



Translating Opioid Research And Policy Into Practice

HCCA St. Louis Regional Conference



MISSOURI HOSPITAL ASSOCIATION

Disclosures

- Shawn Billings has no conflicts of interest and nothing to disclose.

Objectives

Following the presentation, participants will be able to:

- Report on statewide efforts of integrating a Medication-First Model when treating opioid use disorder (OUD).
- Describe statewide strategies to decrease prescription opioids in circulation via prescribing guidelines and the utilization of the Prescription Drug Monitoring Program.
- Identify current initiatives that leverage peer recovery support to bridge patient access to evidence-based opioid use disorder treatments through transitions of care.

Diagnosing Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following criteria, occurring within a 12-month period.

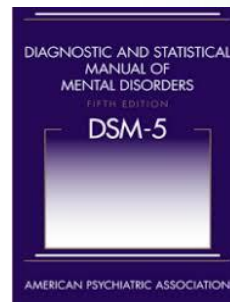
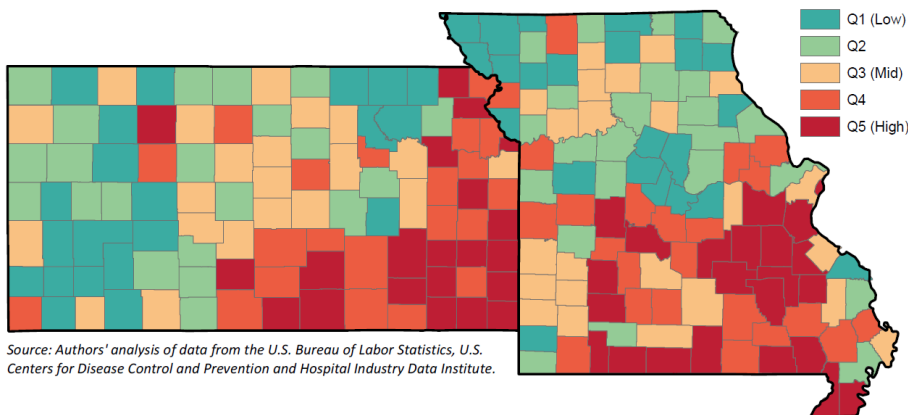


TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	<ul style="list-style-type: none"> • Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	<ul style="list-style-type: none"> • Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	<ul style="list-style-type: none"> • Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	<ul style="list-style-type: none"> • Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

Source: DSM-5 Diagnostic and Statistical Manual of Mental Disorders

Opioid Dependence Risk in Kansas and Missouri Counties 2016-2017

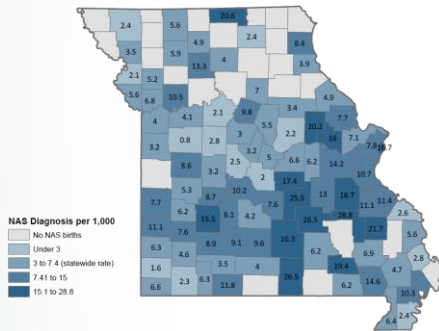


Source: Authors' analysis of data from the U.S. Bureau of Labor Statistics, U.S. Centers for Disease Control and Prevention and Hospital Industry Data Institute.

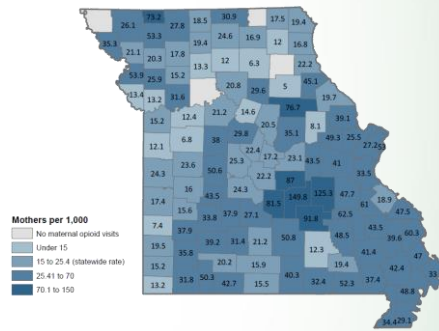
Figure 5: Opioid Dependence Risk in Missouri and Kansas Counties Estimated With Principal Component Analysis of Unemployment, Drug-Related Mortality, Morphine Milligram Equivalents Prescribed Per Capita and Hospital Utilization for Opioid Misuse (component 1 shown in map)

Incidence of NAS in Missouri by County During 2016 and 2017: Rate per 1,000 Births Identified with Diagnosis Codes for the Infant vs. Linking New and Expectant Mothers to Hospitalizations for Opioid Misuse

Rate of NAS Detected by Diagnosis on Hospital Discharge Record, 2016-2017



Rate of New and Expectant Mothers with an Opioid-Related Inpatient or ED Visit: Rate per 1,000 Births by County, 2016-2017



DATA AND ANALYTICS POWERED BY **HIDI**

MISSOURI STR - Medication First Model

- Patients with OUD receive timely pharmacotherapy treatment – prior to lengthy assessments or treatment plan development.
- Maintenance pharmacotherapy is delivered without contraindicated tapering or time limits.
- Individualized psychosocial services are offered but not required.
- Medicines are meant to address withdrawal symptoms, cravings and increase treatment retention.



STR Medication First Successes FY 2018

- 28 treatment agencies are funded, providing treatment at 44 sites
- Statewide, STR has provided treatment for 1,922 individuals with OUD
- Of those, 1,320 individuals (69%) still are receiving treatment and/or support



9

Opioid Prescribing Guidelines And Alternatives To Opioids



Pain Management Alternatives to Opioids & Prescription Painkillers

1. Corticosteroids (steroids) 
2. Nonsteroidal Anti-inflammatory Drugs
3. Acetaminophen
4. Physical Therapy
5. Exercise
6. Chiropractic Treatment
7. Acupuncture
8. Meditation
9. Yoga
10. Cognitive Behavioral Therapy (CBT)

It's possible to treat pain without prescription medications

10

CDC Guideline for Chronic Pain

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 Nonpharmaceutical therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmaceutical therapy and nonopioid pharmacologic therapy, as appropriate.

2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
 U.S. Food and Drug Administration
 U.S. Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/guidelines/prescribing/guidelines.html

https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ERXAs opioids for acute pain
- Follow-up and reevaluate risk of harm, reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/acting (ERXAs) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess individual benefits and risks when considering increasing dosage to >50 MME/day or carefully justify a decision to titrate dosage to >90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should reduce benefits and harms with patients within 1 to 2 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months, or more frequently if needed, on the net amount of benefit versus harm. Clinicians should discuss other therapies and use with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should separate into the assessment plan strategies to mitigate risk, including considering other substances whose factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosage (>90 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid therapy or controlled substances that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing if harm remains or persists (medications as well as other controlled prescription drugs and illicit drugs).

11 Clinicians should not prescribe opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or naltrexone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/guidelines/prescribing/guidelines.html

Emergency Department Opioid Rx Guidelines

MISSOURI ACADEMY OF FAMILY PHYSICIANS | MISSOURI ASSOCIATION OF SURGEONS | MISSOURI DENTAL ASSOCIATION | MISSOURI STATE MEDICAL ASSOCIATION

OPIOID USE IN MISSOURI: Strategy for Reduced Misuse and Abuse

EMERGENCY DEPARTMENT POLICY RECOMMENDATION
 — Effective December 2015

- 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.^{1,2}
- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.³
- Non-narcotic treatment of symptomatic, non-traumatic tooth pain should be utilized when possible.⁴
- 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.^{5,6}
- 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.^{7,8}
- 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.^{9,10}
- Emergency department physicians and providers should not provide prescriptions for controlled substances that are claimed to be hot or designer.¹¹
- 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.^{12,13}
- When narcotics are prescribed, emergency department staff should counsel patients on proper use, storage, and disposal of narcotic medications.¹⁴
- 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.¹⁵

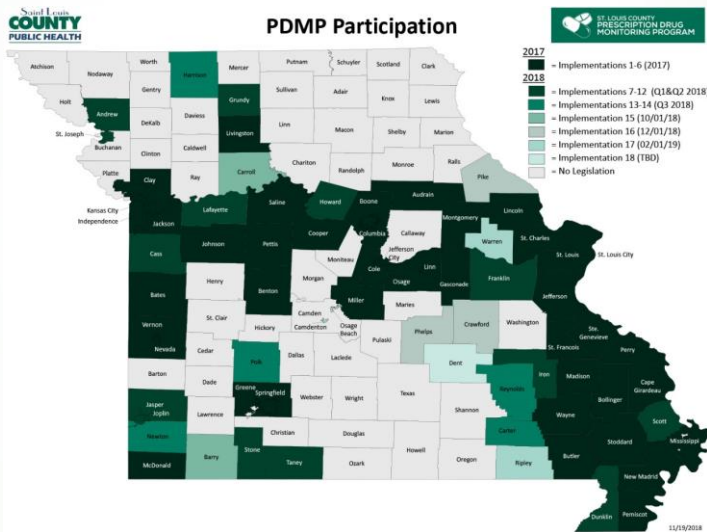
In November 2015, the Missouri Academy of Family Physicians, Missouri Association of Osteopathic Physicians & Surgeons, Missouri College of Emergency Physicians, Missouri Dental Association, Missouri Hospital Association, and Missouri State Medical Association jointly recommended a set of hospital emergency department guidelines to reduce variation in opioid prescribing practices.

REVISED Opioid Rx Guidelines:

In Missouri, new [opioid prescribing recommendations](#) designed to guide hospital-based physicians' use have been adopted and released by a coalition of health care policy and advocacy organizations. The revised guidance reflects evolving best practices in the use of opioids for pain management and changes in the law designed to reduce the opioid addiction crisis.

- Title change to reflect hospital versus ED
- Specifically reference the CDC Chronic Pain Guideline
- Refer to Senate Bill 826
- Revise naloxone statement from policy to practice – consider discharging patients with a prescription for naloxone, if at risk of overdose
- PDMP query and medication-assisted treatment should be policy statements but not guidelines.

Prescription Drug Monitoring



Documentation: We Have it — What Now?

Nearly half a million yearly U.S. hospital discharges for a range of primary treatment include patients' diagnosis of OUD without opioid overdose, detoxification, or rehabilitation services. Inpatient stays present an important opportunity to link OUD patients to treatment to reduce opioid-related morbidity and mortality.

Source: [J Subst Abuse Treat](#). 2018 Sep;92:35-39. doi: 10.1016/j.jsat.2018.06.008. Epub 2018 Jun 20.

15

Statewide Opioid Initiatives



16

Treating Opioid Overdose in the Emergency Department: Treatment Initiation and Community Linkage



- Patient overdoses and arrives in the ED.
- An ED buprenorphine-waivered physician is contacted.
- Buprenorphine induction occurs in the ED.
- A Recovery Coach is contacted and meets with the patient in the ED.
- The ED physician provides patient with a bridge prescription (2-5 days) buprenorphine.
- The Recovery Coach assists the patient with a timely referral to outpatient MAT, behavioral therapy, and support groups.



17



FDA-Approved Medications to Treat Opioid Use Disorder

	Naltrexone (Vivitrol®, ReVia®)	Buprenorphine/Naloxone (Suboxone®)	Methadone
Mechanism	Opioid antagonist	Opioid partial agonist/partial antagonist	Opioid agonist
Availability	Extended-release injection, tablet	Sublingual, buccal, implant, injection	Usually syrup formulary
Initiation	Must wait to initiate until patient has been free of opioids for 7-10 days	Must wait to initiate until after withdrawal symptoms have started to appear	May initiate immediately to avoid withdrawal
Abuse Potential	No abuse potential	Less likely than methadone; only a partial agonist	Low compared to other opiates; very low within methadone clinic
Patient Population	<ul style="list-style-type: none"> Concomitant alcohol dependence Highly motivated patients 	<ul style="list-style-type: none"> Improving insurance coverage Decreases mortality in heroin users 	Improving insurance coverage
Prescribing Restrictions	None	Must receive DATA 2000 waiver	OTP Clinic

Source:

https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/59bab107f09ca461180d6429/1505407240927/Opioid+STR+Implementation+Guide_nonDMH.pdf

19

MHA's Current Efforts in Support of Evidence-Based Treatment Integration

- The production and dissemination of guidance documents to promote statewide alignment with evidence-based treatment of Opioid Use Disorder
- Collaboration with the Missouri College of Emergency Physicians to raise awareness of the need for additional physicians waived to prescribe buprenorphine
- Convening stakeholders throughout the state to establish hospital-initiated programming that links patients to medical treatment, recovery support services and behavioral therapy post-discharge (EPICC/NAS Programming)
- Advocacy for statewide adoption of the PDMP to promote safer prescribing practices
- Promoting alternatives to opioids



20

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