MISSOURI HOSPITAL ASSOCIATION

Opioids: A Strategy to Reduce Misuse and Abuse

December 1, 2015

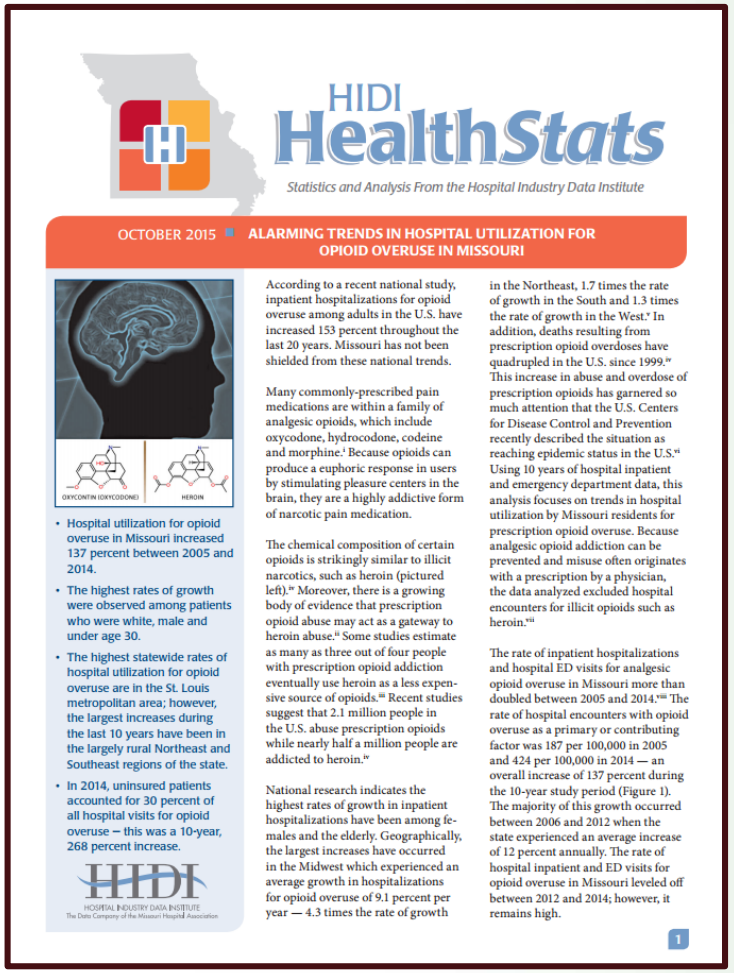
National Opioid Crisis

- Since 1999
  - Consumption, prescriptions, overdose and deaths all have increased approximately 300 percent
- 2013
  - 46,000 deaths from overdose
    - More than motor vehicle accidents
    - 50 percent from opioids and heroin
- Touches every community, every population

Opioid Overuse in Missouri

Opioid Misuse and Abuse

- Nationally, an alarming increase of opioid-related
  - Prescriptions
  - Consumption
  - Chronic, non-medical use
  - Abuse
  - Hospitalizations
  - Death
- Missouri hospital utilization
  - White, males under age 30
  - Rural — Northeast and Southeast
  - St. Louis metropolitan area
  - Report generated dozens of news stories across the state



HIDI HealthStats

Statistics and Analysis From the Hospital Industry Data Institute

OCTOBER 2015 ■ ALARMING TRENDS IN HOSPITAL UTILIZATION FOR OPIOID OVERUSE IN MISSOURI

- Hospital utilization for opioid overuse in Missouri increased 137 percent between 2005 and 2014.
- The highest rates of growth were observed among patients who were white, male and under age 30.
- The highest statewide rates of hospital utilization for opioid overuse are in the St. Louis metropolitan area; however, the largest increases during the last 10 years have been in the largely rural Northeast and Southeast regions of the state.
- In 2014, uninsured patients accounted for 30 percent of all hospital visits for opioid overuse – this was a 10-year, 268 percent increase.

HIDI
HOSPITAL INDUSTRY DATA INSTITUTE
The Data Company of the Missouri Hospital Association

According to a recent national study, inpatient hospitalizations for opioid overuse among adults in the U.S. have increased 153 percent throughout the last 20 years. Missouri has not been shielded from these national trends.

Many commonly-prescribed pain medications are within a family of analgesic opioids, which include oxycodone, hydrocodone, codeine and morphine.[i] Because opioids can produce a euphoric response in users by stimulating pleasure centers in the brain, they are a highly addictive form of narcotic pain medication.

The chemical composition of certain opioids is strikingly similar to illicit narcotics, such as heroin (pictured left).[ii] Moreover, there is a growing body of evidence that prescription opioid abuse may act as a gateway to heroin abuse.[iii] Some studies estimate as many as three out of four people with prescription opioid addiction eventually use heroin as a less expensive source of opioids.[iii] Recent studies suggest that 2.1 million people in the U.S. abuse prescription opioids while nearly half a million people are addicted to heroin.[iv]

National research indicates the highest rates of growth in inpatient hospitalizations have been among females and the elderly. Geographically, the largest increases have occurred in the Midwest which experienced an average growth in hospitalizations for opioid overuse of 9.1 percent per year — 4.3 times the rate of growth in the Northeast, 1.7 times the rate of growth in the South and 1.3 times the rate of growth in the West.[v] In addition, deaths resulting from prescription opioid overdoses have quadrupled in the U.S. since 1999.[iv] This increase in abuse and overdose of prescription opioids has garnered so much attention that the U.S. Centers for Disease Control and Prevention recently described the situation as reaching epidemic status in the U.S.[vi] Using 10 years of hospital inpatient and emergency department data, this analysis focuses on trends in hospital utilization by Missouri residents for prescription opioid overuse. Because analgesic opioid addiction can be prevented and misuse often originates with a prescription by a physician, the data analyzed excluded hospital encounters for illicit opioids such as heroin.[vii]

The rate of inpatient hospitalizations and hospital ED visits for analgesic opioid overuse in Missouri more than doubled between 2005 and 2014.[viii] The rate of hospital encounters with opioid overuse as a primary or contributing factor was 187 per 100,000 in 2005 and 424 per 100,000 in 2014 — an overall increase of 137 percent during the 10-year study period (Figure 1). The majority of this growth occurred between 2006 and 2012 when the state experienced an average increase of 12 percent annually. The rate of hospital inpatient and ED visits for opioid overuse in Missouri leveled off between 2012 and 2014; however, it remains high.

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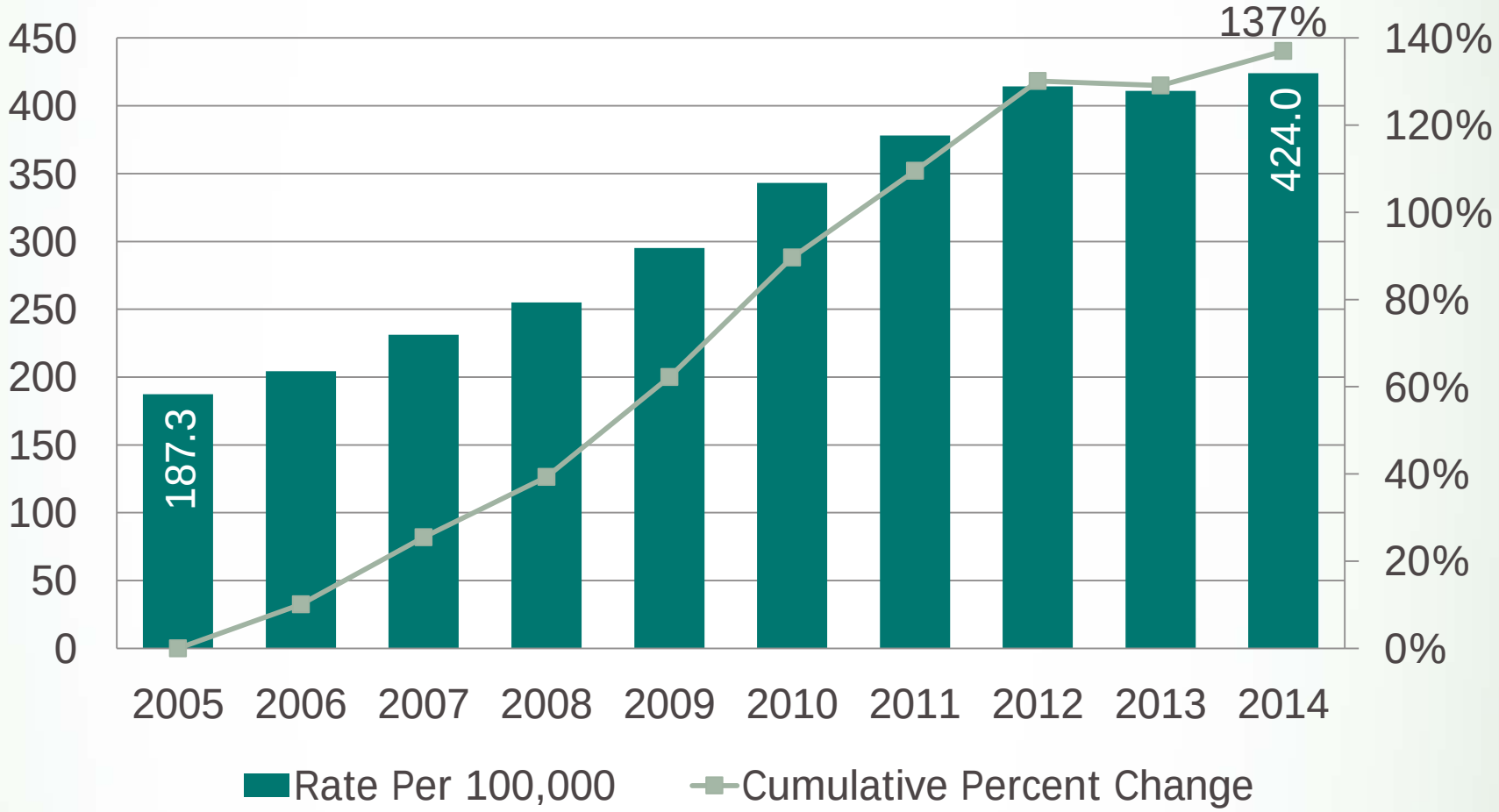
Rate of Hospital Inpatient and Emergency Department Visits and Cumulative Percent Change in Missouri, 2005 — 2014

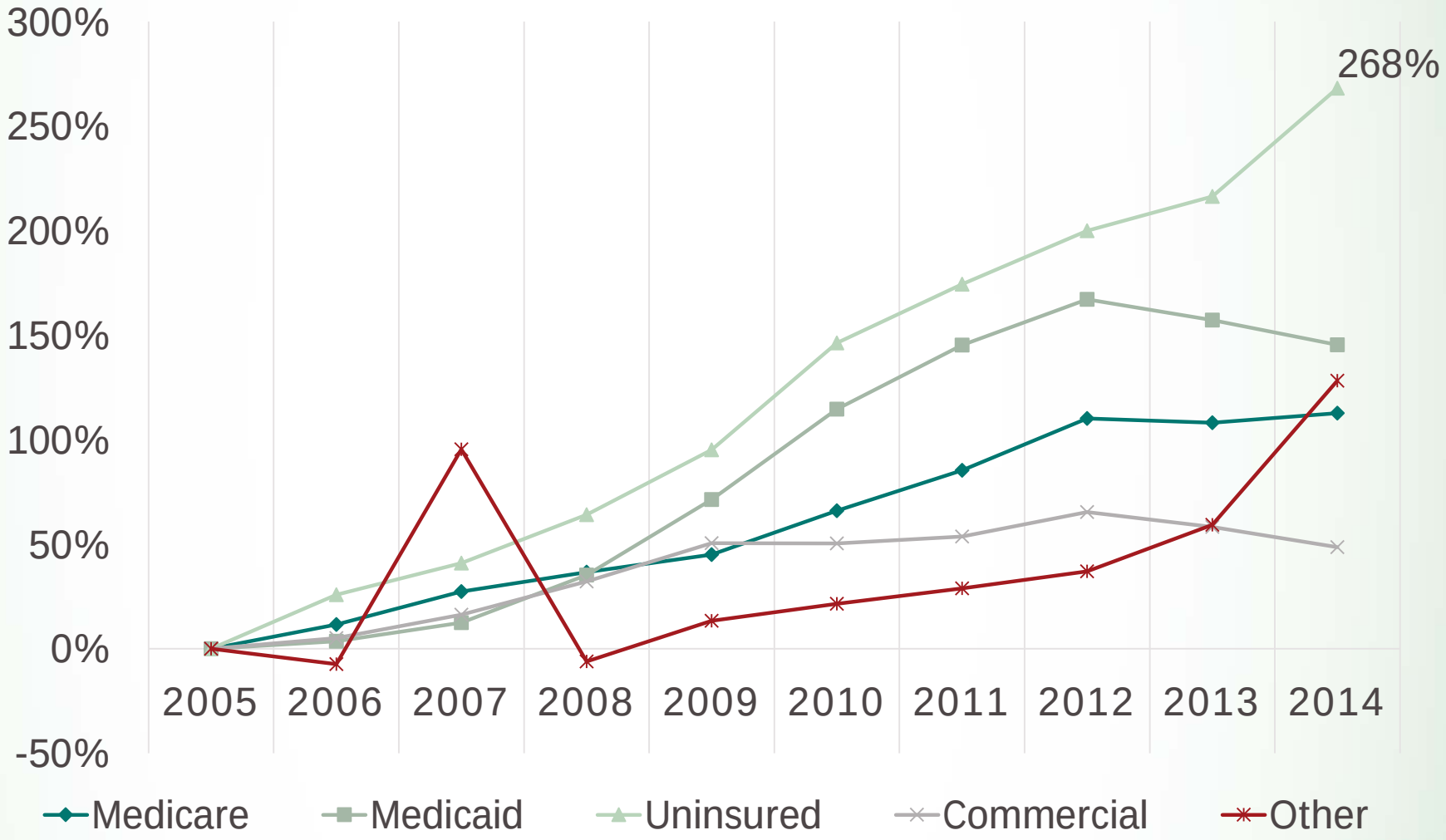


Source: HIDI HealthStats October 2015. Alarming Trends in Hospital Utilization for Opioid Overuse in Missouri

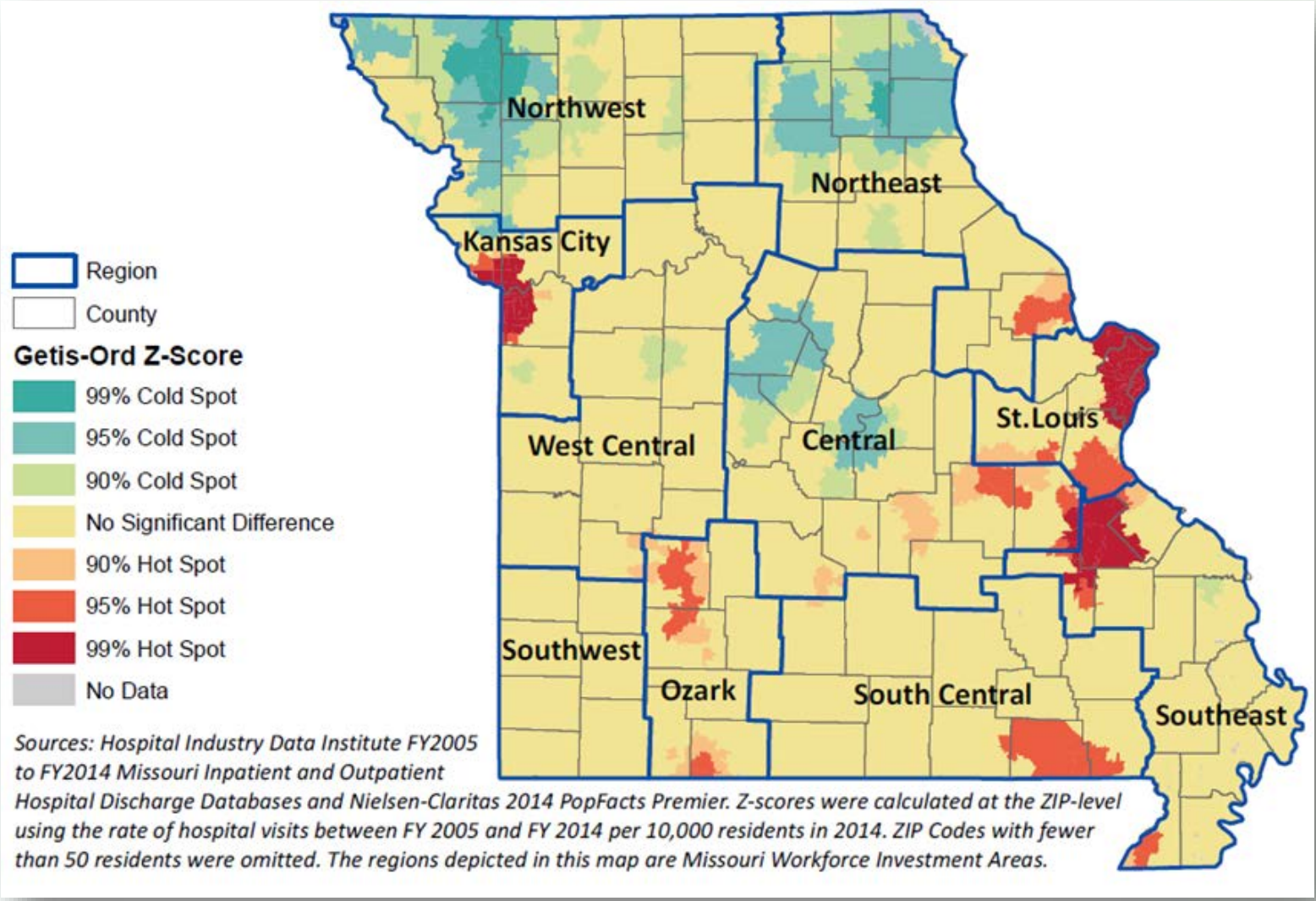
Hospital Inpatient and Emergency Department Visits for Opioid Overuse by Patient Demographics, Region and Setting, 2005 Compared to 2014

	2005		2014		10-yr Percent Change
	Visits	Percent	Visits	Percent	
Total	10,847	100%	25,711	100%	137.0%
Patient Gender					
Female	5,500	50.7%	12,698	49.4%	130.9%
Male	5,347	49.3%	13,013	50.6%	143.4%
Patient Age					
Under 30	2,830	26.1%	7,251	28.2%	156.2%
30-50	4,756	43.8%	10,947	42.6%	130.2%
Over 50	3,261	30.1%	7,513	29.2%	130.4%
Patient Race					
White	8,485	78.2%	20,289	78.9%	139.1%
Non-white	2,362	21.8%	5,422	21.1%	129.6%
Patient Region					
Central	990	9.1%	2,337	9.1%	136.1%
Kansas City	1,642	15.1%	3,399	13.2%	107.0%
Northeast	331	3.1%	954	3.7%	188.2%
Northwest	284	2.6%	641	2.5%	125.7%
Ozark	1,186	10.9%	2,402	9.3%	102.5%
South Central	385	3.5%	803	3.1%	108.6%
Southeast	618	5.7%	1,644	6.4%	166.0%
Southwest	545	5.0%	985	3.8%	80.7%
St. Louis	4,466	41.2%	11,726	45.6%	162.6%
West Central	382	3.5%	796	3.1%	108.4%

Hospital Inpatient and Emergency Department Visits for Opioid Overuse by Payer, Cumulative Percent Change 2005 to 2014



2005-2014 ZIP Code Hot Spots for Opioid Overuse-Related Hospital Visits



Sources: Hospital Industry Data Institute FY2005 to FY2014 Missouri Inpatient and Outpatient Hospital Discharge Databases and Nielsen-Claritas 2014 PopFacts Premier. Z-scores were calculated at the ZIP-level using the rate of hospital visits between FY 2005 and FY 2014 per 10,000 residents in 2014. ZIP Codes with fewer than 50 residents were omitted. The regions depicted in this map are Missouri Workforce Investment Areas.

Challenges

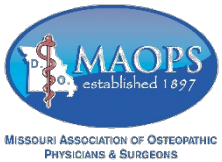
A Provider's Perspective

- Variation in practice
- No history or source of information
- ED volume, surge and demand for care
- Regulatory
- Malpractice
- Patient satisfaction
- Manipulation
- Intimidation and threats

Missouri Policy Efforts

- Absence of a prescription drug-monitoring program
- Absence of a registry system
- Missouri DHSS Prescription Overdose Drug Workgroup — education and policy approach
- Proposed state legislation
  - Prescription drug-monitoring program
  - Registry
  - Broader dispensing of Naloxone

Planned Approach



Provider Associations Partnership

- ✓ Missouri Academy of Family Physicians
- ✓ Missouri Association of Osteopathic Physicians and Surgeons
- ✓ Missouri College of Emergency Physicians
- ✓ Missouri Dental Association
- ✓ Missouri Hospital Association
- ✓ Missouri State Medical Association

American College of Emergency Physicians: Critical Questions

- What is the utility of state prescription drug-monitoring programs?
- For adult ED patients with acute low back pain, are opioids more effective than other medications?
- For adult ED patients whom opioids are appropriate — are short-acting, schedule II, more effective than short-acting, schedule III?
- For adult ED patients with acute exacerbation of chronic noncancer pain, do the benefits of opioids on discharge outweigh the potential harm?

Prescription Drug-Monitoring Programs

- What is the utility of state prescription drug-monitoring programs?
  - The use of a state prescription drug-monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping.
- Level C recommendation, based on limited literature and consensus panels

Adult Acute Low Back Pain

- For adult ED patients with acute low back pain, are opioids more effective than other medications?
  - ED physician should ascertain whether nonopioids and nonpharmacological therapy will be adequate
  - Opioids should be reserved for patients with more severe pain or pain refractory
  - If opioids are indicated, the lowest practical dose should be provided; less than one week
- Level C recommendation

Form of Opioid

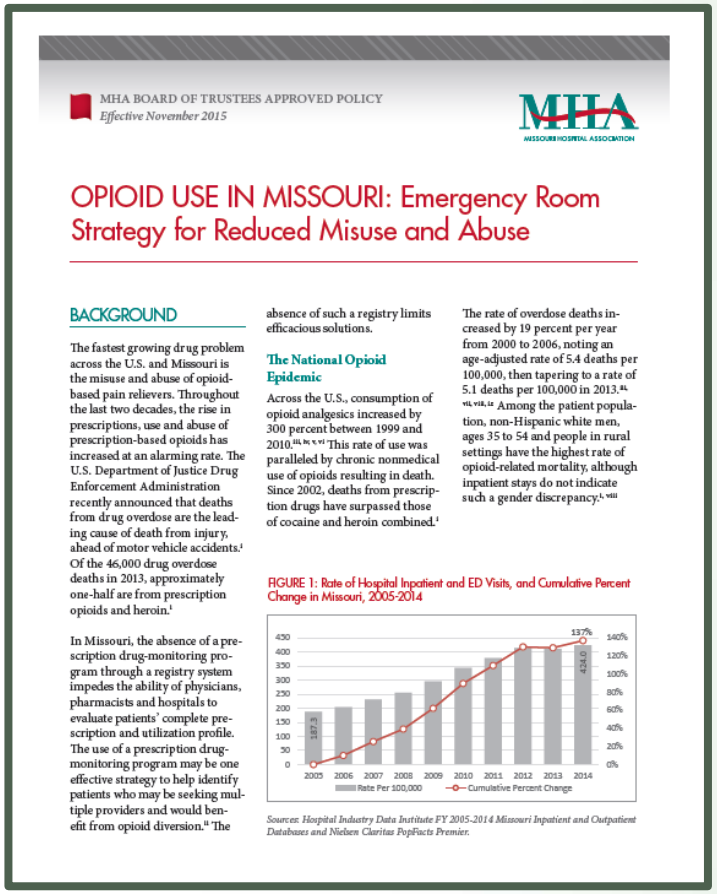
- For adult ED patients whom opioids are appropriate — are short-acting, schedule II, more effective than short-acting, schedule III?
  - For short-term relief of acute musculoskeletal pain, schedule II drugs may be prescribed if considering the patient's benefit and risk
  - Superior relief of schedule II over schedule III is inadequate
- Level B recommendation

Opioid: Benefit Versus Harm

- For adult ED patients with acute exacerbation of chronic noncancer pain, do the benefits of opioids on discharge outweigh the potential harm?
  - ED physician should avoid routine prescribing of outpatient opioids for this patient profile
  - If prescribed, the lowest practical dose for a limited duration should be prescribed; less than one week
  - Consider the patient's risk for opioid misuse, abuse or diversion, utilize registry
  - If practicable, honor established patient-physician agreements
- Level C recommendation

Multi-Faceted Strategy Needed

- Emergency department prescribing practices
- Primary care prescribing and pain management practices
- Quality improvement programs — adverse drug events
- Assessment for abuse risk and referral to behavioral health or treatment centers



MHA BOARD OF TRUSTEES APPROVED POLICY
Effective November 2015

MHA
MISSOURI HOSPITAL ASSOCIATION

OPIOID USE IN MISSOURI: Emergency Room Strategy for Reduced Misuse and Abuse

BACKGROUND

The fastest growing drug problem across the U.S. and Missouri is the misuse and abuse of opioid-based pain relievers. Throughout the last two decades, the rise in prescriptions, use and abuse of prescription-based opioids has increased at an alarming rate. The U.S. Department of Justice Drug Enforcement Administration recently announced that deaths from drug overdose are the leading cause of death from injury, ahead of motor vehicle accidents.[i] Of the 46,000 drug overdose deaths in 2013, approximately one-half are from prescription opioids and heroin.[i]

In Missouri, the absence of a prescription drug-monitoring program through a registry system impedes the ability of physicians, pharmacists and hospitals to evaluate patients' complete prescription and utilization profile. The use of a prescription drug-monitoring program may be one effective strategy to help identify patients who may be seeking multiple providers and would benefit from opioid diversion.[ii] The absence of such a registry limits efficacious solutions.

The National Opioid Epidemic

Across the U.S., consumption of opioid analgesics increased by 300 percent between 1999 and 2010.[iii, iv, v, vi] This rate of use was paralleled by chronic nonmedical use of opioids resulting in death. Since 2002, deaths from prescription drugs have surpassed those of cocaine and heroin combined.[i]

The rate of overdose deaths increased by 19 percent per year from 2000 to 2006, noting an age-adjusted rate of 5.4 deaths per 100,000, then tapering to a rate of 5.1 deaths per 100,000 in 2013.[ii, vii, ix] Among the patient population, non-Hispanic white men, ages 35 to 54 and people in rural settings have the highest rate of opioid-related mortality, although inpatient stays do not indicate such a gender discrepancy.[i, viii]

FIGURE 1: Rate of Hospital Inpatient and ED Visits, and Cumulative Percent Change in Missouri, 2005-2014

Sources: Hospital Industry Data Institute FY 2005-2014 Missouri Inpatient and Outpatient Databases and Nielsen Claritas PopFacts Premier.

Missouri Recommendations

- Consistent with national and other state guidelines
- Engaged providers and associations
- Reviewed for risk and liability
- Board approval from all associations

MISSOURI ACADEMY OF FAMILY PHYSICIANS

MAOPS established 1897
MISSOURI ASSOCIATION OF OSTEOPATHIC PHYSICIANS & SURGEONS

MISSOURI COLLEGE OF EMERGENCY PHYSICIANS
MoCEP

MDA
Missouri Dental ASSOCIATION

MHA
MISSOURI HOSPITAL ASSOCIATION

MSMA
Missouri State Medical Association

Emergency Department: Suggested Recommendations

- Focused pain assessment
- Evidence-based diagnosis
- Non-narcotic treatment of non-traumatic tooth pain
- Communication between emergency room and primary care physicians
- Prescriptions limited to 72 hours
- New acute conditions for shortest duration*
- Refuse requests to provide prescriptions for refills “lost” or “destroyed”
- Avoid prescribing long-acting or controlled-release opioids; consider abuse-deterrent forms of opioids
- Counsel about handling*
- Encourage policies allowing Naloxone dispensing

*New recommendation added December 1, 2015.

Recommendations: Assessment

- A focused pain assessment prior to determination of treatment plan; if the patient's pain prohibits a comprehensive assessment, then judicious use of opioids to alleviate pain is suggested. While the pain assessment should include risk factors for addiction and the incorporation of non-narcotic analgesics, a specific written, comprehensive assessment is not required.

Sources: Cantrill, AHRQ, New York City

Recommendations: Assessment

- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.

Sources: AHRQ

Recommendations: Treatment

- Non-narcotic treatment of symptomatic, non-traumatic tooth pain should be utilized when possible.
- Treatment of patients with acute exacerbation of existing chronic pain should begin with an attempt to contact the primary opioid prescriber or primary care provider, if circumstances are conducive.

Sources: Cantrill, AHRQ, Maryland

Recommendations: Treatment

- For new conditions requiring narcotics, the length of the opioid prescription should be at the provider's discretion. The provider should limit the prescription to the shortest duration needed that effectively controls the patient's pain. Outpatient access to follow-up care should be taken into consideration regarding the length of the prescription.

Sources: AHRQ, New York City

Recommendation: Duration

- Opioid analgesic prescriptions for chronic conditions, including acute exacerbation of existing chronic pain, management should be limited to no more than 72 hours, if clinically appropriate and assessing the feasibility of timely access for follow-up care.

Sources: Cantrill, AHRQ, Maryland

Recommendation: Replacement

- Emergency department physicians and providers should not provide prescriptions for controlled substances that are claimed to be lost or destroyed.
- Unless otherwise clinically indicated, emergency department physicians and providers should not prescribe long-acting or controlled release opioids. If indicated, prescribers should provide tamper-resistant, or abuse deterrent, forms of opioids.

Sources: Cantrill, AHRQ, New York City, Maryland

Recommendation: Handling

- When narcotics are prescribed, emergency department staff should counsel patients on proper use, storage and disposal of narcotic medications.

Sources: New York City, Maryland

Recommendation: Policy

- Beyond the emergency department, health care providers should encourage policies that allow providers to prescribe and dispense Naloxone to public health, law enforcement and family as an antidote for opioid overdoses.

Sources: Cantrill, Maryland

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