 Americans die every day from an opioid overdose.

At least half of all opioid overdose deaths involve a prescription opioid.

Source: Centers for Disease Control and Prevention
Sobering statistics

Minnesota counties with the highest rates of death from opioid overdose between 1999 and 2014

- Anoka
- Carlton
- Cass
- Hennepin
- Mille Lacs
- St. Louis

Source: Minnesota Public Radio; Centers for Disease Control and Prevention
Sobering statistics

The number of people who have died from opioid overdoses in Minnesota rose more than 500 percent in that same period.

Source: Minnesota Public Radio; Centers for Disease Control and Prevention
A dangerous trend

National Overdose Deaths
Number of Deaths from Prescription Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder
Sobering statistics

The amount of opioids prescribed and sold in the U.S. quadrupled since 1999, but the overall amount of pain reported by Americans hasn’t changed.

Source: Centers for Disease Control and Prevention
Sobering statistics

249 million

That’s enough prescriptions for opioid pain medication were written by healthcare providers in 2013 to provide a bottle of pills.

Source: Centers for Disease Control and Prevention
How much does Essentia prescribe?

270,000,000 mg morphine equivalent units (MEUs)

2014 Essentia Health prescriptions system-wide
The transition to heroin

- A growing number of young people who start abusing prescription drugs are switching to heroin, which is cheaper and easier to buy.
- Prescription pain pills cost $20 to $60, while heroin costs $3 to $10 a bag.

Source: Centers for Disease Control and Prevention, NBC News
Community impact

Source: Duluth News Tribune, published July 13, 2014; photo from 2011
Impact on our tiniest patients

Percentage of Duluth NICU patients born suffering from opioid withdrawal with a diagnosis of “Neonatal Abstinence Syndrome” or NAS

Source: Essentia Health-St. Mary’s Medical Center NICU admission diagnosis - NAS
The root of the problem: What is pain?

- Acute
- Post-operative
- Malignant
- **Chronic**
Understanding pain

The problem with treating the state of the chronic pain mindset..

“If I cure 70 percent of a patient’s pain, the remaining 30 percent becomes 100 percent of their pain.”

- Anonymous
Now we know...

We should have proceeded with caution.

Narcotics are not the only way or even an effective way to treat chronic non-malignant pain.
Adverse effects of narcotics

- Constipation
- Nausea
- Somnolence
- Obesity
- Narcotic bowel syndrome
- Hyperalgesia
- Hypogonadism
- Traffic collisions/impaired work
- Sleep disturbance

Dependence is inevitable

Progression of opioid dependence

Source: Ballantyne, Jane, Essentia Health Friday Grand Rounds, Jan. 10, 2014
Long-term effects of opioid dependence

Source: Essentia Health patient education materials
CDC recommendations 2012

**CDC:** Opioids are ineffective for some chronic conditions.

- **Low back pain**
  (without a patho-anatomic diagnosis)
- **Headache**
- **Fibromyalgia**

Source: Ballantyne, Presentation to CDC, October 24, 2012
CDC recommendations 2016

CDC targets primary care providers: They account for **50%** of prescription opioids dispensed.

- Opioids are not the first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- When opioids are started, prescribe them at the lowest possible dose.

Source: Centers for Disease Control and Prevention
Taking on Opioids: Essentia’s Approach
Stepping forward during the crisis

For much of the past two decades, medical best practices have encouraged chronic opioid analgesic therapy (COAT) for the treatment of non-malignant chronic pain. Experts increasingly understand that opioids are generally not an effective long-term therapy for these patients.

Since we helped to create the problem, we have to take the lead on creating a solution.
Purpose of new Standard of Care

• Provide **safe and effective** patient care

• Help **prevent diversion and abuse** of opioid medications for a safe community
First steps to manage COAT population

2008-2010

- Implemented Treatment Agreements including urine drug screenings and pill counts
- Refills given only at visit
- Developed metrics to monitor up-to-date Treatment Agreements

Issues

- Did not address inappropriate COAT prescribing
- Inconsistent management/monitoring of patients
Progressive efforts

2013-2015

• Convened summit to develop Essentia’s Guiding Principles for COAT

• Served as a cornerstone for all future COAT efforts
Essentia Guiding Principles for COAT

• Essentia Health supports the use of evidence based guidelines and best practice standards for pain management.

• We recognize that opioids are not generally effective for the long term treatment of chronic non-cancer pain and may also have public health consequences.

• Chronic opioid treatment is not generally indicated for frequent headache, non-specific low back pain, and fibromyalgia.

• We recognize that long-term chronic opioid use leads to severe side effects which may include: hyperalgesia, hypogonadism, dependence, addiction, osteoporosis, fatigue, somnolence, and cognitive dysfunction.

• For patients where opioids are indicated we endorse the limit of 120 mg daily 90 mg daily morphine dose equivalents (MDE).

• The Unanimity of provider adherence to Essentia opioid prescribing best practices is critical to patient safety and community health.
2013-2015

- Education of providers and staff
- Develop and implement new processes and tools to assess and manage COAT patients
Creating a system-wide approach

2015

• Reviewed prescribing practices
• Developed new Standard of Care
• Utilized EHR tools and support departments
Included are:
Non-malignant chronic pain patient taking a:

- **long-acting opioid** *(includes tramadol)*
- **short-acting opioid** *(includes tramadol)*
  - With enough pills available to take 2 or more times a day (for 2 of the last 3 months)
  - and/or With 2 or more prescriptions for 60 or more days (for 2 of the last 3 months)

Excluded are:
- Hospice patients
- Oncology patients with an active oncology treatment plan (Beacon)
- Nursing Home patients (structured medical oversight setting)
Goals of COAT initiative

1. Minimize number of new chronic pain patients started on COAT.
Goals of COAT initiative

What we did:

• Educate primary care staff and physicians/advanced practitioners so they understand the opioid crisis and why we need to change

• Leadership presentations to provider groups
2. Reduce diversion and abuse of opioids prescribed by Essentia physicians and advanced practitioners.
Goals of COAT initiative

What we did:

- Tightened language in Treatment Agreements
- Refills only at scheduled visits (chronic and acute)
- Require at least one annual urine drug screening; pill counts and PMP checks at each pain visit
3. Taper patients off high doses, and taper **willing** patients off opioids where therapy is inappropriate for diagnosis.
Goals of COAT initiative

What we did:

• Patient-reported pain assessment and depression/anxiety screen at every pain visit

• Increased length of annual COAT assessment for more patient education and discussion
Important Team Members

• Clinical Pharmacists and Ambulatory Pharmacy Dept.
  – Assist physicians/APs with Tapers
  – PMP checks prior to all COAT visits

• Central Call Centers
• Abstracting Services
• Risk Management
Important tools

Developed data reports to:

• Identify COAT population.
• Monitor adoption of new protocols.
• Measure if goals are being met.
  – Reduction in new COAT patients
  – Overall reduction in COAT patients
A case for transparency

EHR reports allow providers to drill down to list of COAT patients.
Staff training for new Standard of Care

- In fall 2015, more than 90% of primary care physicians and APs completed 5 hours of training.
- Primary care staff completed 4 hours of training.
- Training covered:
  - Reason for changes
  - How to use tools in EHR
  - How to have conversations with patients
  - Tapering protocols
Implementing new COAT protocols

**Fall 2015:** New COAT Standard of Care rolled out in primary care system-wide.

**At each pain visit:** (at least four per year)
- PMP checked
- Assess for risk of abuse, treatment efficacy, depression and anxiety
- Patient education on risks and alternatives
- Offer to help patients taper if ready

**Annually:**
- Treatment agreement signed
- Random UDS (may be more frequent)
Community coalitions formed

- Began monthly meetings October 2015
- Share best practices, ideas and information
- Created joint news release
- Includes law enforcement and dentistry representatives
- Community education efforts
Community coalitions formed
Patient Education

Steps for a successful taper

1. Talk with your health provider.
2. Sign an agreement between you and your health care team.
3. Slowly reduce the opioid use every 2 to 4 weeks.
4. Regularly follow up with your provider and/or pharmacist.
5. Use other medicine to help manage pain.
6. Pill count at each visit and urine drug screens.
7. Reduce pain in the safest way possible.

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Taking on Opioids: Our Progress
## Current COAT patient volumes

### April 2016

<table>
<thead>
<tr>
<th>Essentia Region</th>
<th># of patients</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>851</td>
<td>1.72%</td>
</tr>
<tr>
<td>East</td>
<td>4,612</td>
<td>2.43%</td>
</tr>
<tr>
<td>West</td>
<td>2,398</td>
<td>2.34%</td>
</tr>
<tr>
<td>Patients without an Essentia PCP</td>
<td>1,208</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,069</strong></td>
<td><strong>2.75%</strong></td>
</tr>
</tbody>
</table>
Our progress

12%

The decrease of primary care patients on COAT in the first 8 months of FY16.
Our progress

Monthly COAT Patient History


Patients with contract

COAT patients

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Our progress

July 2014 → April 2016

23% fewer COAT patients
Reducing new COAT patients

New COAT patients

- Jul. 2014
- Sept. 2014
- Nov. 2014
- Jan. 2015
- Mar. 2015
- May. 2015
- Jul. 2015
- Sept. 2015
- Nov. 2015

New COAT patients
July 2014 35% fewer April 2016

35% fewer new COAT patients started on therapy each month
COAT data is available to all staff through a metric dashboard on Essentia’s intranet, “The Source.”
Looking ahead

• Continuous **quality improvements** for COAT Standard of Care (incorporate CDC guidelines)

• **Monitoring progress** in primary care

• Ongoing **collaboration with community** task force

• Partnering with community **addiction treatment** programs
Goal: Adopt COAT Standard of Care in non-primary care specialty sections

Expectations:

• All Essentia patients on COAT will be managed to the COAT Standard of Care.
• The prescribing physician/AP is accountable for managing patients.
• Patients are not sent to their PCP for management of COAT unless a collaborative partnership has been established between the specialist and PCP.
FY 17: Acute Pain Management

Post-Surgical Prescribing:

- Developing post-surgical prescribing guidelines (including interface with primary care)
- Educate/train staff
- Monitor implementation
FY17: Acute pain management

**ED Setting:**

- Developed prescribing guidelines for patients on COAT
- Developed prescribing guidelines for patients presenting with acute pain
- Educate/train staff
- Monitor implementation
Addiction Summit

Presentations to educate on:

- Nature of Addiction
- Diagnosing Opioid Use Disorder (OUD)
- Effective treatment models for OUD including MAT

Discussion of collaboration and partnership models with local treatment programs.
New Collaborations for Addiction

• Prelude to a new standard:
Putting the pieces together

New prescribing policies

New prescribing policies

Dedication & commitment

Staff training

Staff training

Physician Leadership

Patient education

Dedication & commitment

Community partnerships

Leadership support

Community partnerships

Robust electronic health records

Physician Leadership

Physician Leadership

Leadership support

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