Responding to the Opioid Epidemic in Washington State

Washington Patient Safety Coalition
October 26, 2016
Presenters

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Department of Health

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Program Director
Bree Collaborative
Overview

- Opioid abuse and misuse in Washington
  - Epidemiology of the epidemic
  - Relationship between Rx opioids and heroin
- State initiatives to address the epidemic
  - State Opioid Response Plan
  - Bree Collaborative
- Taking action!
Age-adjusted Rates of Drug Overdose Deaths by State, US 2014

Rate per 100,000
WA = 13.3
Other states = 6.3 - 35.5

Trends in the Rate of Opioid Overdose Deaths*, WA State 2006–2015

Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

Note: Intentional self-poisonings account for ~9% of all opioid overdose deaths

718 deaths in 2015
Rates of Opioid Overdose Deaths* by County of Residence, 2011–2015

Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

WA Age-adjusted Rate = 9.8 per 100,000
Rates of Opioid Overdose Deaths by Race/Ethnicity, WA State 2011–2015

<table>
<thead>
<tr>
<th>Race / Ethnicity</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>12.4</td>
</tr>
<tr>
<td>Black</td>
<td>12.3</td>
</tr>
<tr>
<td>AIAN</td>
<td>34.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.1</td>
</tr>
<tr>
<td>Asian</td>
<td>1.2</td>
</tr>
<tr>
<td>Pacific</td>
<td>15.1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: DOH Death Certificates
* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6
Rates of Unintentional Opioid Overdose Deaths by Age Group, WA 2012–14

Source: DOH Death Certificates, methodology identifies opioid deaths using both ICD-10 codes and the literal text on the death certificate, and excludes intentional deaths due to opioid overdose
Opioid-related Disease Burden in WA

2. Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) and Oregon State Hospital Discharge Data, 2014.
3. Treatment and Assessment Report Generation Tool, 2014
Neonatal Abstinence Syndrome Incidence Rates per 1,000 Hospital Births, WA 1990–2012

Rates* of opioid pain reliever (OPR) overdose death, treatment admissions, and kg of OPR sold --- US, 1999--2010

- Age-adjusted rates per 100,000 population for OPR deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

Source: MMWR 2011;60(43):1487-1492
Opioid Use among Youth in Washington, 2006–2014

Trends in the use of Rx-type opiates to “get high” among 10th graders and the association with heroin use

The proportion of 10th graders reporting using prescription-type opioids to get high in the past month declined significantly from 10% to 5% from 2006-2014.

Among 10th graders those who reported they had used prescription-type opioids to get high in the past month 19% had ever used heroin, compared to 3% among those not using prescription-type opioids to get high.

**Source:** Healthy Youth Survey, analysis Alcohol and Drug Abuse Institute, University of Washington
“Before you began using heroin were you hooked on prescription-type opiates?”

Source: UW Alcohol and Drug Abuse Institute, Results from the 2015 Washington State Drug Injector Health Survey (http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf)

<table>
<thead>
<tr>
<th>Source</th>
<th>Any (n = 11,018,735)</th>
<th>1-29 (n = 7,037,205)</th>
<th>30-99 (n = 2,110,122)</th>
<th>100-199 (n = 1,103,312)</th>
<th>200-365 (n = 768,096)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given by a friend or relative for free</td>
<td>54.4 (52.9-56.0)</td>
<td>61.9 (59.7-64.0)</td>
<td>48.5 (45.6-51.5)</td>
<td>37.7 (33.0-42.5)</td>
<td>26.4 (20.9-32.9)</td>
</tr>
<tr>
<td>Prescribed by ≥1 physicians</td>
<td>19.7 (18.4-21.1)</td>
<td>17.9 (16.2-19.7)</td>
<td>19.5 (17.0-22.3)</td>
<td>26.5 (22.2-31.4)</td>
<td>27.3 (22.3-32.9)</td>
</tr>
<tr>
<td>Stolen from a friend or relative</td>
<td>4.9 (4.4-5.3)</td>
<td>5.3 (4.7-6.0)</td>
<td>4.6 (3.6-5.7)</td>
<td>4.1 (2.7-6.0)</td>
<td>2.9 (2.1-4.1)</td>
</tr>
<tr>
<td>Bought from a friend or relative</td>
<td>11.3 (10.4-12.1)</td>
<td>7.6 (6.7-8.5)</td>
<td>15.6 (13.4-18.0)</td>
<td>18.3 (15.4-21.5)</td>
<td>23.2 (18.0-29.3)</td>
</tr>
<tr>
<td>Bought from a drug dealer or other stranger</td>
<td>4.2 (3.8-4.8)</td>
<td>2.1 (1.7-2.6)</td>
<td>5.3 (4.1-6.9)</td>
<td>8.2 (6.5-10.3)</td>
<td>15.2 (12.0-19.1)</td>
</tr>
<tr>
<td>Other</td>
<td>5.5 (4.7-6.3)</td>
<td>5.3 (4.3-6.4)</td>
<td>6.4 (5.4-7.7)</td>
<td>5.2 (3.5-7.8)</td>
<td>5.0 (2.9-8.4)</td>
</tr>
</tbody>
</table>

* Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.

* Estimate is statistically significantly different from that for highest-frequency users (200-365 days) (P < .05).

* Includes written fake prescriptions and those opioids stolen from a physician’s office, clinic, hospital, or pharmacy; purchased on the Internet; and obtained some other way.

Monitoring the Future prospective study

Surveyed 12th graders and followed them through age 23 (n=6220)

Legitimate opioid use before high school graduation independently associated with 33% increased risk of future opioid misuse

Association concentrated among individuals with little drug experience and disapproval of illegal drug use at baseline

## Number of days supplied for opioid prescriptions

<table>
<thead>
<tr>
<th>Age</th>
<th>Lowest Residential Area</th>
<th>State Avg</th>
<th>Highest Residential Area</th>
<th>High/Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE PATIENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–6</td>
<td>Bellevue</td>
<td>5.5</td>
<td>19.6</td>
<td>Edmonds</td>
</tr>
<tr>
<td>7–11</td>
<td>Bellevue</td>
<td>6.1</td>
<td>35.0</td>
<td>Vancouver</td>
</tr>
<tr>
<td>12–19</td>
<td>Enumclaw</td>
<td>6.3</td>
<td>45.7</td>
<td>Port Angeles</td>
</tr>
<tr>
<td>20–44</td>
<td>Bellevue</td>
<td>27.7</td>
<td>165.0</td>
<td>Moses Lake</td>
</tr>
<tr>
<td>45–64</td>
<td>Pullman</td>
<td>47.7</td>
<td>156.3</td>
<td>Forks</td>
</tr>
</tbody>
</table>

| MALE PATIENTS |                     |           |                          |          |
| 2–6           | Bellevue              | 6.0       | 22.7                     | Edmonds  | 3.8 x    |
| 7–11          | Bellevue              | 5.5       | 15.7                     | Port Angeles| 2.9 x   |
| 12–19         | Coupeville            | 5.5       | 20.8                     | Clarkston| 3.7 x    |
| 20–44         | Toppenish             | 27.4      | 170.1                    | Aberdeen | 6.2 x    |
| 45–64         | Bellevue              | 44.7      | 161.4                    | Aberdeen | 3.6 x    |
“How interested are you in getting help to cut down or quit your drug use?”

Source: UW Alcohol and Drug Abuse Institute, Results from the 2015 Washington State Drug Injector Health Survey (http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf)
Treatment need for opioid abuse or dependence exceeds capacity for opioid agonist medication assisted treatment (OA-MAT) in the US

Source: Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication assisted treatment. AJPH. 2015
Unintentional Poisoning Work Group

• Established in 2008 by the Department of Health
• Currently, co-lead by:
  – Department of Health
  – DSHS Division of Behavioral Health and Recovery
  – Health Care Authority
  – UW Alcohol and Drug Abuse Institute
• Open to any partners who want to participate
• Led development of State Opioid Response Plan during 2015; began implementation in 2016
State Opioid Response Plan

Priority Goals

Goal 1: Prevent Opioid Misuse & Abuse
   - Improve Prescribing Practices

Goal 2: Treat Opioid Dependence
   - Expand Access to Treatment

Goal 3: Prevent Deaths from Overdose
   - Distribute naloxone to heroin users

Goal 4: Use Data to Monitor and Evaluate
   - Optimize and expand data sources

Priority Actions

Leads:
- Department of Labor & Industry, DSHS Division of Behavioral Health and Recovery
- DSHS Division of Behavioral Health and Recovery
- UW Alcohol & Drug Abuse Institute
- Department of Health
Executive Order

• Implement safe prescribing practices
• Explore non-opioid alternatives to pain
• Expand access to medication assisted treatment
• Increase use of PMP
How the Bree Collaborative Fits Health Care Environment

Broken Healthcare System

Low Quality

High Cost

Bad Outcomes

Little Equity

Washington State wanting to increase quality, reduce cost

Bree Collaborative
Identify health care services with high:
- Variation
- Utilization
Without producing better outcomes

House Bill 1311
Choosing a Topic

Inefficiency
Variation
Waste
Increased Use
Patient Harm
High Use

Proven Strategies for Change

Topic
Past Work

- Obstetrics
- Cardiology
- Elective Total Knee and Total Hip Replacement Bundle and Warranty
- Elective Lumbar Fusion Bundle and Warranty
- Coronary Artery Bypass Surgery Bundle and Warranty
- Low Back Pain and Spine SCOAP
- Hospital Readmissions
- End-of-Life Care
- Addiction Screening
- Prostate Cancer Screening
- Oncology Care
Current Topics

- Bariatric Surgical Bundled Payment Model and Warranty
- Pediatric Psychotropic Drug Use
- Implementing AMDG Guidelines for Prescribing Opioids for Pain
- Behavioral Health Integration
Future Topics

- Re-Review Total Knee and Total Hip Replacement Bundle and Warranty
- Alzheimer’s Disease and Other Dementias
- Opioid Use Disorder
- Hysterectomy
A Call to Action!

- Decrease stigma around substance abuse disorders
- Screen for opioid misuse / opioid use disorder
- Follow AMDG / CDC opioid prescribing guidelines
- Use the Prescription Monitoring Program
- Become waivered to prescribe buprenorphine
- Incorporate curricula on opioid prescribing and opioid use disorder into training programs
Recommendations on Addiction Screening
January 2015

- Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
- Increase appropriate alcohol and other drug use screening
- Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
- Decrease barriers for facilitating referrals to appropriate treatment facilities
- Address the opioid addiction epidemic
Screening, Brief Intervention, Referral to Treatment (SBIRT)

Systematically “identify, reduce, and prevent problematic use, abuse and dependence on alcohol and illicit drugs.”

- Brief
- Public-health approach
- Universally screens all patients
- Occurs in variety of settings
- Seamless transition between screening, brief intervention, brief treatment, and referral to specialty chemical dependency treatment
- Demonstrated success

Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration (WA-SBIRT)

- For Medicaid clients
- Started as five-year grant from SAMHSA (2003 to 2008) to WA to implement SBIRT in nine emergency departments
  - Declines in substance abuse, anxiety, depression, homelessness, and cost for those receiving brief intervention
  - Increased abstinence, employment, chemical dependency admissions
- Second grant to expand services for another five years (2011 to 2016) in clinics
  - 85,124 total screened (January 2012 – August 2016)

Next steps depend on the patient’s risk levels determined by a score on the AUDIT or DAST-10:

1. **Low Risk**: AUDIT score of 0-6 for women and 0-7 for men, DAST-10 score of 0
   No intervention.

2. **Risky**: AUDIT score of 7-15 for women and 8-15 for men, DAST-10 score of 1-2
   Brief intervention.

3. **Harmful**: AUDIT score of 16-19 for both women and men, DAST-10 score of 3-5
   Brief intervention and referral to brief treatment.

4. **Dependent**: AUDIT score of over 20 for both women and men, DAST-10 score of 6 or more
   Brief intervention and referral to chemical dependency treatment.
Interagency Guideline on Prescribing Opioids for Pain

Developed by the Washington State Agency Medical Directors’ Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials.

www.agencymeddirectors.wa.gov

AMDG  
agency medical directors’ group

Written for Clinicians who Care for People with Pain  
Opioid Prescribing Guideline Implementation

Members

- Gary Franklin, MD, MPH (Chair), Medical Director, Washington State Department of Labor and Industries
- Chris Baumgartner, Director Prescription Monitoring Program, Washington State Department of Health
- David Buchholz, MD, Medical Director of Provider Engagement, Premera Blue Cross
- Washington State Dental Association
- Tanya Dansky, MD, Chief Medical Officer, Amerigroup
- Charissa Fontinos, MD, Deputy Chief Medical Officer, Washington State Health Care Authority
- Frances Gough, MD, Chief Medical Officer, Molina
- Dan Kent, MD, Chief Medical Officer, United Healthcare
- Kathy Lofy, MD, Chief Science Officer, Washington State Department of Health
- Jaymie Mai, PharmD, Pharmacy Manager, Washington State Department of Labor and Industries
- Mark Murphy, MD, Addiction Medicine, Multicare Health
- Greg Rudolf, MD, Pain Services, Swedish
- Shirley Reitz, PharmD, Pharmacist, OmedaRx, Cambia Health
- Mike Schiesser, MD, Evergreen Health
- Danny Stene, MD, Medical Director, First Choice Health
- Mark Stephens, Principal, CareSync Consulting, LLC
- Hugh Straley, MD, Chair, Bree Collaborative
- Gregory Terman MD, PhD, Professor, Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior
- Emily Transue, Acting Chief Medical Director, Coordinated Care
- Michael Von Korff, ScD, Senior Investigator, Group Health Research Institute
Focus Areas

• Reduce acute opioid use
  • Focus on adolescents (e.g., after dental procedure, sports injury)
  • Only prescribing opioids when appropriate
  • Only prescribing # of pills needed for acute pain

• System Implementation
  • Long-term goal: non-pharmacological alternatives to opioids

• Enhance clinician education
  • Diffuse AMDG guidelines (via WSMA, WSDA, CME)
  • Get desktop tools to clinicians
  • Work with UW to stabilize funding for tele-pain

• Improved use and interoperability of the WA Prescription Monitoring Program
  • Developing common measure definitions
Developing Draft Opioid Metrics

- Metrics related to the state of our state (e.g., death and overdose rate)
- Metrics useful to health plans, or to the agencies, or individual docs, on quality improvement efforts related to implementation.

I. Short-term prescribing indicators

II. Long-term prescribing indicators

III. Morbidity and Mortality Indicators
Prescription Monitoring Program (PMP)

System Overview

- **Dispensers**
  - Submit data on schedule II-V controlled substances

- **Pharmacists**
  - Reports Available

- **State PMP**
  - Reports Available

- **Prescribers**
  - Reports Available

- **Law Enforcement Licensing Other**
Purpose of Washington’s PMP

Help Prevent Prescription Drug Overdoses!

• Give healthcare providers more information for making patient care decisions

• Help healthcare providers recognize patterns of misuse ensuring SBIRT opportunities not missed

• Make sure those in need of scheduled prescription drugs receive them

• Curb the illicit use of prescription drugs
Accessing the PMP

• To sign up: http://www.doh.wa.gov/pmp
• Healthcare providers can use delegates
• Healthcare systems can access PMP data electronically through their EMRs via state Health Information Exchange (One Health Port)
• House Bill 2730 (effective June 2016)
  – Allows access for prescribers who do not prescribe controlled substances
  – Facilities/groups authorized rather than individual providers
Medications for Opioid Use Disorders

Methadone
(full opioid agonist)

Buprenorphine
(partial opioid agonist)

Naltrexone/Vivitrol®
(opioid antagonist)
## Does Opioid Replacement Therapy Work?

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Retention in treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Old studies (pre 2000)</td>
<td>3</td>
<td>505</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>Subtotals only</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>750</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>3.05 [1.75, 5.35]</td>
</tr>
<tr>
<td>1.2 New studies</td>
<td>4</td>
<td>750</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>4.44 [3.26, 6.04]</td>
</tr>
<tr>
<td>2 Morphine positive urine or hair analysis</td>
<td>6</td>
<td>1129</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>0.66 [0.56, 0.78]</td>
</tr>
<tr>
<td>3 Self reported heroin use</td>
<td>6</td>
<td></td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>Subtotals only</td>
</tr>
<tr>
<td>4 Criminal activity</td>
<td>3</td>
<td>363</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>0.39 [0.12, 1.25]</td>
</tr>
<tr>
<td>5 Mortality</td>
<td>4</td>
<td>576</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>0.48 [0.10, 2.39]</td>
</tr>
</tbody>
</table>

Buprenorphine vs. Placebo


<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>buprenorphine MT n/N</th>
<th>placebo maintenance n/N</th>
<th>Risk Ratio M-H, Random 95% CI</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahmadi 2003a</td>
<td>28/41</td>
<td>12/41</td>
<td></td>
<td>21.5%</td>
<td>2.33 [1.39, 3.92]</td>
</tr>
<tr>
<td>Ahmadi 2004</td>
<td>134/171</td>
<td>46/171</td>
<td></td>
<td>26.1%</td>
<td>2.91 [2.25, 3.78]</td>
</tr>
<tr>
<td>Johnson 1995a</td>
<td>22/30</td>
<td>40/60</td>
<td></td>
<td>25.8%</td>
<td>1.10 [0.83, 1.46]</td>
</tr>
<tr>
<td>Ling 1998</td>
<td>97/188</td>
<td>74/185</td>
<td></td>
<td>26.6%</td>
<td>1.03 [0.81, 1.32]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>430</strong></td>
<td><strong>457</strong></td>
<td></td>
<td>100.0%</td>
<td><strong>1.74 [1.06, 2.87]</strong></td>
</tr>
</tbody>
</table>

Total events: 281 (buprenorphine MT), 172 (placebo maintenance)
Heterogeneity: Tau² = 0.23; Chi² = 34.65, df = 3 (P<0.00001); I² = 91%
Test for overall effect: Z = 2.18 (P = 0.030)
Test for subgroup differences: Not applicable

Source: Cochrane Database of Systematic Reviews; 6 FEB 2014 DOI: 10.1002/14651858.CD002207.pub4
Suboxone / Buprenorphine

- Currently only MDs and DOs allowed to prescribe
- 8 hours CME for MDs and DOs
- Submit waiver application to SAMHSA notify DEA
- Comprehensive Addiction & Recovery Act (2016):
  - Will allow PAs and ARNPs to prescribe; requires rules be written first
  - Increased max number of allowable patients from 100 to 275
Conclusions

• Approximately two opioid-related deaths occur every day in Washington
• Overdose deaths due to heroin are increasing
• Opioid use disorder is a chronic relapsing condition that is preventable and treatable
• Healthcare providers have a significant role in addressing this epidemic
Questions?

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www.breecollaborative.org
Recommendations available here:
www.breecollaborative.org/about/reports
Medium Dose Buprenorphine vs. Medium Dose Methadone

Source: Cochrane Database of Systematic Reviews; 6 FEB 2014 DOI: 10.1002/14651858.CD002207.pub4