Saving Lives by:

Altering Prescribing Practices

Tools and Strategies for Rural Opioid Work

by
Mark Satterfield, MD

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Northern Sierra Opioid Safety Coalition
Plumas - Lassen - Sierra - Modoc

Plumas County Public Health Agency
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Defining the Crisis

- It was 2011 when we first suspected we had a problem with excess prescribing of opioid pain medicines in Plumas County.
- There were too many prescription drug overdoses coming in to our ERs.
- Some of these people would return a month or two later with another overdose despite the ER doctor notifying the prescribing physician of the need to reduce the responsible medications.
- Too many younger people were on high-potency opioids like methadone and oxycodone for their ongoing non-cancer pain (back, fibromyalgia, headaches).

Defining the Crisis - 2

- **Older people were dying accidentally and prescription opioids were showing up in the coroner's toxicology reports.**
- **When certain doctors went on vacation, ERs would fill up with patients who had run out of their opioids and were requesting refills from the ER.**
- **Comparative data for the state as a whole and other counties were delayed and overlooked.**

- ***Efforts began in 2012 to address the problem, and what follows is what we did and how it impacted our county and coalition area.***

Summary of Our Results

- **In 2012 Plumas County had six times higher incidence of prescription opioid related accidental deaths than the California average. We became the highest in the state in 2014.**
- **Between 2012 and 2017 we reduced opioid prescribing by 61% county wide.**
- **The opioid related accidental death rate dropped dramatically.**
- **How did we do it? (and will it work for others?)**

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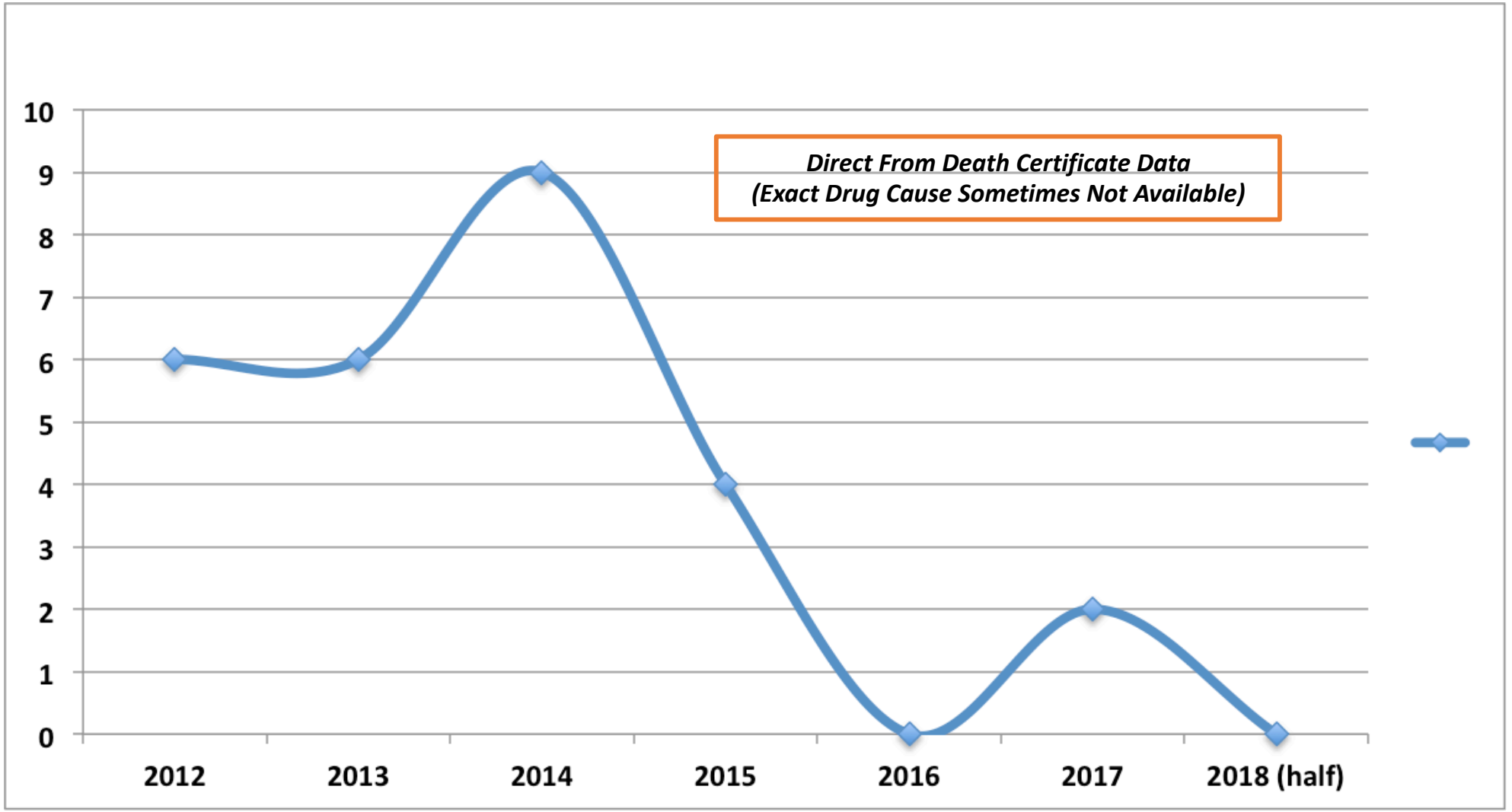
Accidental Prescription Opioid Deaths

By Year – Plumas County



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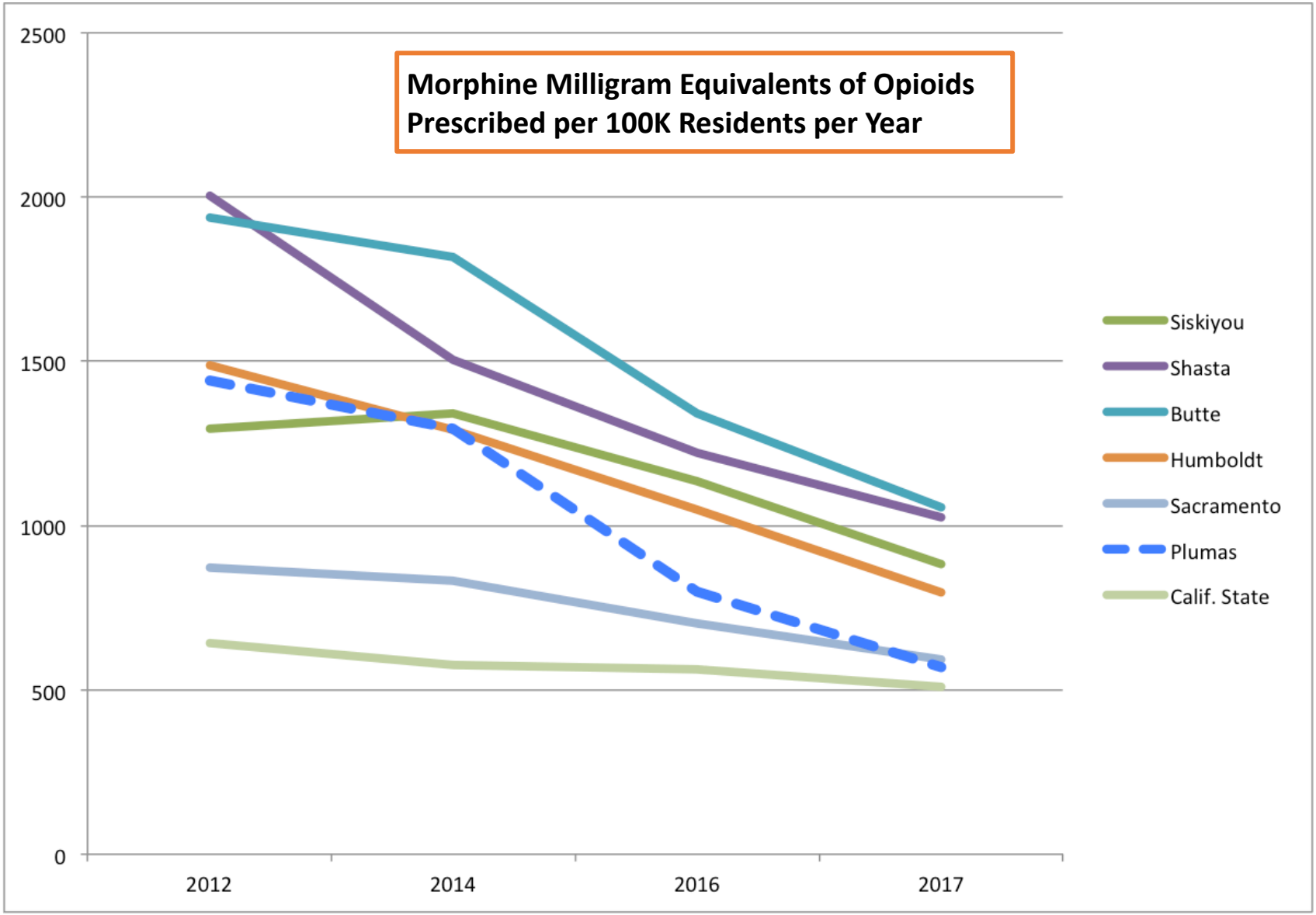
Prescribed Opioids



California Opioid Overdose Surveillance Dashboard - 2018

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By the Numbers

Opioid Prescribing and Deaths Over Time

California - State, Counties, Plumas Communities

MME opioids prescribed PER 100K people PER year by Prescriber Location								*Rx opioid related deaths PER 100k people PER year*			
Location	**Zip Code**	**2012**	**2014**	**2016**	**2017**	**Percent Decrease 2012-17**	***2017 Percent More MME than Calif avg***	**2012**	**2014**	**2016**	**2017**
Quincy Area	***95971***	***2132***	***2186***	***1094***							
Graeagle Area	***96103***	***4272***	***1338***	***1026***							
Portola Area	***96122***	***1320***	***1327***	***746***							
Chester Area	***96020***	***3853***	***2537***	***2124***							
Plumas Co	**all**	**1441**	**1294**	**799**	**569**	**-61%**	***12%***	**22.8**	**20.5**	**0.0**	**11.1**
Lassen Co	all	2067	1660	1020	**782**	**-62%**	*81%*	13.5	13.3	12.2	
Modoc Co	all	1162	761	636	**348**	**-70%**	*13%*	43.7	14.2	0.0	
Siskiyou Co	all	1295	1343	1136	**883**	**-32%**	*102%*	14.4	6.6	11.1	
Shasta Co	all	2004	1505	1223	**1025**	**-49%**	*118%*	13.6	9.8	3.6	
Butte Co	all	1938	1818	1343	**1056**	**-46%**	*139%*	8.7	5.8	4.6	
Humboldt Co	all	1489	1291	1049	**797**	**-46%**	*87%*	14.2	15.4	13.6	
Sacramento Co	all	873	833	701	**592**	**-32%**	*25%*	2.6		2.2	
California State	**all**	**644**	**576**	**562**	**508**	**-21%**	**0%**	**3.3**	**3.5**	**3.2**	**3.2**

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NSOSC

Other Nearby Counties and CA State

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What We Did (1)

- **These people are in PAIN, so we acknowledged that and increased access to pain specialists and their expertise.**
  - ***This was an important insight by the leadership team at Eastern Plumas Healthcare (Portola), who initiated this in 2012.***
  - ***Recruited pain specialists with Anesthesia or Physical Medicine and Rehabilitation background to consult in person and via telemedicine.***
  - ***All chronic non-malignant pain patients were asked to consult with the pain specialist at least once before returning to their primary doctor for ongoing pain management.***
  - ***Pain specialists are often hard to come by.***
    - ***Project ECHO (developed in New Mexico to improve care of rural Hepatitis C patients) and telemedicine can help to obtain pain specialist consultation.***

What We Did (2)

- **Adopted the CDC Guidance for treatment of non-cancer pain with opioids and got the message out to all regional doctors and other healthcare providers (FNP, PA):**
  - ***Opioids are an ineffective and hazardous treatment of chronic non-malignant pain (such as fibromyalgia or ongoing back pain)***
  - ***Increase expertise in the use of non-opioid treatments whenever possible.***
  - ***Prescribe the smallest number of pills that are reasonable.***
  - ***Avoid combining opioids and benzodiazepines.***
  - ***People on more than 90 MME (morphine milligram equivalents) a day or on both opioids and benzodiazepines are at particularly high risk of dying.***
  - ***Initiate opioid and/or benzodiazepine tapers for these high risk patients.***

What We Did (3)

- **Secured funding from the California Healthcare Foundation in 2015 to help us form a regional coalition for opioid safety involving Plumas, Lassen, Modoc, and Sierra counties. The Northern Sierra Opioid Safety Coalition (NSOSC) was born. We significantly exceeded our 2 year goals:**

  1. ***Significantly reduce opioid prescribing.***
  2. ***Increase availability of medication assisted treatment (MAT) of opioid use disorder.***
  3. ***Increase availability of naloxone.***

What We Did (4)

- **Sought and received support from healthcare organization administrations to reduce opioid prescribing.**
  - ***To enhance patient safety -- the prescription opioid epidemic is dangerous to patients and must be stopped.***
  - ***To improve quality of pain control -- opioids are not shown to be effective in management of chronic pain.***
  - ***Often people's pain is improved after tapering off of opioids because of OHS (opioid hyperalgesia syndrome).***
  - ***Organization leadership understood the idea that to achieve better and safer long term control of pain some patients would need to be helped through a limited period of increased pain and discomfort.***
  - ***Anticipated the increase in patient complaints that occurred, and were ready to respond in a compassionate and positive way.***
  - ***Ensured that patient complaints about pain management were not allowed to jeopardize providers ongoing employment, a reason doctors claim they are sometimes reticent to reduce opioid and benzodiazepine prescribing.***

What We Did (5)

- **Recognized that providers (MD, DO, FNP, PA) overwhelmingly want to provide safe and effective care. We made sure providers had access educational opportunities to learn how to best accomplish that.**
  - ***Pain specialists shared their expertise with primary providers through consultations, case presentations, and Grand Rounds.***
  - ***For example, in Quincy we had five Grand Rounds over a 2 year period on evaluation and control of pain and safe use of opioids.***
  - ***These events were well attended by providers.***
  - ***Ultimately primary care providers enjoyed increased success caring for their chronic pain patients with less use of habit forming and dangerous medications.***

What We Did (6)

- **Many Providers:**
  - ***modified their prescribing habits to improve pain control and reduce risk.***
  - ***were not part of the problem to begin with.***
- **A Few Providers:**
  - ***had their contracts not renewed.***
  - ***retired.***
  - ***left the area.***
  - ***were sanctioned by DEA. (Which really sends a shock wave through a medical community.)***

What We Did (7)

- **We also made sure policies were in place to:**
  - ***prevent early or Emergency Room prescription opioid medication refills.***
  - ***encourage providers to check CURES (prescription drug monitoring program) -- insure "one provider, one pharmacy".***
  - ***require checking of urine toxicology.***
  - ***consider a lenient attitude regarding marijuana for those > 21 years old***
    - **This may be a safer drug that can help some people deal with chronic pain or anxiety without resorting to opioids or benzodiazepines.**
  - ***consider a compassionate policy on missed appointments that makes termination/transfer of care a rarely implemented "last resort."***

What We Did (8)

- **Acknowledged that each provider has a valid perspective on treating pain and needs to be a respected member of the team.**
  - ***Encouraged respect for patients and their concerns.***
  - ***Encouraged respect for evidence based treatment.***
  - ***Acknowledged that some potentially effective treatments do not lend themselves to double-blind placebo controlled study validation.***
  - ***Acknowledged that patient selected treatments that might be reliant on the placebo effect may be a useful adjunct to help some people manage their pain.***

Being Done Now

- **Academic Detailing**
  - ***Sponsored by the California Department of Public Health***
  - ***In addition to relying on Grand Rounds, conferences, and journal reviews, the idea is to bring the evidence based advice directly to the clinician in a convenient, readily accessible format.***
  - ***Pharmaceutical company detailing is known to be effective at modifying physician (and PA/FNP) prescribing behavior.***
  - ***Instead of promoting a product for financial gain, academic detailing advocates for evidence based provider behavior which is in the best interest of the patient and public health.***
  - ***Examples:***
    - **Safe prescribing of opioids.**
    - **Appropriate prescribing of antibiotics.**
  - ***Thus far there is limited evidence of effectiveness (i.e. less prescribing, less mortality), but Plumas County is part of the research to define that.***

Effective in Other Communities

- **Restricted medication formulary that requires prior authorization for certain medications, doses, combinations, or amount dispensed.**
  - ***Partnership Healthcare***
  - ***Kaiser***
  - ***California Health and Wellness; Anthem BlueCross***
  - ***State laws requiring PDMP (prescription drug monitoring programs – CURES in California) be checked before prescribing opioids and a treatment plan defined for longer-term opioid treatment.***

Some Ways Rural Providers May Differ From their Urban Counterparts

- **Rural providers (MD, DO, FNP, PA) often:**
  - ***are in short supply***
  - ***work long hours***
  - ***take a lot of call***
  - ***must care for and stabilize critically ill patients with limited resources.***
  - ***feel isolated from their urban peers***
  - ***have more limited access to high quality CME (continuing medical education) and specialist colleagues.***
  - ***may be caring for their personal friend, neighbor, spouse's boss, kid's teacher or soccer coach. It can be harder to say "no" to these patients if they want to maintain or increase their opioids or benzodiazepines.***

Some Ways Rural Providers May Differ From their Urban Counterparts

- **Rural providers are also often:**
  - ***very dedicated to their patients and want to give great care.***
  - ***willing to work hard.***
  - ***thirsty for high quality CME.***
  - ***more willing to take a noon-hour or an evening for CME/Grand Rounds.***
  - ***under contract to a public healthcare district with conscientious administrative leadership and a board of directors who are actively engaged in insuring safe, effective, and courteous care.***

The Transition to Injection Opioids

- **Just a few years ago more than 60% of opioid related deaths were due to *prescription* opioids.**
- **Now 70% are *illicit injection* opioids (heroin, fentanyl).**
- **This change increases the urgency of insuring that "harm reduction" interventions are widely available in both urban and rural areas.**
  - ***clean syringes.***
  - ***widespread availability of naloxone (including first responders).***
  - ***access to opioid use disorder treatment (including MAT).***
  - ***ALS (advanced life support) ambulances.***
  - ***high quality local hospital emergency services.***

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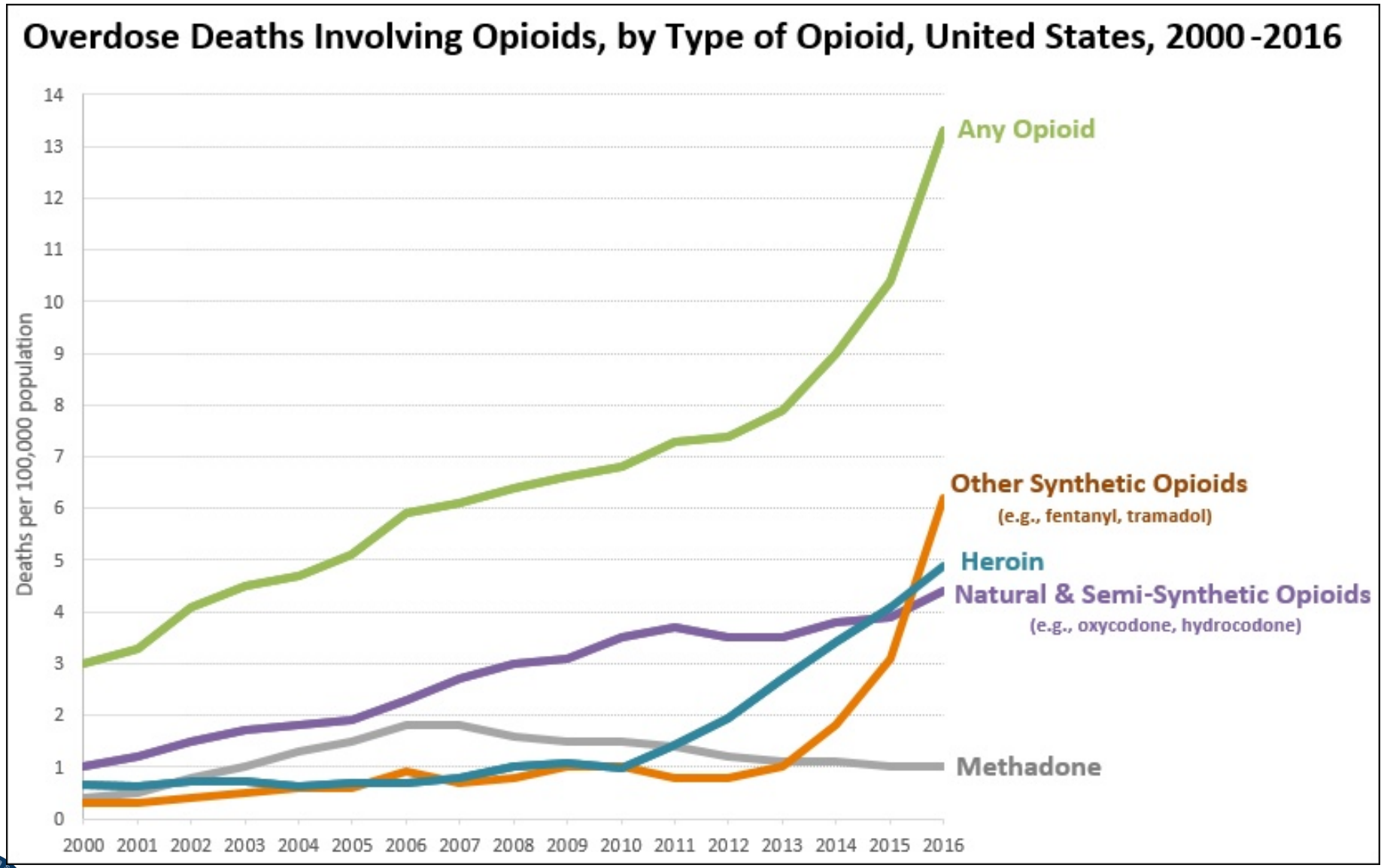
The Transition to Injection Opioids



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30% of Deaths Still Involve Prescription Opioids

- **There is room to make better use of naloxone training and dispensing to save prescription opioid overdose victims.**
- **A review of coroner's reports substantiates the following recommendations.**

Can We Make Family & Friend Administered Naloxone More Effective in Preventing Prescription Opioid Overdose Deaths?

1. **Family or friend administered naloxone is spectacularly successful at saving the lives of *injection* drug users. Why?**
    1. ***They often inject when friends are present.***
    2. ***It is absolutely clear what is happening: the person just injected drugs and now isn't breathing and is turning blue. Naloxone saves a life!***
2. **Family or friend administered naloxone hasn't been as successful saving the lives of *prescription* opioid users. Why?**
    1. ***Prescription opioid users are often alone when they most need the naloxone, having gone to bed and often after friends and family have gone home or to their own room.***
    2. ***Too often nobody figures out that the victim is headed to an overdose state. Maybe they've had some alcohol, or been seen confused and stuporous before and recovered after "sleeping it off." It can take more than an hour for pills to reach their lethal level in the blood stream!***

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Keys to Saving the Prescription Opioid Overdose Family Member or Friend

1. ***RECOGNITION that it might be an overdose, and SOMEONE STAYING WITH THE POSSIBLE VICTIM are often the missing KEYS to preventing prescription drug overdose deaths.***
2. ***It's not enough to just prescribe and train family and friends to administer naloxone. They need to understand that prescription drug overdoses happen slowly and often go unrecognized until it's too late.***
3. ***As mentioned above, when a person overdoses on IV opioids it is immediately apparent the person is in trouble and the cause is opioids. They just injected drugs and now they are not breathing and turning blue.***
4. ***Hopefully there are bystanders who have naloxone and know how to give it, and the person is saved.***
5. ***That is too often NOT the case in prescription ODs! The victim gets worse over a period an hour or more. Friends or family have often left them alone ("to sleep it off") at precisely the WRONG time.***

Keys to Saving the Prescription Opioid Overdose Family Member or Friend

6. ***WHAT MUST HAPPEN! Family & friends need to know to call 911 early, when the victim is getting more confused, snoring heavily, stumbling, or getting stuporous (but still breathing!).***
7. ***If they choose NOT to call 911, (believing the victim is OK and getting better), they need to STAY WITH THE PERSON until it is absolutely certain they do not need emergency help.***
8. ***Of course, give the naloxone if they cannot be readily aroused (while awaiting an ALS ambulance) and start CPR if necessary.***
9. ***Having a capable person there to recognize a slowly progressing overdose, stay with the victim, call 911 (if necessary), give naloxone (if necessary), and initiate CPR (if necessary) are the keys.***
10. ***<u>The victim has usually been left ALONE when a prescription overdose takes a life.</u>***

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Prevention of Addiction!

- **Harm reduction (most of this conference) is ESSENTIAL, but there's more we can be doing to PREVENT addiction.**
  - ***The impact of ACEs (adverse childhood events).***
    1. **They include: abusive parenting (physical, emotional, sexual), parent arrested, neglect, substance abuse in the home, mental illness in the home, etc.**
    2. **Have been shown to be highly correlated with addiction (and other poor social, physical, and emotional outcomes).**
  - ***Some evidence based ways to mitigate ACEs, resulting in improved outcomes and reduction in addiction.***
    1. **Teaching parenting skills and appropriate parental response to ACEs.**
    2. **All children need to have at least one consistent adult who cares about what happens to them. It doesn't need to be a parent or even a grandparent.**
    3. **Big Brothers, Big Sisters.**
    4. **Life-Skills Training (Jr.-Sr. High School) Botvin.**

Take Aways

Altering Prescribing Practices

- Clinic administration has to be on board.
- Need one or more physician champions.
- Make pain specialists available.
- Provide plenty of educational opportunities.
- Track the Rx's.
- Make policy parallel to CDC guidance.
- Expect and mitigate patient complaints.
- Anticipate possible change in provider personnel.
- Teach people how to recognize and respond to the gradual onset of a prescription opioid overdose.
- We must learn to PREVENT addiction.

THANK YOU !!

- **Questions?**
- **Comments??**
- ***Slides are available at the Plumas County Public Health Agency website: http://countyofplumas.com/index.aspx?nid=2559***

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