Addressing the Opioid Epidemic In Rhode Island

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Disclosures

None

Epidemiology of the Opioid Epidemic: Pain in the United States

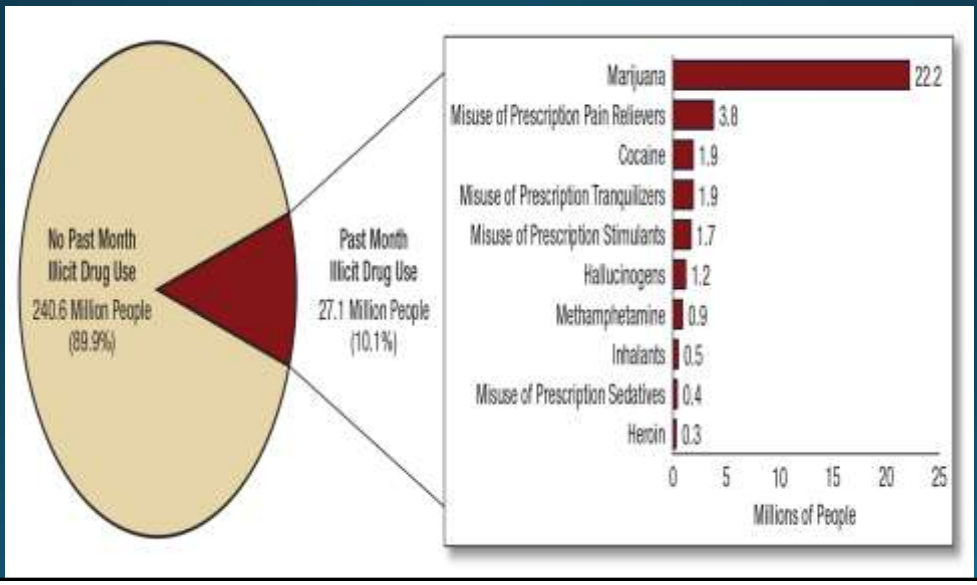
- Approximately 30% of Americans have pain
- Older adults: 40%
- Opioids are most prescribed class of medications in the U.S.
- 2014: 245 million prescriptions for opioids
  - 65% for short term (less than 3 weeks use)
  - 3-4% of population (9-11.5 million) receive chronic opioid therapy

Volkow and McLellan, 2016, Chou et al. 2014

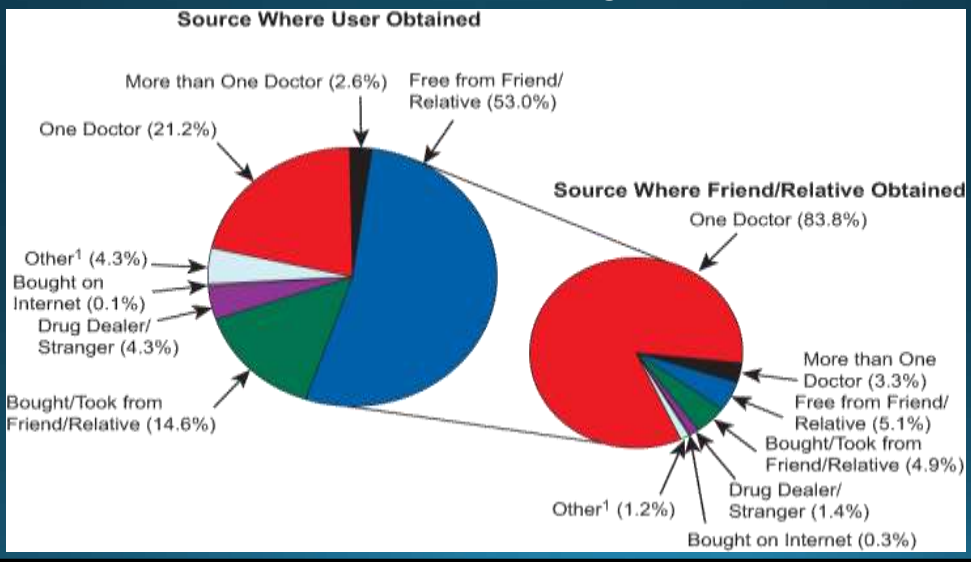
Misuse and Diversion

- Opioids are important analgesics for acute pain
- Less evidence for effectiveness in chronic pain
- Increases in misuse and diversion have tracked with increased prescribing
- Mu receptors are widespread in the brain: pain perception, emotional response to pain, pleasure, respiratory depression
- Safety issues and adverse events including overdose, death, and addiction

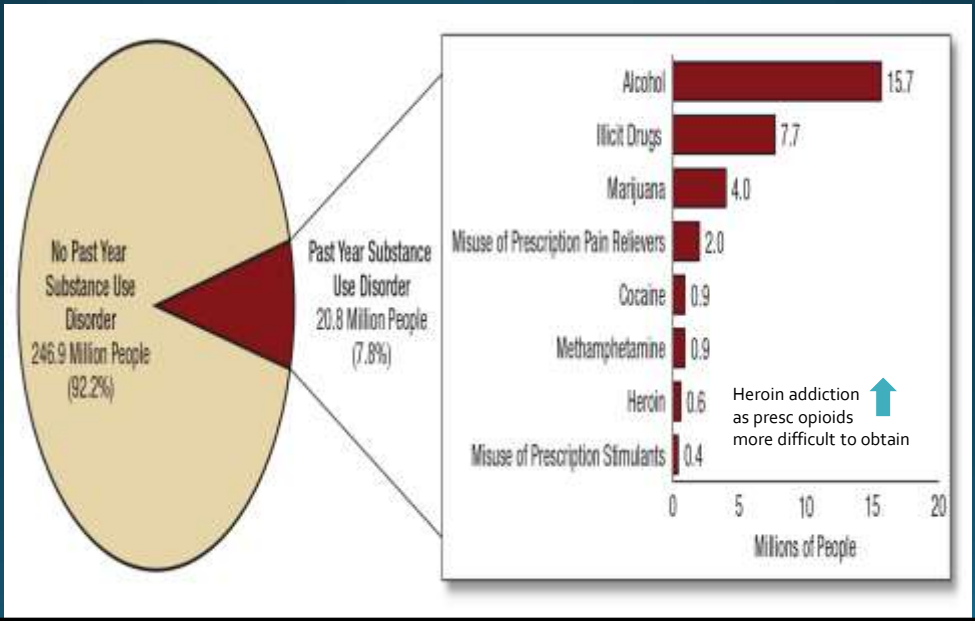
Numbers of Past Month Illicit Drug Users among People Aged 12 or Older
2015
National Survey on Drug Use and Health, 2016



Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2013



Numbers of People Aged 12 or Older with a Past Year Substance Use Disorder: 2015
NSDUH, 2016



DRUG OVERDOSE-RELATED DEATHS: A PREVENTABLE PUBLIC HEALTH ISSUE

- Since 2009 drug overdose deaths are leading cause of injury death in the U.S. – more than even car crashes
- Majority of drug overdose-related deaths are caused by prescription opioids and heroin
- 1999 to 2010: Opioid prescribing quadrupled
- 1999 to 2013: Rate for drug poisoning deaths involving opioid analgesics nearly quadrupled*
- 2015: Opioid analgesic related deaths: 18,893; heroin-related deaths: 10,574
- 1999-09: 6 fold increase in admissions for OUD related to misuse of prescribed opioids

*Most frequently involved in deaths: oxycodone, hydrocodone, methadone, in combination w/alcohol or other drugs, most often benzodiazepines

Opioid Use Disorder in Rhode Island

From 2011-15 opioid overdose deaths increased by 50%

2015: Over 250 overdose deaths

50% of those deaths involved fentanyl

75% of overdose deaths are in men

Majority of overdose deaths occur in 20-59 year olds

18% of overdose decedents were people released from ACI in the past year

Addressing the Epidemic: Governor's Task Force on Opioid Overdose Prevention and Intervention

- Prevention: Safe Opioid Prescribing
- Rescue: Access to naloxone
- Expand peer recovery services and treatment options that help people start recovery.
- Treatment: Increase access to Medication-Assisted Treatment (MAT)

Safe Opioid Prescribing

- All prescribers registered for PDMP use in 2016.
  - Pharmacists enter scheduled prescriptions into the database.
- Warnings on co-prescribing of opioids and benzodiazepines.
- DOH CME course on benzodiazepine use
- DOH to offer pain management CME in June 2017

Safe Opioid Prescribing

- Proposal for RI Health Insurance Medical Directors:
- Acute Pain/Injury and Opioid Prescribing Policy
- No more than 30 morphine mg equivalents/day (MME/d) and no more than 20 doses
  - http://www.health.ri.gov/healthcare/medicine/about/safeopioidprescribing/
  - http://www.globalrph.com/opioidconverter2.htm
- Multiple prescriptions can not be written at once
- Prior authorization needed for:
  - Long acting/extended release opioid for acute pain
  - Prescription for an immediate release opioid that exceeds 30 MME/d
  - Immediate release opioid with quantity exceeding 20 doses for acute pain

Safe Opioid Prescribing

- ED/Hospital standards for addressing opioid use disorder
- Level 3
- Based on Perry-Goldner law on discharge planning
  - Patient involvement, contact of emergency contact, peer specialist, PCP, referral to substance use disorder care, potential for starting MAT in the ED (Level 2 or 1)
- Substance use disorder screen
- Safe storage and disposal education
- Naloxone prescribing
- Opioid overdoses reported to database within 48 hours
- Urine drug screens on all opioid overdoses

Naloxone Distribution

- Outreach to high risk groups
  - Drug users/injectors
  - Overdose survivors
  - Part of peer recovery coaching in street outreach e.g.: in collaboration with local police departments in conjunction with:
  - Educational, harm reduction, and facilitated treatment entry programs to survivors, their families, and their social networks
- Naloxone distribution to those receiving opioids
  - Pharmacists should offer to all with Schedule II prescriptions or those receiving opioids and benzodiazepines

Peer Support

- Peer Support is increasingly offered to overdose victims in Emergency Departments
- Peer outreach is a critical component of assisting people with opioid use disorder into treatment
- Geographically concentrated in areas hit hardest: Pawtucket, Warwick
- Peers are being incorporated into Centers of Excellence

Treatment

- Prescription pain medications and heroin are the same types of drugs: opioids
- Treatments are the same
- Medical Withdrawal ("Detoxification")
  - *> 90% relapse rate in the year following treatment*
  - *High risk for overdose when relapse occurs*
  - *Should not be a stand alone treatment*

Treatment

- Combination of FDA-approved medication:
  - Naltrexone
  - Methadone
  - Buprenorphine/naloxone

  with psychosocial treatments and ancillary treatment components:
  - Counseling: Coping skills/relapse prevention
  - Education
  - PDMP use
  - Toxicology screening
  - Treatment Agreements

Decisions about Medication Assisted Treatment: Naltrexone

- Opioid antagonist
- No mood altering or reinforcing effects
- Prevents opioid effects including 'high'
- Decreased craving
- No abuse liability
- No special training/DEA registration required for clinicians to prescribe
- No tapering needed to discontinue use
- Tablet and once a month injectable (addresses issues related to adherence)
- Can't be used in people needing opioid analgesics for pain
- But can be used in people with pain who should not receive opioids and who can be treated with alternative pain management

The FDA-approved indication for extended-release (XR) injectable naltrexone is the prevention of relapse to an opioid use disorder following opioid detoxification

Candidates for Naltrexone

- Patients who are detoxified and abstinent but at risk for relapse
  - Released from a controlled setting (prison, residential program)
  - Moving back to old neighborhood
  - With increased stress or worsening of psychiatric problems
  - Probation/parole status or employed in safety sensitive position and need to demonstrate that risk of opioid use is low
- Patients with less severe form of a disorder
  - Short history of use, lower level of use
- Young adults who are often unwilling to commit to a long-term agonist maintenance
- Co-occurring alcohol use disorder

Methadone and Buprenorphine/Naloxone

- Long acting, once daily medications
- NOT 'substituting one drug for another'
- Medications are titrated to a therapeutic dose:
  - Withdrawal blocked
  - Craving reduced or stopped
  - Tolerance occurs so that mood-altering effects are diminished

Methadone

- Only available through methadone maintenance programs (opioid treatment programs (OTPs))
- Take home doses contingent on progress in treatment
  - Attending clinic and counseling
  - Stopping illicit drug use
- Large majority of methadone deaths are related to methadone prescribed for pain; not from OTPs

Buprenorphine: Unique in Opioid Use Disorders MAT

- Prescribing opioids to those with addiction prohibited since 1914
- Buprenorphine first drug approved for office-based treatment of opioid addiction
  - Available by prescription
  - Up to 30 day prescription may be given with refills
  - Physicians with DEA waiver can prescribe

Buprenorphine

- Mu opioid receptor partial agonist
- Strong affinity for mu opioid receptors; slow to dissociate
- Schedule III
- Little effect on respiration or cardiovascular responses at high doses
- Induction onto medication when in mild-moderate withdrawal (can be started in a SUD program and continued or can be started from office-based practice)
- Maintenance form: buprenorphine/naloxone combination; except pregnant women: use mono-formulation
- Average dose once daily: 8/2-16/4 mg daily (sublingual)

Buprenorphine

- Can be used for withdrawal treatment or maintenance
- Maintenance treatment more effective than withdrawal treatment
- Mild withdrawal syndrome
- Primary care physicians, psychiatrists, addiction specialists are expected to be providers of this treatment
- Drug Interactions: Atazanavir/ritonavir: increases buprenorphine concentrations; rifampin: decreases buprenorphine concentrations; opiate withdrawal possible

Buprenorphine Induction

- **To begin buprenorphine treatment:**
  - Patient must show signs of mild-moderate opiate withdrawal
  - Use Clinical Opiate Withdrawal Scale or Objective Opiate Withdrawal Scale to quantify
  - Begin with 2/0.5-4.1 mg buprenorphine/naloxone
  - Can re-dose in 2 hours if opiate withdrawal diminished by first dose
  - 8/2 mg first day dose
  - Return to clinic to re-evaluate next day; increase dose if indicated
  - Most stabilize on 8/2-16/4 mg daily
  - FDA approved dose range is up to 24/6 mg daily

Facts about Medication Assisted Treatment (MAT)

- **Benefits:**
  - Lifestyle stabilization
  - Improved health and nutritional status
  - Decrease in criminal behavior
  - Employment
  - Decrease in injection drug use/shared needles: reductions in risk for HIV and viral hepatitis/medical complications of injection drug use
  - Helps to prevent relapse when used as a maintenance therapy

Myths about MAT

- 'Detox' is the best approach to treatment
- People only need a few weeks/months of treatment
  - Opioid use disorders are chronic, relapsing conditions
    - *No different than other chronic conditions: diabetes, high blood pressure, obesity, depression*
- Medication doses should be 'held low'

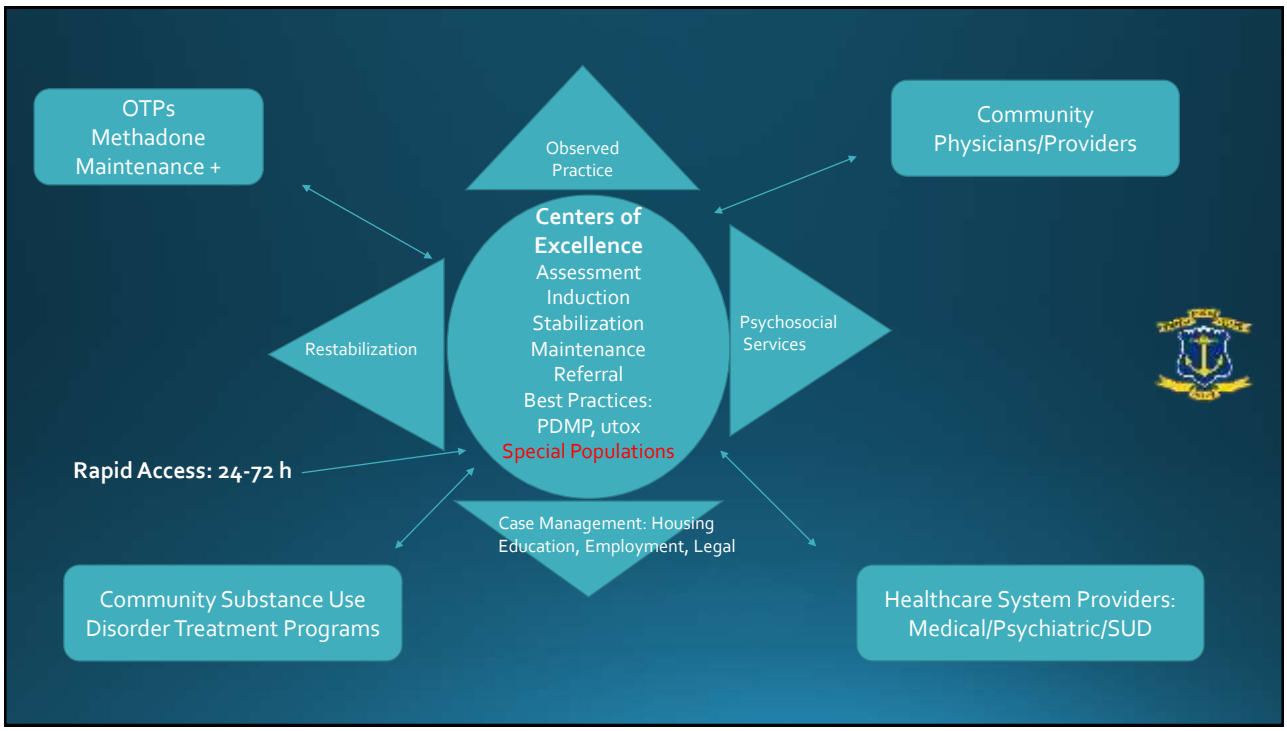
  There is no medical basis for:
  - arbitrary dosing limits—use FDA and SAMHSA guidance
  - for limiting treatment duration—let patients and their doctors decide these issues

Barriers to Treatment Access for Opioid Use Disorder

- Physician Concerns:
  - Lack of training in the assessment and treatment of SUDs
  - That the needs of patients with substance use disorders will exceed their capacity
  - Lack of support services in their communities

Expansion of Access to MAT

- Two Approaches:
- Treatment
  - Creation of Centers of Excellence
- Provider Education
  - DATA waiver trainings
  - Continued education/training supports
  - Centers of Excellence:
    - Observed practice
    - Ongoing collaboration/mentoring



Centers of Excellence: BHDDH Certification Requires Intensive Services

- Specialized care focusing on treatment of opioid use disorder, but providing primary care and, in some centers, psychiatric care, assistance with education/vocation
- Max length of stay: 6 months and transfer to community providers
- Certification from BHDDH: need to provide 2 of the 3 FDA approved MAT
- Provide individual and group counseling which can continue after patient is discharged from the COE
- If relapse occurs, patient can be referred back to the COE for restabilization
- COE offers practical experience (e.g.: buprenorphine induction) to community providers
- Plans for a Project Echo type of ongoing, statewide support

Provider Education

- DATA waiver trainings
  - Assist physicians in obtaining DEA waiver to prescribe buprenorphine for OUD from office-based practice
  - Provide training to support staff to better prepare practices for treatment of OUD
  - Two 8 hour trainings; over 300 trained
- Continue DATA waiver trainings using Half and Half format as requested
  - Collaboration with RI Board of Medical Licensure and Discipline/RI Dept. of Health to determine where trainings are wanted across the state.
  - Provide at least 4 DATA waiver trainings yearly
  - Sponsor: American Academy of Addiction Psychiatry/SAMHSA PCSS-MAT

Ending the Epidemic

- Increase access to treatment: Train physicians and other clinicians who will provide treatment for opioid use disorders
- Continue to train healthcare professionals in safe and appropriate use of opioids and alternatives to use of opioids for pain
- Continue to educate the public about the dangers of misuse of pain medications and safe use when necessary including safe storage and disposal
- Use PDMPs, treatment agreements, and toxicology screens to increase safety
- Provide evidence-based treatment to all who need it for as long as it is clinically indicated

Pharmacists Play a Large Role!

- Interactions with public that can help to address the opioid risk issues:
  - Naloxone education/distribution
  - COE ← Pharmacists → Community PCPs
  - Education regarding risks/drug interactions with opioids
  - PDMP data entry
  - PDMP use to address any safety concerns with filling a prescription
- Making treatment resources available to public at pharmacies:

CALL THE RECOVERY HELPLINE:

- **401-942-STOP**
- **401-942-7867**

Thank you!

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401-462-1525