A MICHIGAN TALE OF COMBATING OPIOIDS

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SIMPLE QUESTION – "DO WE HAVE A DRUG PROBLEM"

In 2012 Dr. Hamed began talking about Emergency Department traffic related to drugs.

We began discussing how much time and energy is wasted on processing those patients who are looking for drugs.

Dr. Hamed started searching for an example of how an ED might impact this behavior.

The State of Washington had developed policies that were being employed in ED's and we began evaluating how this might work in Michigan.

SIMPLE QUESTION ANSWER – "YES WE HAVE A DRUG PROBLEM"

In 2010 there were 18,954,172 prescriptions written for controlled substances in Michigan.

In 2011 there were 19,763,680 prescriptions written for controlled substances in Michigan.

In 2012 there were 20,991,020 prescriptions written for controlled substances in Michigan.

In 2012 the 21 million prescriptions written accounted for 1,388,349,630 units of controlled substances dispensed.

IS THIS PROBLEM UNIQUE TO MICHIGAN - NO

In Michigan more than one narcotic prescription for every Michigan resident – 107 per every 100 residents.

WHY AN OXY-FREE ED?

We are a Critical Access Hospital with limited resources.

Our ED bed capacity is 5.

We see an average of 6,000 visits per year.

We staff with one physician, 1-2 RN’s and 1 ED tech (usually).

Imaging coverage is on-call after normal business hours.

PRE OXY-FREE ED WORK

Re-visited the State of Washington model with an eye on policies, initial success and level of enforcement.

Literature review of opioid related adverse events and trends in the U.S.

Looked at narcotic drug prescribing policies in other ED's, clinics and health systems across the U.S.

Engaged in discussions with out-of-state ED medical directors that shared our concern and were in various stages of policy development.

TARGET START DATE & COMMUNITY OUTREACH

Symbolic target of January 1, 2013 however we implemented February 1, 2013.

Informed local primary care providers, law enforcement, local pharmacies, county mental health and county public health departments.

Engaged in radio and newspaper media blitz and announcements.

Most importantly, prepared staff to compassionately deal with patients seeking narcotic drugs.

DRUG SEEKING & DRUG ABUSE DEFINED

Drug Seeking Behavior: Manipulative and/or demanding medication. This can include obtaining or attempting to obtain a prescription drug, procure or attempt to procure the administration of a drug by fraud, deceit, willful misrepresentation, forgery, alteration of a prescription, willful concealment of a material fact, or use of a false name or address.

Drug Abuse: The use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

WHAT IS A TYPICAL PATIENT SCENARIO?

“Worst pain ever” (headache, back, leg, toothache, etc.). This patient will need to be worked up to rule out any real problems while consuming resources and space.

“Allergic to NSAIDS” and of course they know that the only thing that works is Dilaudid, Morphine, Fentanyl, Vicodin, Oxycodone, Lortab, etc.

“Don’t worry I have a ride” just in case there is an IM/IV opiate administered.

AFTER EMERGENT CONDITION IS RULED OUT

With few exceptions, patients with chronic conditions are only treated with non DEA schedule 2, 3 or 4 substances while in the ED.

Patient is responsible for maintaining active prescriptions with their PCP or Pain Specialist (no refills or replacement of lost/stolen meds).

Chronic Pain Conditions: migraine, back/neck, pelvic/ovarian, dental, fibromyalgia, musculoskeletal, etc.

Problem if a patient has 2 visits in 30 days, 6 visits in a year for painful condition and/or frequent narcotic use as seen in MAPS review.

IS IT ACUTE OR CHRONIC?

If it is determined that this is a chronic pain patient: 1) encourage them to follow up with their normal provider; 2) if they don't have a provider then they will be provided a list of providers and clinics accepting new patients.

If it is determined that this is an acute pain patient: 1) the ED provider may decide to administer a schedule 2-4 drug in the ED; 2) patient must have a responsible adult with them for transportation home; 3) responsible adult will be with them until the full effects of the drugs are gone.

TREATED ACUTE CONDITION RETURNS

Patient treated in the ED returns for additional schedule 2-4 drugs will be advised: 1) ED care is not warranted and they must seek specialty or generalist care; 2) no schedule 2-4 drugs will be prescribed.

PATIENT WITH DRUG SEEKING BEHAVIOR
DOCUMENT, DOCUMENT, DOCUMENT

Why you think they are exhibiting drug seeking behavior.

Appropriate medical exam done (EMTALA).

Review blood and urine tests.

MAPS search & record.

Feedback/data from internal or external providers.

Objective/Subjective findings – what they say, how they act.

INTERACTION WITH DRUG SEEKING PATIENT

Be clear but non-confrontational when communicating with patient about policy and treatment plan.

If narcotics are given, limited supply of 2-3 days only.

Refer to a primary care provider and/or pain clinic.

Other resource referrals: social services, counselor, behavioral therapist.

Use non-narcotic analgesics, local nerve blocks, physical therapy.

Recommend a pain contract with primary care or pain clinic.

MICHIGAN AUTOMATED PRESCRIPTION SYSTEM

MAPS is a prescription monitoring program that is used to identify and prevent diversion by collecting information on schedule 2-4 substances.

If you are able to prescribe then you can query the data for patient specific reports.

Data is stored in a secure data base within the Department of Health & Human Services.

Prescription data is submitted daily so patients don't "load up" between data submissions.

OUR OXY-FREE ED RESULTS

60 Day Follow-Up: Saw a 60% reduction in prescriptions and no decline in ED volume.

1 Year Follow-Up: Maintained a 51% reduction in prescriptions.

2 Year Follow-Up: Saw a 57% reduction in prescriptions.

5 Year Follow-Up: 90% reduction in prescriptions compared to January 2013:

- Jan 2013 – 210 prescriptions compared to Jan 2018 – 19 prescriptions;
- Jan 2013 – 4,053 opioid pills compared to Jan 2018 – 114 opioid pills.

MOST REMARKABLE RESULT

- Jan 2013 – 19.3 pills/prescription compared to Jan 2018- 6 pills/ prescription
- This represents a 70% reduction in pills/prescription!

RESULTS (CONT.)

Job satisfaction and employee moral increased: “less time spent on frequent fliers”.

Our campaign was discovered by some national media websites that resulted in interest in policies.

Physicians point to policy to make it easier to discharge without argument.

Physicians see more “quality” visits.

Less stressed work environment.

PATIENT COMPLAINTS

Initial policy language stated that “we will provide you with non-narcotic…”

New policy language states that “patients that have chronic pain may be treated with non-narcotic/non-sedative medications only as a temporary treatment, at the discretion of the physician”. “We may provide you with a non-narcotic…”

EMTALA CONCERNS

Avoid using signs or providing literature that might deter a patient from seeking emergency care in your ED.

There is no CMS statement on the Oxy-Free ED concept, no test cases to refer to however pre-registration signage seems to be the greatest potential red flag.

COMMUNITY SUPPORT

Over the past 5 years the community has been very supportive.

We believe this support is directly related to the initial outreach and request for input on policy development.

In 2017 we were able to bring a Families Against Narcotics support group to the county (in 2013 they did not think we had enough community support).

MICHIGAN TODAY

MAPS is a mandatory check if prescribing controlled substances for more than 3 days.

Prescriber must be registered in MAPS before prescribing.

Must comply with specific informed consent provisions when prescribing opioids.

Cannot prescribe more than a 7 day supply of an opioid within a 7 day period if treating a patient for acute pain.

We've been doing this since February of 2013!

FUTURE GOALS

Implementation across all hospitals in the East Central Region of Michigan.

Sustained reduction in preventable drug-related deaths.

MAPS access by non-providers/dispensers (ED clerical).

ED able to notify the prescribing provider of a patient overdose or violation of their pain contract.

Working with the Michigan Center for Rural Health to inform and encourage others to follow our program.

FUTURE GOALS (CONT.)

Offering internally directed therapeutic options for opioid addicted patients.

Use tele-health evaluations by addiction specialists.

Initiation of detox therapy via an affiliated tertiary rehab program.

Medication assisted therapy and/or intensive mental health counseling.

Development of a local opioid maintenance program with tele-health support on selection of appropriate candidates.

CHALLENGES

Need to be confident staff are trained and prepared: documents, literature, video skits.

Physicians need to prove they have registered with MAPS; username and close monitoring of compliance in the beginning.

MAPS can be time consuming during peak hours.

Lower volume ED’s are more likely to be successful.

More documentation.

Many applauded our effort but no official endorsements.

KEYS TO SUCCESS

Staff Education.

Provider Education.

Provider Enforcement.

Ongoing Quality/Risk Assessment.

Consistency.

Word of Mouth.

TAKE AWAY POINTS

Prescription drug abuse is such an increasing phenomenon, that ED visits for the nonmedical use of prescription and over the counter drugs are now comparable to ED visits of ilicit drugs like heroin and cocaine.

An enforced narcotic medication prescribing policy in the ED can help decrease the amount of prescription narcotics being prescribed unnecessarily.

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