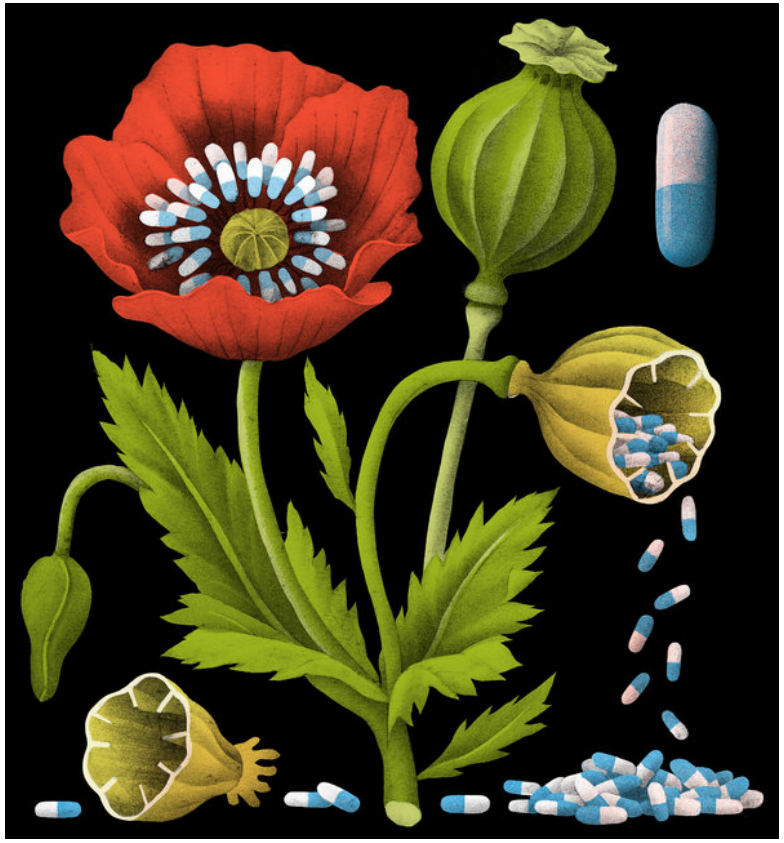
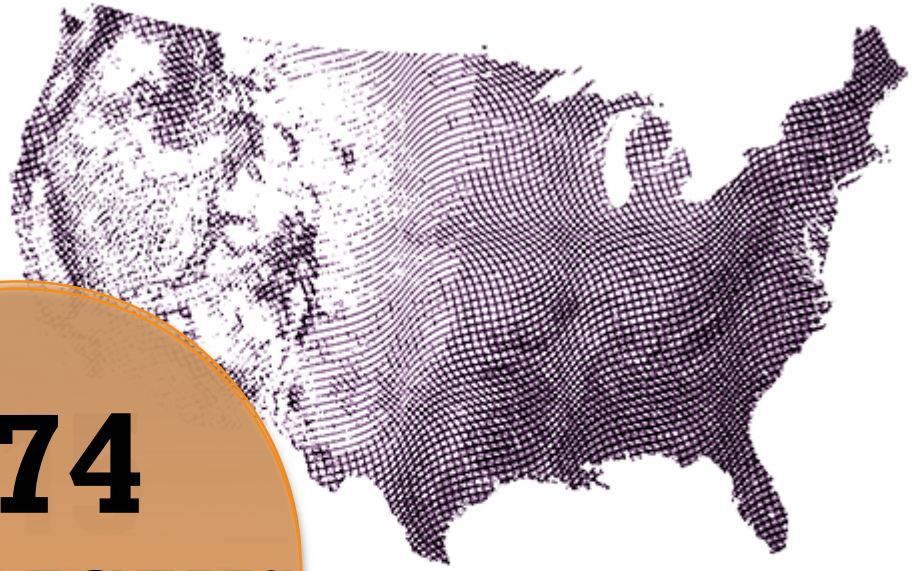
A RHC's Experience in Addressing Opioid Use and Abuse



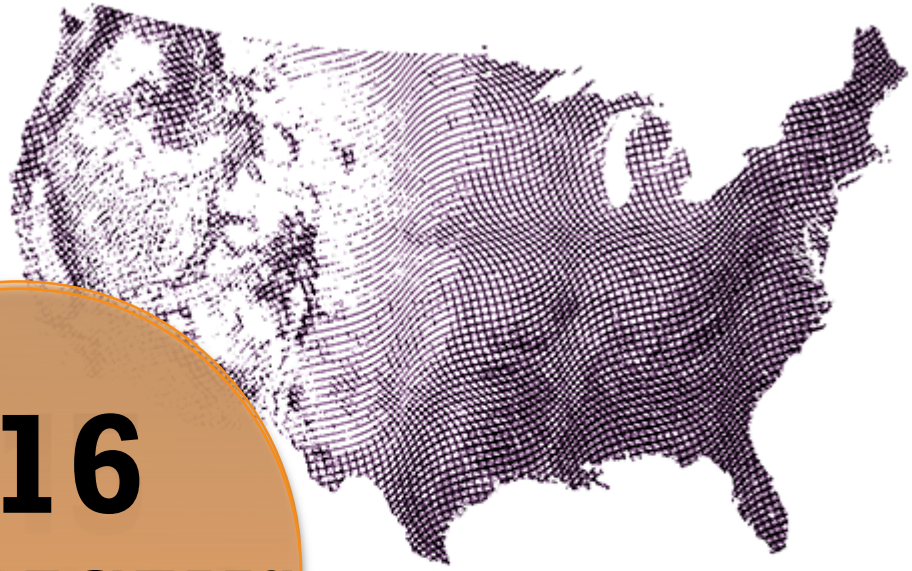
Bjorn Rune Lie

Sam Rabinowitz M.D
Medical Director
Fairchild Medical Clinics
Siskiyou Against Rx Addiction (SARA)
Yreka, California
srabinowitz@fairchildmed.org
530-842-3507



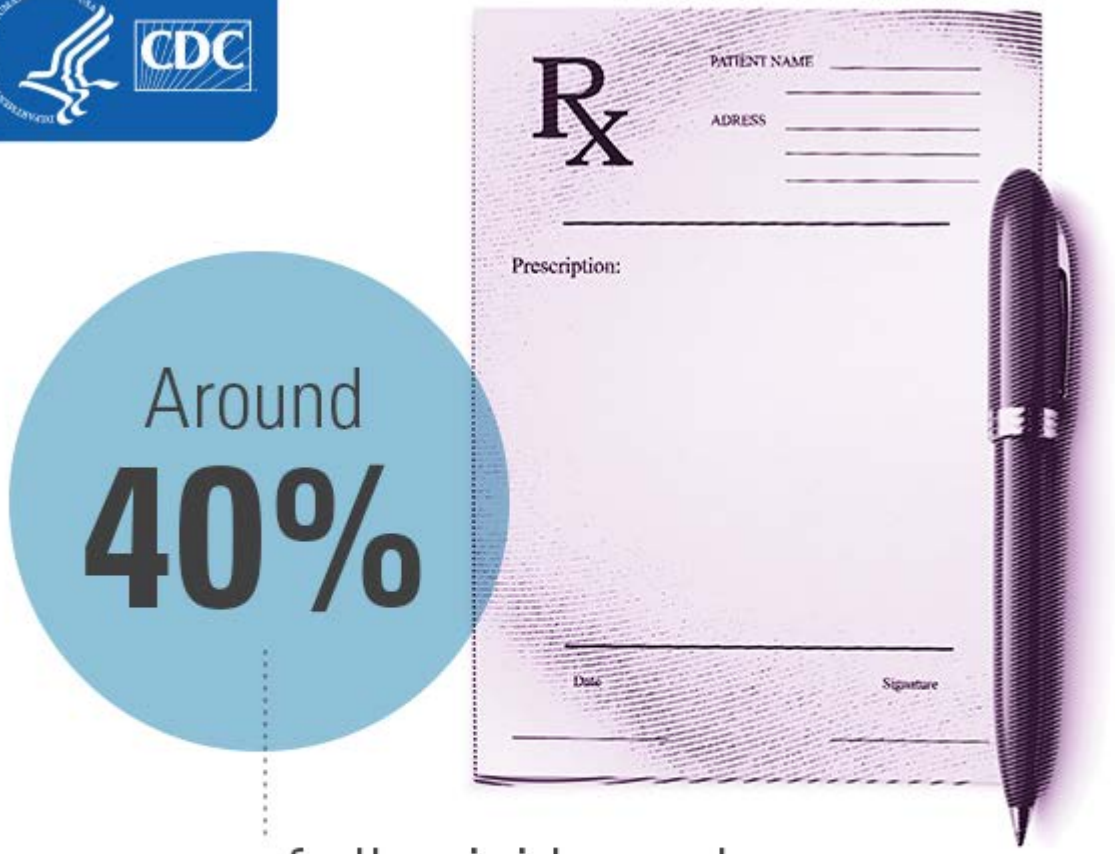
174
AMERICANS

die every day from
a **drug overdose**



116
AMERICANS

die every day from an
opioid overdose

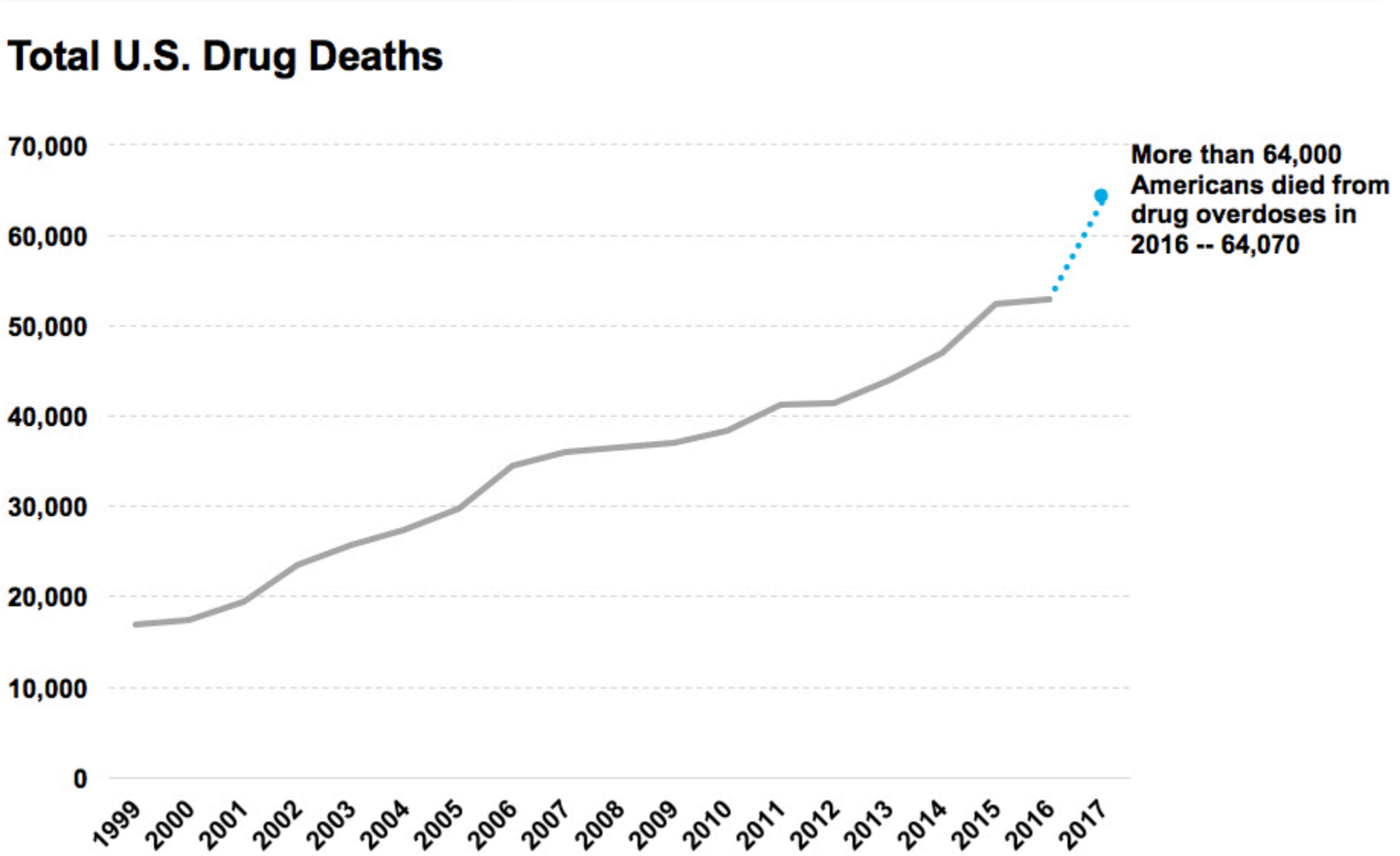


Around

40%

of all opioid overdose deaths involve a **prescription opioid**.

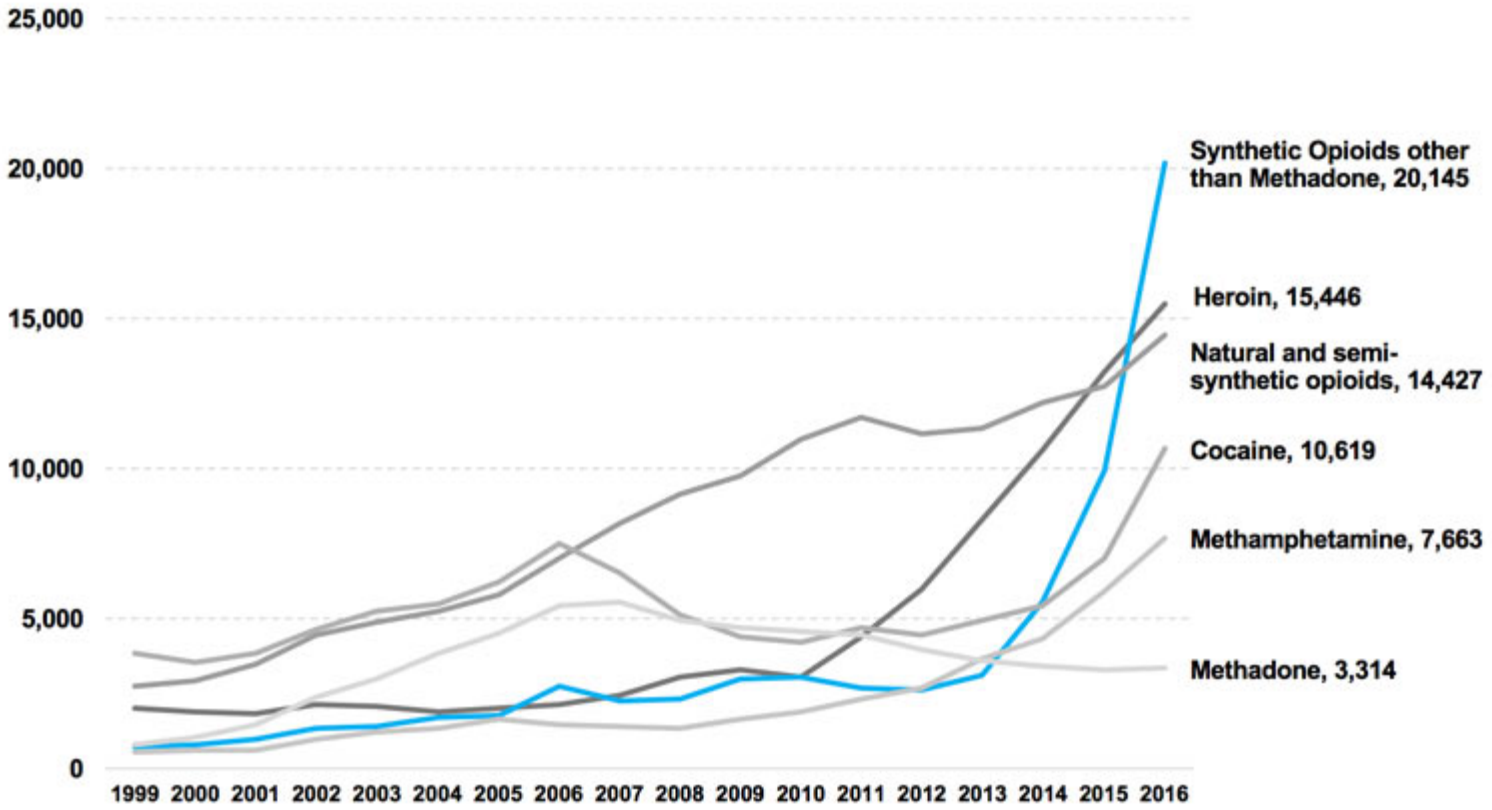
From 1999 to 2016, the amount of prescription opioids dispensed in the U.S. nearly **quadrupled**.



More than 64,000 Americans died from drug overdoses in 2016, including illicit drugs and prescription opioids--nearly double in a decade.

Source: CDC WONDER

Drugs Involved in U.S. Overdose Deaths, 2000 to 2016

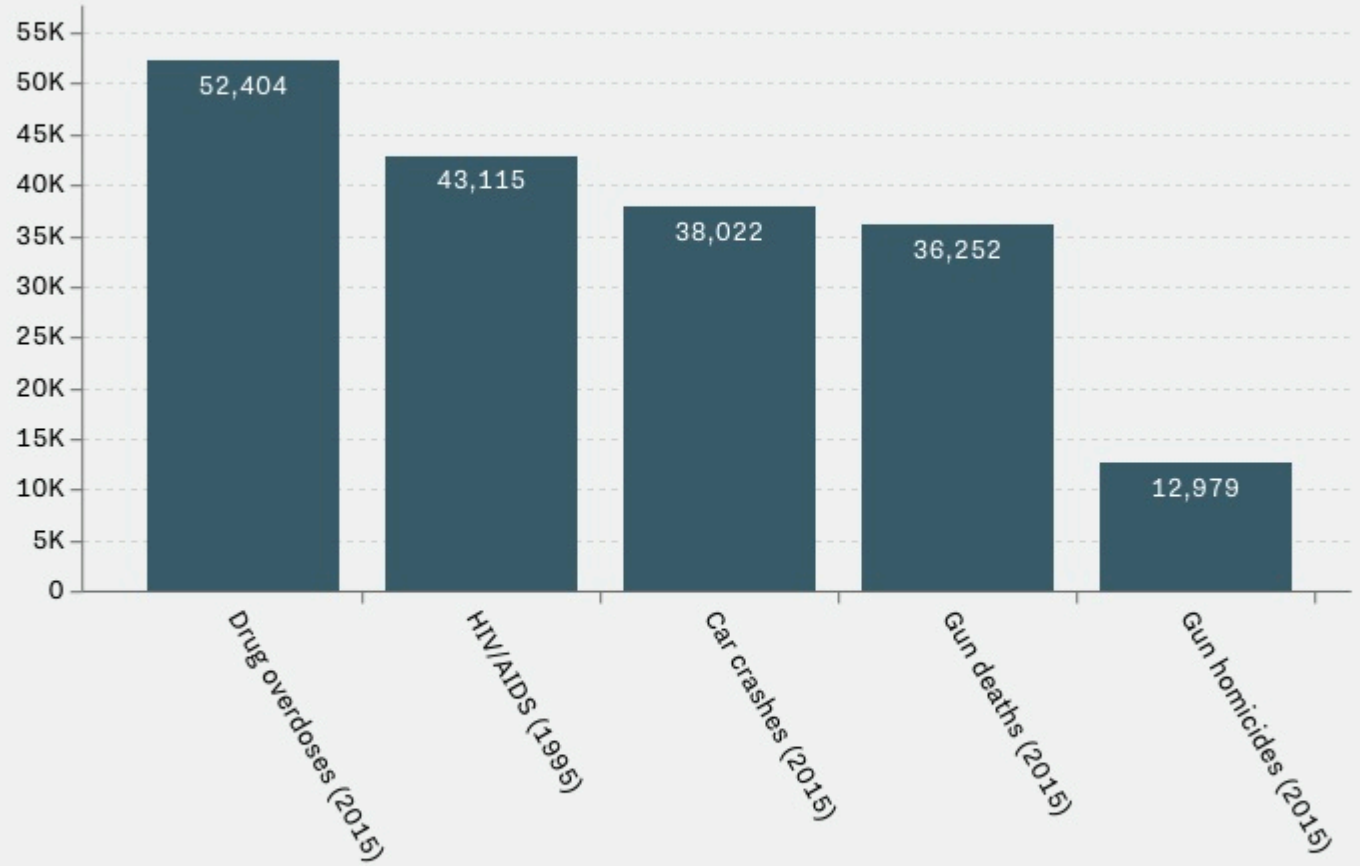


Among the more than 64,000 drug overdose deaths estimated in 2016, the sharpest increase occurred among deaths related to fentanyl and fentanyl analogs (synthetic opioids) with over 20,000 overdose deaths.

Source: CDC WONDER

Drug overdoses killed more people in 2015 than HIV/AIDS at its 1995 peak

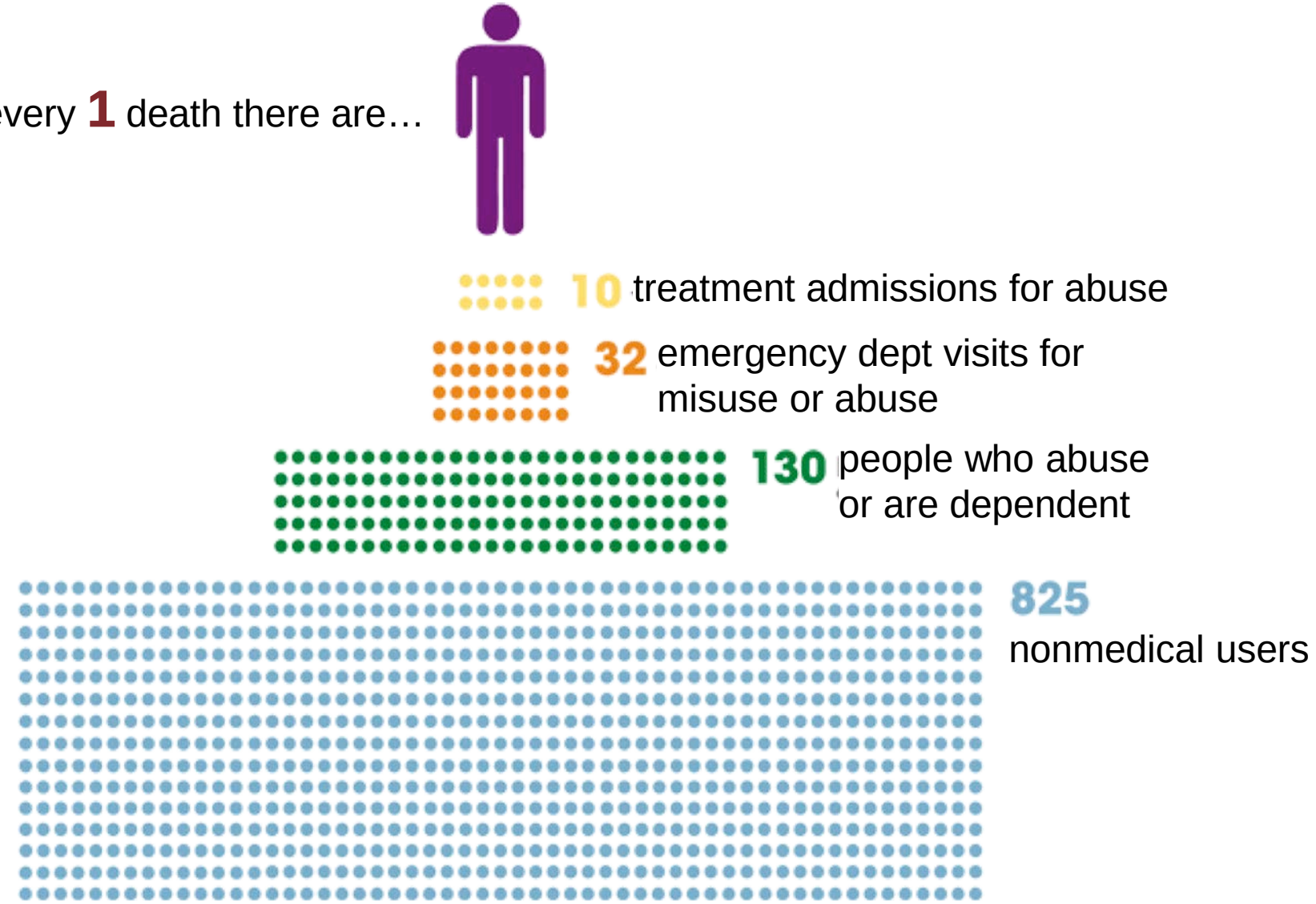
Total deaths in America by cause and year



Source: Centers for Disease Control and Prevention

Vox

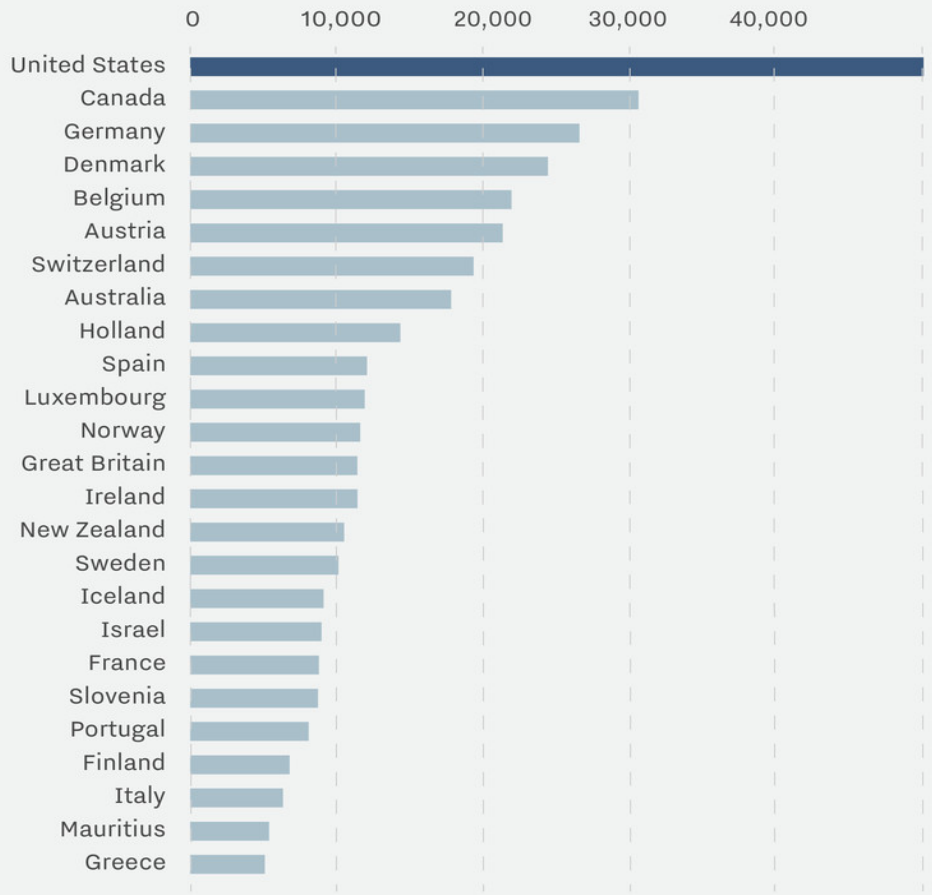
For every **1** death there are…



Source: CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. CDC Policy Impact: Prescription Painkiller Overdoses. Available at: https://www.cdc.gov/drugoverdose/pubs/index.html#tabs-760094-4

Americans consume more opioids than any other country

Standard daily opioid dose for every 1 million people



Source: United Nations International Narcotics Control Board

Credit: Sarah Frostenson

Vox

THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016...

116
People died every day from opioid-related drug overdoses

11.5 m
People misused prescription opioids[1]

42,249
People died from overdosing on opioids[2]

2.1 million
People had an opioid use disorder[1]

948,000
People used heroin[1]

170,000
People used heroin for the first time[1]

2.1 million
People misused prescription opioids for the first time[1]

17,087
Deaths attributed to overdosing on commonly prescribed opioids[2]

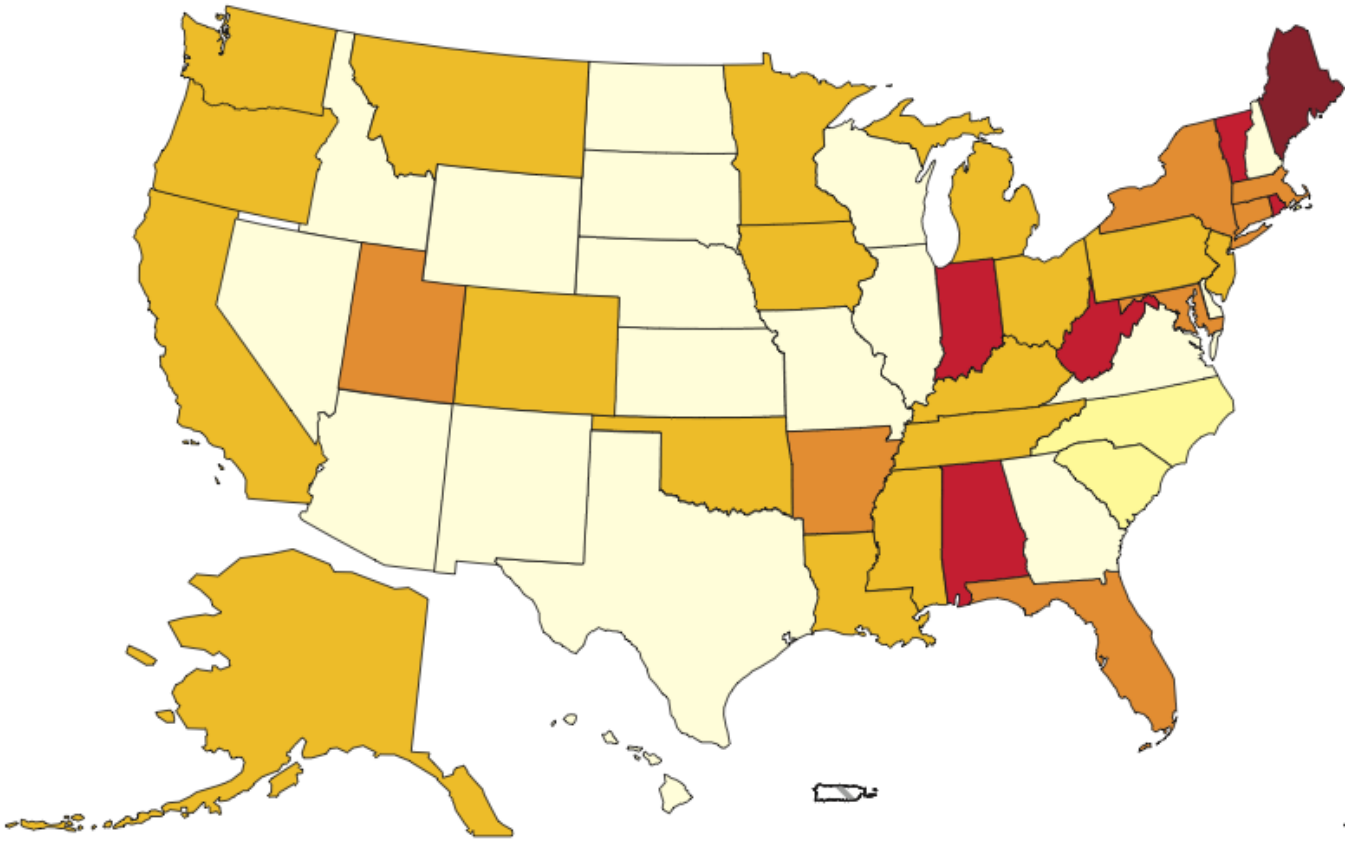
19,413
Deaths attributed to overdosing on synthetic opioids other than methadone[2]

15,469
Deaths attributed to overdosing on heroin[2]

504 billion
In economic costs[3]

Sources: [1] 2016 National Survey on Drug Use and Health, [2] Mortality in the United States, 2016 NCHS Data Brief No. 293, December 2017, [3] CEA Report: The underestimated cost of the opioid crisis, 2017

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



1999

(range 1 - 50)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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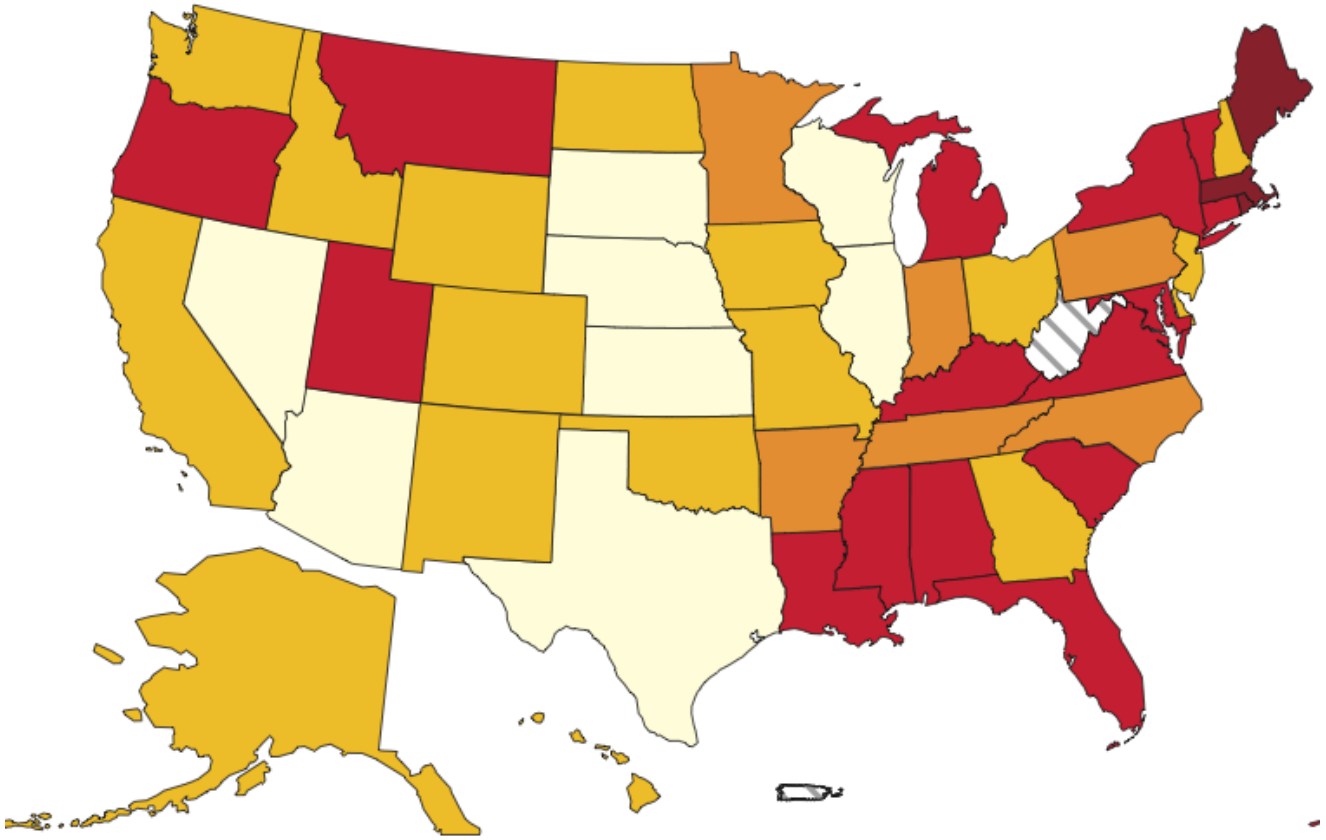

2001

(range 1 – 71)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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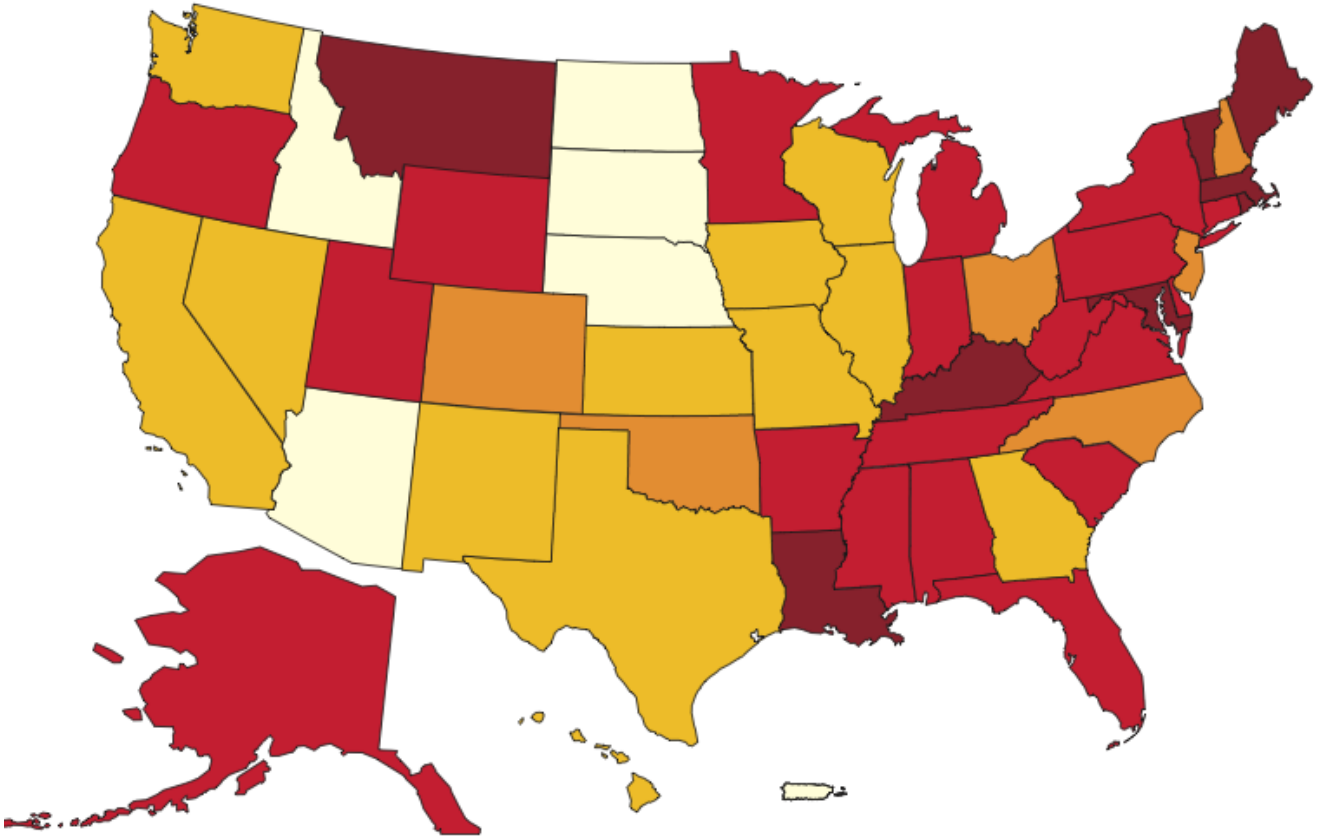

2003

(range 2 – 139)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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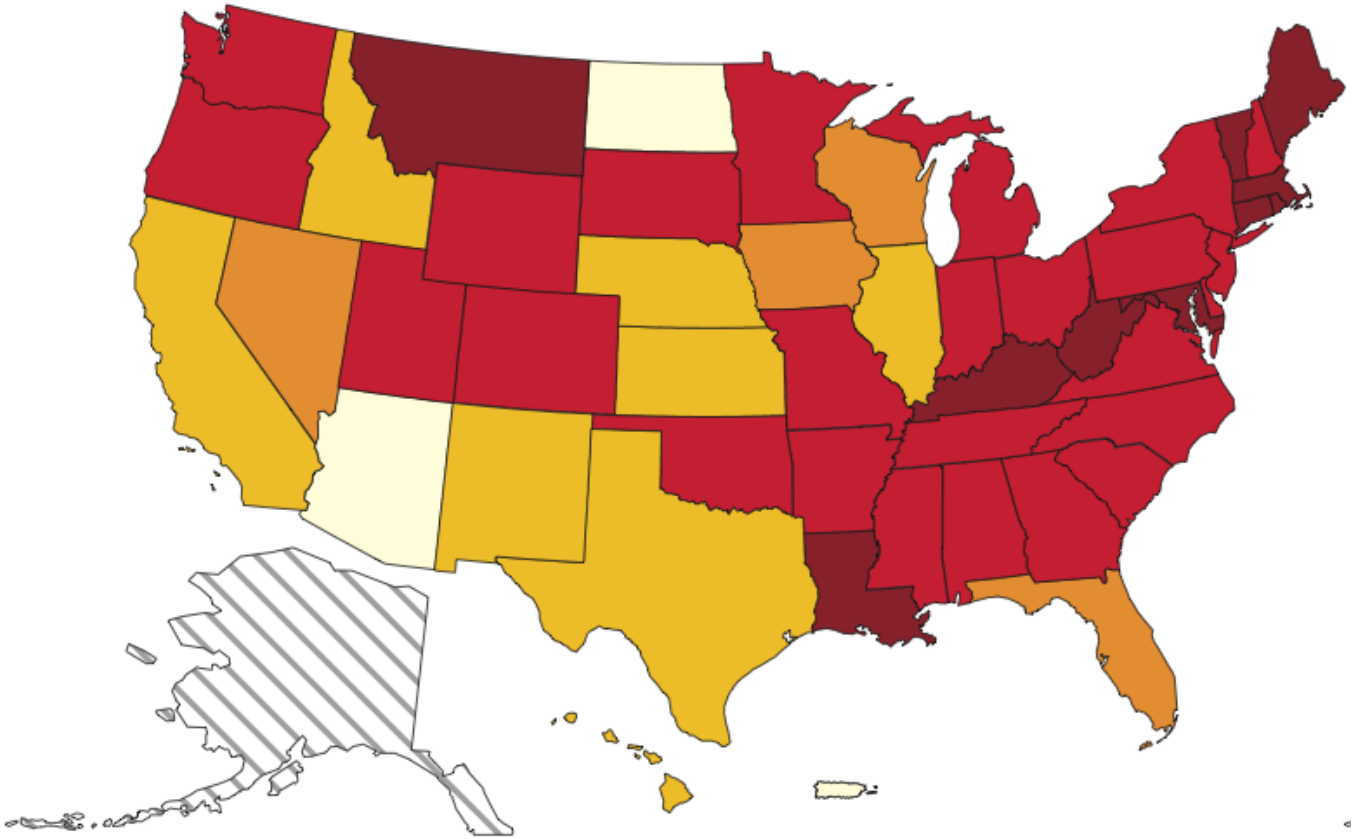

2005

(range 0 – 214)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

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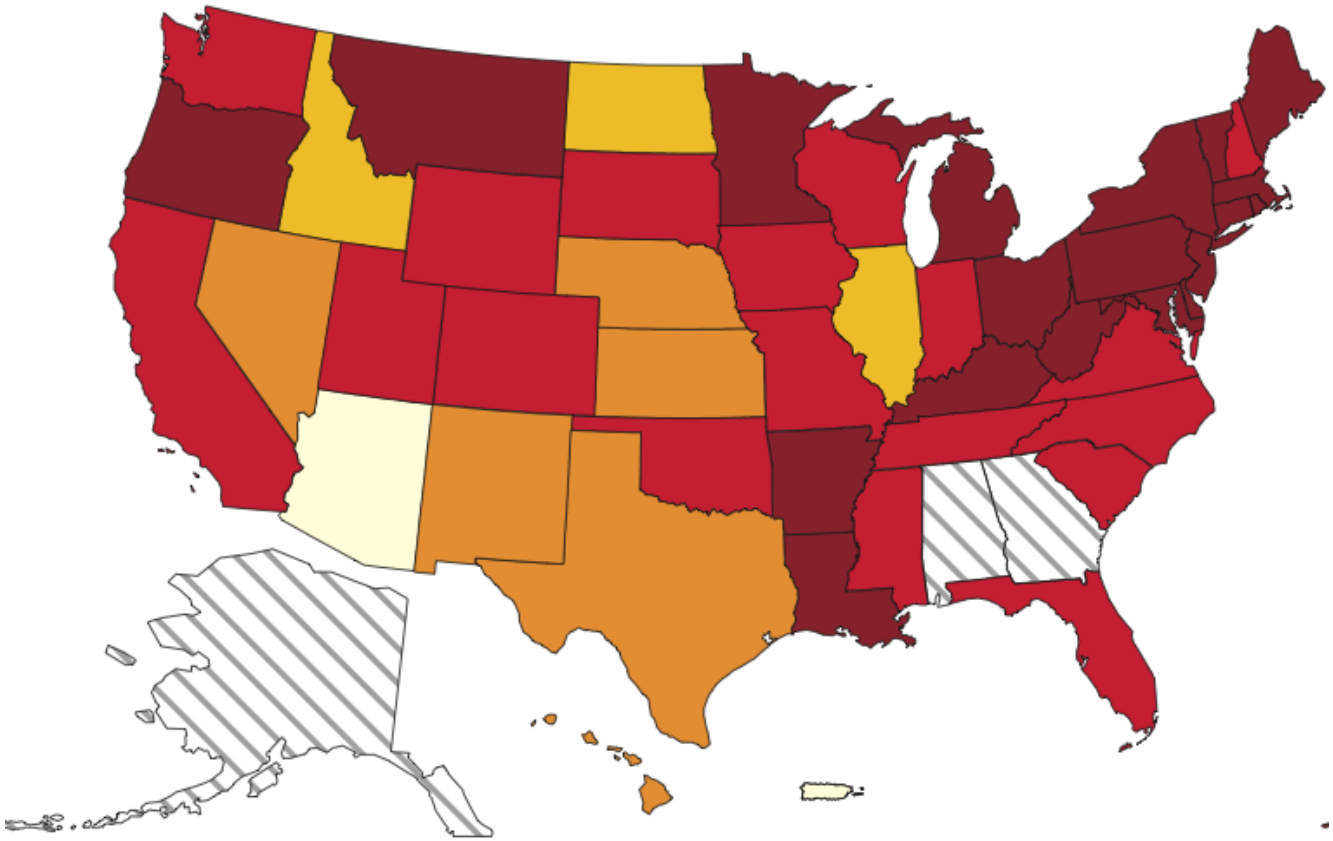

2007

(range 1 – 340)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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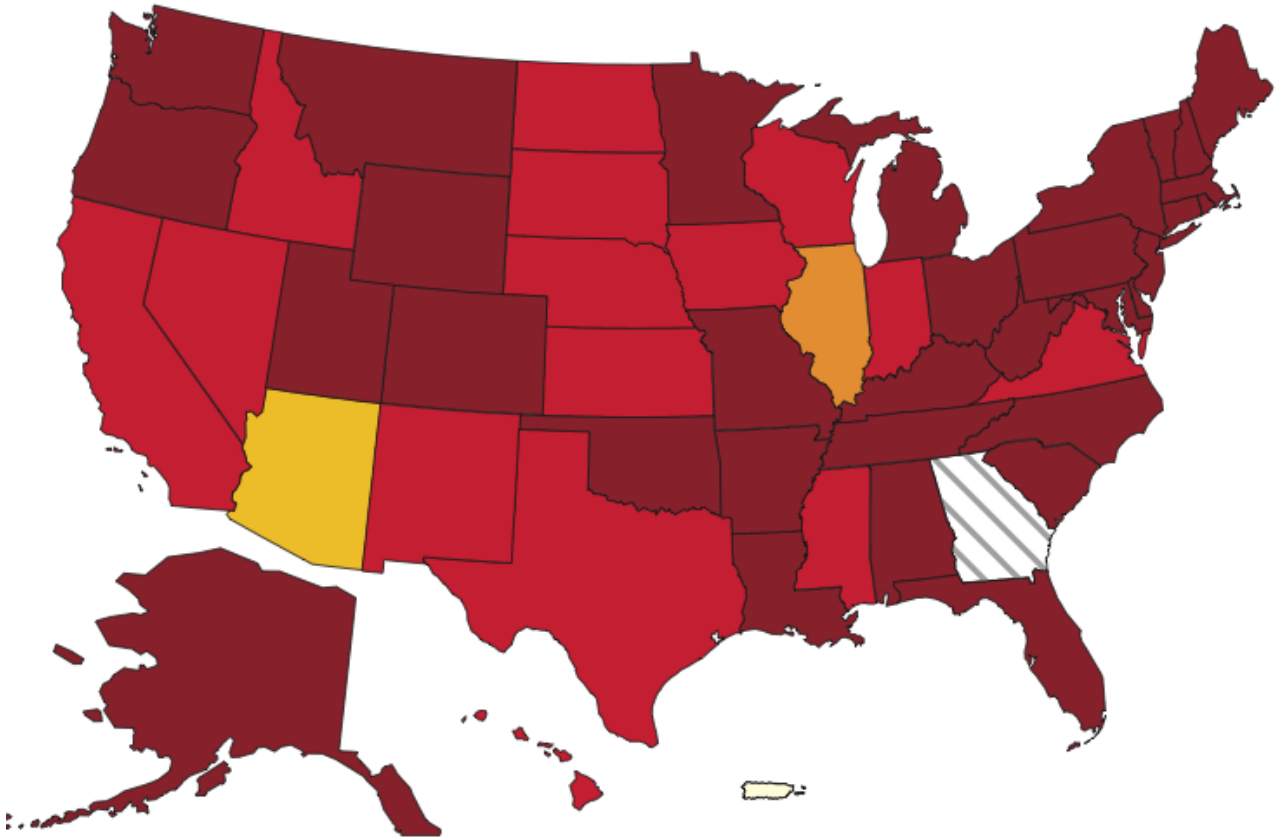


2009

(range 1 – 379)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

N Engl J Med. 1980 Jan 10;302(2):123.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

FDA approved OxyContin in 1995

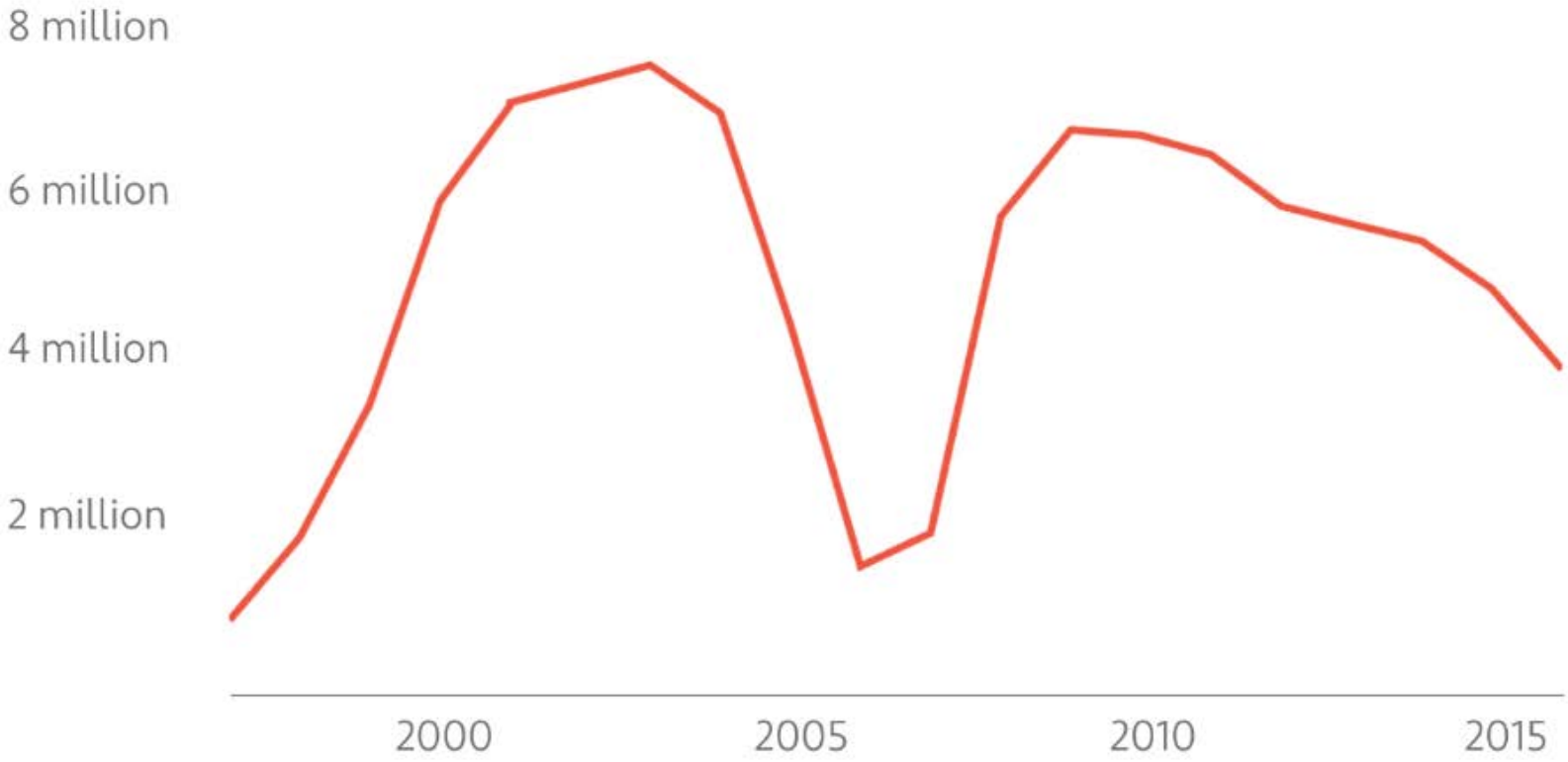
Believing it "would result in less abuse potential"

DRUG ABUSE AND DEPENDENCE (Addiction)

OxyContin is a mu-agonist opioid with an abuse liability similar to morphine and is a schedule II controlled substance. Oxycodone products are common targets for both drug abusers and drug addicts. Delayed absorption as provided by OxyContin tablets, is believed to reduce the abuse liability of a drug.

Drug addiction (drug dependence, psychological dependence) is characterized by a preoccupation with the procurement, hoarding, and abuse of drugs for non-medicinal

OxyContin prescriptions 1997-2016



Data courtesy of IQVIA

Sarah Menendez/Marketplace

FDA Approved Opioids

- 2010: Oxycontin (reformulated - cut, broken, chewed, crushed or dissolved)
- 2010: Exalgo ER (crush and extraction resistant).
- 2011: Nucynta ER (crush resistant).
- 2011: Oxecta (unpleasant snort, forms gel if dissolved).
- 2011: Opana ER (reformulated crush and intravenous-use resistant).
- 2014: Tarquiniq ER (naloxone which is released only if the tablet is altered)
- 2014: Embeda a (naltrexone which is released only if the tablet is altered).
- 2014: Hyslinga ER (crush and intravenous-use resistant).
- 2015: Zohydro ER s (a viscous gel is created when altered)
- 2015: OxyContin for pediatric use
- 2015: MorphaBond (crush and intravenoususe resistant).
- 2015: Xtampza ER (capsules can be opened and mixed with food, properties make it difficult to abuse nasally or intravenously)

AB-487 Medical professionals: conduct. (2001-2002)

AB 487, signed into law on October 4, 2001, requires most California-licensed physicians to take, as a one-time requirement, 12 units of continuing medical education (CME) on "pain management" and "the appropriate care and treatment of the terminally ill."

This bill would require the Division of Medical Quality to develop standards before June 1, 2002, for the investigation of complaints concerning the management, including, but not limited to, undertreatment, undermedication, and medication of pain and to include in its annual report to the Legislature a description of actions relating to that practice.

The New York Times

HEALTH | PERSONAL HEALTH

When It Comes to Severe Pain, Doctors Still Have Much to Learn

By JANE E. BRODY FEB. 15, 2005

My surgeon did a marvelous job replacing my arthritic knees and, at the same time, straightening my terribly bowed legs when, at 63, I decided to have knee replacement surgery.

Although a class given at the hospital before the operation repeatedly emphasized the importance of adequate pain control, the surgeon and his helpers were not experts in treating prolonged, debilitating postoperative pain.

They are hardly alone. Pain management is not generally taught as a part of medical education, not even to residents in orthopedic surgery. As a result, most doctors are clueless or unnecessarily cautious about treating pain, especially chronic pain like that caused by incurable neurological or muscular disorders.

They are especially ill-informed about opioids, which are synthetic versions of morphine, the most potent painkillers that can be taken by mouth.

As Dr. Jennifer P. Schneider writes about opioids in her book "Living With Chronic Pain" (Healthy Living Books, $15.95), "Fear and lack of knowledge of these drugs prevent many doctors from prescribing them for people whose pain is caused by anything other than cancer."

Yet, she continues, in 1995 The Journal of the American Medical Association lamented the reluctance of physicians to prescribe needed pain medication. The journal stated: "Bringing about significant change may depend on empowering patients to demand adequate pain treatment. This empowerment will not come easily, especially if opioids must be used for pain relief and if the pain is of a nonmalignant origin."

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> "Millions of people suffer needlessly year after year because their doctors do not know how to treat pain properly and don't refer patients to doctors who do know."

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"Many doctors are afraid to prescribe narcotic drugs like oxycodone, fearing they will create addiction problems. But that in fact rarely happens to chronic pain patients who don't have a history of addiction."

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"Furthermore, undertreatment of pain can actually cause a chronic problem when the nervous system changes in response to continuing pain signals. Nerves can become permanently hypersensitive to painful and nonpainful stimuli, like touch or vibration."

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"With chronically undertreated pain, the painful area can also spread well beyond the original injured site, as happened to a man I know who now has to take 500 milligrams a day of OxyContin"

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Pain. 2006 Nov;125(1-2):172-9. Epub 2006 Jul 13.

Critical issues on opioids in chronic non-cancer pain: an epidemiological study.

Eriksen J[1], Sjøgren P, Bruera E, Ekholm O, Rasmussen NK.

Author information

Abstract

The aim of the study was epidemiologically to evaluate the long-term effects of opioids on pain relief, quality of life and functional capacity in long-term/chronic non-cancer pain. The study was based on data from the 2000 Danish Health and Morbidity Survey. As part of a representative National random sample of 16,684 individuals (>16 years of age), 10,066 took part in an interview and completed a self-administered questionnaire. Cancer patients were excluded. The interview and the self-administered questionnaire included questions on chronic/long-lasting pain (>6 months), health-related quality of life (SF-36), use of the health care system, functional capabilities, satisfaction with medical pain treatment and regular or continuous use of medications. Participants reporting pain were divided into opioid and non-opioid users. The analyses were adjusted for age, gender, concomitant use of anxiolytics and antidepressants and pain intensity. Pain relief, quality of life and functional capacity among opioid users were compared with non-opioid users. Opioid usage was significantly associated with reporting of moderate/severe or very severe pain, poor self-rated health, not being engaged in employment, higher use of the health care system, and a negative influence on quality of life as registered in all items in SF-36. Because of the cross-sectional nature causative relationships cannot be ascertained. However, it is remarkable that opioid treatment of long-term/chronic non-cancer pain does not seem to fulfil any of the key outcome opioid treatment goals: pain relief, improved quality of life and improved functional capacity.

Comment in

Opioids for chronic pain: taking stock. [Pain. 2006]
Mortality from opioid analgesics must not be ignored. [Pain. 2007]
Caution with epidemiological data in relation to chronic opioid use. [Pain. 2007]

PMID: 16842922 DOI: 10.1016/j.pain.2006.06.009

[Indexed for MEDLINE]

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- AMA
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- MBC

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War on Pain Updated: Pain Management and the Appropriate Care and Treatment of the Terminally Ill

AB 487, signed into law on October 4, 2001, requires most California-licensed physicians to take, as a one-time requirement, 12 units of continuing medical education (CME) on "pain management" and "the appropriate care and treatment of the terminally ill." This series qualify to meet the AB 487 requirement.

Physicians with an active license before January 1, 2002, will have until December 31, 2006, to obtain the 12 hours.

Physicians licensed on or after January 1, 2002, must complete the mandated hours by their second license renewal date or within four years whichever comes first.

The 12 required hours shall count toward the 25 hours of approved continuing education each physician is required to complete during each calendar year.

ACTIVITY OVERVIEW:

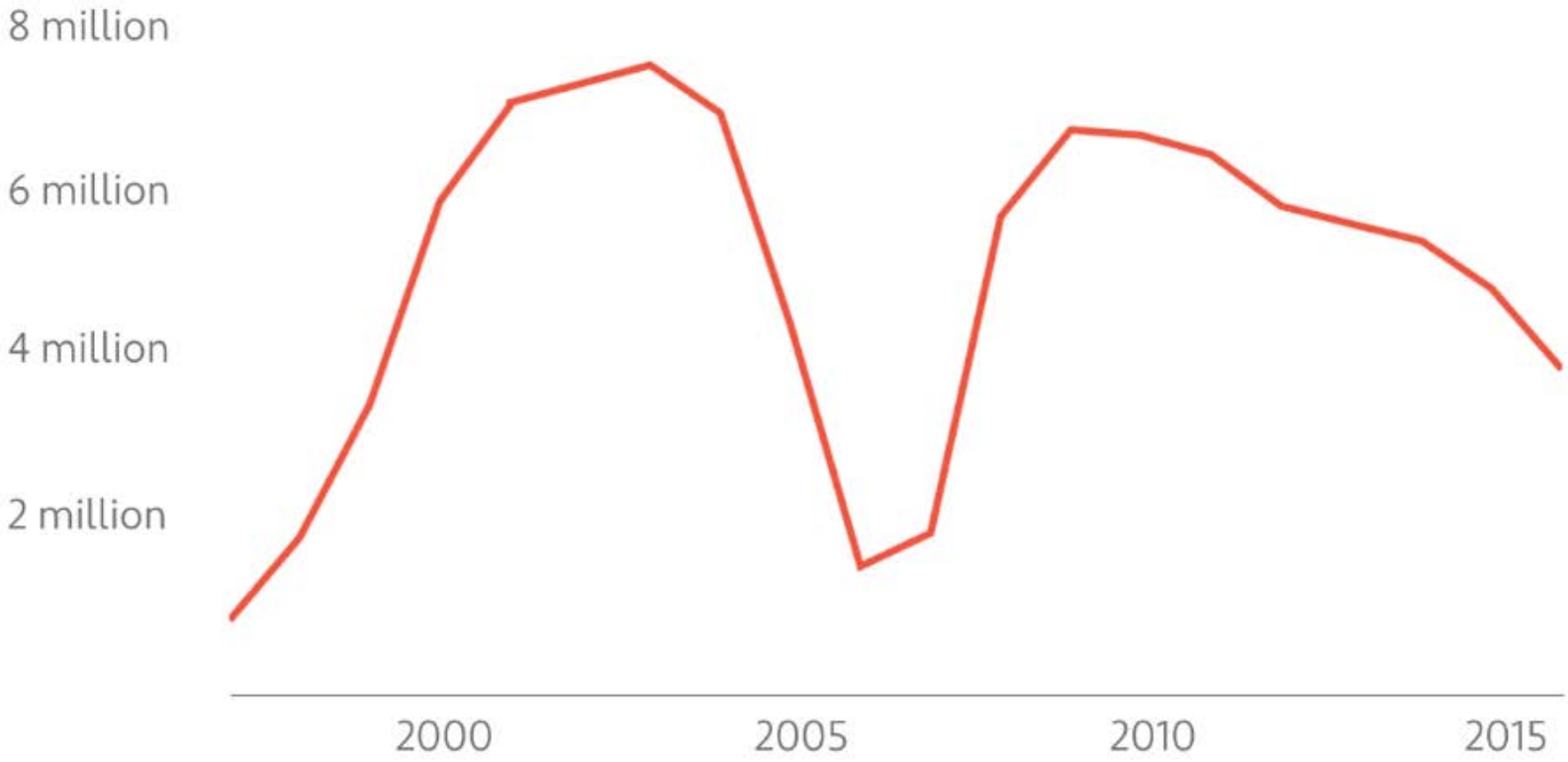
The Office of Continuing Medical Education created the "War on Pain" course as an outreach for California physicians. This series in pain management and end-of-life was created without any pharmaceutical support. It features UC Davis pain specialists who are faculty physicians in the field of pain and palliative medicine.

GOAL:

To meet the requirement for AB 487. California state law required California physicians to obtain a minimum of 12 hours of Category 1 continuing medical education credit in pain management and end-of-life. The "War on Pain" course was created to meet this requirement.

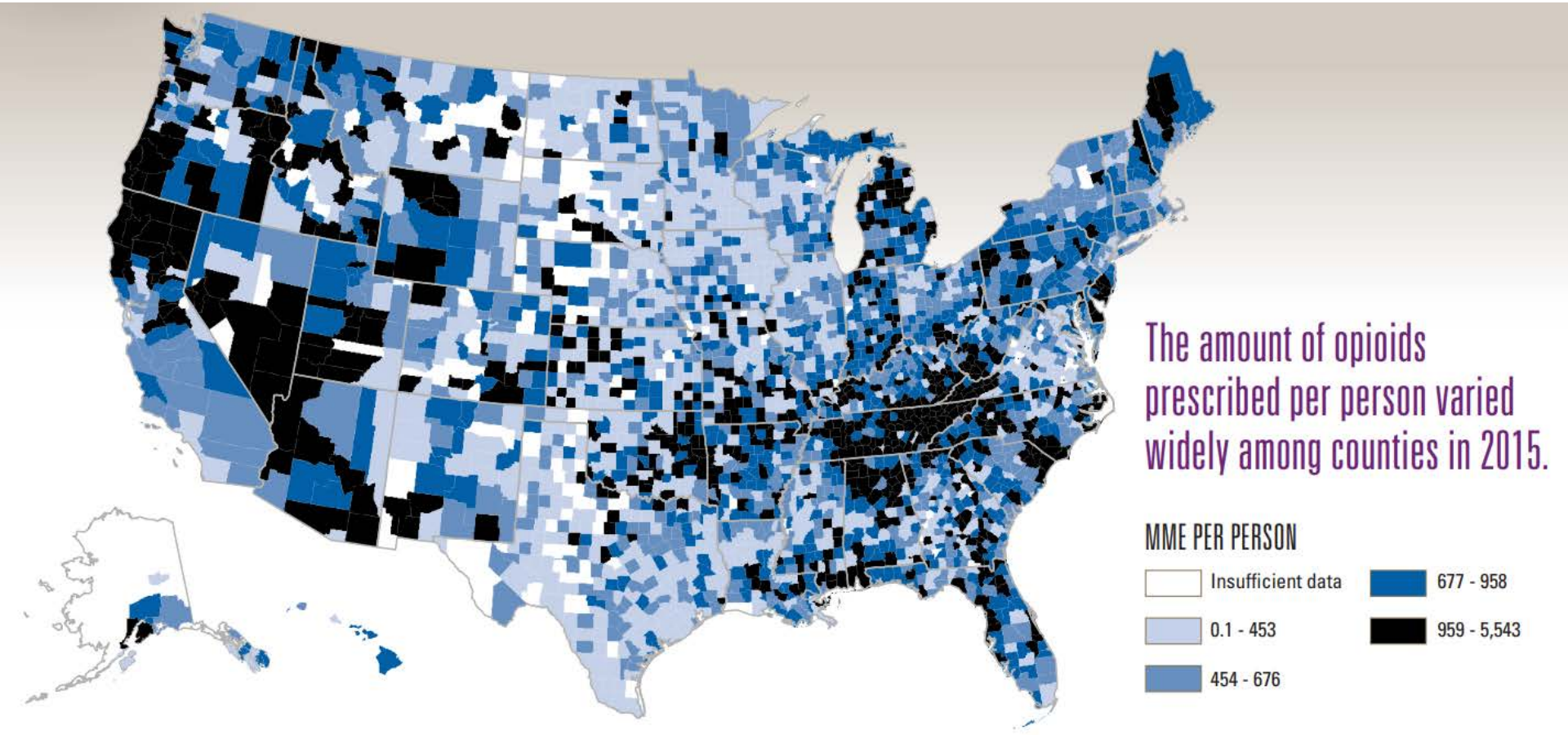
Type: Internet Activity (Enduring Material)

OxyContin prescriptions 1997-2016



Data courtesy of IQVIA

Sarah Menendez/Marketplace



Higher opioid prescribing puts patients at risk for addiction and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids. The 2016 ***CDC Guideline for Prescribing Opioids for Chronic Pain*** offers recommendations that may help to improve prescribing practices and ensure all patients receive safer, more effective pain treatment.

SOURCE: CDC Vital Signs, July 2017

What's Behind the Addiction Crisis in Rural America?

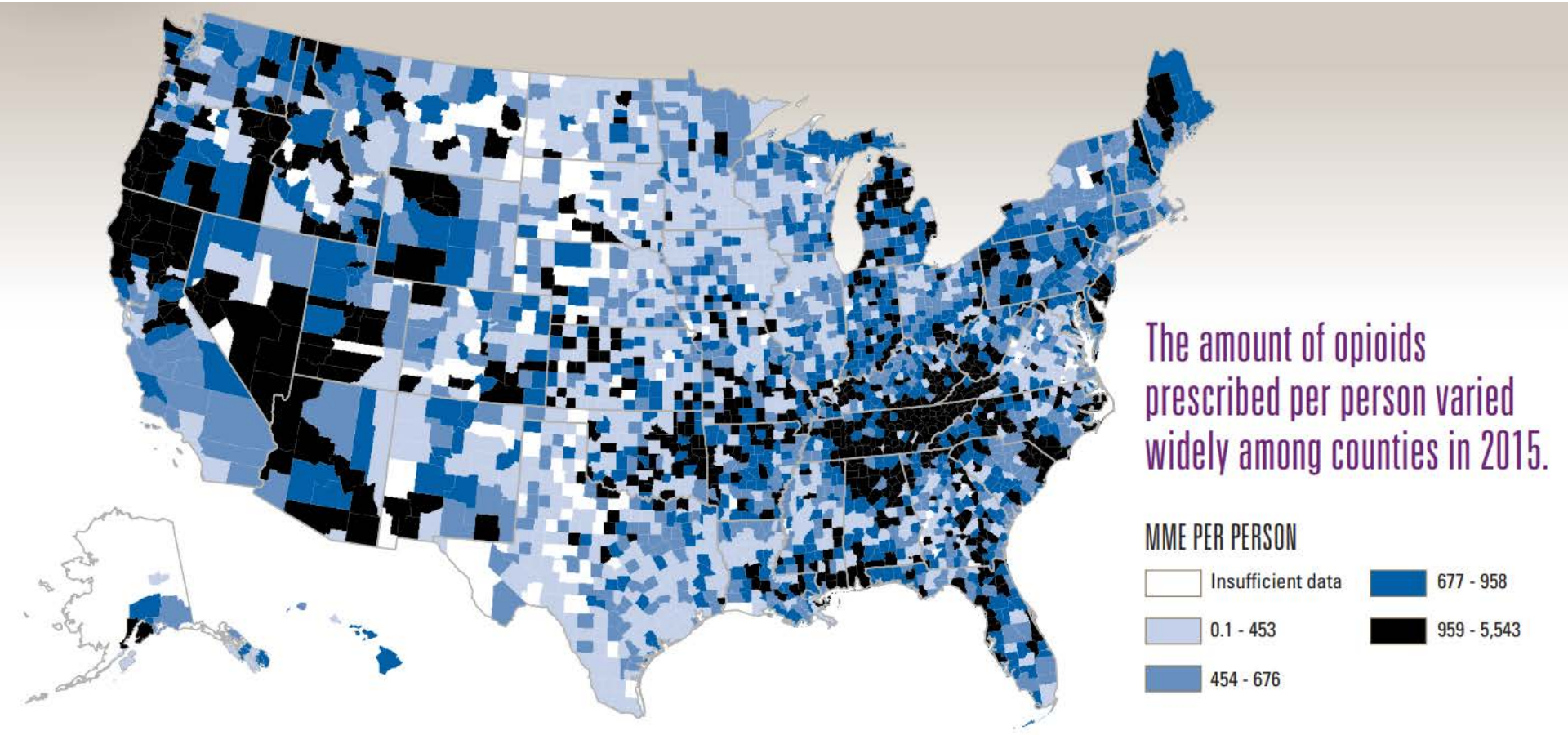
- The Great recession took a significant toll on rural communities
- Increased economic pressures – poverty
- Chronic Pain and injuries are more common than in urban areas
- Increased physically laborious jobs
- Diversion is more common due to need for money
- Large social networks
- Opioids have become "drugs of solace"
- lower Emergency Medical Service (EMS) response times
- Lack of alternative treatment options – drugs become prime option
- Poverty increase the risk not only of addiction but of other physical and mental illnesses
- Lack of addiction treatment capabilities

NRHA

NATIONAL RURAL HEALTH ASSOCIATION

- 92%of substance use treatment facilities located in urban areas.
- 90% of X-Waived physicians practice in urban counties.
- 30 million people living in counties where treatment is unavailable.
- 65% do not have a psychiatrist.
- 53% are without any X-Waived physician.
- 47% lack a psychologist
- 27% do not have a social worker
- 18% lack a behavioral health counselor

2017 report published by the National Rural Health Association



Higher opioid prescribing puts patients at risk for addiction and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids. The 2016 ***CDC Guideline for Prescribing Opioids for Chronic Pain*** offers recommendations that may help to improve prescribing practices and ensure all patients receive safer, more effective pain treatment.

SOURCE: CDC Vital Signs, July 2017

Siskiyou County ranks 7th out of 58 counties in the State of California for the number of annual deaths from opioid overdose.

Fairchild Medical Center

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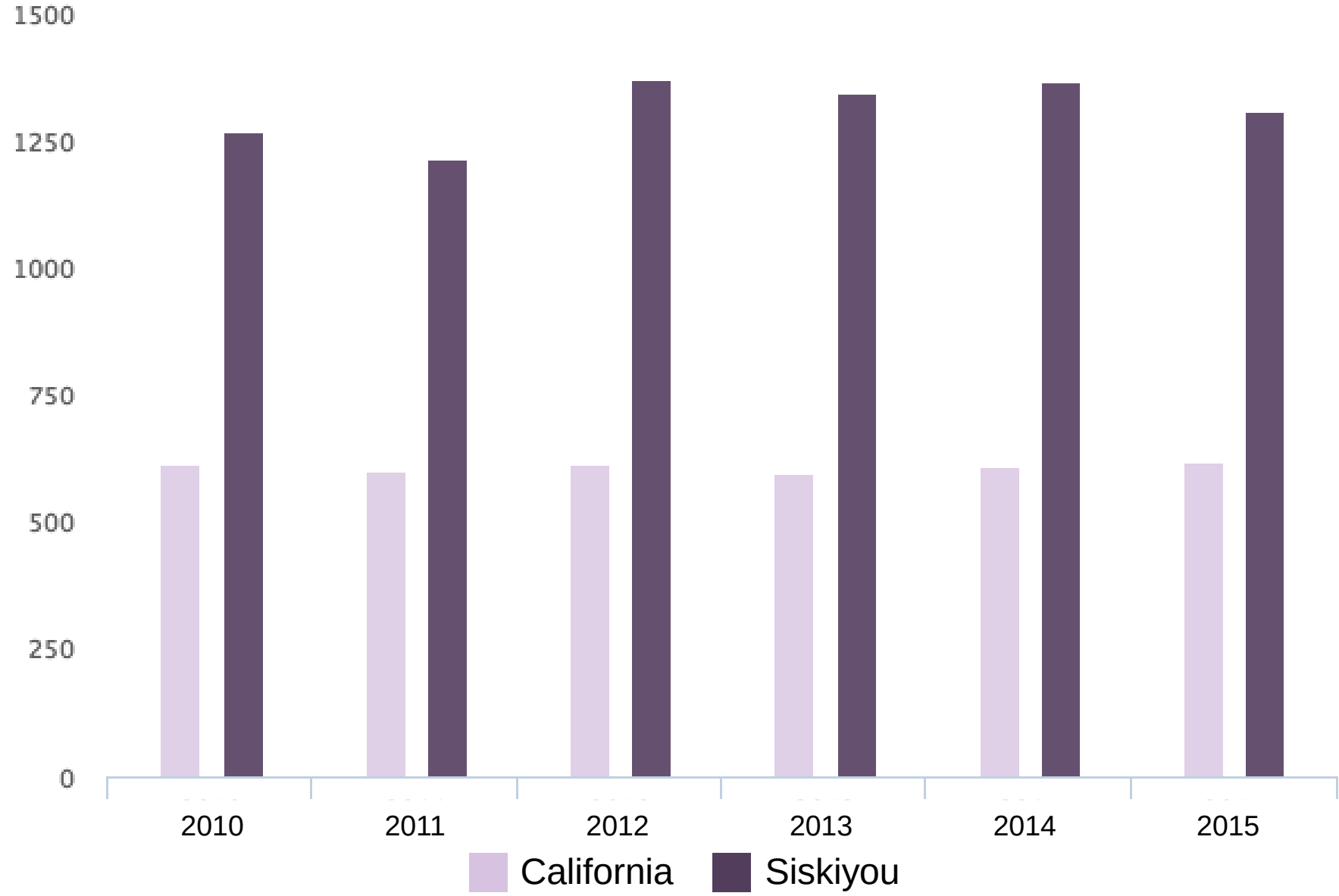
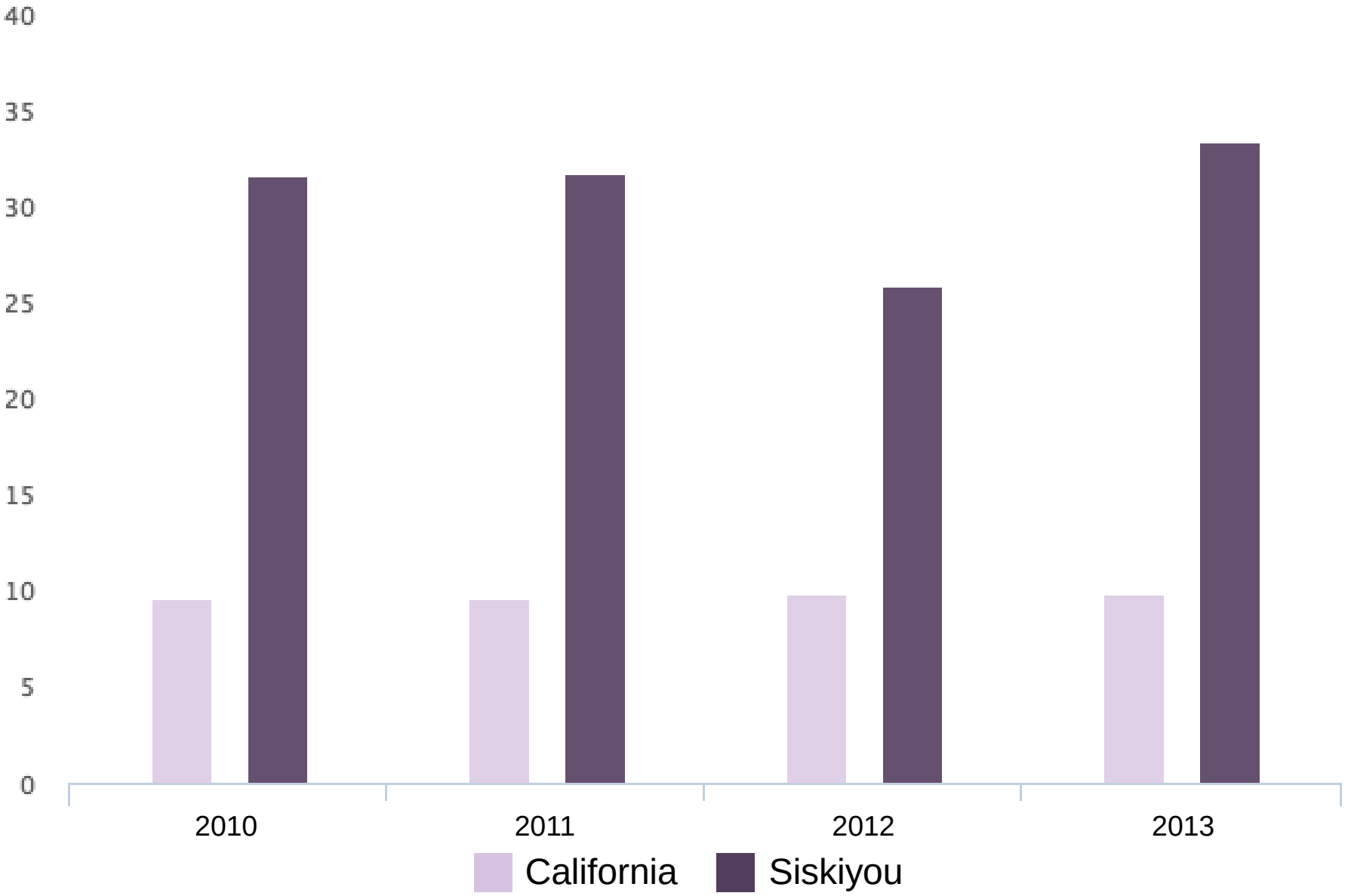
Opioid Prescription Rate

Source: CURES, per 1,000 residents



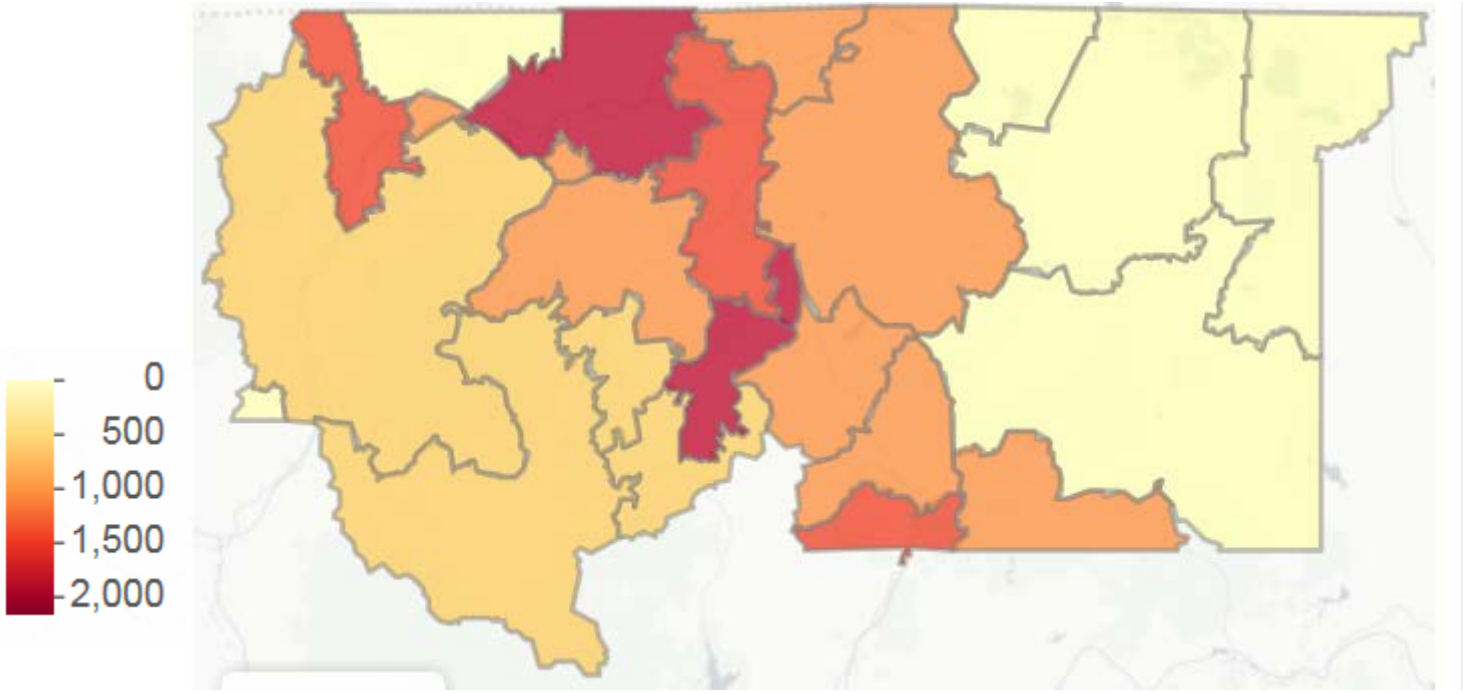
Residents on 90 Sequential Days of Opioids

Source: CURES, per 1,000 residents



Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2013



https://discovery.cdph.ca.gov/CDIC/ODdash/

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- Formed an opioid committee
  - Primary care and behavior health providers
  - ED providers
  - Pharmacists
  - Law enforcement
  - Administration
- Developed policies and procedures for the clinic and ED
  - Only full-time providers can prescribe opioids.
  - Locums and new providers not allowed to prescribe narcotics.
  - Developed a clear and concise patient agreement.
  - Performed urine drug screens at least every 3 months.
  - CURES every 3 months.
- Invited community providers.
- Worked as a team to prevent "provider shopping".
- Formed SARA, the Siskiyou Against Rx Addiction coalition.

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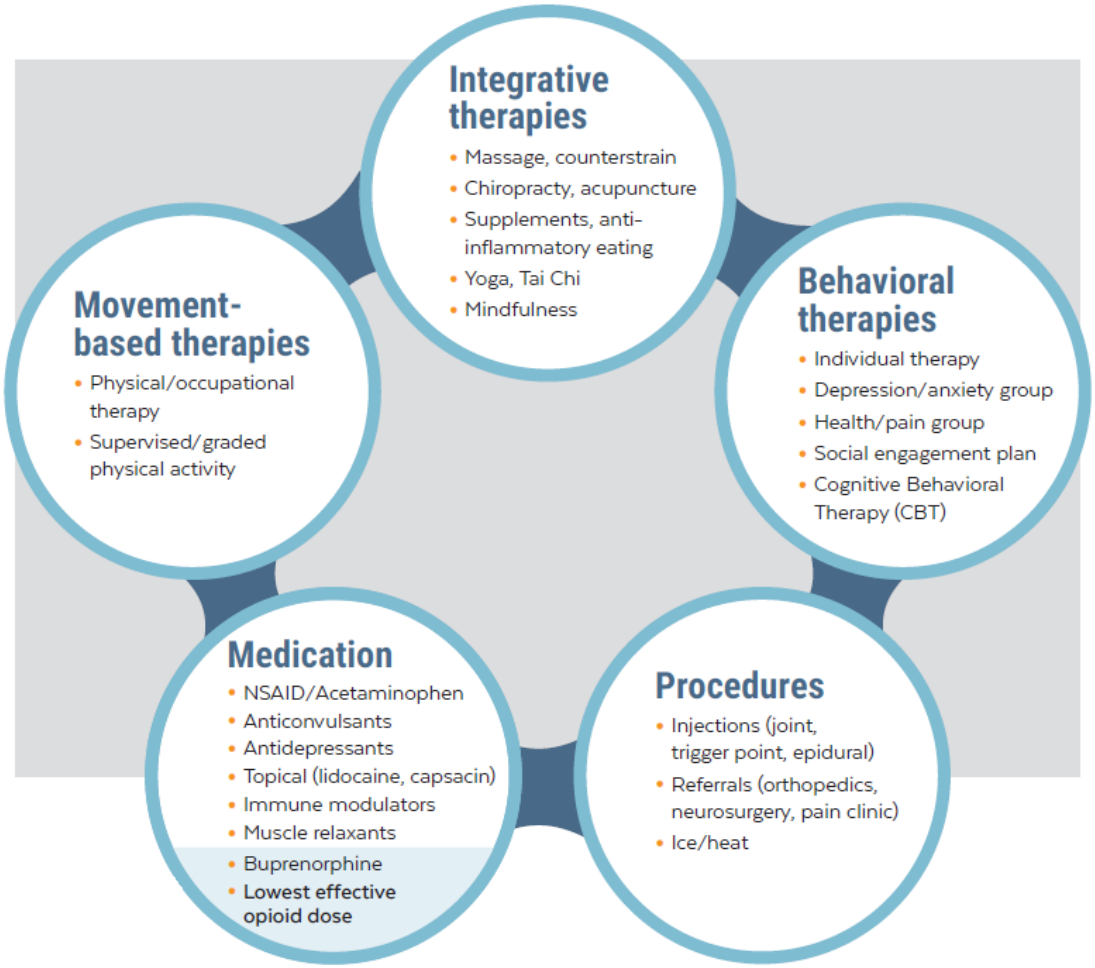
Managing chronic non-cancer pain



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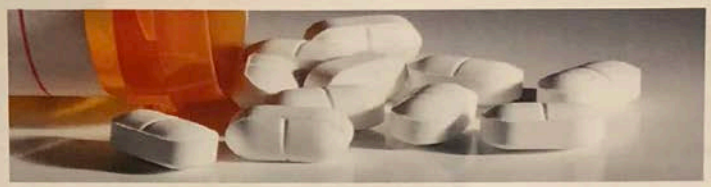
Attention Chronic Pain Patients

The Fairchild Medical Clinic Chronic Pain Agreement is updated and will be in effect **June 1st**.

No more than 90 mg equivalent of Opioids per day per CDC guidelines for non-cancer pain



Patients must choose: Marijuana, Alcohol or Opiates?

The combination is too deadly!

Two drug screens in 6 months that are positive for Marijuana or Alcohol while on Opiates will terminate the Chronic Pain Agreement.

The providers and staff of Fairchild Medical Clinic striving to create a healthier community. Thank You

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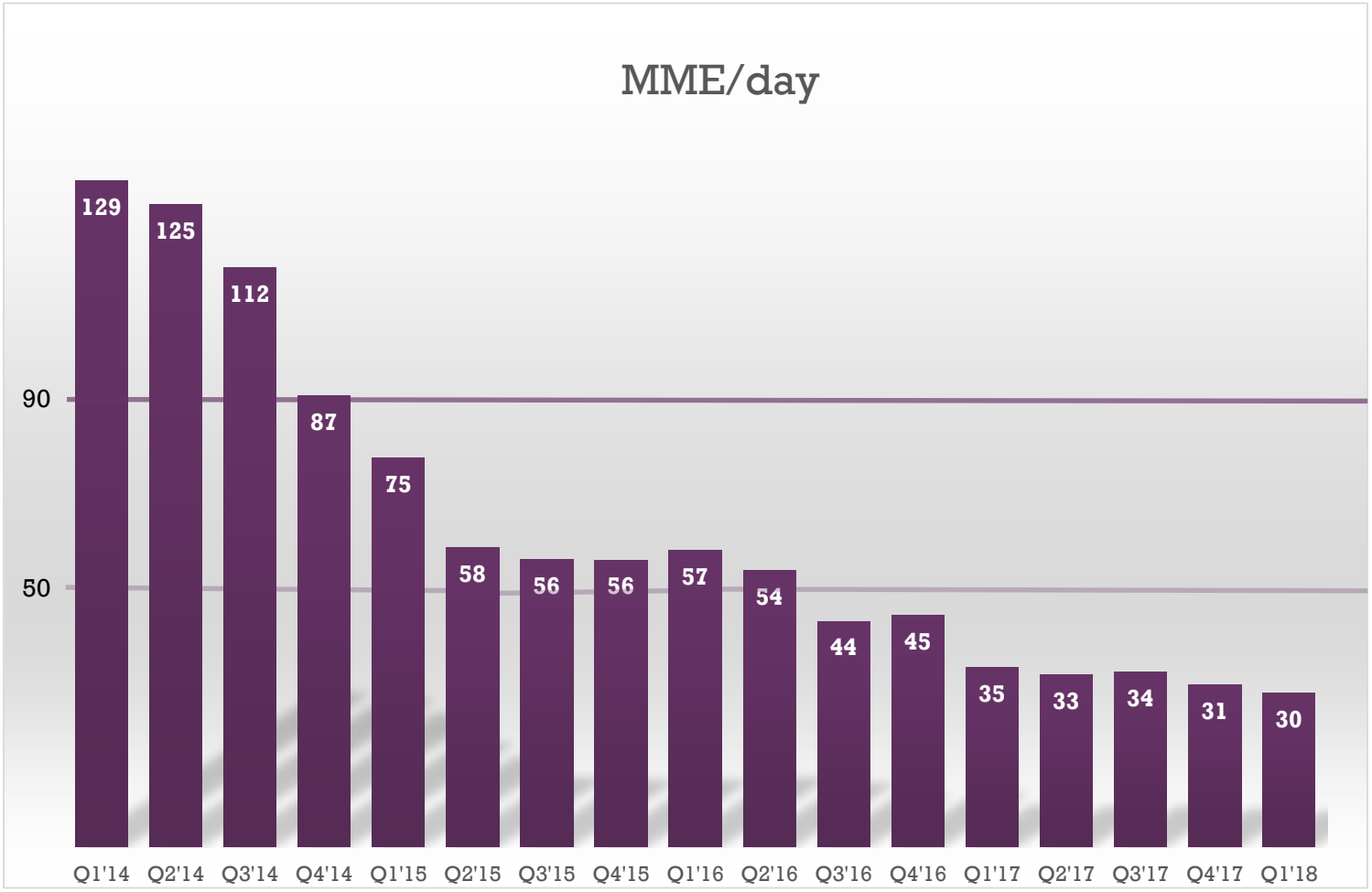
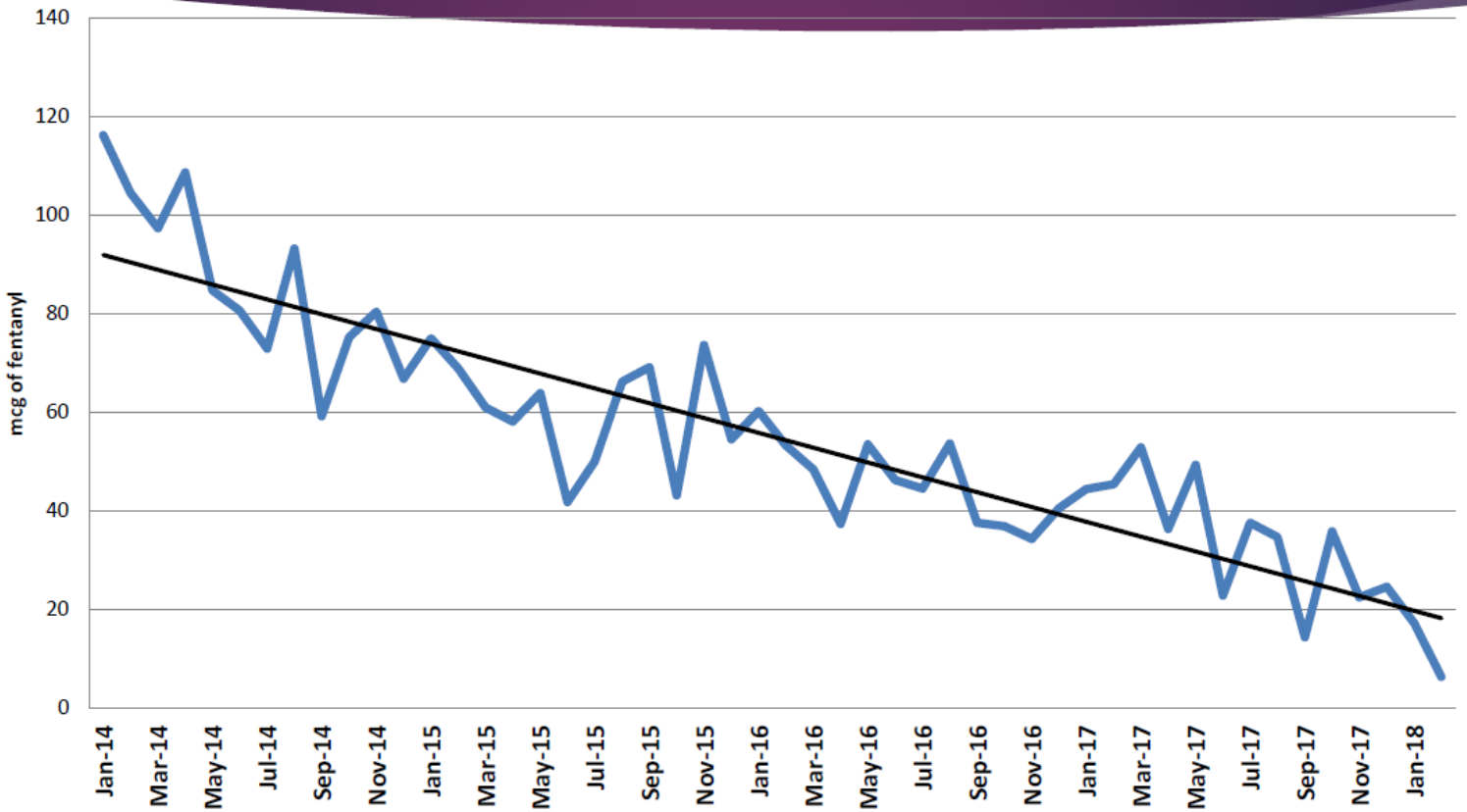


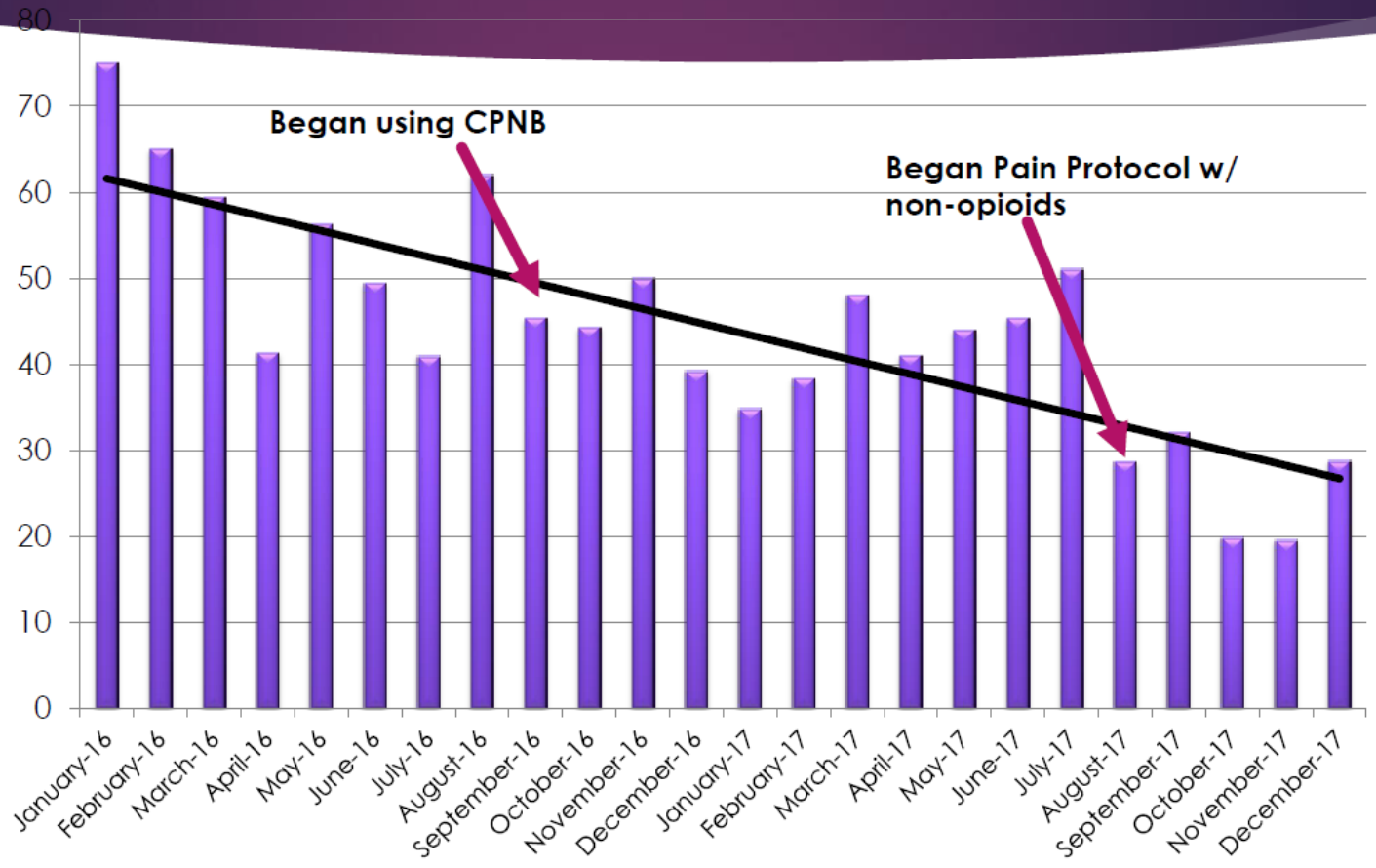
MMCMS

- In 2014 the CRNA group began initiative of employing multimodal analgesia to improve pain control
  - Pre-op opioid alternatives
  - Regional anesthesia blocks
  - Continuous peripheral nerve block infusions
    - Ropivicaine 0.2%

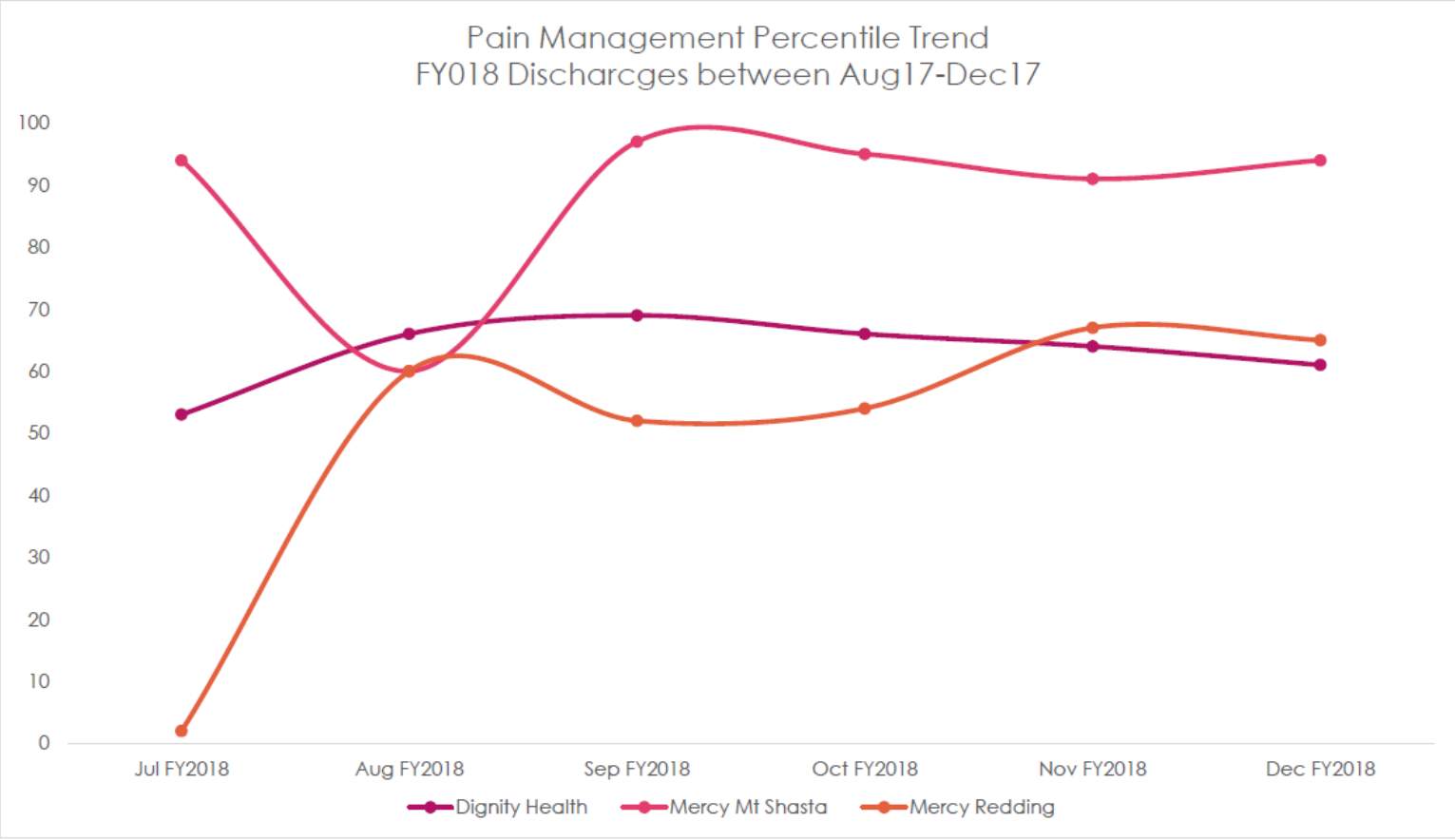
Anesthesia Fentanyl mcg Per Case



Inpatient Morphine Equivalents per Patient Day



Pain Management Satisfaction



Length of Stay

Surgery	2016	2017
TKA	2.4	1.8
THA	2.8	2.7
Hysterectomy	2.25	1
Colon	4.8	3.2

SISKIYOU AGAINST RX ADDICTION

SISKIYOU OPIOID SAFETY COALITION

- An opioid safety coalition formed in October, 2016 with funding by Partnership Health Plan and the California Department of Public Health.
- Joined 25 other coalitions in the State to identify and implement collective actions to reduce the epidemic of opioid addiction, misuse and abuse.

SISKIYOU AGAINST RX ADDICTION

SISKIYOU OPIOID SAFETY COALITION

Overarching Goal:

A 50% reduction in opioid related deaths by the end of 2018

Develop and Implement the Following Priority Areas

1. Supporting safe prescribing practices
2. Expanding access to addiction treatment
3. Increasing naloxone access

SISKIYOU AGAINST Rx ADDICTION

Develop and Implement the Following Priority Areas

1. Supporting safe prescribing practices:

- Implementing common prescribing guidelines for primary care, emergency departments and specialty practices.
- Utilizing CURES (the California prescription database).
- Creating access to non-opioid alternatives for chronic pain management.
- Improving information exchange between emergency departments, health plans and prescribers through real-time communications and data exchange.

Our Goals: - consistent prescribing guidelines in place by June, 2017.

- 80% of prescribers and pharmacists will receive educational visits.

Develop and Implement the Following Priority Areas

2. Expanding access to medication-assisted addiction treatment (MAT):

- Providing education and information to prescribers regarding the research validated benefits of Medication Assisted Treatment (MAT).
- Expanding the number of licensed physicians accepting referrals for buprenorphine treatment.
- Developing workshops and mentoring structures for physicians who are licensed but not yet prescribing buprenorphine.

Our Goal: - The number of practitioners certified to prescribe buprenorphine will increase to 12 by February, 2019.

Develop and Implement the Following Priority Areas

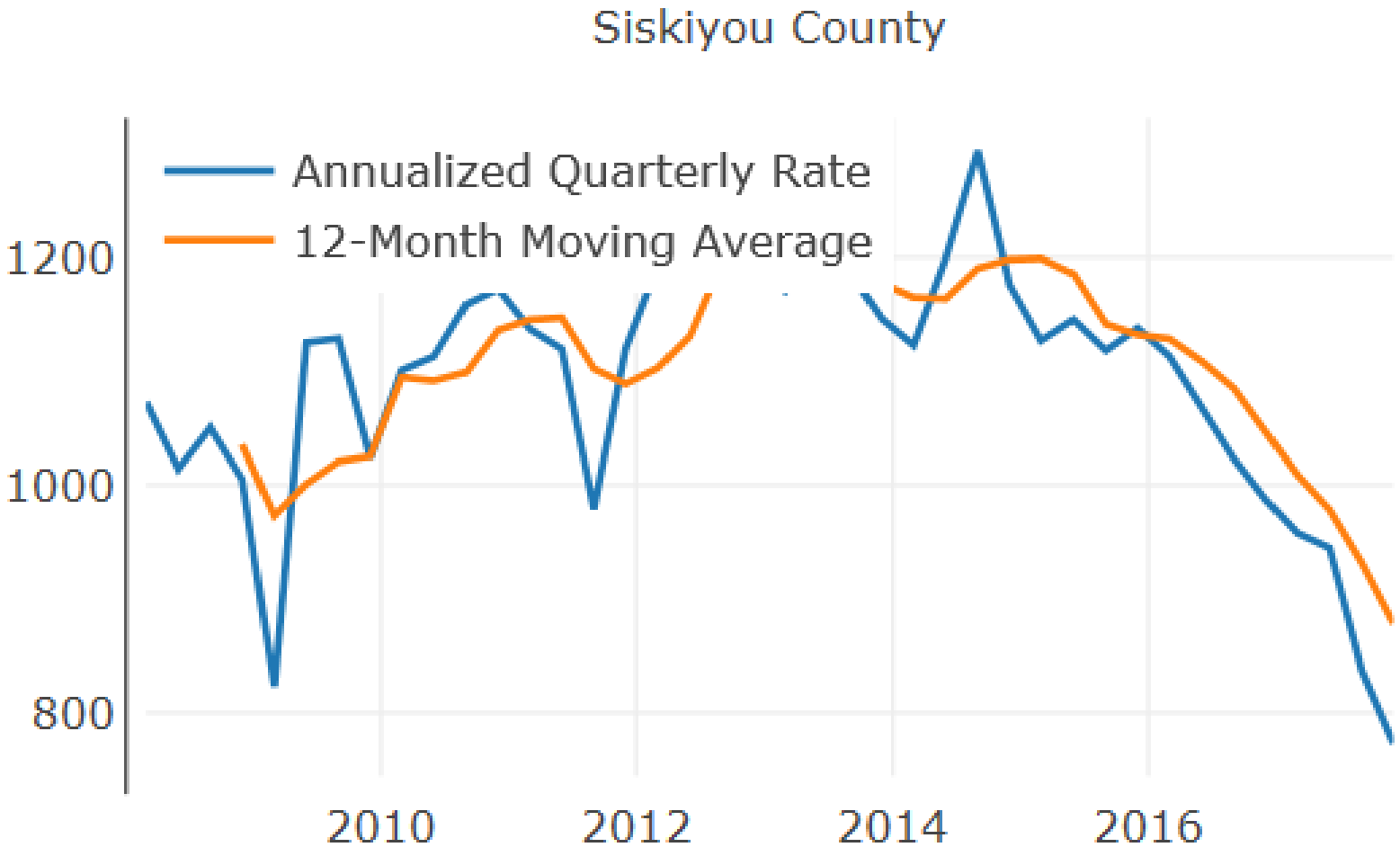
3. Increasing naloxone access:

- Increasing naloxone access for first responders.
- Increased distribution at primary care clinics, community pharmacies or substance abuse programs.
- Promoting co-prescribing of naloxone for patients receiving chronic opioids.

Our Goals: - Law enforcement officers will be trained to administer naloxone and kits will be in patrol cars by April, 2017.

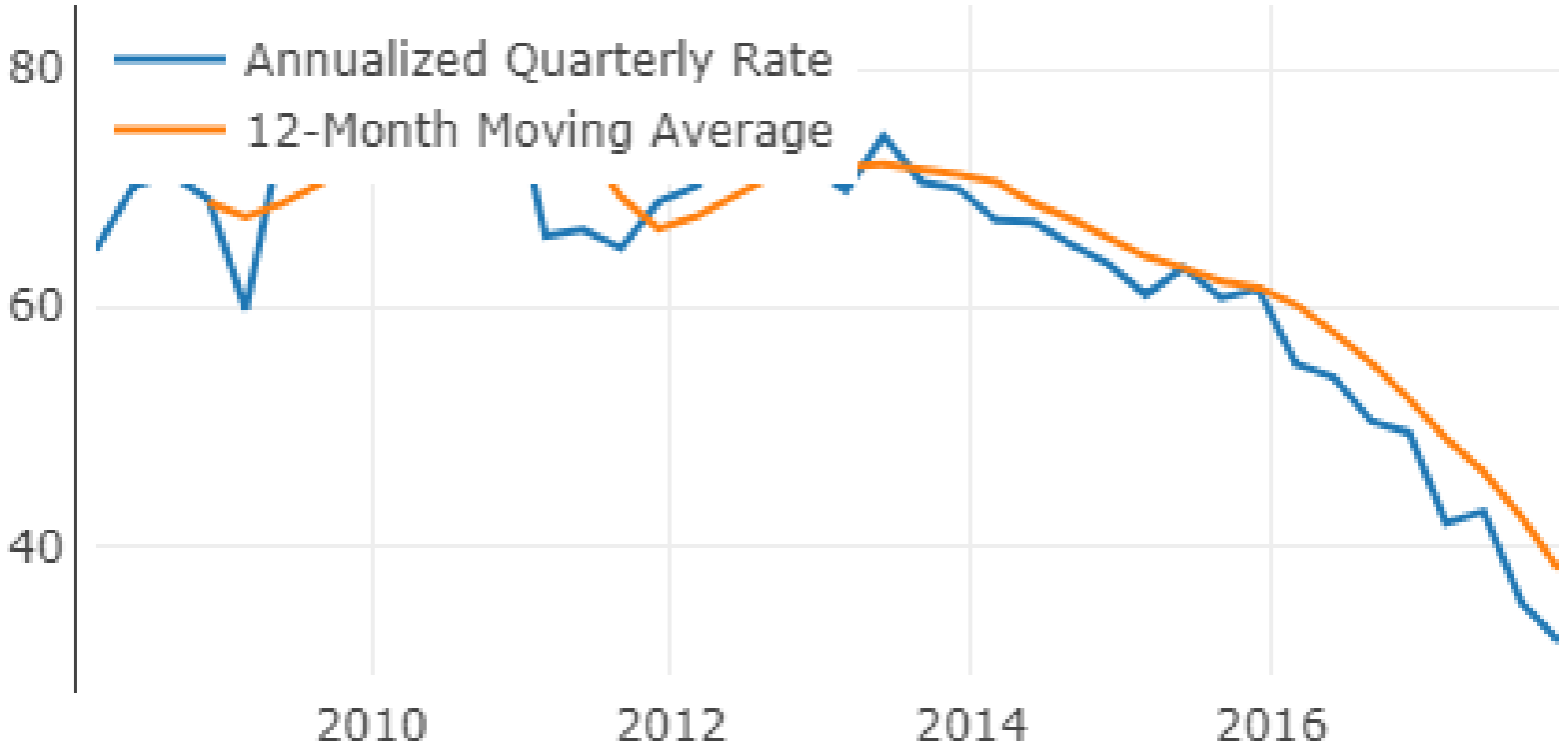
- By February of 2019, naloxone will be available in 3 of the county's 6 pharmacies.

Total Population : **Opioid Prescriptions by Patient Location** : Age-Adjusted Rate per 1k Residents



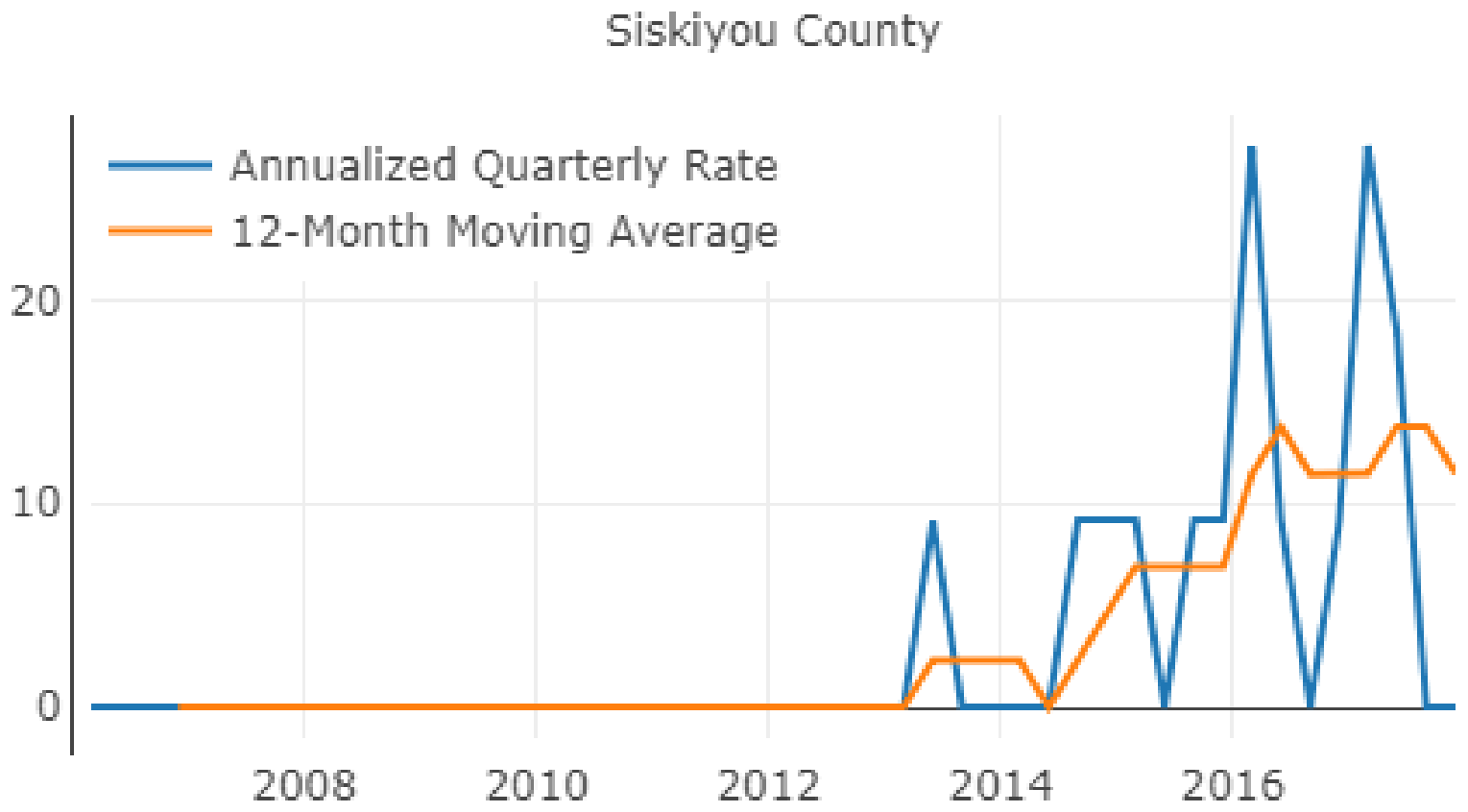
https://discovery.cdph.ca.gov/CDIC/ODdash/

Total Population : **Residents on > 90 MMEs of Opioids** : Age-Adjusted Rate per 1k Residents



https://discovery.cdph.ca.gov/CDIC/ODdash/

Total Population : **Heroin Overdose** ED Visits : Crude Rate per 100k Residents



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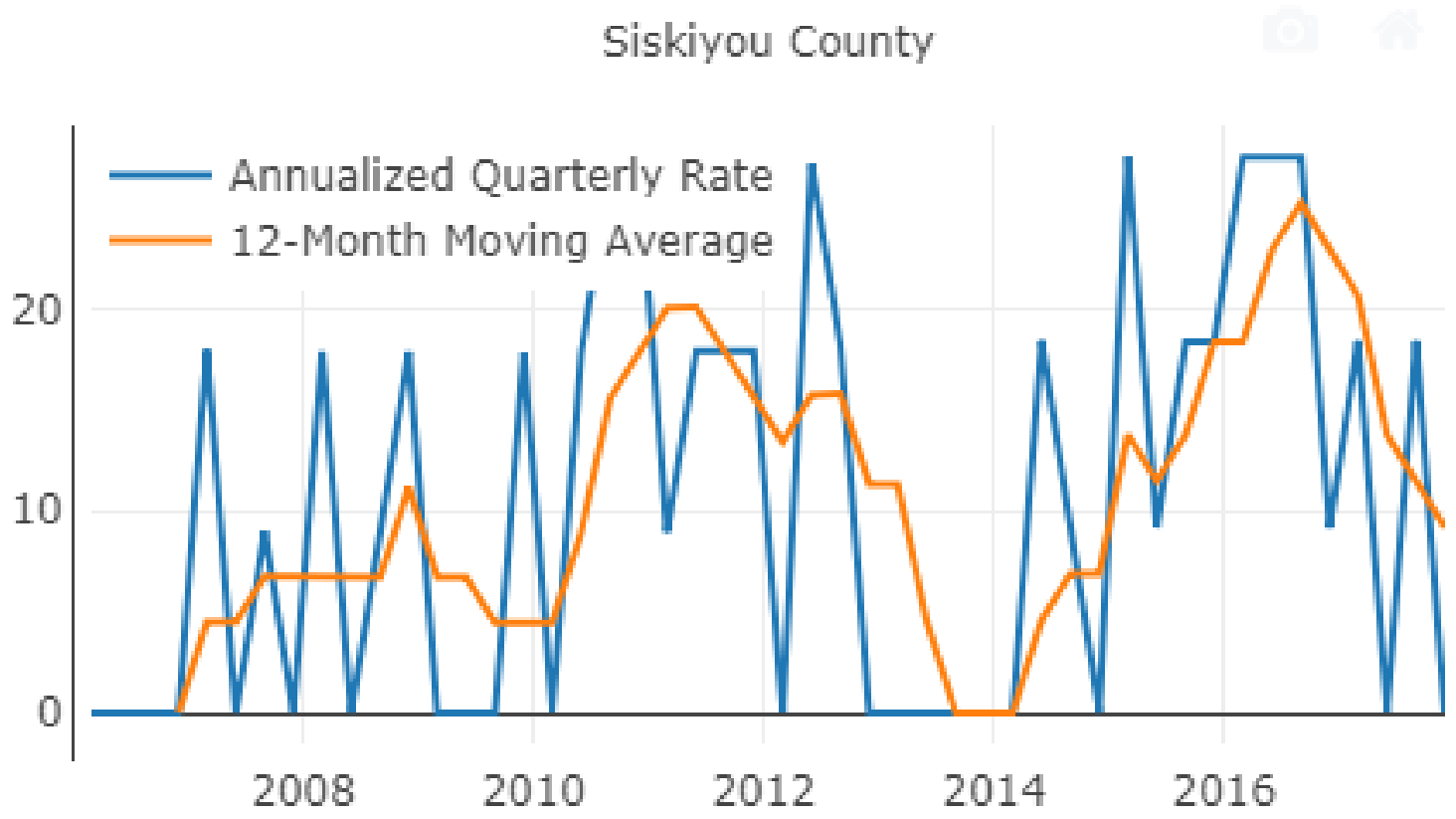
Total Population : **All Opioid Overdose** Deaths : Crude Rate per 100k Residents



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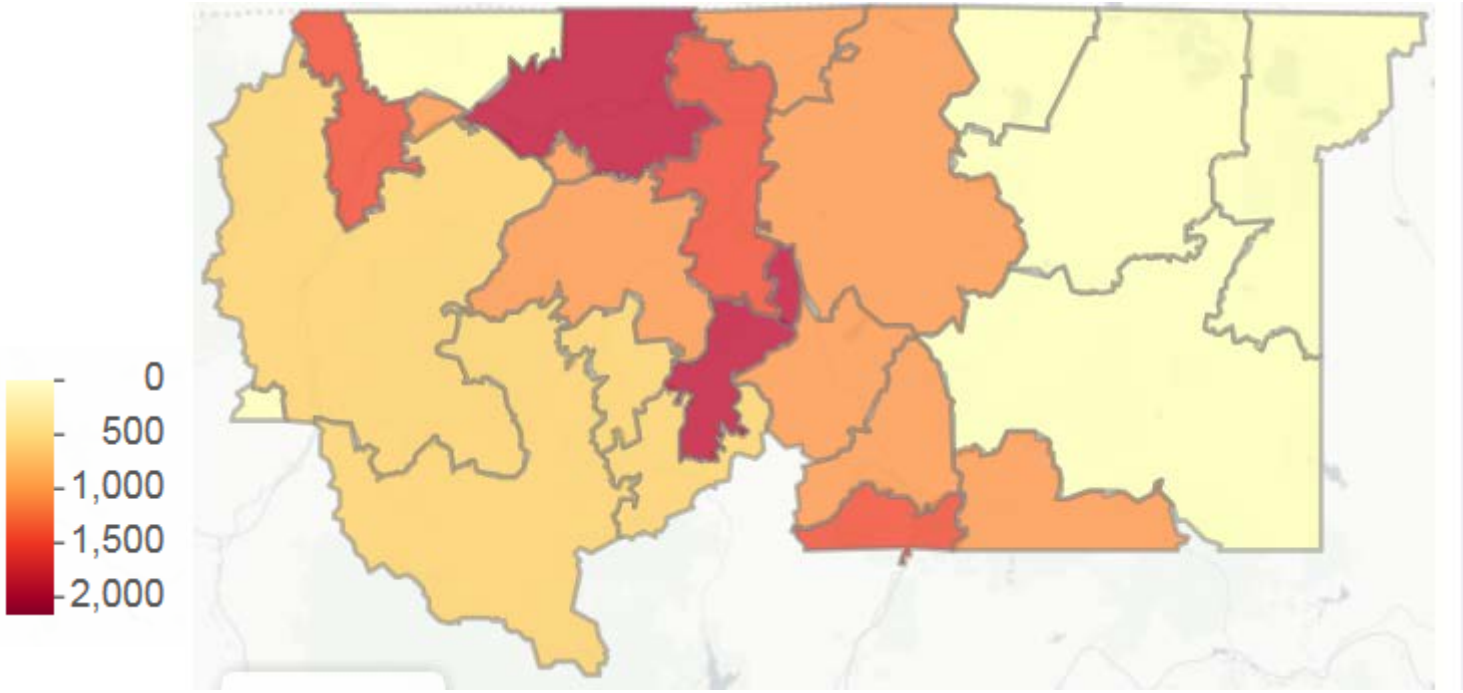
Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2013



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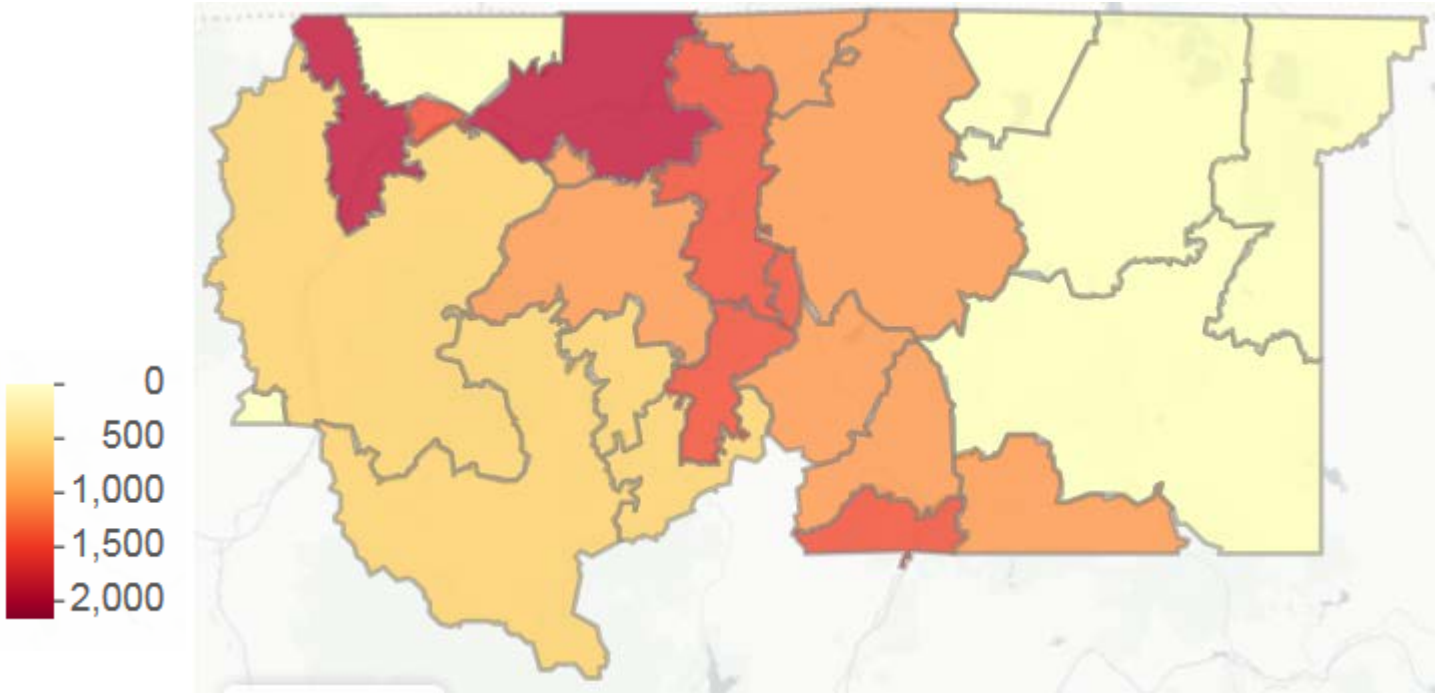
Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2014



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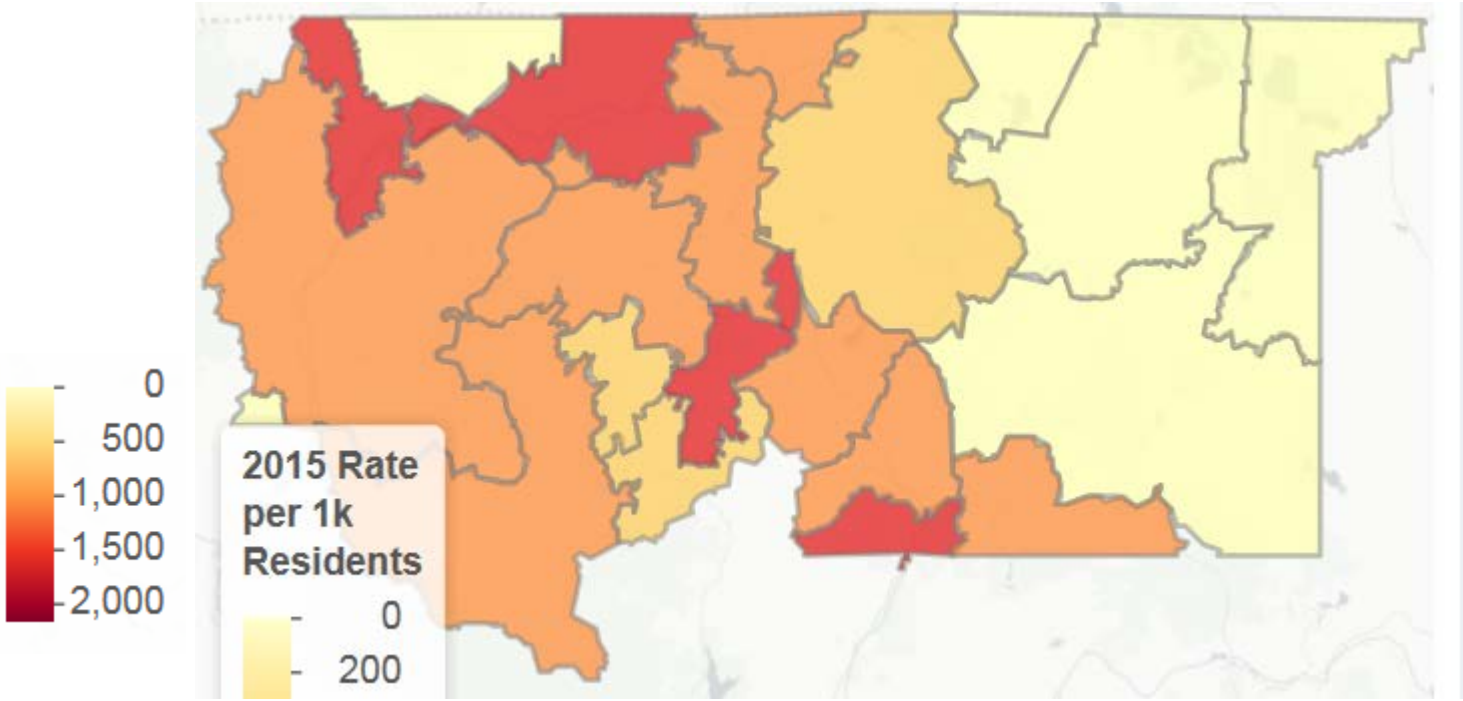
Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2015



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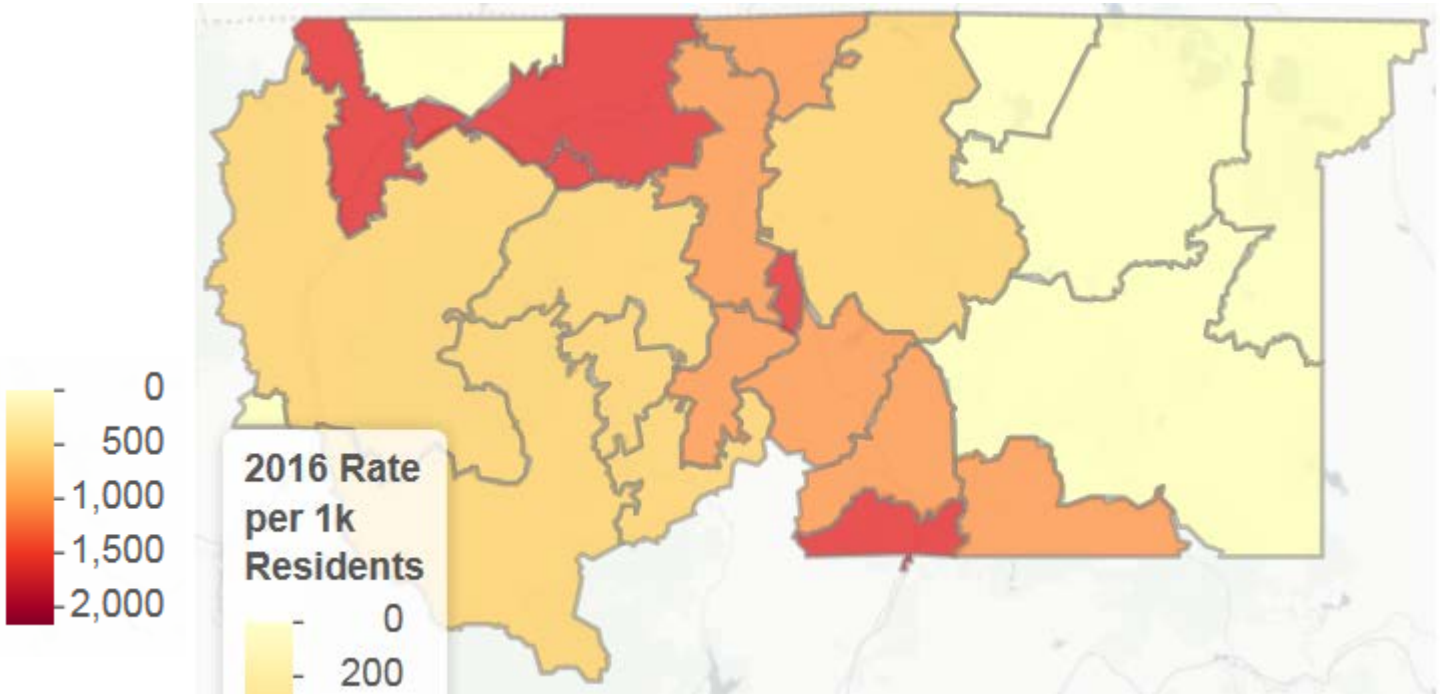
Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2016



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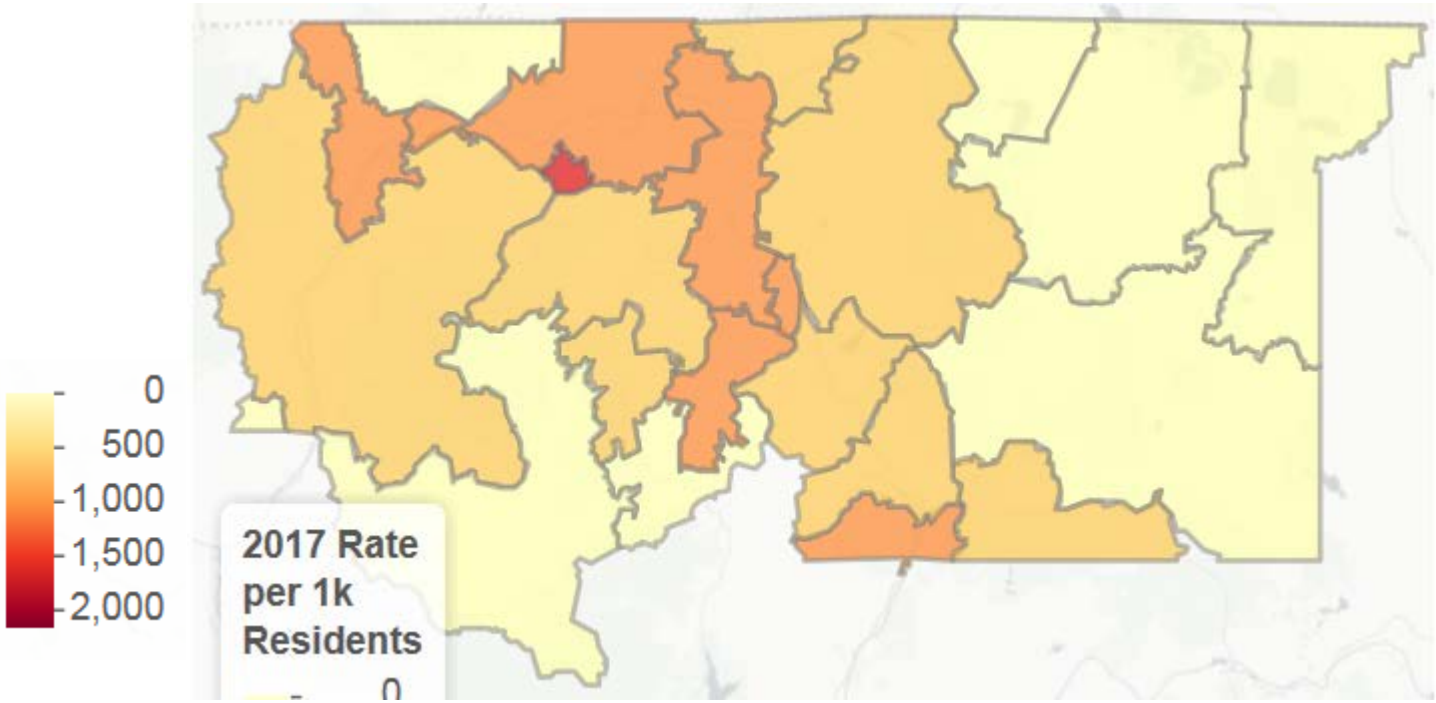
Siskiyou Prescriptions - Total Population - 2017

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents - 2017



https://discovery.cdph.ca.gov/CDIC/ODdash/

Summary

- Siskiyou County is in the midst of a severe epidemic of opioid addiction
- To decrease mortality and bring the epidemic to an end:
  - We must prevent new cases of opioid addiction.
  - We must re-evaluate the number of opioids being prescribed.
  - We must have readily available antidote for opioid overdose.
  - We must ensure access to treatment for people already addicted.
  - We must all work together to provide meaningful jobs and careers for our youth, and those who have successfully undergone treatment.
  - Most importantly we must NEVER, NEVER…

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Siskiyou Against Rx Addiction (SARA)
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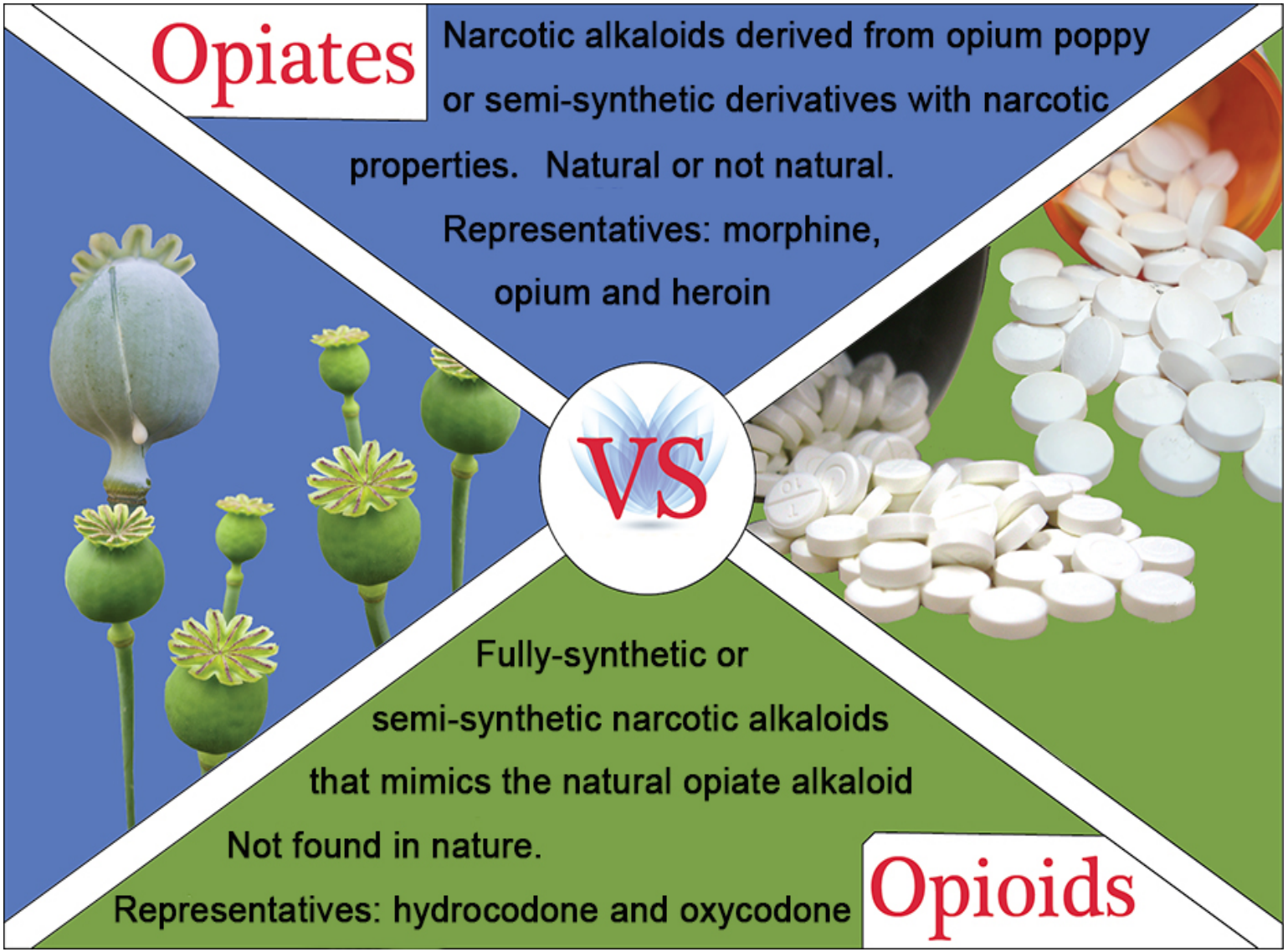
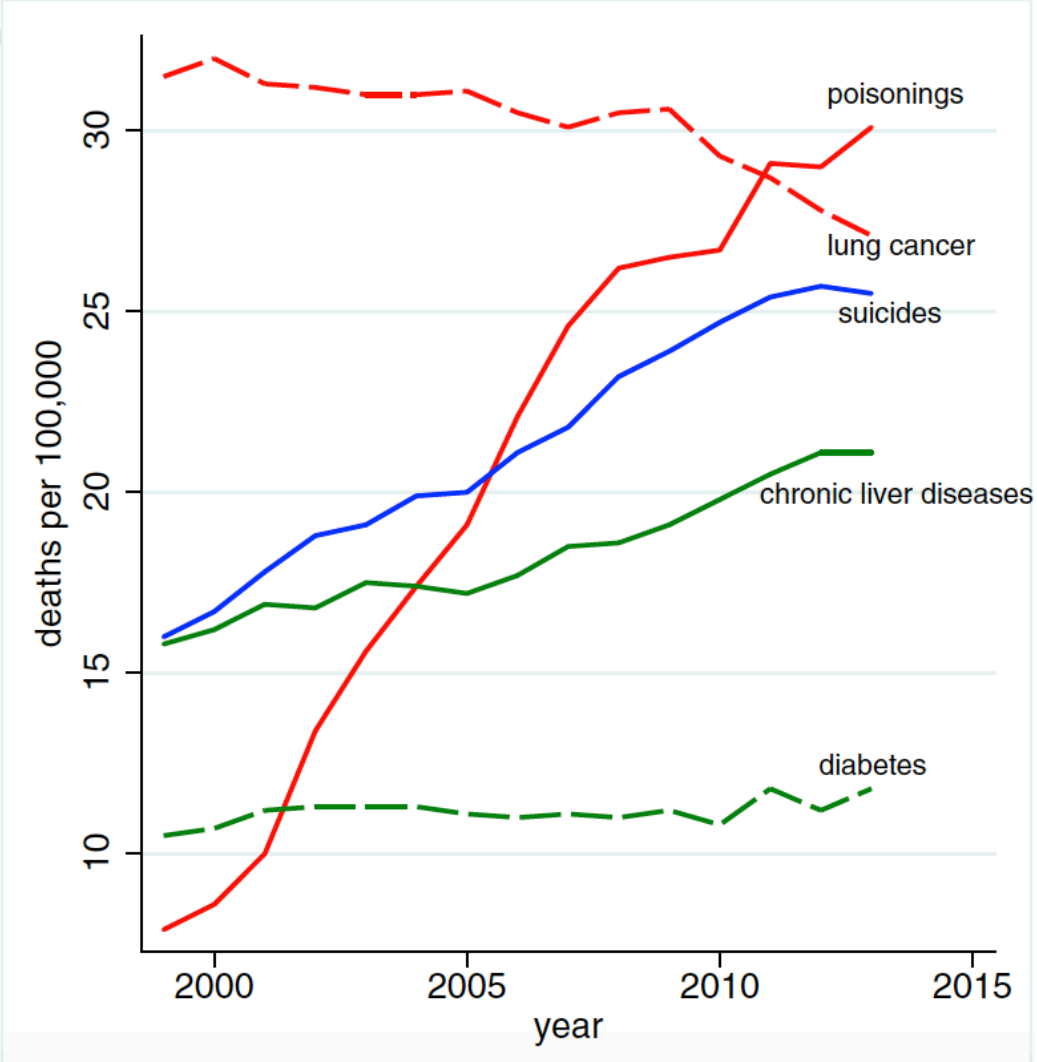
530-842-3507


Opiates
Narcotic alkaloids derived from opium poppy or semi-synthetic derivatives with narcotic properties. Natural or not natural.
Representatives: morphine, opium and heroin
VS
Fully-synthetic or semi-synthetic narcotic alkaloids that mimics the natural opiate alkaloid
Not found in nature.
Representatives: hydrocodone and oxycodone
Opioids

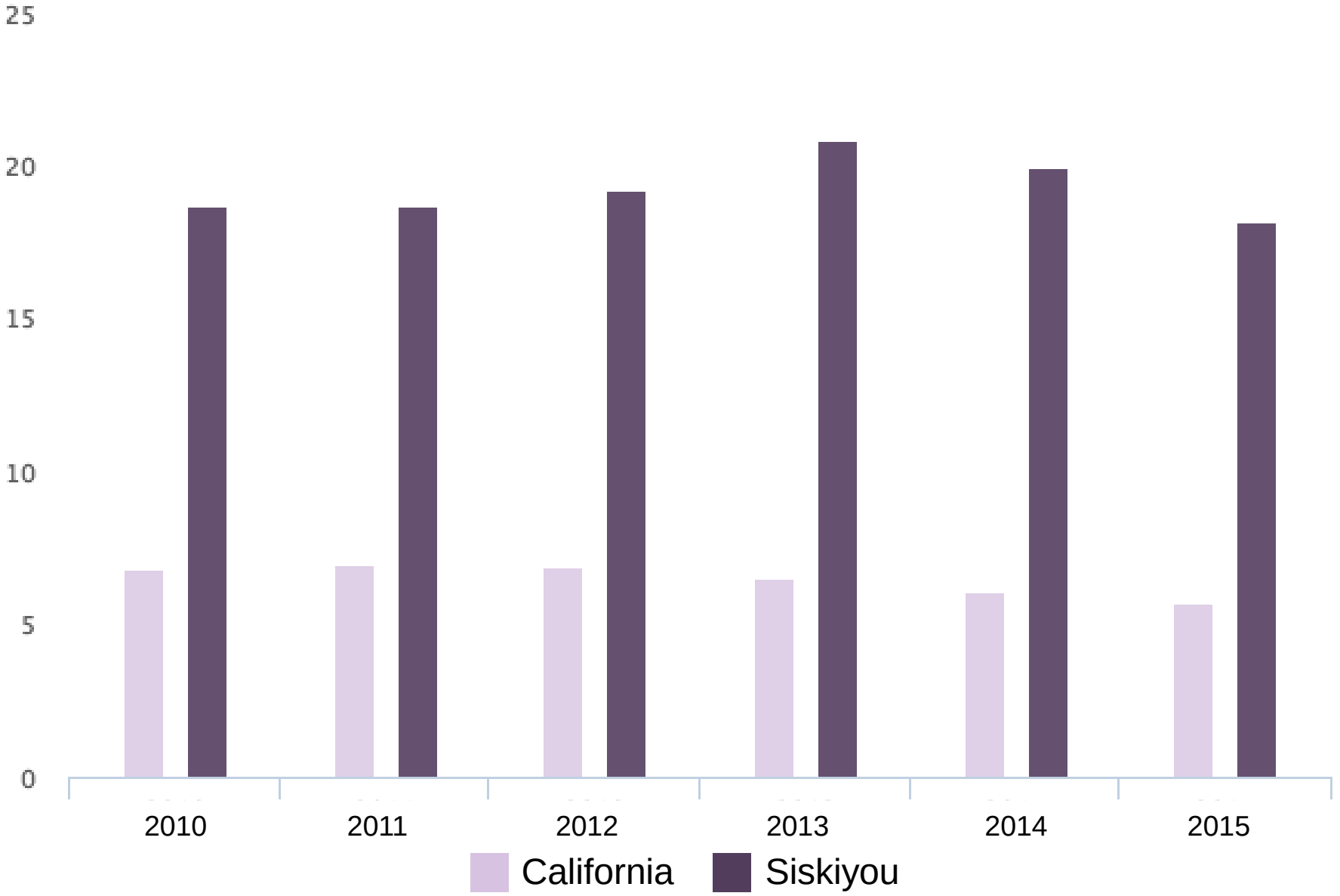
Mortality by cause, white non-Hispanics ages 45–54



Source: Anne Case, Angus Deaton. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences*. November 2, 2015 (online ahead of print).

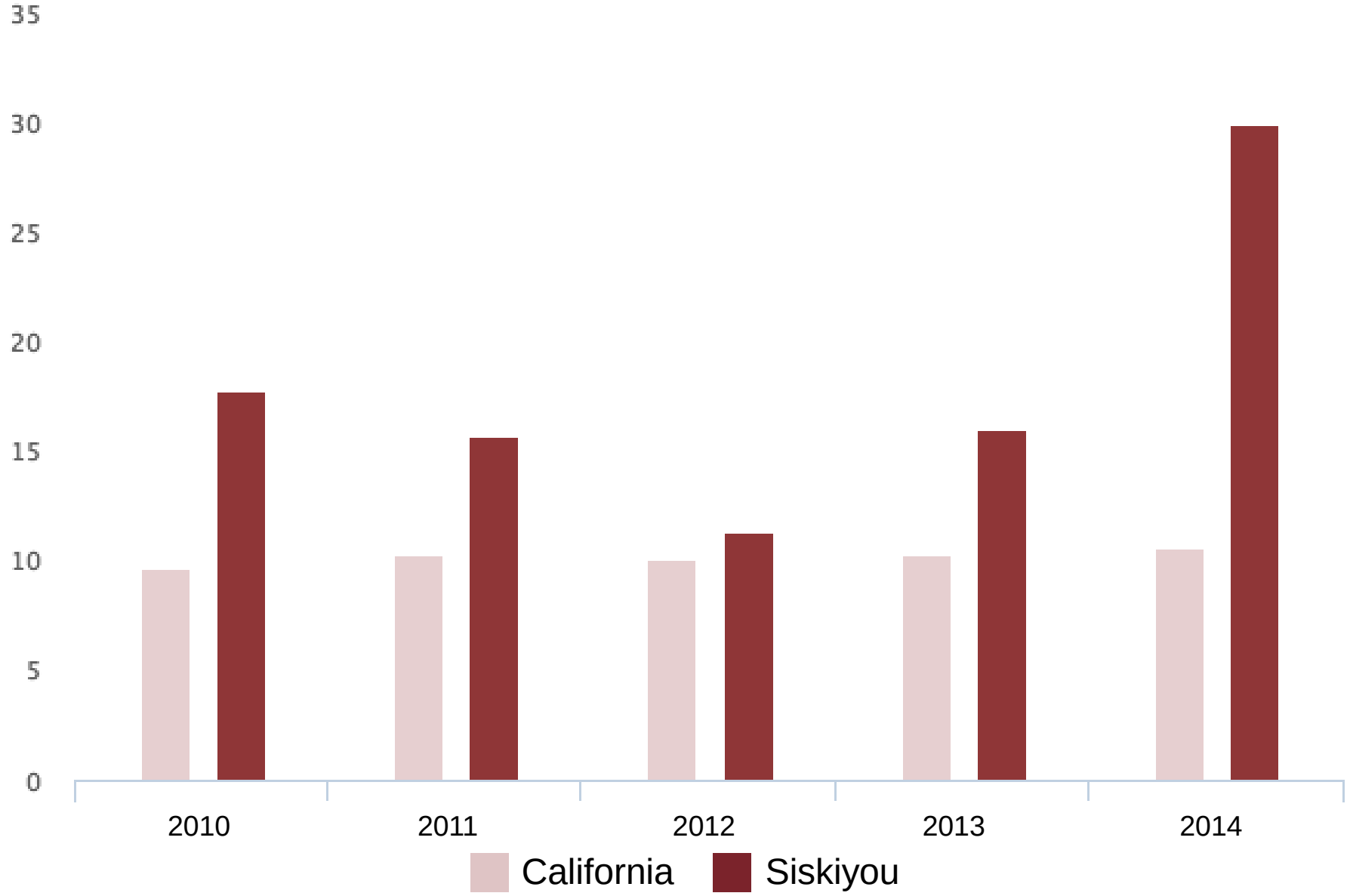
Residents on More than 100 Morphine mg Equivalents per Day

Source: CURES, per 100,000 residents

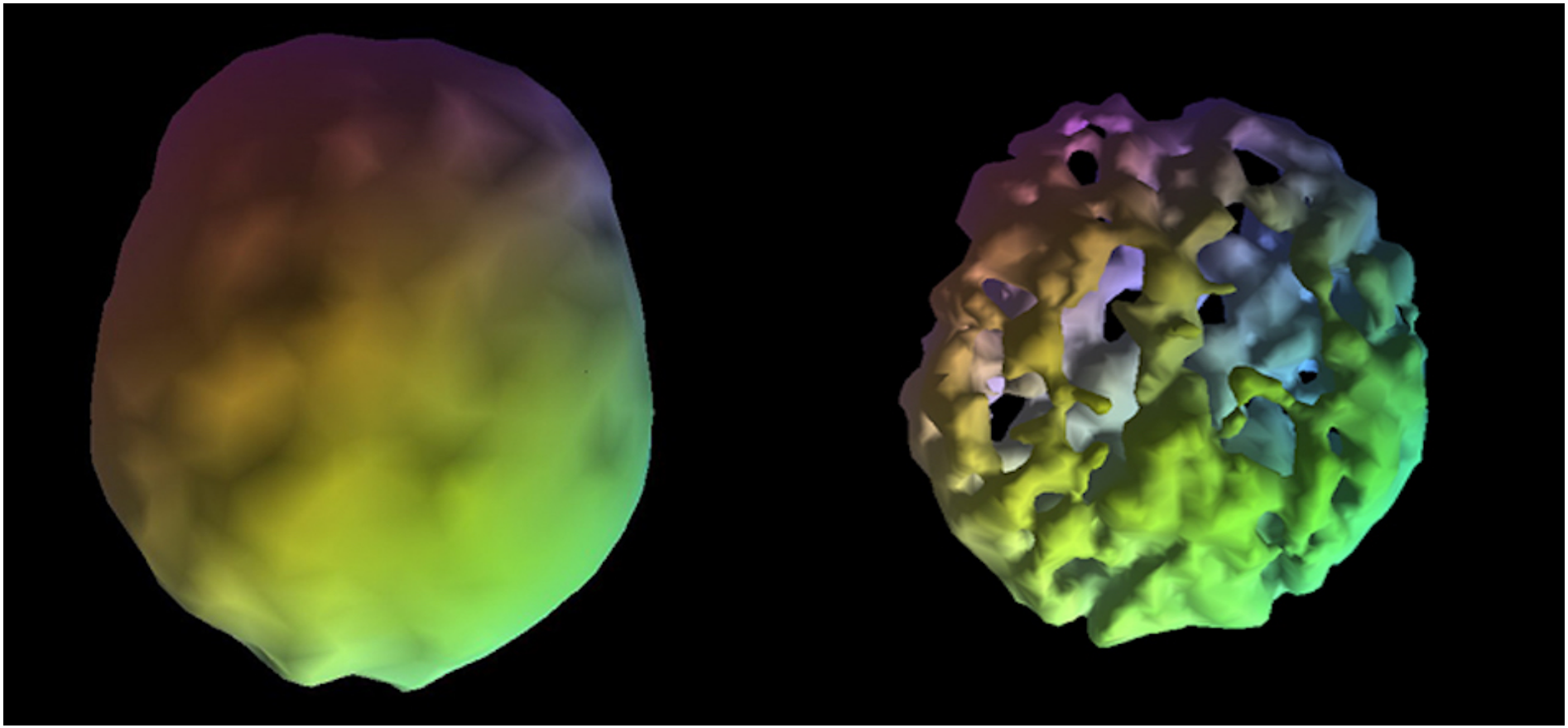


Non-fatal Opioid related ED Visits

Source: CDPH per 100,000 residents

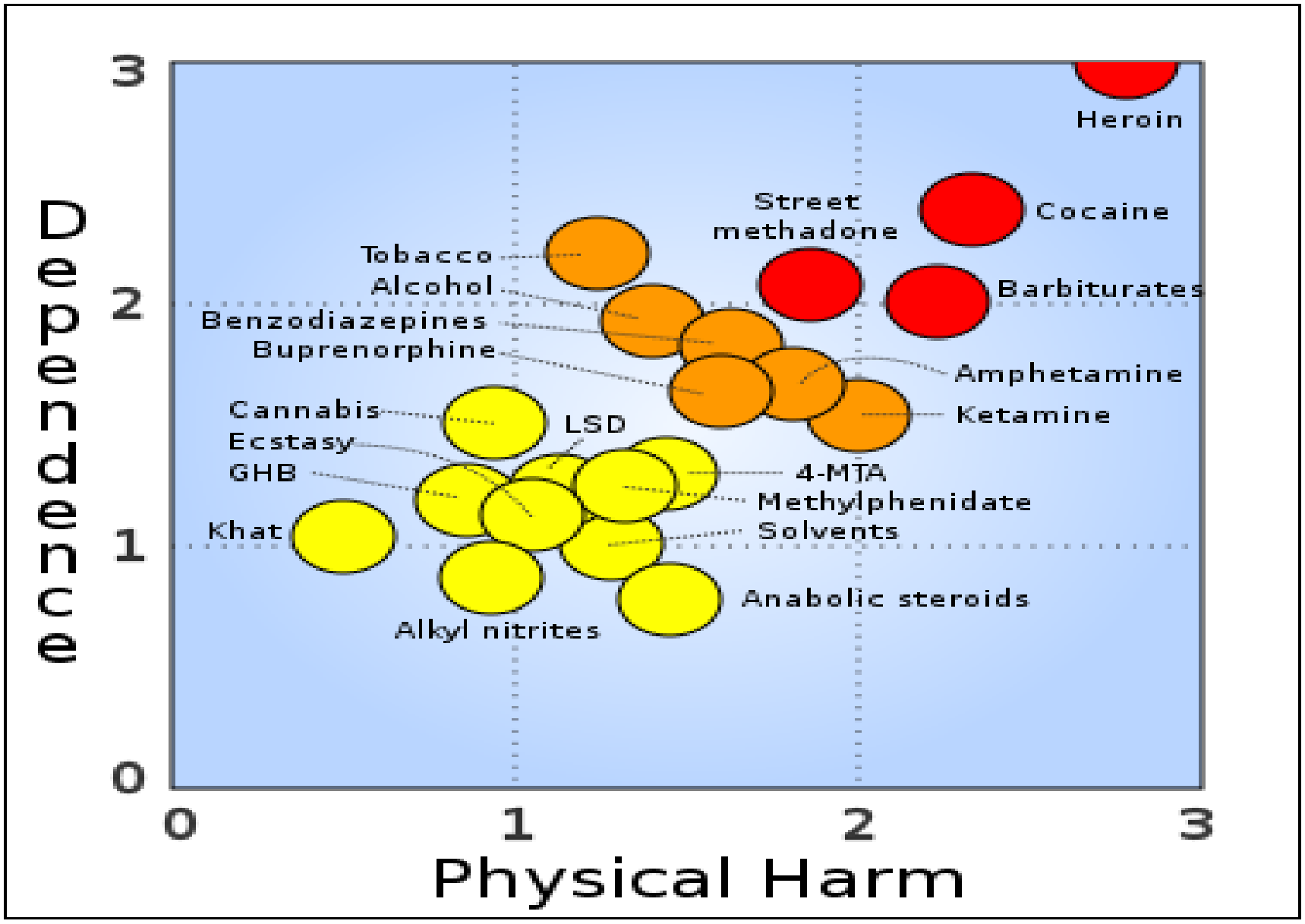


Drugs of abuse change how your brain looks and how it works.



healthy brain

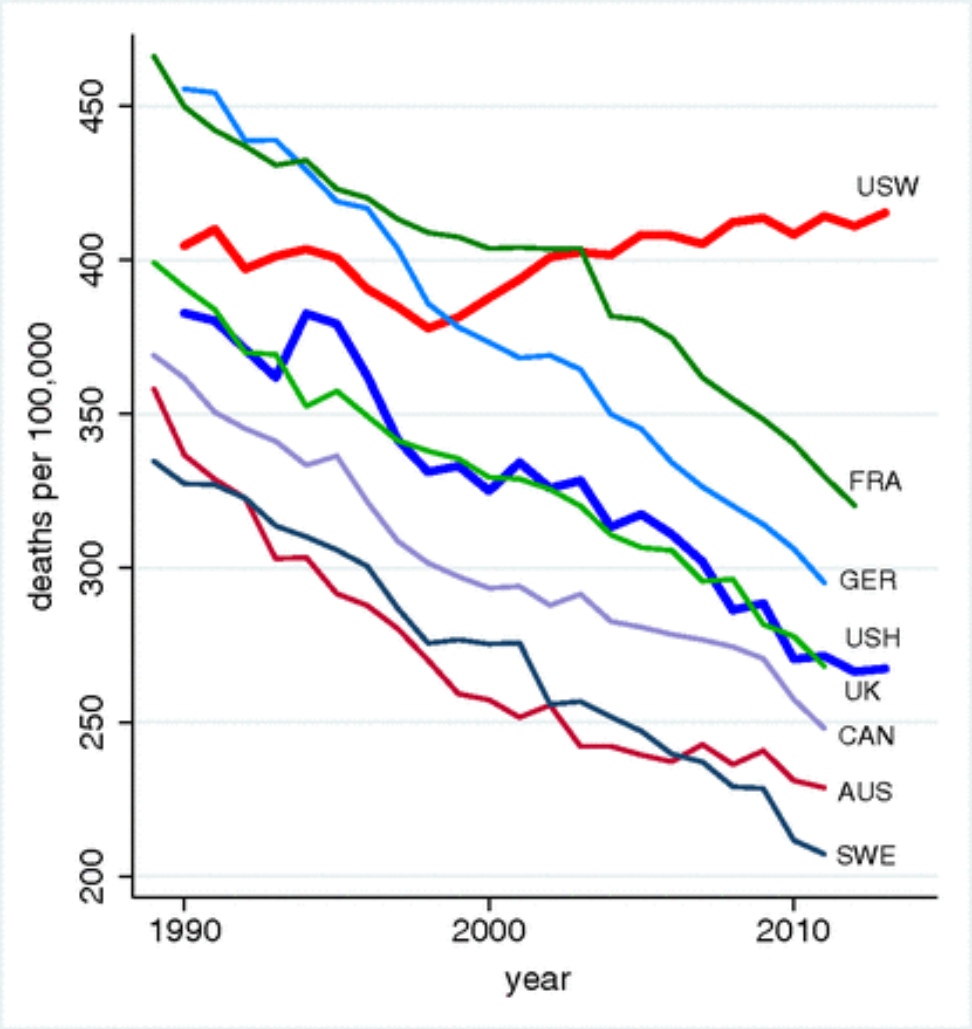
25 years frequent heroin use



Nutt, D; King, LA; Saulsbury, W; Blakemore, C (Lancet 24 March 2007) A 2007 assessment of harm from recreational drug use (mean physical harm and mean dependence liability).

Buprenorphine was approved for medical use in the United States in 1981.[3] In 2012, 9.3 million prescription for the medication were written in the United States.[5] Buprenorphine may also be used recreationally by injection or in the nose for the high it produces.[5] Occasionally it is used recreationally instead of heroin.[5] In the United States it is a Schedule III controlled substance.[5]

Mortality by cause, white non-Hispanics ages 45–54



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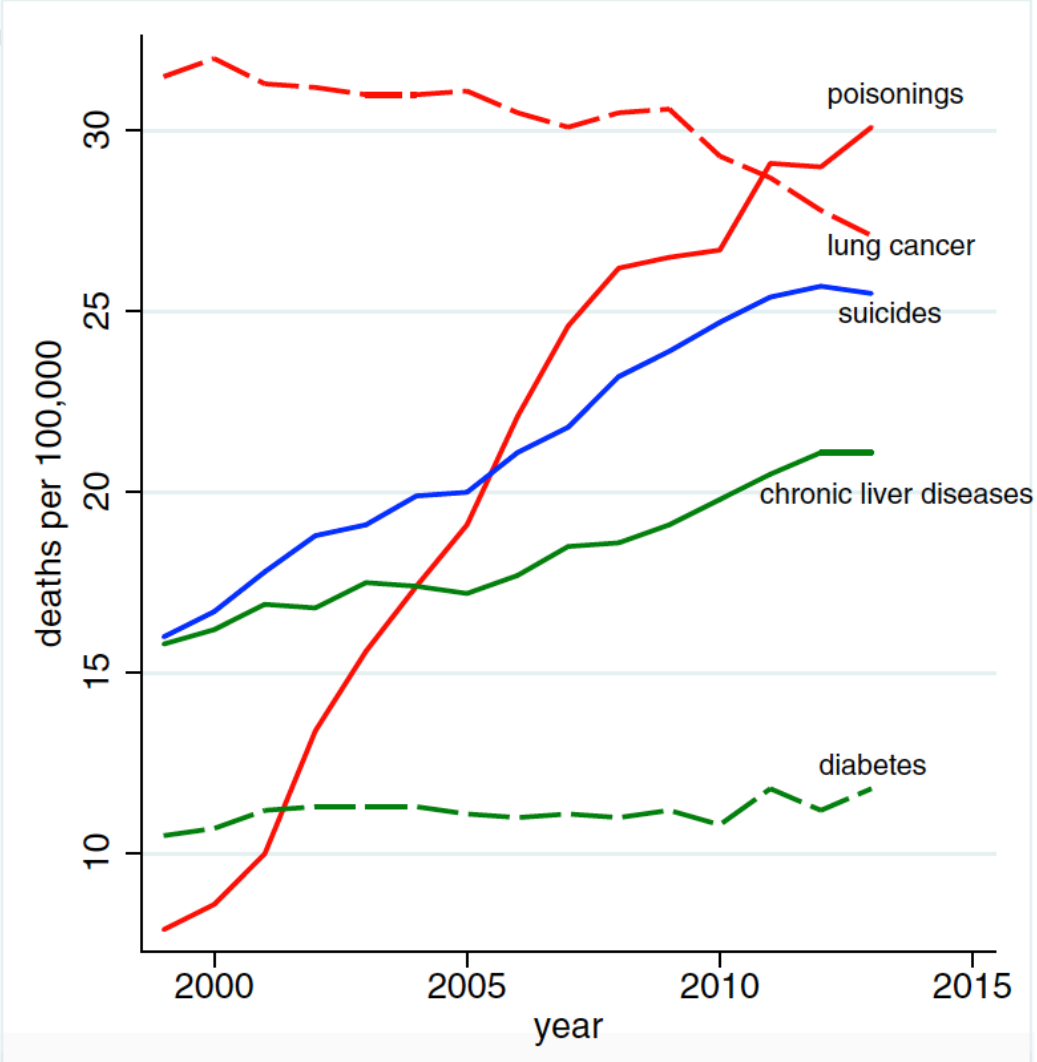

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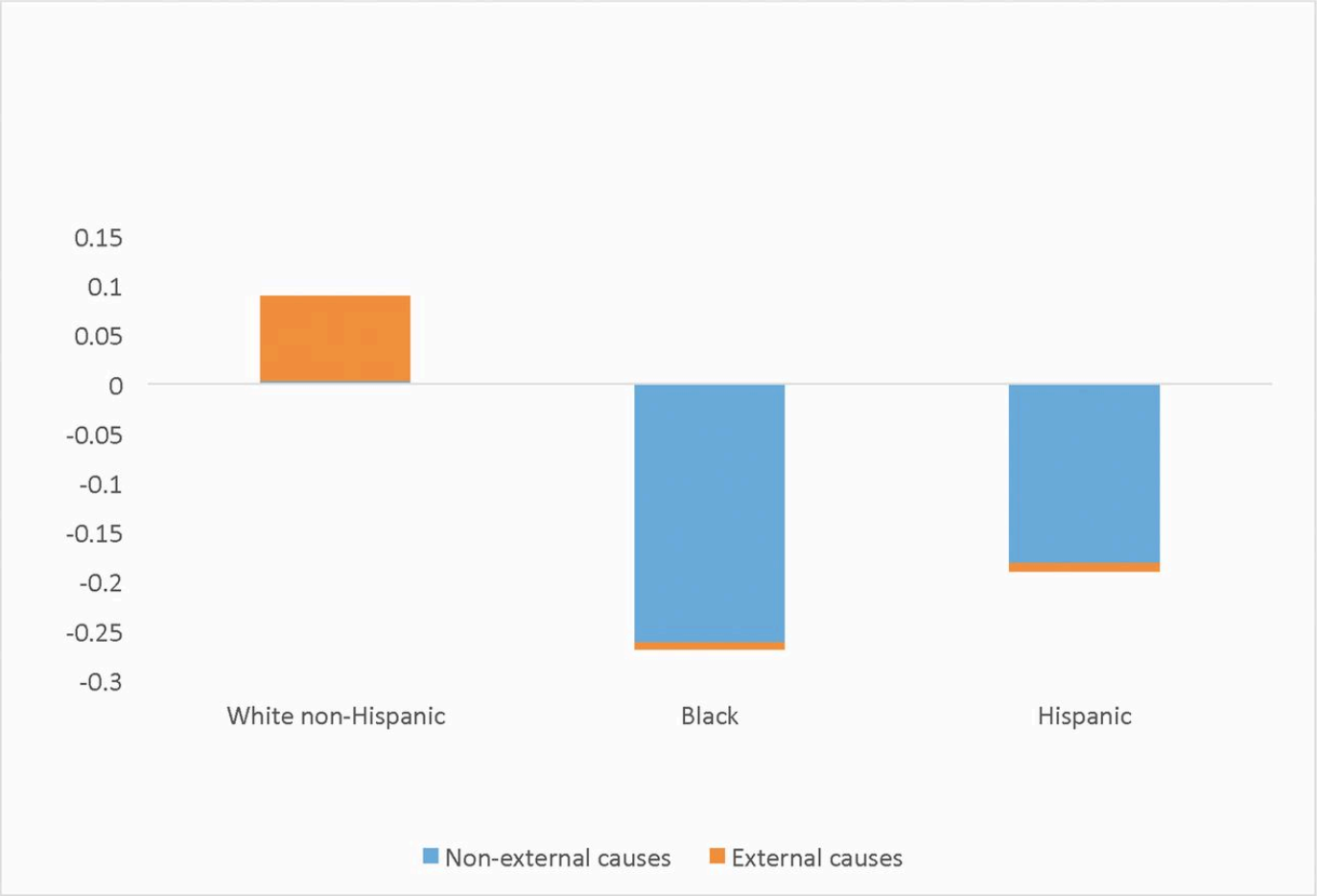
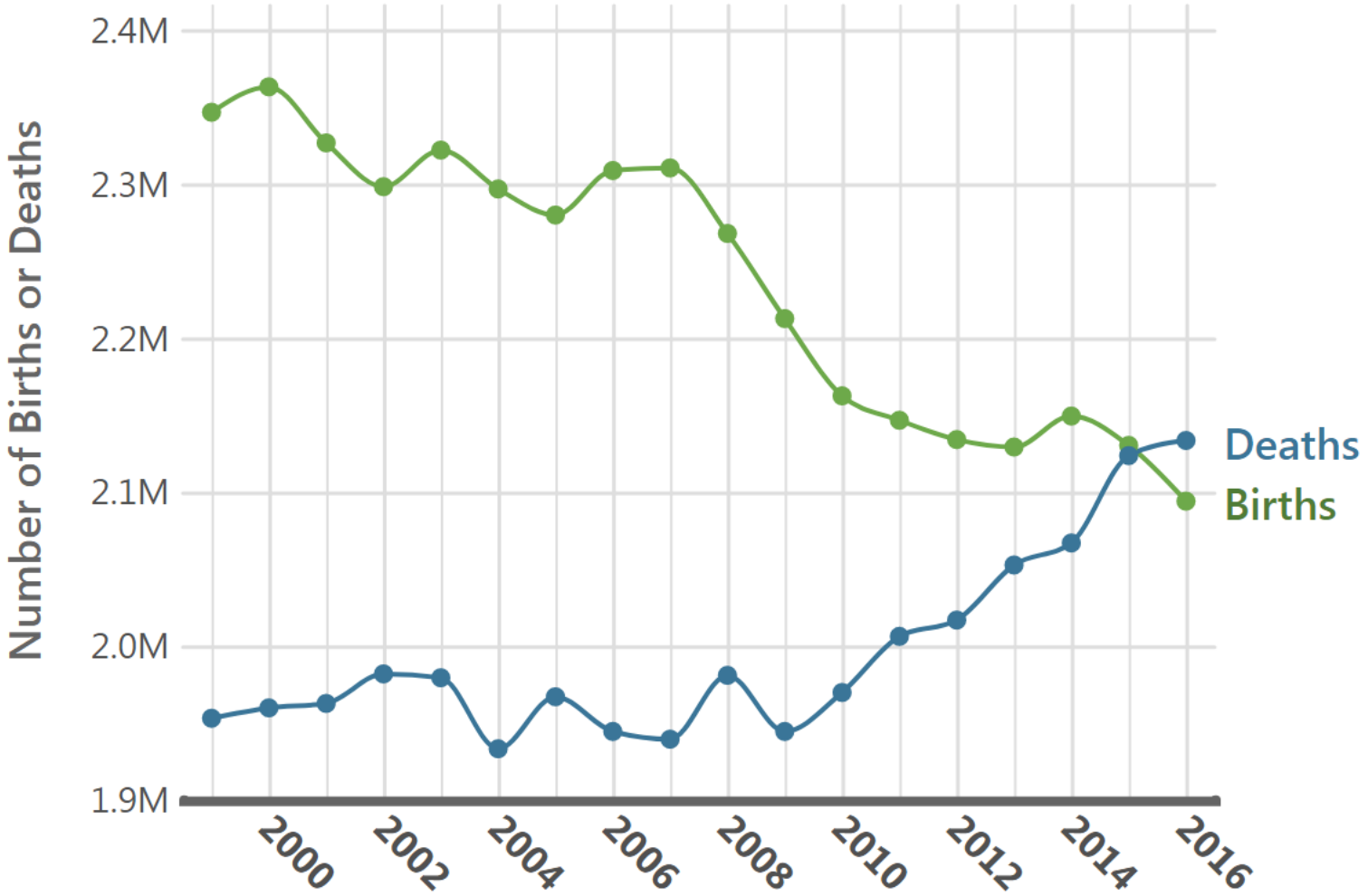


Source: Ellen Meara and Jonathan Skinner . Losing ground at midlife in America. *Proceedings of the National Academy of Sciences*. December 8, 2015.

Figure 1: Number of Births and Deaths Among Whites in the United States, 1999 to 2016



Source: National Center for Health Statistics, Centers for Disease Control

Anesthesia Hydromorphone mg Per Case