MHA BOARD OF TRUSTEES APPROVED POLICY
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MISSOURI HOSPITAL ASSOCIATION

OPIOID USE IN MISSOURI: Strategy for Reduced Misuse and Abuse

BACKGROUND

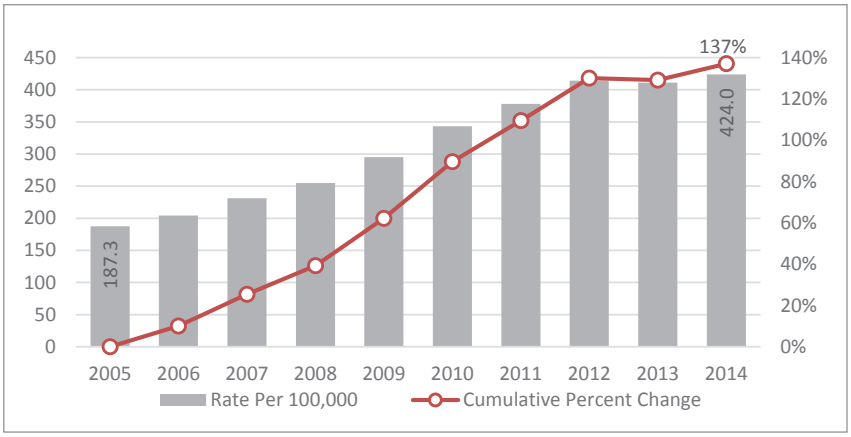
The fastest growing drug problem across the U.S. and Missouri is the misuse and abuse of opioid-based pain relievers. Throughout the last two decades, the rise in prescriptions, use and abuse of prescription-based opioids has increased at an alarming rate. The U.S. Department of Justice Drug Enforcement Agency 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, iii] The absence of such a registry limits efficacious solutions.

The National Opioid Use Profile

Across the U.S., consumption of opioid analgesics increased by 300 percent between 1999 and 2010.[iv, v, vi, vii] 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 per 100,000, in 2013.[iv, vi, viii, ix] Among the patient populations, 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.[iv, x, xi]

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.

TABLE 1: Hospital Inpatient and ED Visits for Opioid Overuse by Patient Demographics, Region and Setting, 2005 Compared to 2014

	2005		2014		10-yr Percent
	Visits	Percent	Visits	Percent	Change
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%
Visit Setting					
Inpatient	7,355	67.8%	15,951	62.0%	116.9%
Emergency Department	3,492	32.2%	9,760	38.0%	179.5%

Opioid-Related Hospitalizations

The rate of inpatient hospitalizations across the U.S. averaged a 5 percent increase each year from 1993 to 2012 and a cumulative 153 percent increase.[xii] Among payors, in 2012, Medicaid and Medicare each billed approximately 33 percent of all opioid-related hospitalizations.[xii]

Missouri's trend in opioid-related hospitalizations demonstrates the same alarming trend. Between 2005 and 2014, hospitalization utilization for opioid overuse increased by 137 percent[xiii] (Figure 1). Hospitalizations for opioid overuse in Missouri are nearly equal among males and females; are increasing more in the under 30 years of age cohort; are similar to the state race profile with 79 percent of opioid hospitalizations occurring among the white population; and are increasing fastest in the Northeast, Southeast and St. Louis geographic areas.[xiii] The complete analysis of opioid-related hospital utilization in Missouri is available in the October issue of *HIDI HealthStats* – Opioid Overuse in Missouri (Table 1).

RECOMMENDED APPROACH

A comprehensive policy approach is needed to address the full impact of the opioid issue. Missouri hospitals and physicians are recommending more targeted steps to reduce misuse and abuse focused on emergency department prescribing practices while providing appropriate clinical care. The balance between managing patient expectations related to pain management and satisfaction with clinical evaluation based on evidence, must be carefully evaluated for each patient.[xiv] Established ED prescribing policies, along with assessment for risk behavior and treatment referral and coordination with primary care, are elements of a comprehensive clinical strategy to reduce opioid misuse and abuse.[xv, xvi, xvii, xviii]

The Missouri Academy of Family Physicians, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri College of Emergency Physicians, the Missouri Dental Association, the Missouri Hospital Association and the Missouri State Medical Association promote the following guidelines for care provided in EDs throughout Missouri.

Across the U.S. and Missouri, some hospitals and EDs already have taken action to reduce the incidence and risk of opioid misuse and abuse among patients.[xvi, xvii, xviii, xix] While not intended to be comprehensive, the following guidelines, based on national guidelines and evidence, provide a foundation from which to manage the morbidity and mortality associated with the misuse and abuse of opioids in Missouri.

Suggested Emergency Department Prescribing Practice Recommendations

- 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.[ii, xv, xvii]
- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.[xv]
- Non-narcotic treatment of symptomatic, non-traumatic tooth pain should be utilized when possible.[xv]
- 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.[ii, xv, xvi]
- 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.[ii, xv, xvi]
- 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.[xv, xvii]
- Emergency department physicians and providers should not provide prescriptions for controlled substances that are claimed to be lost or destroyed.[xv, xvi]
- 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.[ii, xv, xvi, xvii]
- When narcotics are prescribed, emergency department staff should counsel patients on proper use, storage, and disposal of narcotic medications.[xvi, xvii]
- 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.[ii, xvi, xx]

ENDNOTES

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SUGGESTED CITATION

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