GOALS

➤ Define the Emergency Department

➤ The current problem of taking / dispensing opioids in the relation to the ED

➤ Complications from abuse in the ED

➤ Complications from withdrawal in the ED

➤ Steps to move forward
WHAT IS THE EMERGENCY DEPARTMENT?
- A place for “really big problems”?
- Where the uninsured go?
- Where I can go without having to pay?
- Where I can go and pay more to get “an answer”?
- The place that is convent after work?
- The place my primary provider or surgeon sends me when they are not sure, the office is closed, they are out of town, you are in more pain then they know what to deal with.
- My primary care?
- My quick fix?
- Where I go when I am not sure what else to do?
EMTALA

- Federal Law, passed in 1986 as an “anti-dumping law”
- Hospitals that receive Medicare must first provide a screening examination and medical stabilization regardless of insurance status
- Definition of emergent: "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."
EMERGENCY DEPARTMENT

- Emergent Screening and Stabilization
- The Pit to the Front Door
- A Care Coordination Center
- Defining the “E” in ED
  - Emergency
  - Everyone
  - Every time
  - Everything
EXPECTATIONS

Patient Expectations

Reality
THE PERFECT STORM

- Drug Companies - direct marketing to physicians
- The 5th vital sign
- Paying for Value
- Patient satisfaction scores
- Increase demand with decrease resources
- Patient expectations
- Compassion / Desire to help
- Dreamland by Sam Quinones
PRESCRIPTIONS OF PAINKILLERS

Amount of prescription painkillers sold by state per 10,000 people (2010)

SOURCE: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010
DEATHS BY OPIOIDS

Drug overdose death rates by state per 100,000 people (2008)

A TOWERING PROBLEM

For every 1 death, there are...

- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependents
- 825 nonmedical users
Of all individuals currently addicted to Heroin, 82% began misusing prescription opioids. Many of which began with a legitimate medical necessity for pain relief.

Substance Abuse and Mental Health Services Association (SAMHSA), 2013
AND ITS GETTING WORSE
ROLE OF THE EMERGENCY DEPARTMENT
Emergency Department visits involving non-medical use of narcotic pain relievers: 2005-2011 (samhsa.gov)

Nonmedical use of pharmaceuticals includes:
1. taking more than the prescribed dose,
2. taking a medication that was prescribed for another individual,
3. being deliberately poisoned with a medication by another person, and
4. documentation in the medical record that a medication was misused or abused.
Emergency department (ED) visits related to non-medical use of pharmaceuticals involving the narcotic pain relievers methadone and buprenorphine (samhsa.gov)
AN INCREASING PROBLEM

2001 and 2010, the percentage of overall ED visits (pain-related and non-pain-related) where any opioid analgesic was prescribed increased from 20.8% to 31.0%, an absolute increase of 10.2% - Academic Emergency Medicine 2014

Table 2. Prescription and Pill Numbers by Specialty Category (In Order of % Total Rx)

<table>
<thead>
<tr>
<th>Specialty Category</th>
<th>Number Providers</th>
<th>Number Rx</th>
<th>% Total Rx</th>
<th>% Total Pills</th>
<th>Rx/Provider</th>
<th>Pills/Rx</th>
<th>%Rx to Doctor Shopper Per Provider</th>
<th>%Rx to Chronic User per Provider</th>
<th>% Rx to Chronic Users</th>
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</thead>
<tbody>
<tr>
<td>Primary Care/Internal Medicine</td>
<td>384</td>
<td>2709</td>
<td>62.1</td>
<td>65.0</td>
<td>7.1</td>
<td>79</td>
<td>3.3</td>
<td>47.1</td>
<td>6.8</td>
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<tr>
<td>Psychiatry</td>
<td>77</td>
<td>795</td>
<td>18.2</td>
<td>14.0</td>
<td>10.3</td>
<td>58</td>
<td>5.8</td>
<td>55.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Surgery</td>
<td>56</td>
<td>306</td>
<td>7.0</td>
<td>11.5</td>
<td>5.5</td>
<td>123</td>
<td>3.8</td>
<td>69.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Pain</td>
<td>20</td>
<td>257</td>
<td>5.9</td>
<td>7.6</td>
<td>12.9</td>
<td>97</td>
<td>4.9</td>
<td>37.7</td>
<td>12.9</td>
</tr>
<tr>
<td>Emergency/Urgent Care</td>
<td>140</td>
<td>217</td>
<td>5.0</td>
<td>1.5</td>
<td>1.6</td>
<td>22.9</td>
<td>1.0</td>
<td>64.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Dentistry</td>
<td>33</td>
<td>79</td>
<td>1.8</td>
<td>0.5</td>
<td>2.4</td>
<td>19</td>
<td>1.3</td>
<td>55.7</td>
<td>2.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>710</td>
<td>4363</td>
<td>1.8</td>
<td>0.5</td>
<td>2.4</td>
<td>19</td>
<td>1.3</td>
<td>50.7</td>
<td>2.0</td>
</tr>
<tr>
<td>MEAN</td>
<td></td>
<td></td>
<td>6</td>
<td>75</td>
<td>3.1</td>
<td></td>
<td>5.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMPLICATIONS FROM OPIOIDS IN THE ED

- Overdoses
  - 2/3 of Overdoses seen in the ED are from narcotics
  - Does not include deaths that EMS attends, and we call but do not come

- Abdominal Pain
  - Increased constipation
  - Making other symptoms and delay in diagnosis
  - Increase testing and therefore cost

- Impaired Judgement
- Diversion
- Withdrawal
WITHDRAWAL

- Nausea / Vomiting
- Dehydration
- Electrolytes
- Pioloerection
- Shaking
- Sweats
- Total body pain

NOT in itself fatal unless severe complications (like arrhythmia from marked dehydration / electrolyte abnormalities) - it is a fundamentally different withdrawal than alcohol, and therefore managed differently in the ED.
OVERDOSES

- Somnolent (Sleepy)
- Decreased breathing
- Constipation
- Made worse by other depressants
  - Alcohol
  - Benzos
  - Multiple Narcotics
- Possible duel ingestion
  - Tylenol
  - Ibuprofen
- Additional medication
- Narcan- Variable half life

DEATHS INVOLVING PRESCRIPTION OPIOID OVERDOSE
Have Quadrupled in a Decade

LOVE an ADDICT?
CARRY NARCAN
WHAT IS A PROVIDER TO DO

Demand vs Risk
CDC GUIDELINES

1. **ASSESS.** Evaluate for factors that could increase your patient’s risk for harm from opioid therapy such as:
   - Personal or family history of substance use disorder
   - Anxiety or depression
   - Pregnancy
   - Age 65 or older
   - COPD or other underlying respiratory conditions
   - Renal or hepatic insufficiency

2. **CHECK.** Consider urine drug testing for other prescription or illicit drugs and check your state’s prescription drug monitoring program (PDMP) for:
   - Possible drug interactions (such as benzodiazepines)
   - High opioid dosage (≥50 MME/day)
   - Obtaining opioids from multiple providers

3. **DISCUSS.** Ask your patient about concerns and determine any harms they may be experiencing such as:
   - Nausea or constipation
   - Feeling sedated or confused
   - Breathing interruptions during sleep
   - Taking or craving more opioids than prescribed or difficulty controlling use

4. **OBSERVE.** Look for early warning signs for overdose risk such as:
   - Confusion
   - Sedation
   - Slurred speech
   - Abnormal gait
CDC HELP -
WWW.TRUNTHETIDERX.ORG

THE SURGEON GENERAL'S CALL TO END THE OPIOID CRISIS

Read the Letter  Take the Pledge

Surgeon General of the United States
PDMP

- Allows clinicians to make decisions with data instead of judgement
- Allows data based conversations
- Real time and easy access are key
- Changes with SB 74 to increase use and usefulness
~27% of Prescribers wrote 95% of prescriptions (Scheduled II-IV)
HELP FROM SB 74

Sec. 46. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services. (a) On or before December 1, 2016, the department shall collaborate with a statewide professional hospital association to establish a hospital-based project to reduce the use of emergency department services by medical assistance recipients. The statewide professional hospital association shall operate the project. Subject to (b) of this section, the project may include shared savings for participating hospitals. The project must include

(1) an interdisciplinary process for defining, identifying, and minimizing the number of frequent users of emergency department services;

(2) to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits, hospital care plans for frequent users of emergency departments, and data from the controlled substance prescription database;

(3) a procedure for educating patients about the use of emergency departments and appropriate alternative services and facilities for nonurgent care;

(4) a process for assisting users of emergency departments in making appointments with primary care or behavioral health providers within 96 hours after an emergency department visit;

(5) a collaborative process between the department and the statewide professional hospital association to establish uniform statewide guidelines for prescribing narcotics in an emergency department; and

(6) designation of health care personnel to review successes and challenges regarding appropriate emergency department use.

(b) After January 1, 2022, the department may not compensate hospital emergency departments, through shared savings, for a reduction in hospital fees resulting from the project.

(c) The department shall adopt regulations necessary to implement this section, request technical assistance from the United States Department of Health and Human Services, and apply to the United States Department of Health and Human Services for waivers or amendments to the state plan as necessary to implement the projects under this section.
PRE-ESTABLISHED GUIDELINES AND EDUCATION

Prescribing Pain Medication in the Emergency Department

Educational Material

Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and are a major cause of accidental death. Our emergency department strives to provide pain relief options that are safe and appropriate.

Our main job is to look for and treat an emergency medical condition. Chronic pain is best managed and coordinated by primary care providers or a pain specialist outside the emergency department.

We use our best judgment when treating pain, and follow all legal and ethical guidelines. For your safety, we:

- Might not refill stolen or lost prescriptions for medication.
- Do not prescribe missed methadone doses or long-acting pain medication that has a high risk of addiction or overdose.
- Review your health and prescription history to determine the best approach to managing your pain.

- Prescribe the most appropriate pain medication, favoring those with the lowest risk of addiction or overdose, and for no longer than necessary.
- Take into consideration whether you already receive pain medication from another health care provider or emergency department, and whether you have a doctor who can follow up on your condition.
- Will help you find treatment for any pain or medication problems that you may have.
COMMUNITY COMING TOGETHER

[Images of a group of people cheering, a window with a person looking out, and the Alaska Wellness Summit logo: Conquering the Opioid Crisis]
THERE IS HOPE

Prescription Opioid Involved Overdoses Washington State

Sources: Washington State Department of Health, Death Certificates and Hospital Discharge Data
If opportunity doesn't knock, build a door
- Milton Berle
THANK YOU

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