A Call for a Community Health Response Southern Illinois Region
WHEN THE MUSIC CHANGES, SO DOES THE DANCE.

African Proverb
Who is Project Lazarus?

- Non-profit organization
- Believes that communities are ultimately responsible for their own health and that every drug overdose is preventable.

**Prevention – Intervention - Treatment**

- Preventing medicine, heroin, fentanyl OD’s
- Presenting responsible pain management
- Promoting Substance Use Treatment and Support services
Manual labor dominates employment options in this county of 69,000.
Marvelous 4 M’s

Moonshine
Marijuana
Meth
Medicine
Prevent – Intervene - Treat

**Overdose – medicine, heroine, fentanyl**

Who, What, When, Where, Why, How?

- Patient misuse
- Family/Friends sharing to self medicate
- Accidental ingestion
- Recreational User
- Substance Use Disorder/Treatment/Recovery
Overdose deaths are the tip of the iceberg

For every 1 opioid overdose death in 2010 there were...

- 15 abuse treatment admissions
- 26 emergency department visits
- 115 who abuse/are dependent
- 733 nonmedical users

$4,350,000 in healthcare-related costs

SAMHSA NSDUH, DAWN, TEDS data sets

Source: CDC Public Health Week, Baldwin, Emory University, April 2014

North Carolina Injury & Violence Prevention Branch
DATA & EVALUATION
PUBLIC AWARENESS
COALITION ACTION

Provider Education
Hospital ED Policies
Diversion Control
Pain Patient Support
Harm Reduction
Addiction Treatment
Community Education

Opioid Overdose Related Crude Mortality Rate (per 100,000 population) 2015, Illinois

Rate (per 10,000 population) of ED Visits for Opioid Overdose 2015, Illinois

Legend
Crude Rate (per 10,000)
- 0.0 - 1.4
- 1.5 - 2.6
- 2.7 - 4.0
- 4.1 - 6.0
- 6.1 - 8.6

Scale: 0 25 50 100 Miles
Crude Rate of Hospitalizations for Opioid Overdose (per 10,000 population) 2015, Illinois

Legend

Crude Rate 2015
- 0.0 - 0.7
- 0.8 - 1.5
- 1.6 - 2.3
- 2.4 - 3.3
- 3.4 - 4.4
Increase in injection drug use in NC

Among NC residents entering drug treatment

NC TOPPS Data
Varying sources and levels of Data

- Obtaining, interpreting, understanding
- Translate, communicate
- Drive change and practice – policy and guidelines
- Public Health – Community Sectors
From the Conclusions:

• “Available data indicate that the nonmedical use of prescription opioids is a strong risk factor for heroin use.”

• “Yet, although the majority of current heroin users report having used prescription opioids nonmedically before they initiated heroin use, heroin use among people who use prescription opioids for nonmedical reasons is rare, and the transition to heroin use appears to occur at a low rate.”

• “In the majority of studies, the increase in the rates of heroin use preceded changes in prescription-opioid policies, and there is no consistent evidence of an association between the implementation of policies related to prescription opioids and increases in the rates of heroin use or deaths, although the data are relatively sparse.”

• “Alternatively, heroin market forces, including increased accessibility, reduced price, and high purity of heroin appear to be major drivers of the recent increases in rates of heroin use.”

I. Public Awareness – It is crucial to build public identification of prescription drug overdose as a community issue. Identify issue at local level
  • Broad-based outreach – all population groups

II. Coalition Action - A functioning coalition should exist with strong ties to and support from each of the key sectors in the community, Community Sectors
  • Why am I needed
  • What do I need to know
  • What needs to be done
Community Education

“Got Meds?: 

take correctly, store securely, 
dispose properly and never share.”

A prescriber can write appropriately, a pharmacist can dispense properly...but once in the community?
Prevent, Intervention, Treatment... why should I care?
Pharmacy

Happy Hour
5-7 p.m.

Sipress
COMMUNITY

• Why am I/We needed
• What do I/We need to know
• What needs to be done
Chronic Pain Initiative – CPI

PURPOSE

• Reduce risk of patient overdose
• Reduce risk of patient medication diversion
• Treatment of chronic pain - Exploring options in addition to/instead of medications

• Use of the Prescribers Toolkit
  • Bio/Psycho/Social Assessment
  • Overdose/Respiratory Depression Risks
  • Use of Prescription Drug Monitoring Program (CSRS)
  • Treatment Agreement
  • Urine screens/pill counts
  • Co-Prescribing naloxone
  • Prescribing Abuse Deterrent Formulations
“Give it to me straight, Doc. How long do I have to ignore your advice?”
• Overdose/Respiratory Depression – Assess Risks and Benefits
• Use of PDMP
• Abuse Deterrent Formulations
• Patient education/Co-Prescribing naloxone

Prescriber Education

Genetic factors.

Pain

Mental Health

Culture

Substance use

Environmental factors.
Clinically Confusing:

- Is it pain or anxiety or addiction?
- Is it pain and anxiety and addiction?
- Is it “pseudo-addiction”?
- Is it criminal (“scamming”)?

What’s my role: “Am I a clinician or a cop?”
Most continuing medical education on pain management is didactic.

Source: 2011 Project Lazarus Health Director Survey
• “Patients are more satisfied because they feel they're validated having pain. If adhering to the treatment agreement, don't have to feel guilty asking for pain meds.”

• “Patients seem happier since they're given the boundaries up front. More satisfied by knowing what to expect.”

• “Patients are made to be more honest about the issue once it's documented.”

• “Improved perceptions among patients of how they need to contribute to their own plan/treatment.”

• “Patients realize treatment agreement is binding and cannot veer from it.”
Provider Perceptions of Patient Change

Single PCP
Single Pharm
# Prescribers
# Phone Calls
# ED Visits
Opioid Misuse
Pain Mgmt
# Pain Scripts

- Much Improvement
- Some Improvement
- No Improvement
- Don’t Know
- N/A
**Pain Management**

**Chronic Opioid Risk Stratification**

**LOW:**
- ORT < 4 AND
- < 3 “Minor” Risk Factor AND
- No abnormal urine screens

**MODERATE:**
- ORT > 4 OR
- > 2 “Minor” Risk Factor OR
- > 1 abnormal urine screen OR
- Takes over 100mg Oral DME
- Hx substance abuse
- Suboptimal MGMT of psychiatric Dx

**HIGH:**
- ORT > 4 OR
- > 2 “Minor” Risk Factor OR
- 1 or more “Major” Risk Factor OR
- > 1 abnormal urine screen OR
- Documented overdose OR
- Suboptimal MGMT of psychiatric Dx

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**Urine screen:**
- 2x/year
- 4x/year
- 6x/year

**Visit Interval:**
- Up to 3 months
- Up to 2 months
- Up to 1 month

**Review PDMP**
- Every 2 months
- Monthly

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- Substance Use Evaluation as soon as new risk level identified
- Identify and engage patient support system
- Emphasize risk/benefits of medication
- Educate and dispense naloxone
- Abuse deterrent formulations
- Consider home health safety evaluation

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If: Risk > Benefit
STOP Opioid THERAPY
Referral

Buprenorphine
Overdose Rate
15 OD’s per 400 soldiers to 1 per 400.

- 2008 and 2009 non-fatal OD’s were 17 per 1000 soldiers.
- That rate dropped to 1.4 per 1000 soldiers
  - according to WTU Brigade surgeon statistics.

Naloxone and abuse deterrent formulations

After 2 years in this system:
- 25% decline of overall opioid prescribing (140,000 beneficiaries)
- 33% decrease in high dose/long-acting formulations.

A systematic approach to pain management emphasizing risk stratification, risk mitigation, provider education, and other modalities to/with opioids for pain management has resulted in a reduction of opioid prescribing with decreased healthcare utilization and improvement in patient satisfaction.”
Hospital Emergency Department (ED) Policies -

1) Embedded ED Case Manager
2) “Frequent fliers” for chronic pain, non-narcotic medication and referral
3) No refills of controlled substances
4) Mandatory use of PDMP (CSRS)
5) Limited dosing (10 tablets)
6) Co-prescribing naloxone
7) Peer Support
• Law Enforcement, Pharmacist and Facility training on forgery, methods of diversion and drug seeking behavior.
• Pill Take Back Events – Permanent Pill Disposal “Now available for retail pharmacies, hospitals and clinic with pharmacy”
• Project Pill Drop placards placed in medical offices and pharmacies
"at least" two out of every three people who died of an opioid overdose had been prescribed an opioid between 2011 and 2014.

But just 8.3 percent of those decedents had an active opioid prescription in the same month as their death,

83 percent of opioid overdose deaths that had a toxicology report completed the person who died had "illegally-obtained or likely illegally-obtained substances" in their system at their time of death.

DPH points to the information on illegally-obtained substances as "evidence to support an emerging hypothesis that illegally-obtained substances are the driving force behind" the state's epidemic