Virginia Department of Health Professions

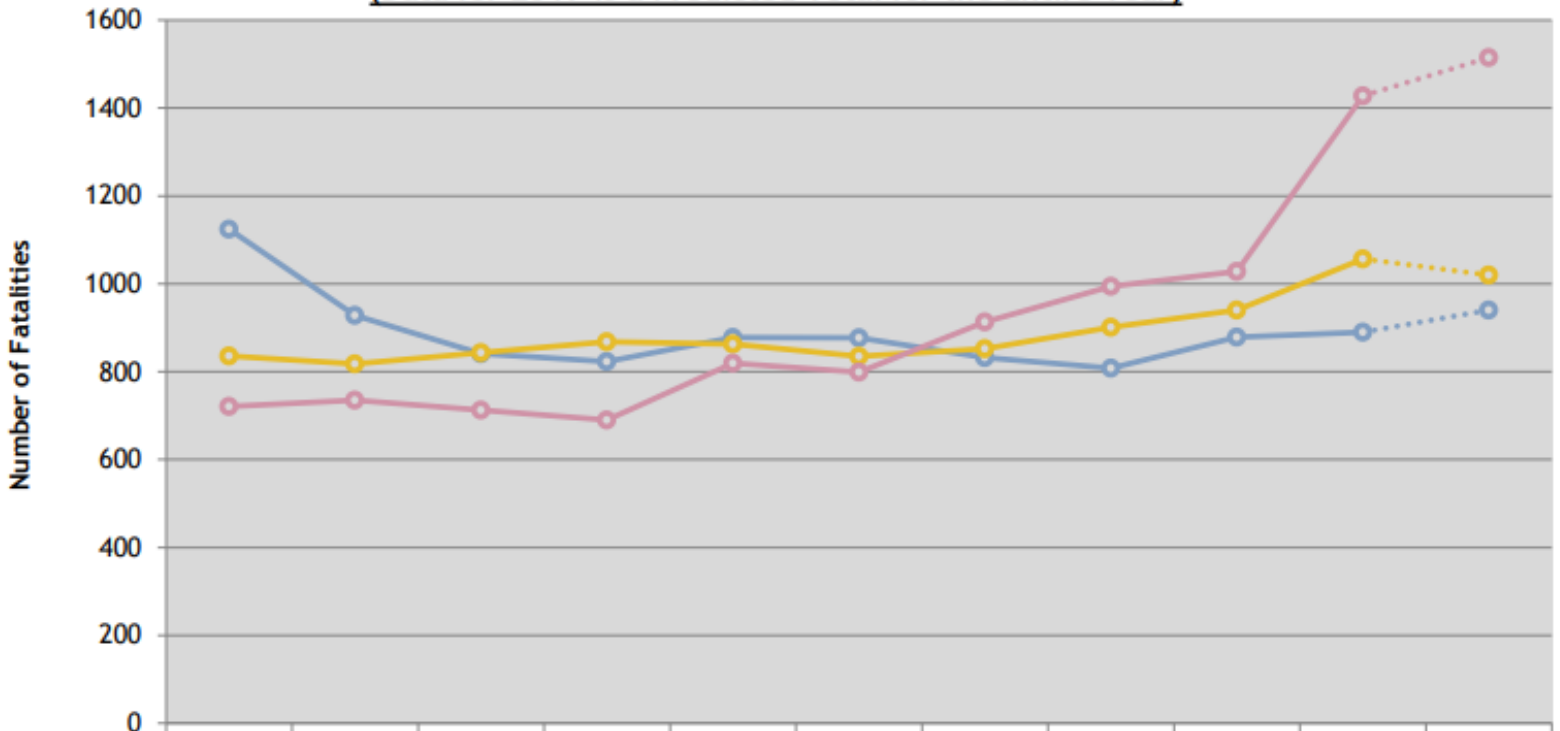
The Opioid Crisis in Virginia

Chiropractic's Role in Addressing the Epidemic

David E. Brown, DC
Director, Department of Health Professions
May 18, 2018

"More Virginians die from drug overdoses than in auto accidents"

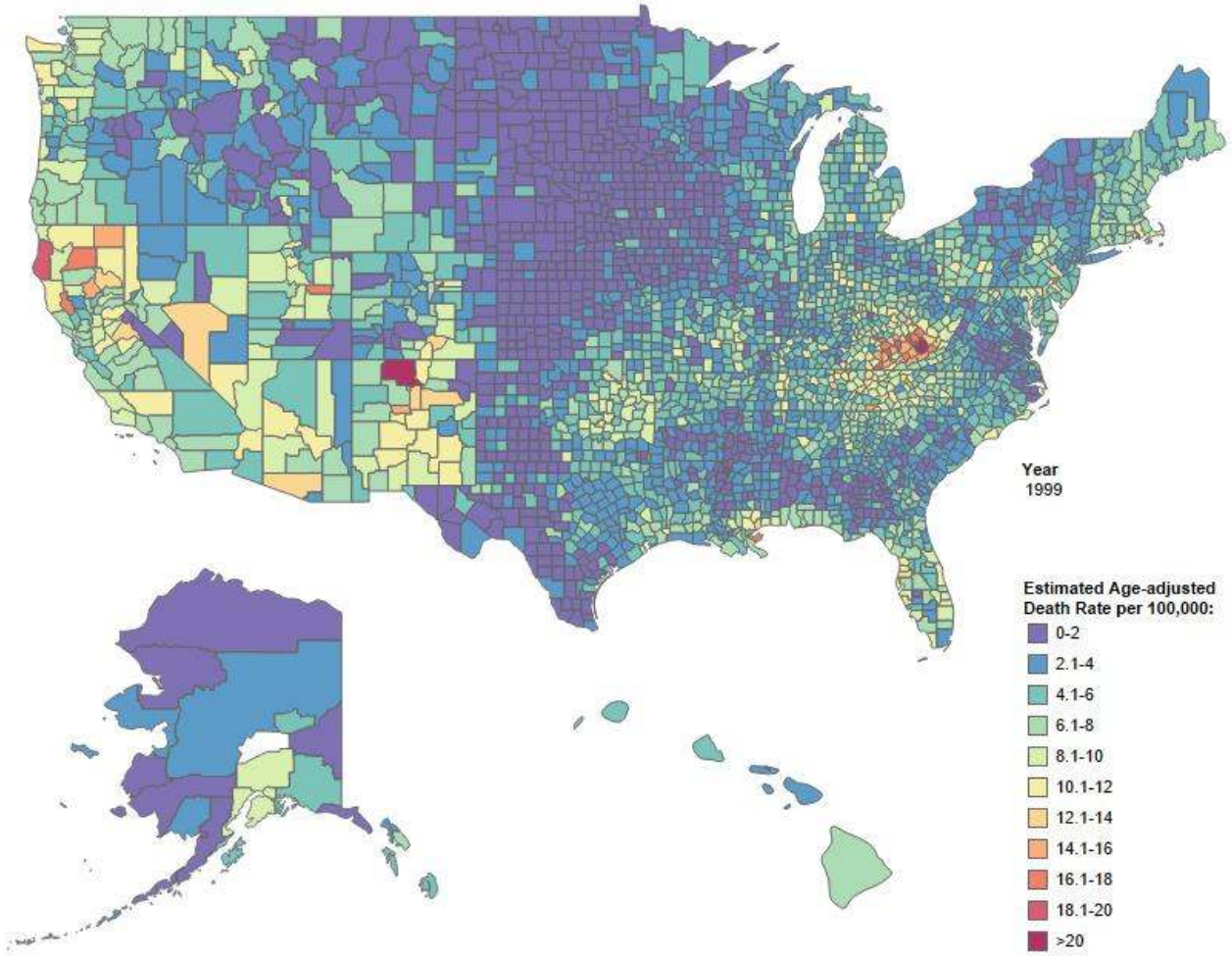
Total Number of Motor Vehicle, Gun, and Drug Related Fatalities by Year of Death, 2007-2017
(Data for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Motor Vehicle Related	1124	928	841	823	878	877	832	808	879	890	940
Gun Related	836	818	843	868	863	835	852	901	940	1057	1020
Fatal Drug Overdose	721	735	713	690	819	799	913	994	1028	1428	1515

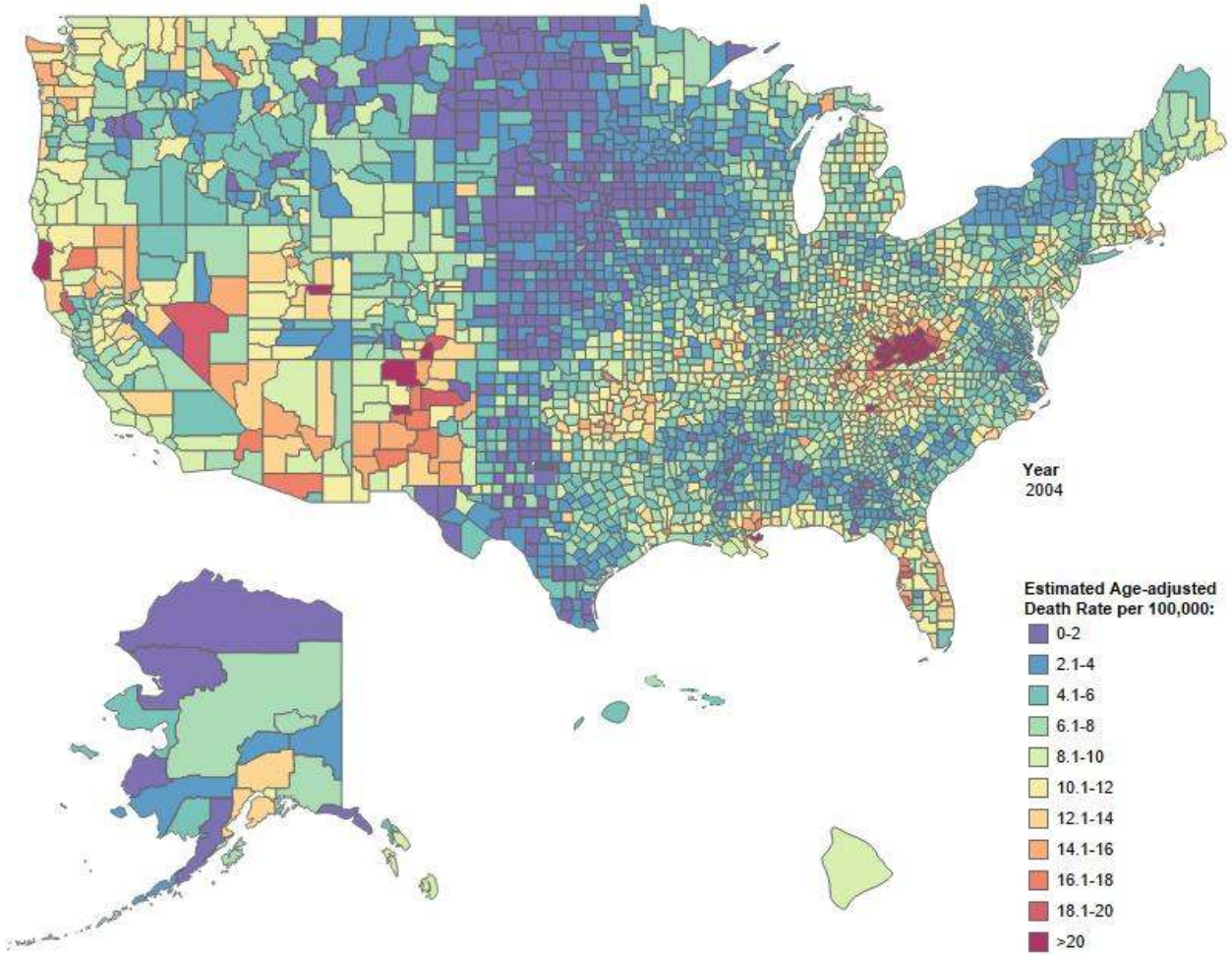
[1] Top 3 methods of death (motor vehicles, guns, and drugs) include all manners of death (accident, homicide, suicide, and undetermined)

1999 - Estimated drug overdose deaths



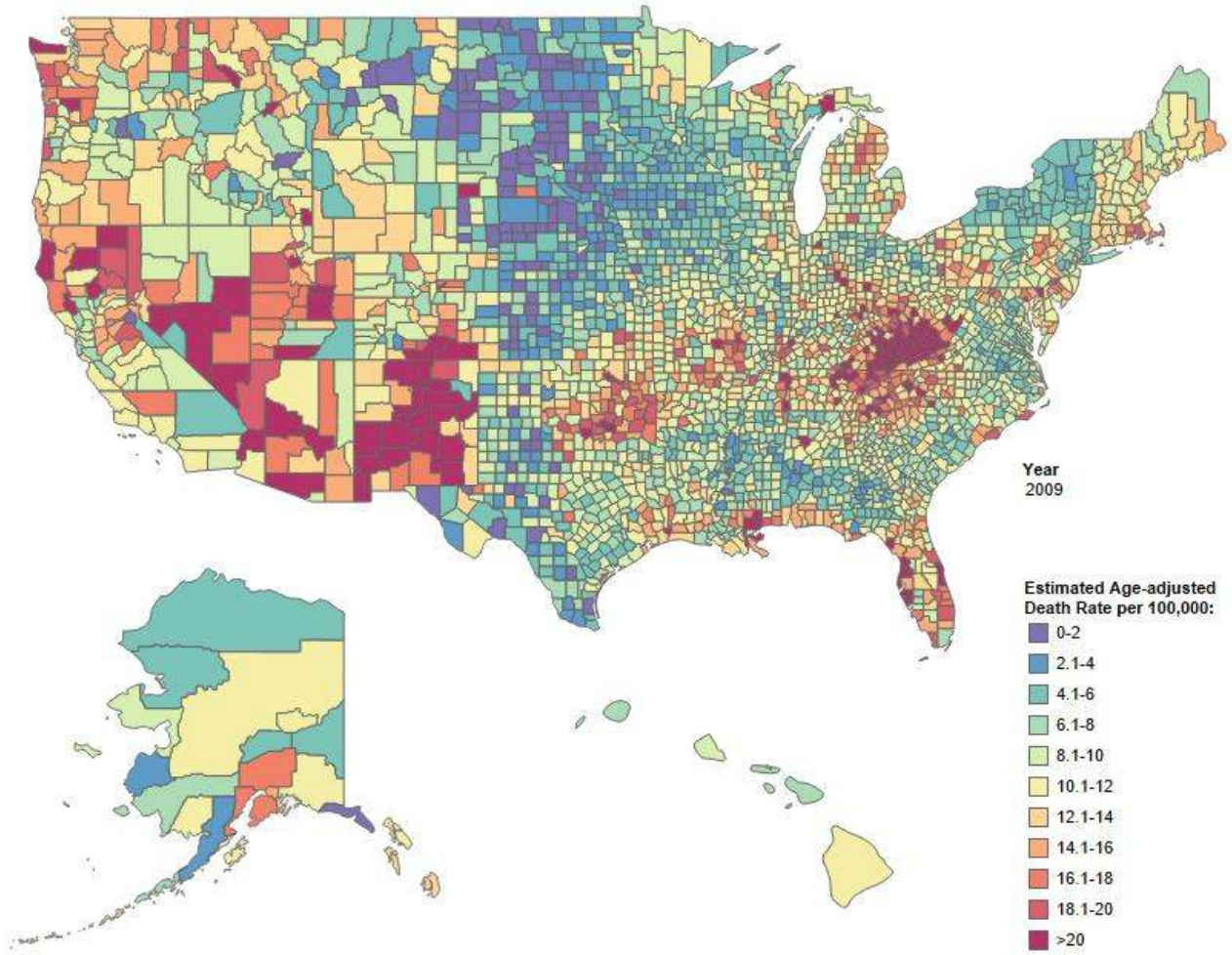
Designed by L. Rossen, B. Bastian & Y. Chong. SOURCE: CDC/NCHS, National Vital Statistics System.

2004 - Estimated drug overdose deaths



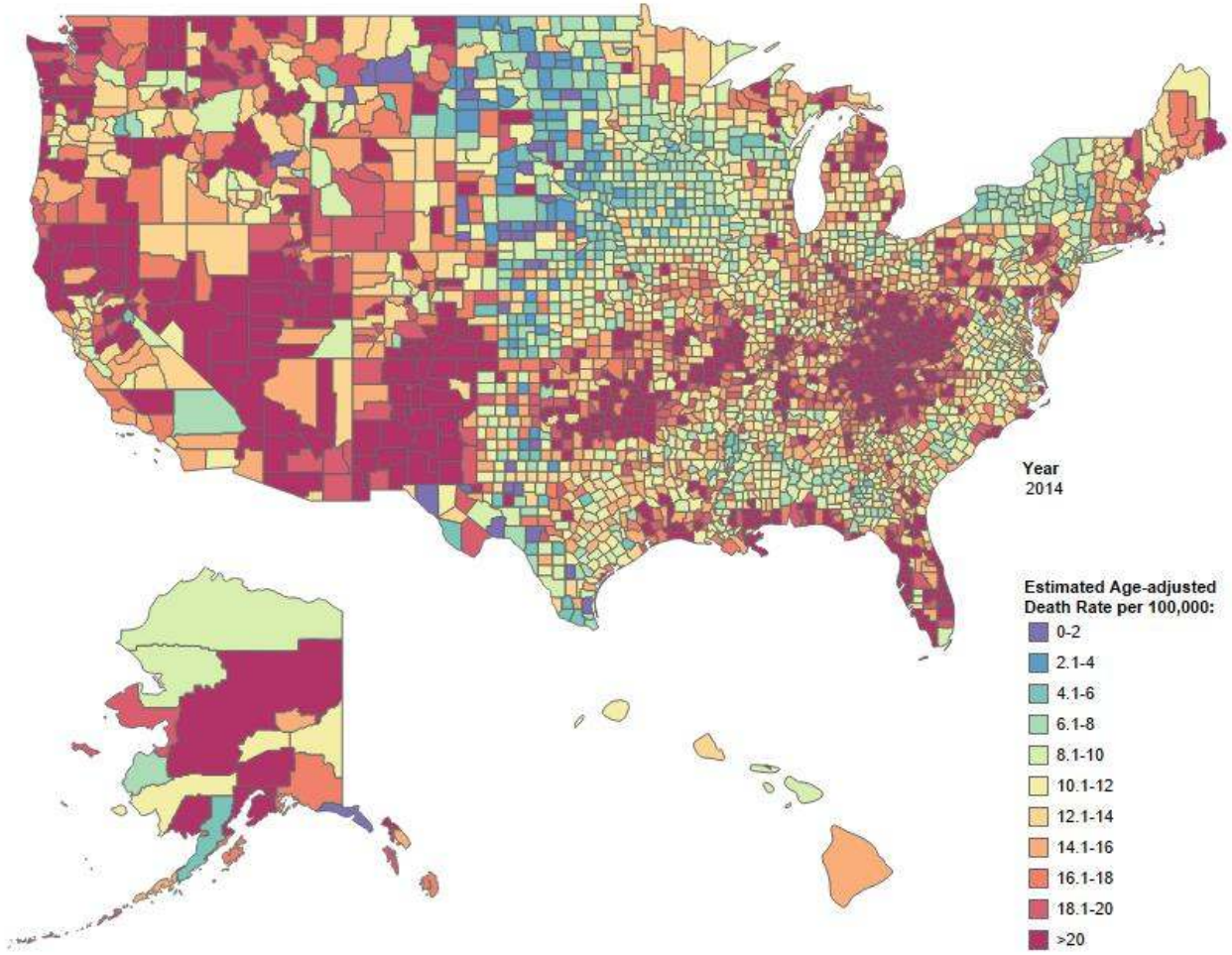
Designed by L. Rossen, B. Bastian & Y. Chong. SOURCE: CDC/NCHS, National Vital Statistics System.

2009 - Estimated drug overdose deaths

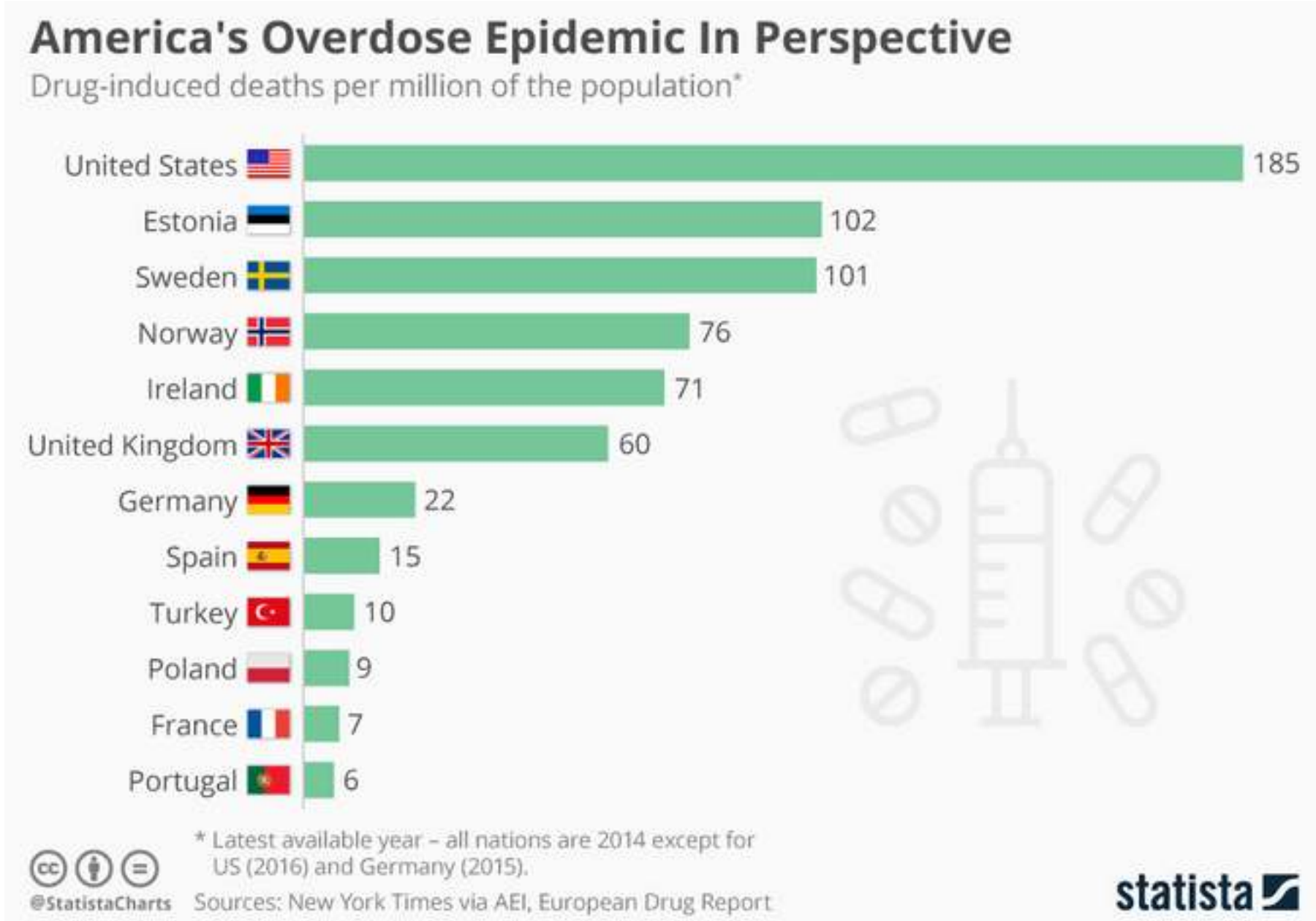


Designed by L. Rossen, B. Bastian & Y. Chong. SOURCE: CDC/NCHS, National Vital Statistics System.

2014 - Estimated drug overdose deaths



Designed by L. Rossen, B. Bastian & Y. Chong. SOURCE: CDC/NCHS, National Vital Statistics System.


America's Overdose Epidemic In Perspective
Drug-induced deaths per million of the population*
United States 185
Estonia 102
Sweden 101
Norway 76
Ireland 71
United Kingdom 60
Germany 22
Spain 15
Turkey 10
Poland 9
France 7
Portugal 6
* Latest available year – all nations are 2014 except for US (2016) and Germany (2015).
@StatistaCharts
Sources: New York Times via AEI, European Drug Report
statista

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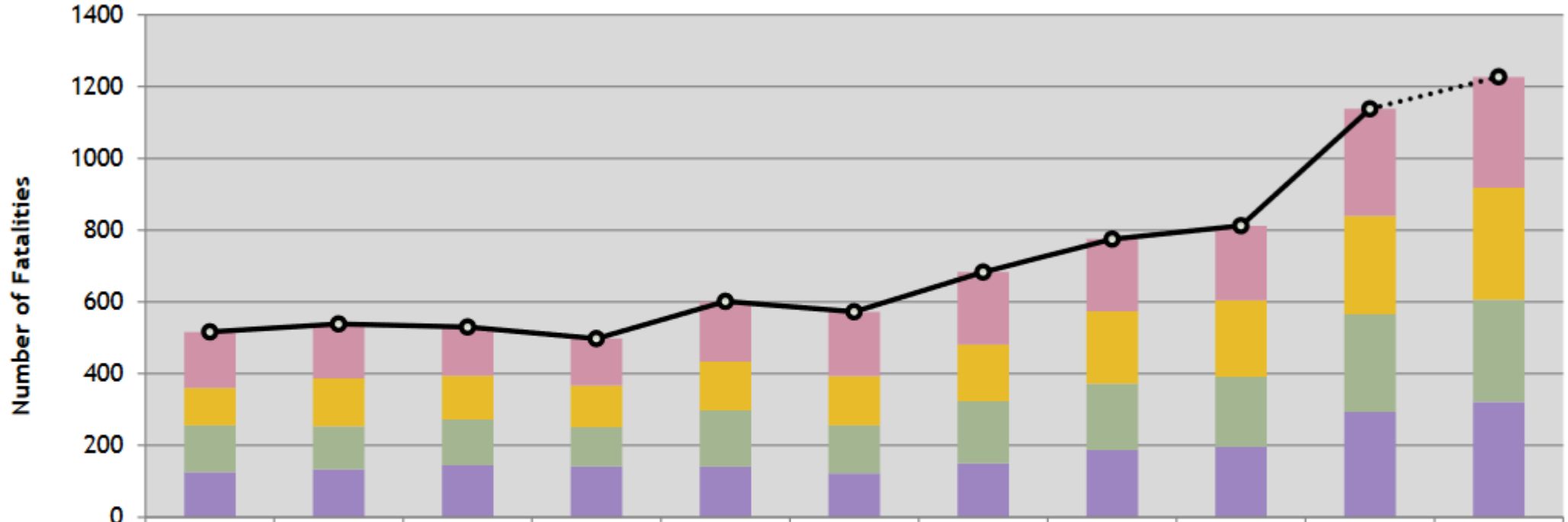
Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2017
('Total Fatalities' for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Q4	156	151	136	131	168	179	202	201	208	298	309
Q3	104	134	122	116	136	137	158	202	213	275	312
Q2	130	120	128	109	156	134	173	185	195	272	285
Q1	126	133	144	142	141	122	150	187	196	293	321
Total Fatalities	516	538	530	498	601	572	683	775	812	1138	1227

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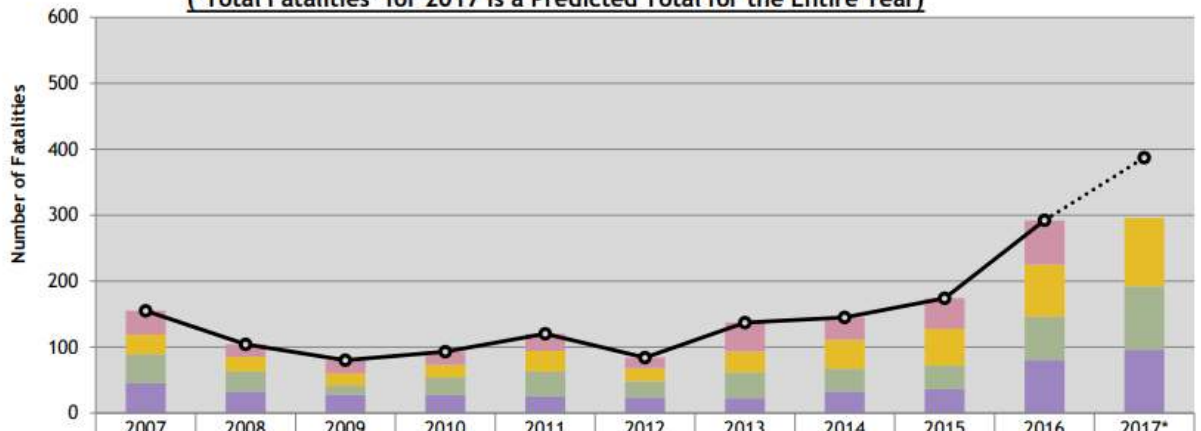
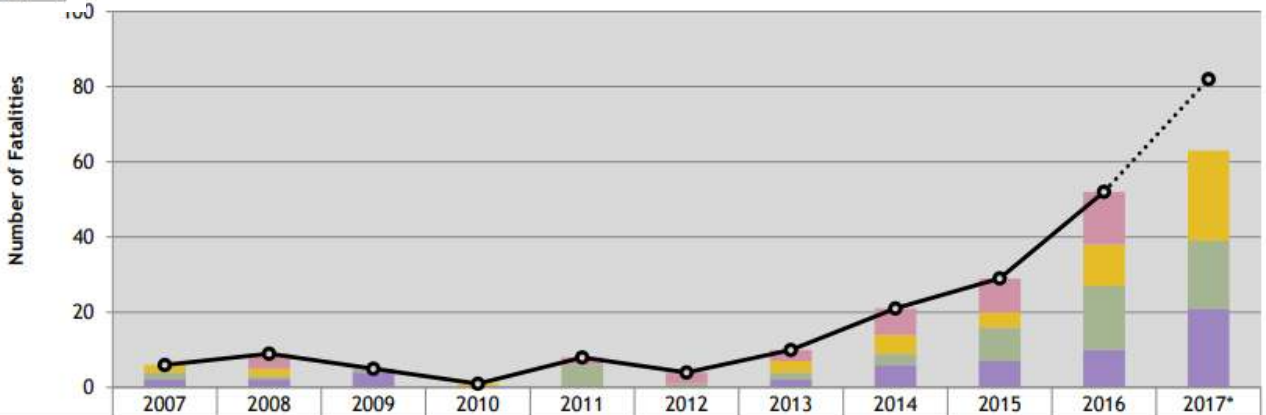
It's not only opioids…

Total Number of Fatal Cocaine Overdoses by Quarter and Year of Death, 2007-2017
('Total Fatalities' for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Q4	36	19	20	20	26	16	44	34	46	67	
Q3	30	22	18	19	31	20	31	44	56	79	104
Q2	44	30	14	27	38	24	40	34	36	66	96
Q1	45	33	28	27	25	24	22	33	36	80	96
Total Fatalities	155	104	80	93	120	84	137	145	174	292	387

Total Number of Fatal Methamphetamine Overdoses by Quarter and Year of Death, 2007-2017
('Total Fatalities' for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Q4	0	4	0	0	2	3	3	7	9	14	
Q3	2	2	0	1	0	0	3	5	4	11	24
Q2	2	1	1	0	6	1	2	3	9	17	18
Q1	2	2	4	0	0	0	2	6	7	10	21
Total Fatalities	6	9	5	1	8	4	10	21	29	52	82

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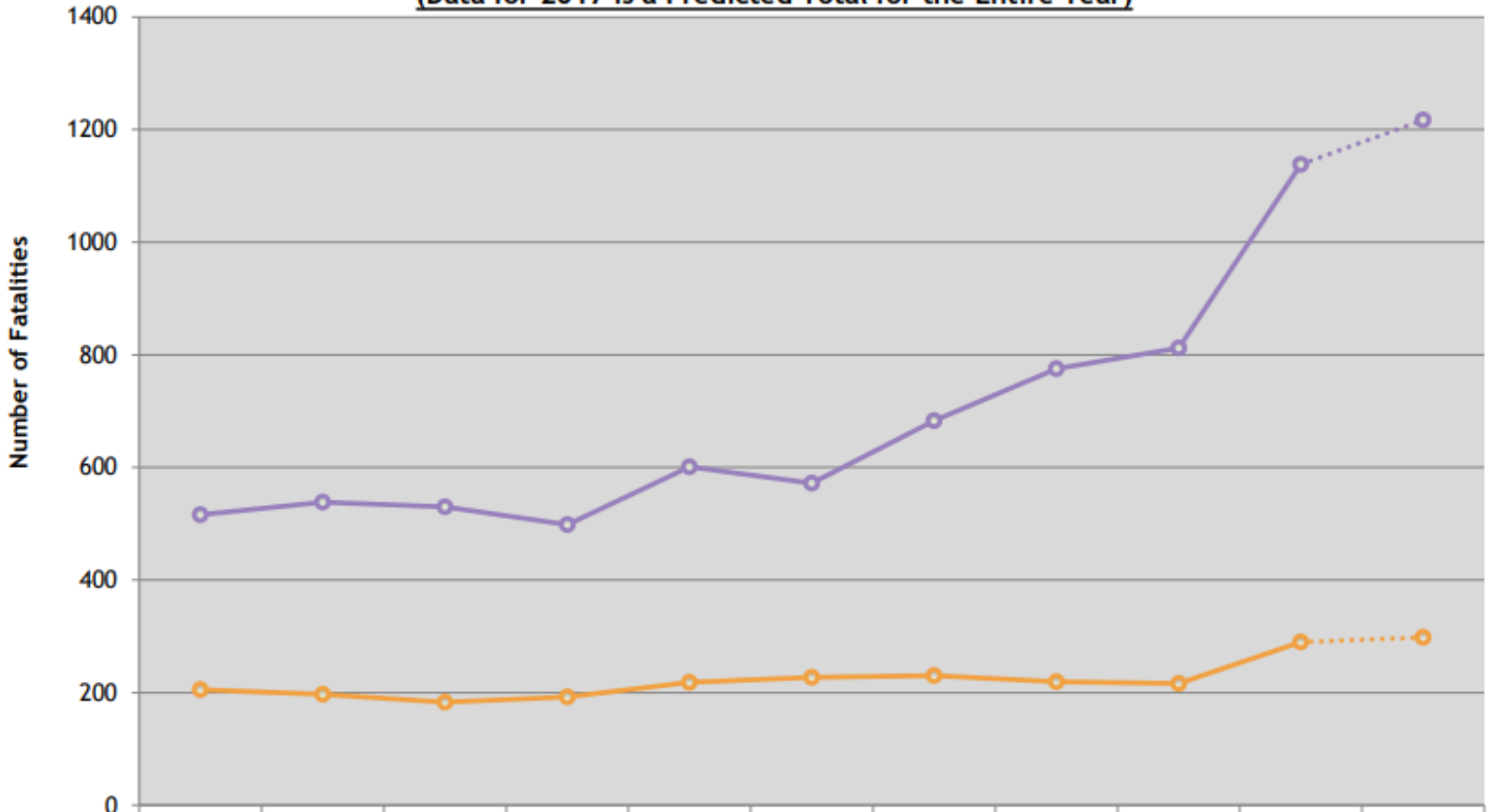
…but it's mostly opioids

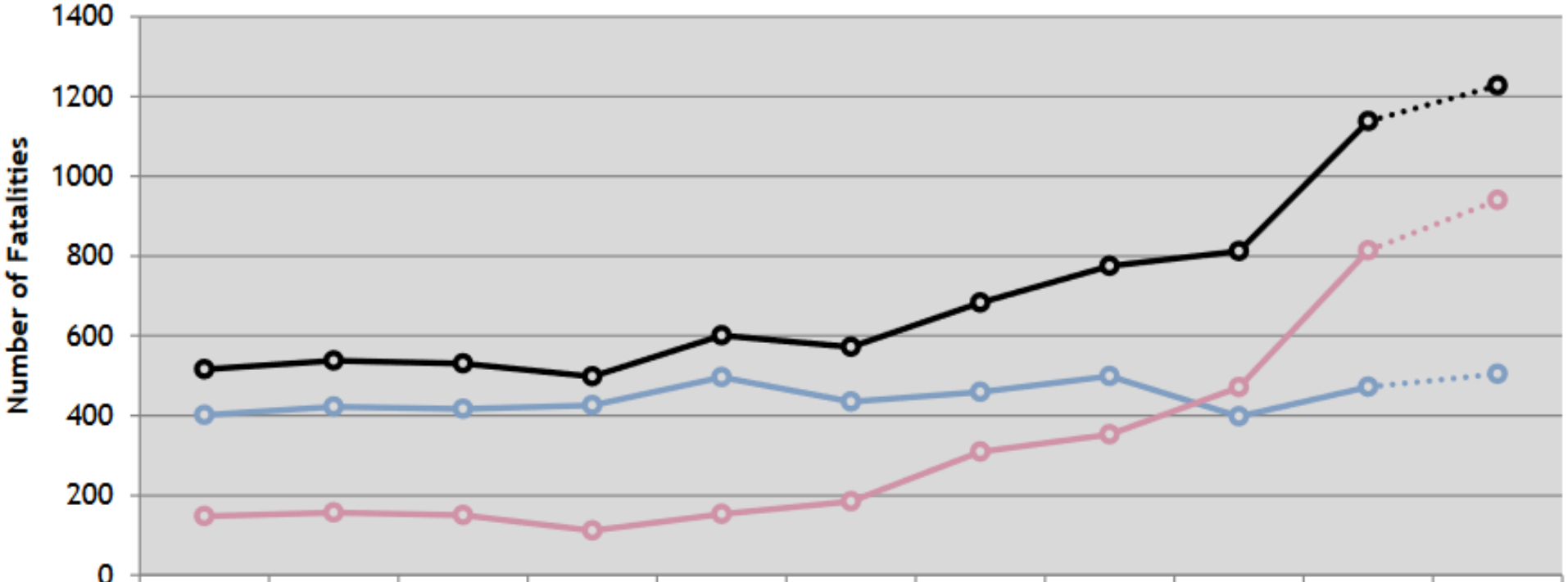
OPIOIDS VS. NON-OPIOIDS

Total Number of Fatal Opioid Overdoses vs. Non-Opioid Overdoses by Year of Death, 2007-2017
(Data for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Opioids	516	538	530	498	601	572	683	775	812	1138	1217
Non-Opioids	205	197	183	192	218	227	230	219	216	290	298

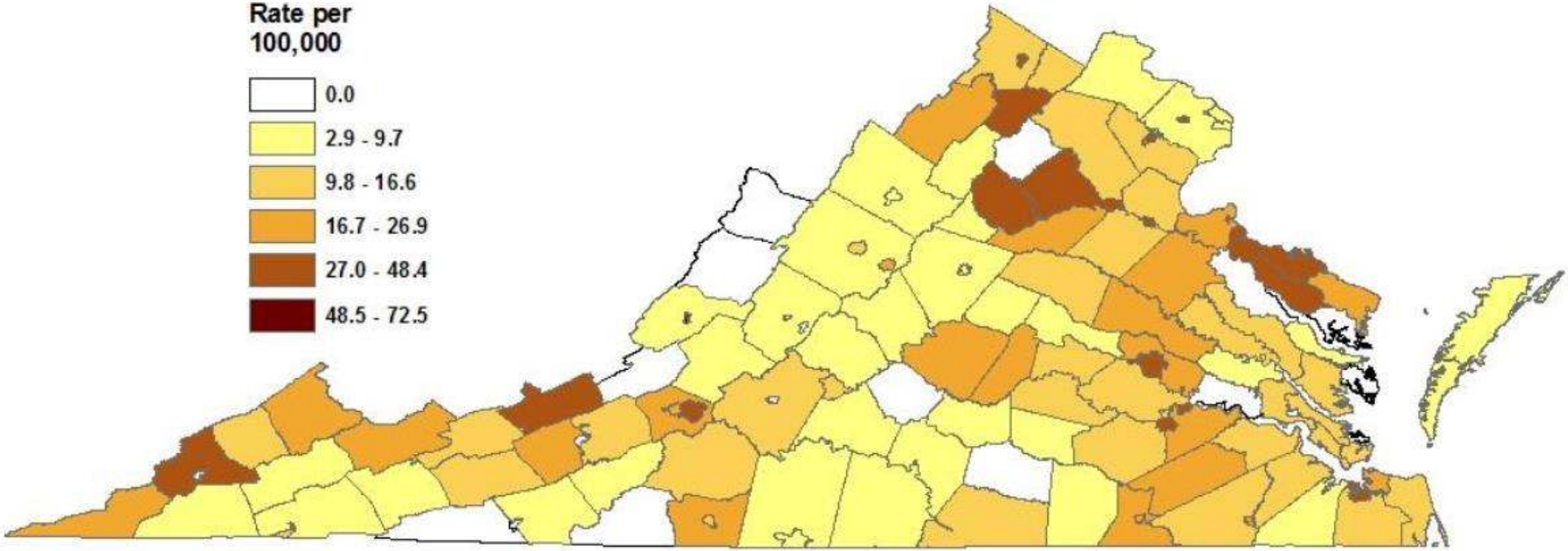
Total Number of Prescription Opioid (Excluding Fentanyl), Fentanyl and/or Heroin, and All Opioid Overdoses by Year of Death, 2007-2017
('Total Fatalities' for 2017 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
All Opioids	516	538	530	498	601	572	683	775	812	1138	1227
Prescription Opioids (excluding fentanyl)	401	422	417	426	496	435	459	499	398	472	504
Fentanyl and/or Heroin	148	157	150	112	153	185	309	353	471	814	940

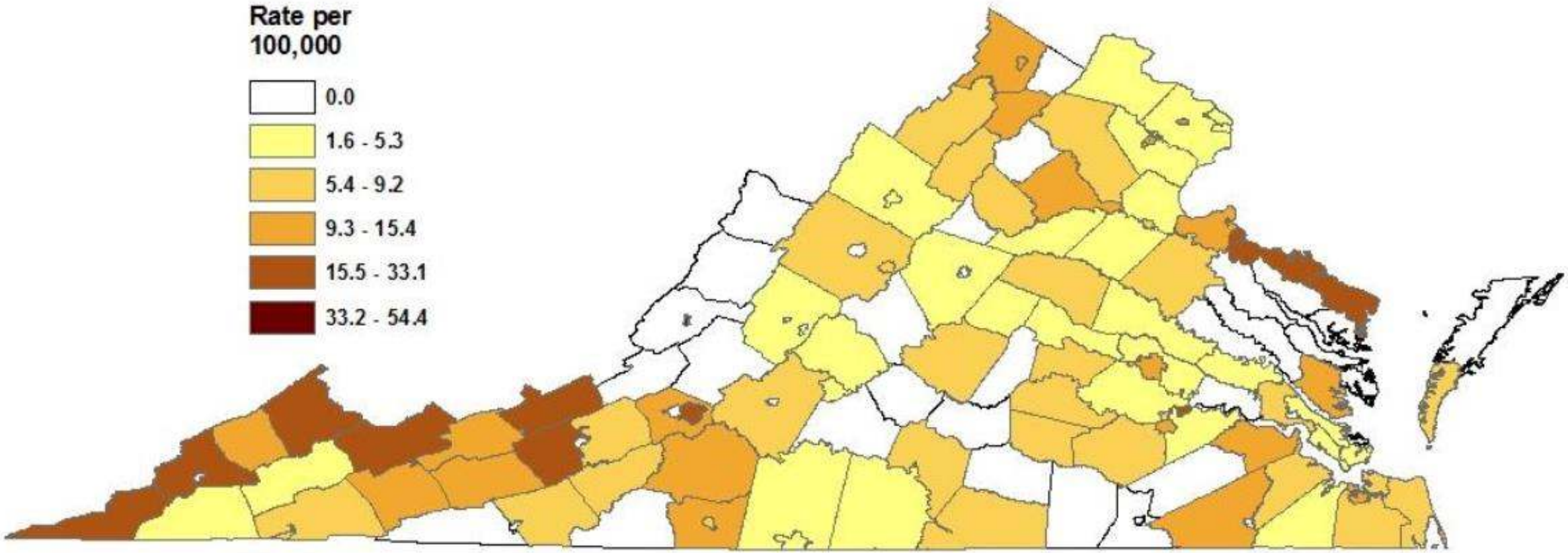
Source: Virginia Department of Health, Office of the Chief Medical Examiner, 2018

Rate of All Fatal Opioid Overdoses by Locality of Overdose, 2017



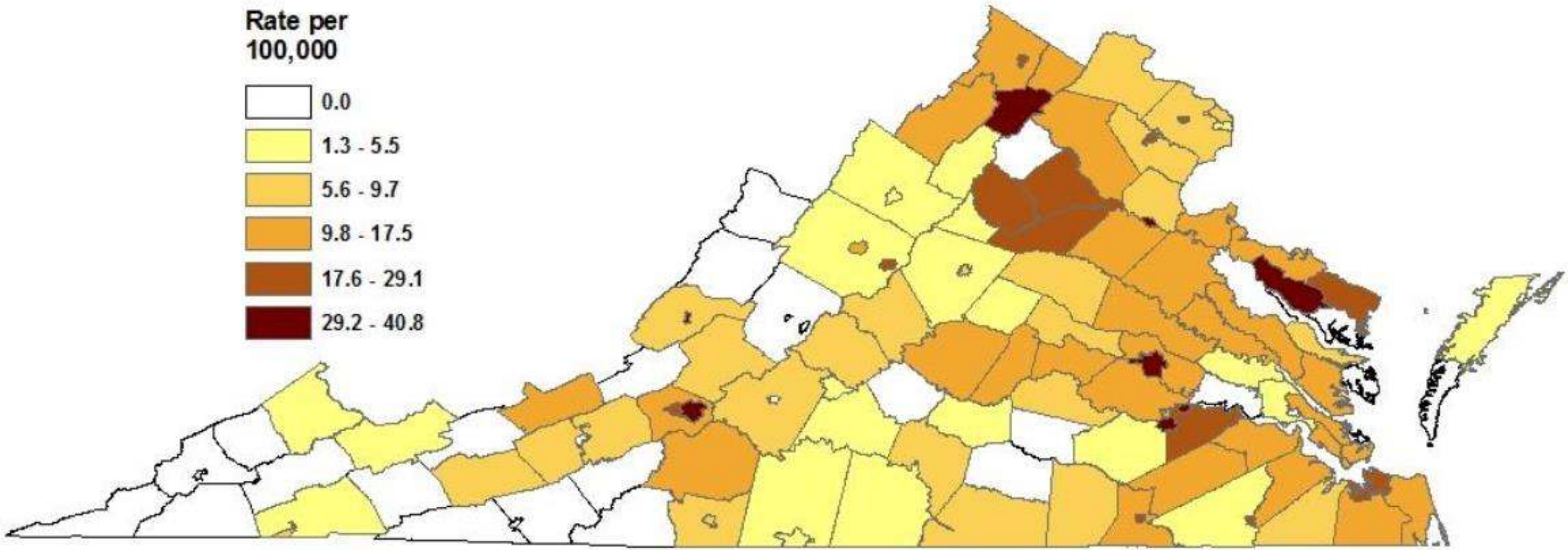
Source: Virginia Department of Health, Office of the Chief Medical Examiner

Rate of Fatal Prescription Opioid (Excluding Fentanyl) Overdoses by Locality of Overdose, 2017



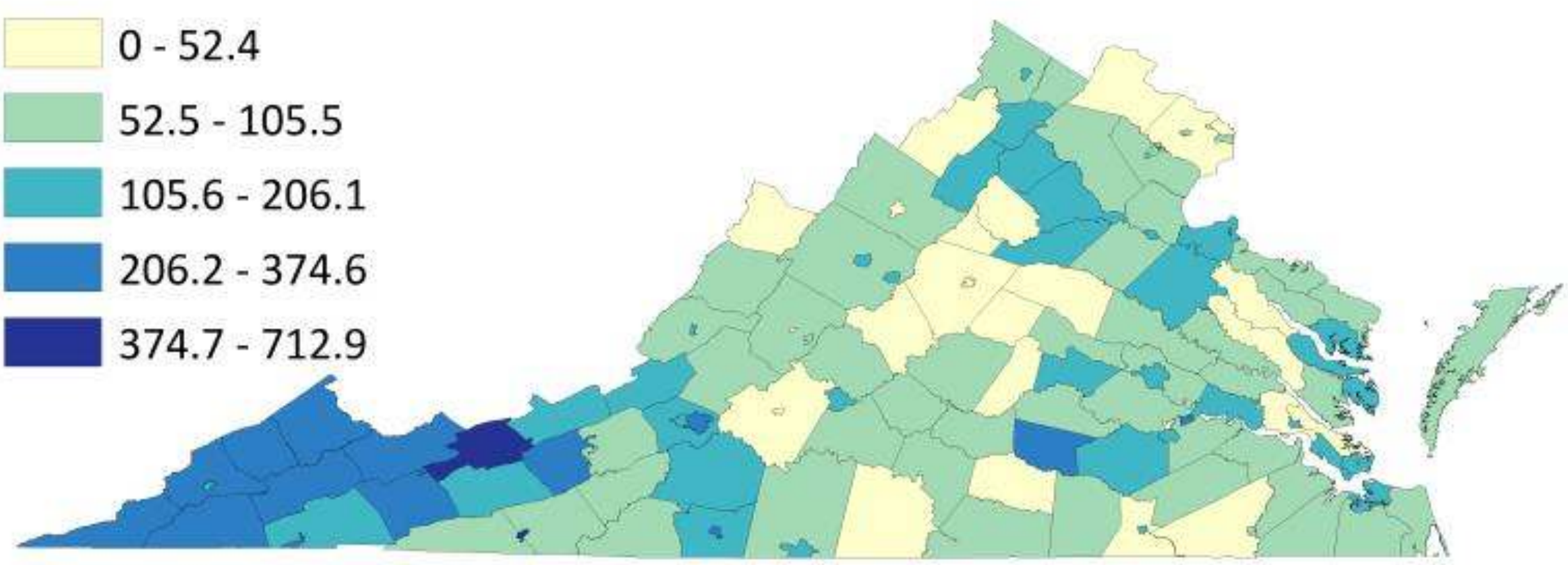
Source: Virginia Department of Health, Office of the Chief Medical Examiner

Rate of Fatal Fentanyl (Rx, Illicit, or Analogs) and/or Heroin Overdoses by Locality of Overdose, 2017



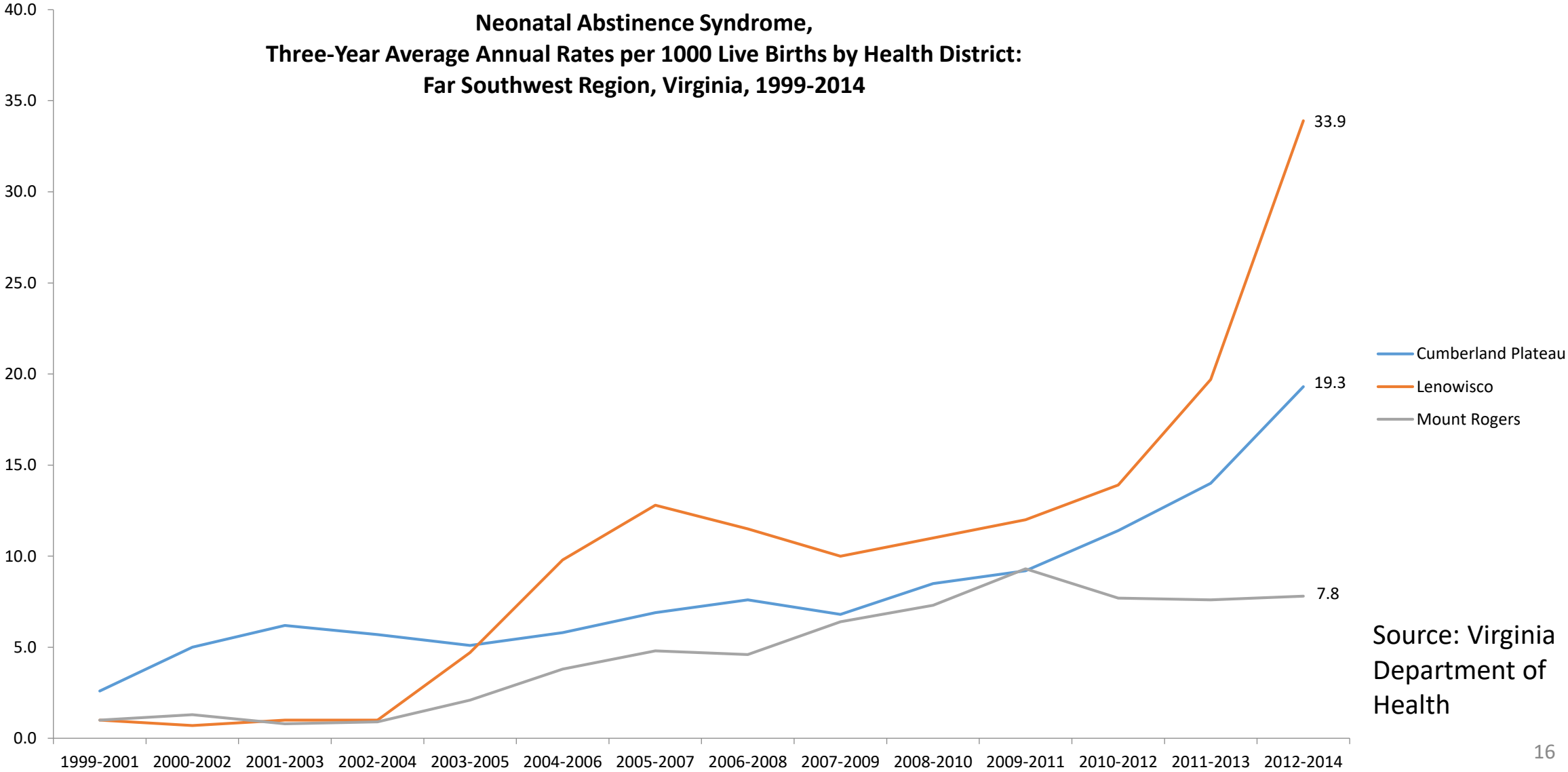
Source: Virginia Department of Health, Office of the Chief Medical Examiner

Reported hepatitis C per 100,000

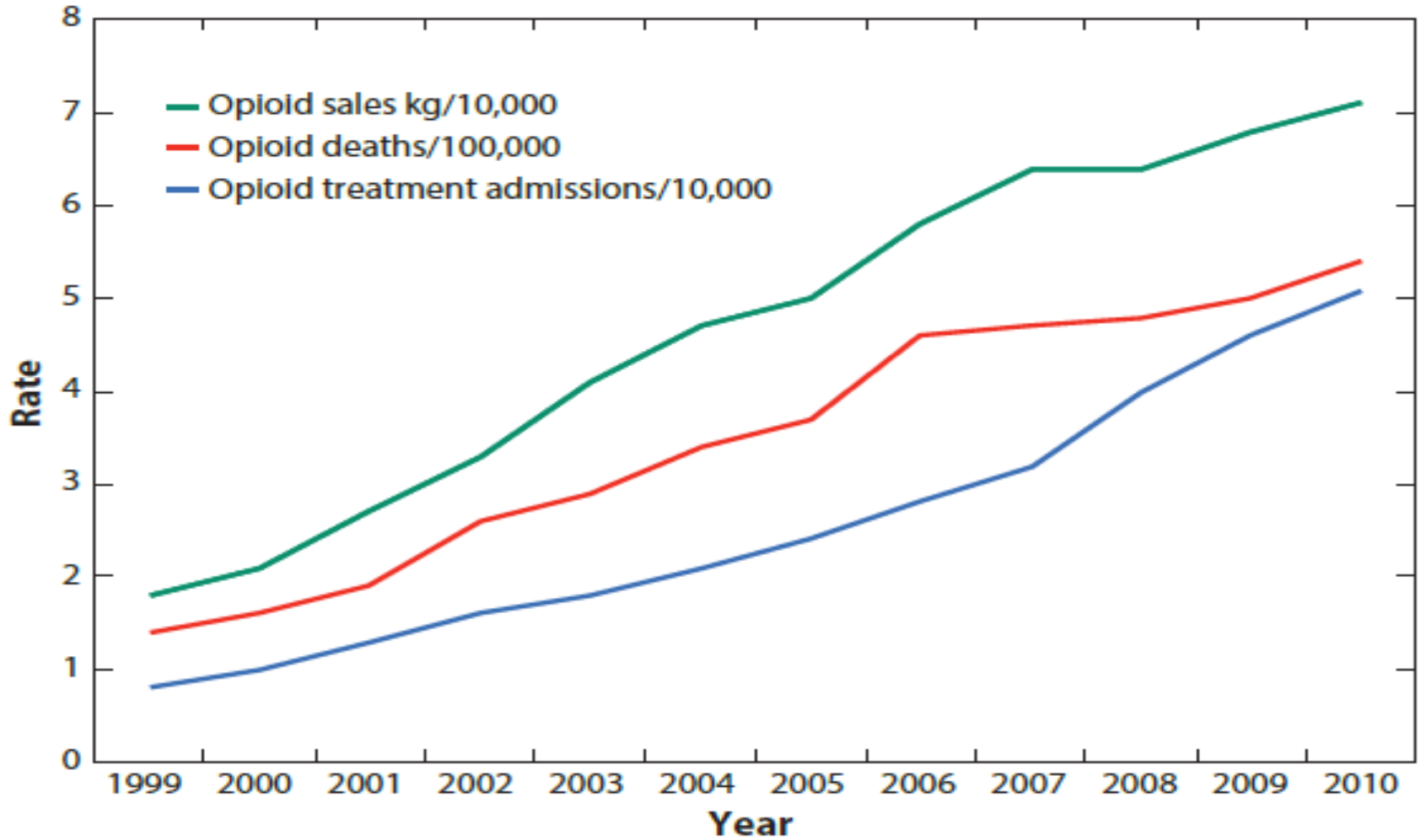


Source: Virginia Department of Health, 2016

**Neonatal Abstinence Syndrome,
Three-Year Average Annual Rates per 1000 Live Births by Health District:
Far Southwest Region, Virginia, 1999-2014**



Source: Virginia Department of Health



Annual Review of Public Health 2015 Vol. 36: 559-574

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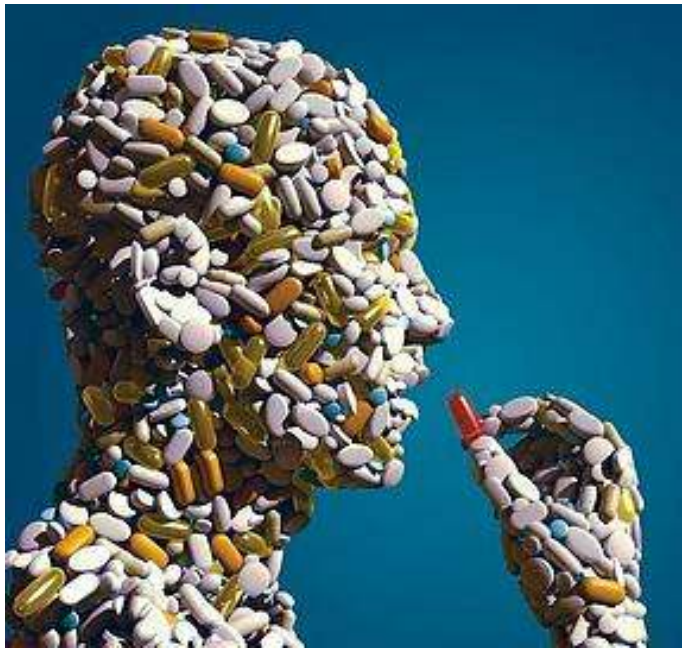

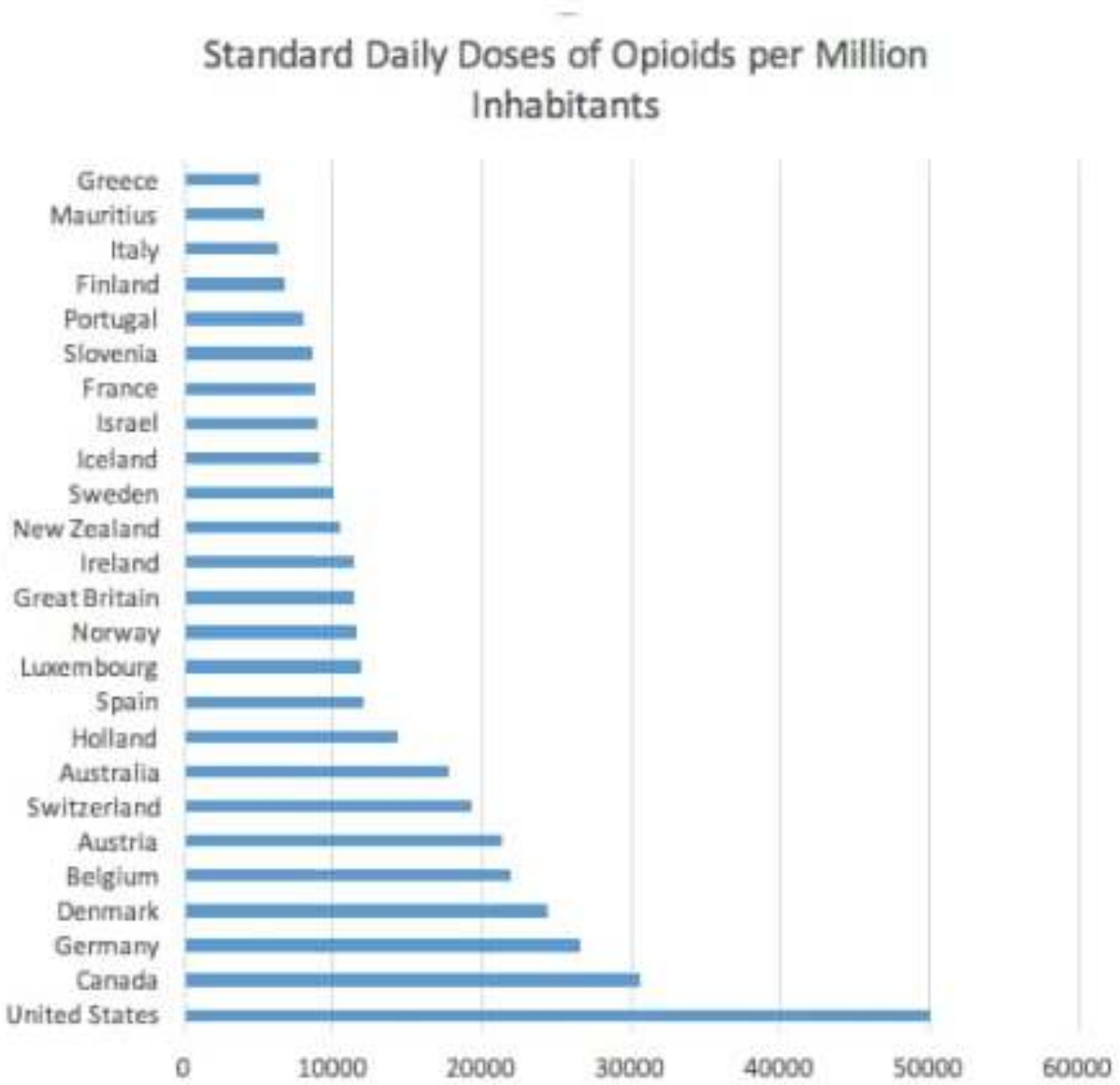

Washington Post, 3/15/17

How did we get here?

- Late 1990's: pain is undertreated
  - Pain as 5th vital sign
  - Pain scales mandatory
  - Opiates are safe
- Aggressive marketing by pharmaceutical industry
- Lack of medical training in pain management, addiction and prescribing of opioids

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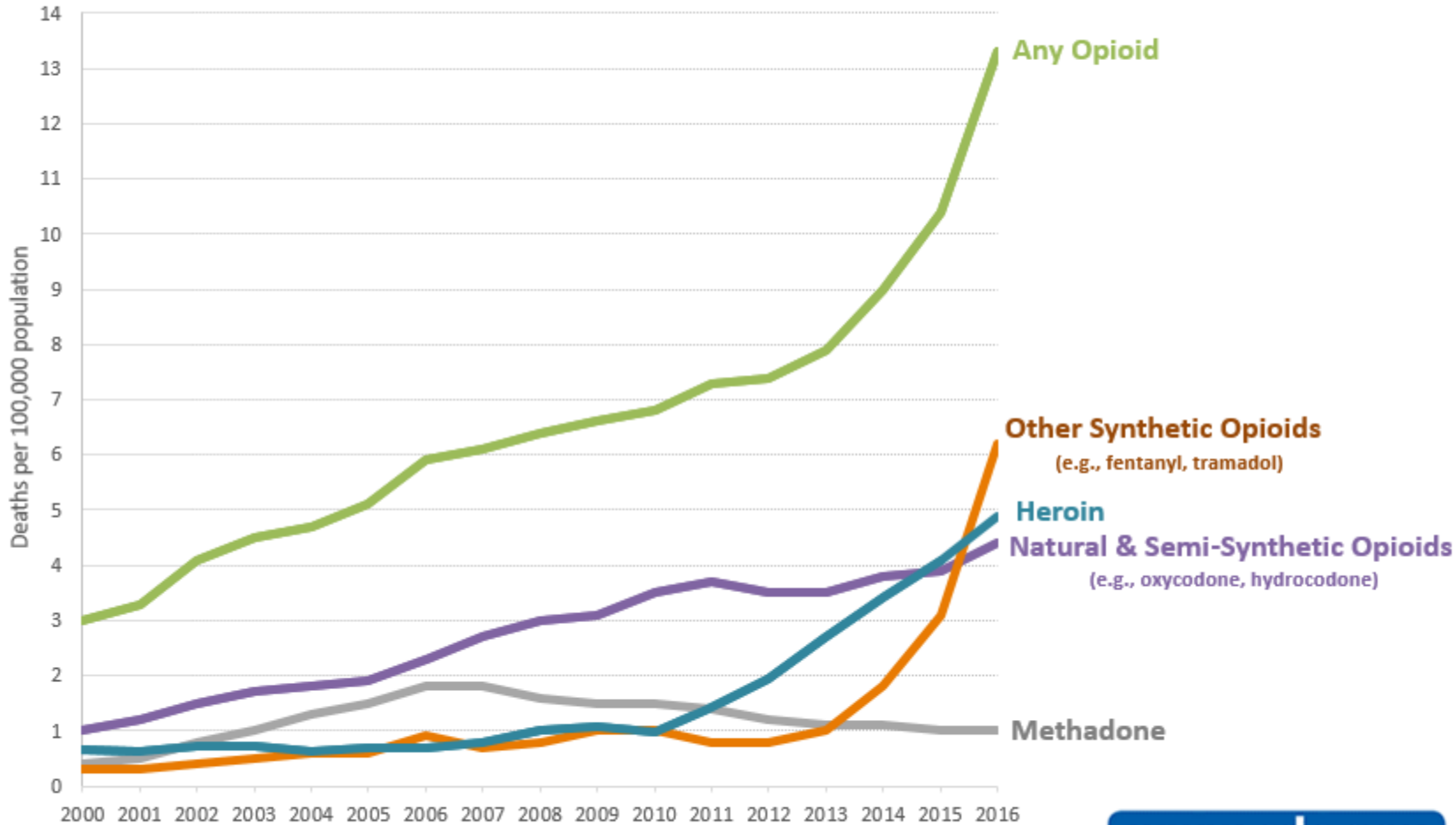
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

www.cdc.gov
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Prescription Opioids and Heroin

- Prescription opioid use is a risk factor for heroin use
  - Numerous stories of addiction following prescribing for acute pain
  - Dependence on or abuse of prescription opioids associated with a 40-fold increased risk of heroin abuse
  - 75% - 85% of heroin users first opioid was prescription
    - Obtained from family, friends or personal prescription
    - In the 1960s, 80% first opioid was heroin
  - 11% of high school seniors report non-medical use of prescription opioids

Source: National Institute on Drug Abuse

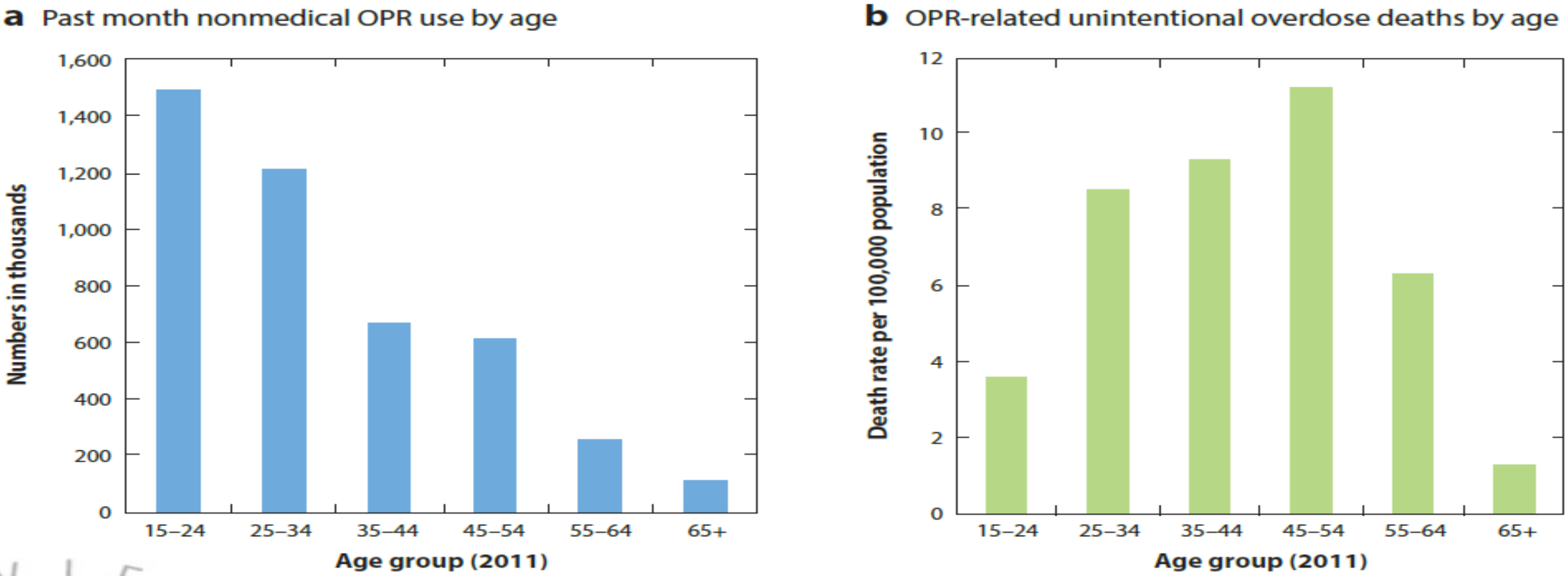

Figure 4

(*a*) Past month nonmedical OPR use by age versus (*b*) OPR-related unintentional overdose deaths by age. Abbreviation: OPR, opioid pain reliever. Sources: 58, 68.

Annual Review of Public Health 2015 Vol. 36: 559-574

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- *Licenses and regulates all prescribers, pharmacists and pharmacies*
  - Board of Nursing
  - Board of Medicine
  - Board of Pharmacy
  - Board of Dentistry
  - Board of Veterinary Medicine
  - Board of Optometry
- Prescription Monitoring Program
- Health Practitioners Monitoring Program

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Prescription Monitoring Program

- 24/7 Database of Schedule II – IV Prescriptions
- Resource for Prescribers and Pharmacists
- Mandatory use prescription > 7 days supply
- Pharmacies, other dispensers report within 24 hours
- PMP is interoperable with 24 states, including DC, MD, WV, KY, NC & TN
- Reporting of outlier prescribing, dispensing for investigation
- Reporting of doctor shopping behavior to law enforcement

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Health Practitioners Monitoring Program

- Substance use disorder, psychiatric disorder or physical disability
- Administered by the VCU Department of Psychiatry
- Safe return to practice for health care practitioners
- Can include a stay of disciplinary action
- All licensees of DHP are eligible

Virginia Statewide Initiatives

- Needle exchange
- e-Prescribing of opioids in 2020 (workgroup)
- Opioid curricula (workgroup)
  - Medicine, Dentistry, Nursing, PA, Pharmacy
  - Non-prescriber workgroup
- Naloxone distribution
  - Revive trainings
  - Commissioner of Health Standing Order
- CE to include 2 hours opioids (MDs, NPs)

Virginia Statewide Initiatives

- Opioid Prescribing Regulations
  - Board of Medicine
  - Board of Nursing
  - Board of Dentistry
  - Board of Veterinary Medicine
- PMP check if prescription > 7 days supply
- Unusual patterns of prescribing reported to DHP by PMP for investigation
- ARTS Program
  - Peer Recovery Specialists
- Reporting of veterinary dispensing to PMP if >7day supply

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Commonwealth of Virginia

EMERGENCY REGULATIONS FOR OPIOID PRESCRIBING BY NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 90-30-10 et seq.

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Prescribing Regulations

- Mandated by 2017 legislation
- Emergency regulations, effective March 15, 2017
  - Permanent regulations within 18 months
  - Opportunity for comment and amendment
  - Created using a Regulatory Advisory Panel
  - Based on guidelines, best practices
- Acute Pain
- Chronic Pain

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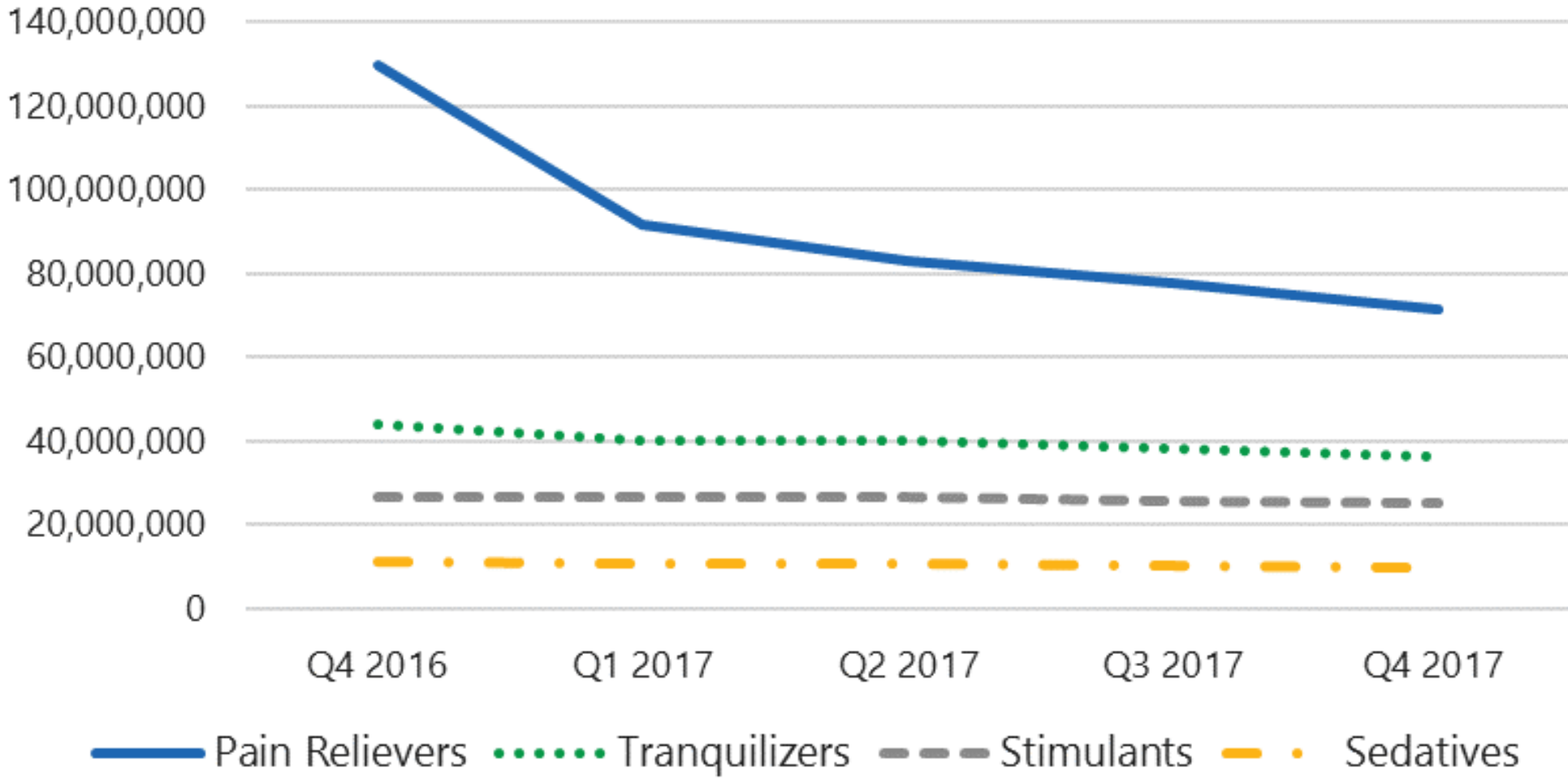
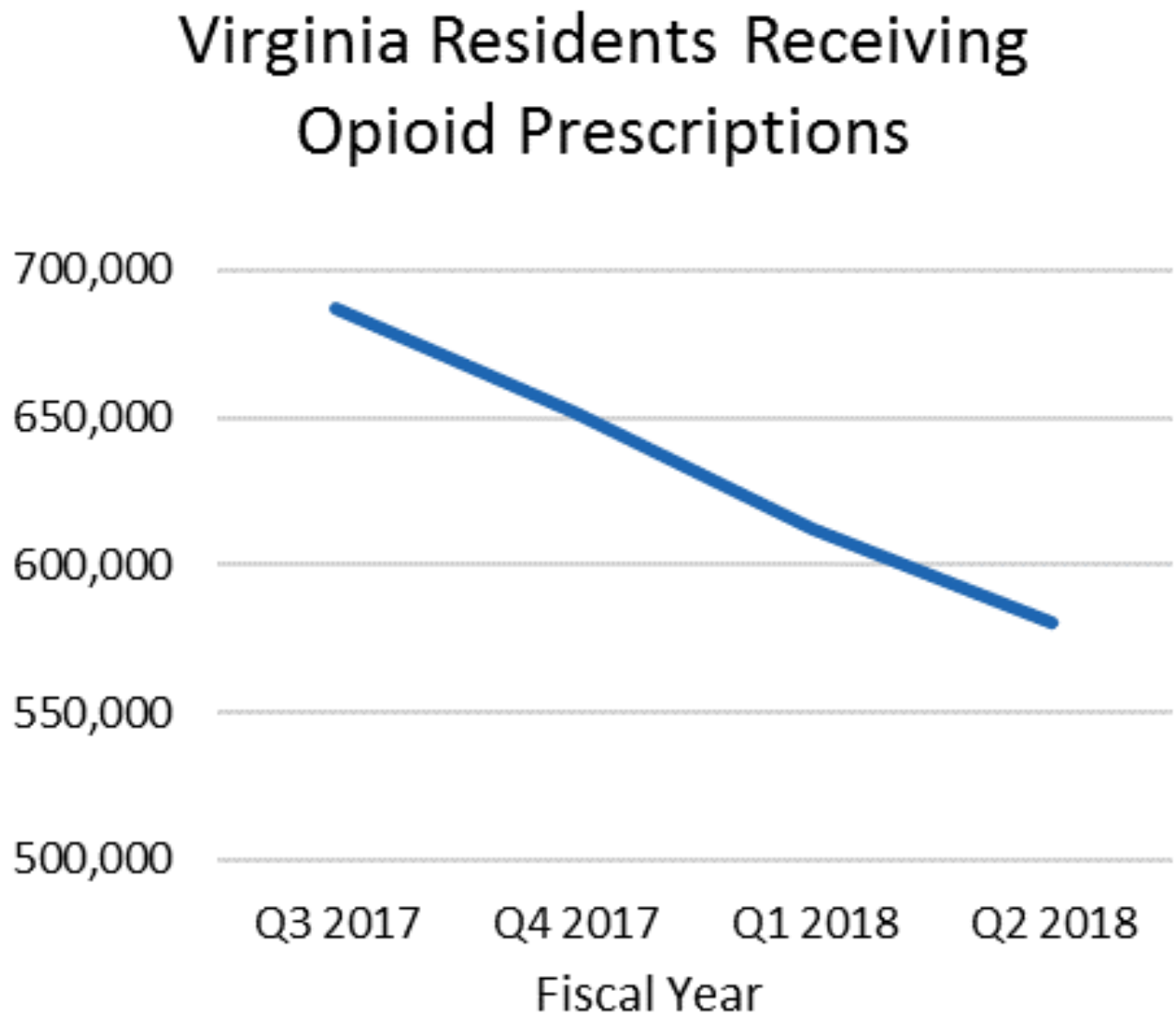
Regulations: Acute Pain
Key Concepts

- Consider non-pharmacologic and non-opioid treatments prior to using opioids
- Co-prescribing of benzodiazapines, sedative hypnotics, and carisoprodol only if extenuating circumstances
- Consider the MME
  - Document why the initial dose should exceed 50 MME/day
  - Prescribe naloxone if >120MME/day, hx prior overdose or abuse, or concomitant benzodiazepine
- 7-day limit unless extenuating circumstances are documented

Doses Dispensed by Drug Type




Virginia Residents Receiving Opioid Prescriptions
700,000
650,000
600,000
550,000
500,000
Q3 2017
Q4 2017
Q1 2018
Q2 2018
Fiscal Year

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HB2161 & SB1179 - 2017

Delegate Todd Pillion & Senator Ben Chafin

Secretary of Health and Human Resources; workgroup to establish educational guidelines for training health care providers in the safe prescribing and appropriate use of opioids

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Secretary HHR to convene workgroup

- DBHDS, VDH, DHP and SCHEV
- Schools of Medicine, Dentistry, & Pharmacy
- PA and Nursing Education Programs
- Develop Educational Standards & Curricula
  - Safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse
  - Pain management
  - Addiction
  - Proper prescribing
- Prescriber and Non-Prescriber Competencies
- *Upcoming Roll-out of Competencies*
- *On-line Tool for Schools, Practitioners*

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Core Competency Topics in Addiction, Opioids, and Pain Management

1. The opioid crisis
    a. History and current situation
2. Addiction
    a. Science of addiction
    b. Prevention and early intervention
    c. Recognition of addiction
    d. Treatment of addiction
    e. Prevention of fatal overdose
3. Pain management
    a. Science of pain
    b. Assessment (diagnosis) and treatment planning
    c. Treatment of pain
    d. Opioids and pain
4. Communicating with patients and caregivers
    a. General strategies for difficult conversations and effective communication
    b. Key communication topics

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Core Competency Topics in Addiction, Opioids, and Pain Management

c. **Treatment of pain**

i. Special populations in pain management, such as palliative/end of life care, patients with cancer, or pediatric/geriatric populations.

ii. Non-pharmacologic treatment of pain, including active care and self-care, evidence- and non-evidenced based approaches, and multimodal pain management

iii. The challenges in discussing with patients the psychological aspects of pain and the role of the central nervous system

iv. Non-opioid pharmacologic management of pain

v. Adverse Drug Event Prevention for all pain medications

vi. The roles in an interdisciplinary pain management team; the significance of issues such as anxiety, depression and sleep in pain management; and the impact of the placebo effect

vii. Goals and expectations in the treatment of pain, based on diagnosis and pain continuum

viii. When and where to make a pain referral

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But What About Those Who Are Already Addicted to Opioids?

The Pharmaceutical Journal

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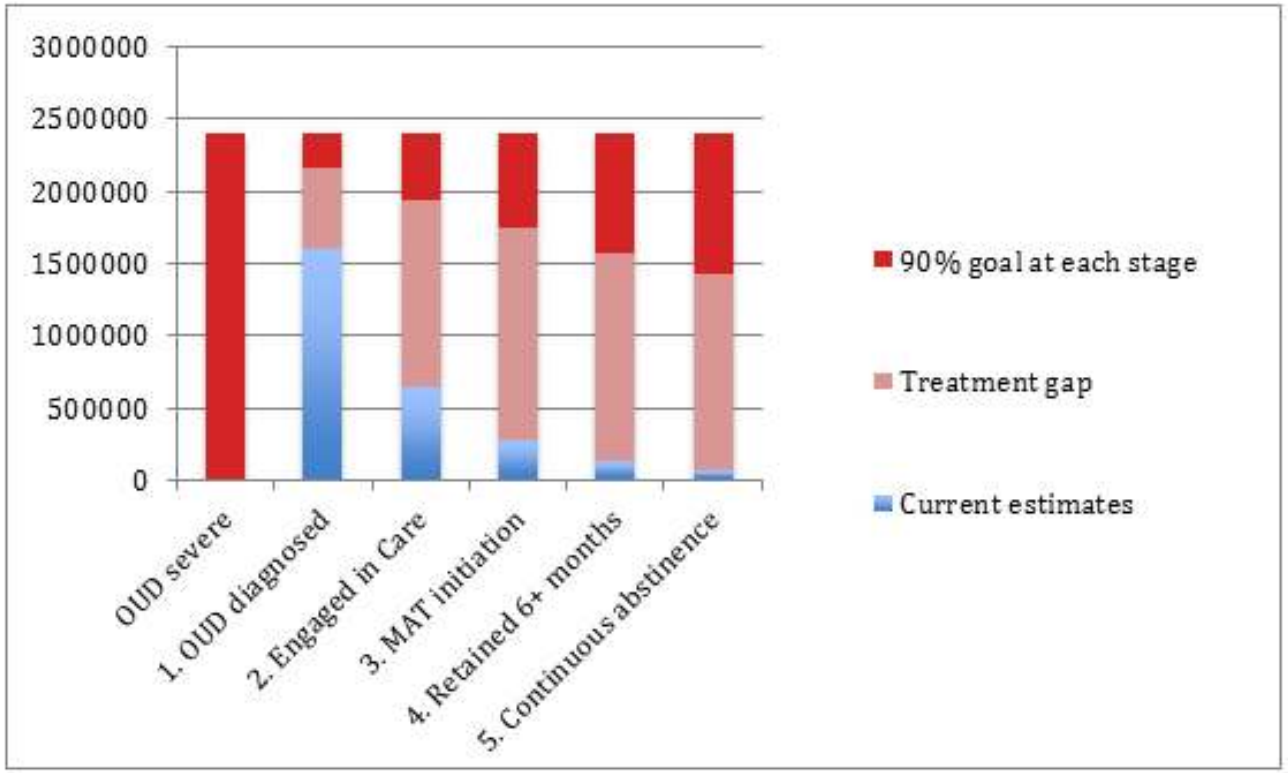
Cleveland Clinic Health Essentials

Figure 1. Current Treatment Gap in the Substance Abuse Treatment System along Opioid Use Disorder Cascade of Care (as of 2014)



Source: Health Affairs Blog
March 13, 2017

Addressing the Treatment Gap

- Medication Assisted Treatment: Buprenorphine, Methadone
  - The most effective treatment for Opioid Use Disorder
- Increase the number of MAT-waivered providers
  - Includes Nurse Practitioners
    - SAMHSA, AANP, ASAM training courses
  - Waivered providers to waivered prescribers
- Medicaid Expansion
- Medicaid ARTS program
  - Increased reimbursement across the continuum of care
- Nurse Care Managers – Massachusetts, NYC
- Peer Recovery Specialists

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Chiropractic's Role

From the Core Competencies in Addiction, Pain Management and Opioid Prescribing:

ii. Non-pharmacologic treatment of pain, including active care and self care, evidence- and non-evidenced based approaches, and multimodal pain management

From the Board of Medicine Regulations on Opioid Prescribing:

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

From the Center for Disease Control:

1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

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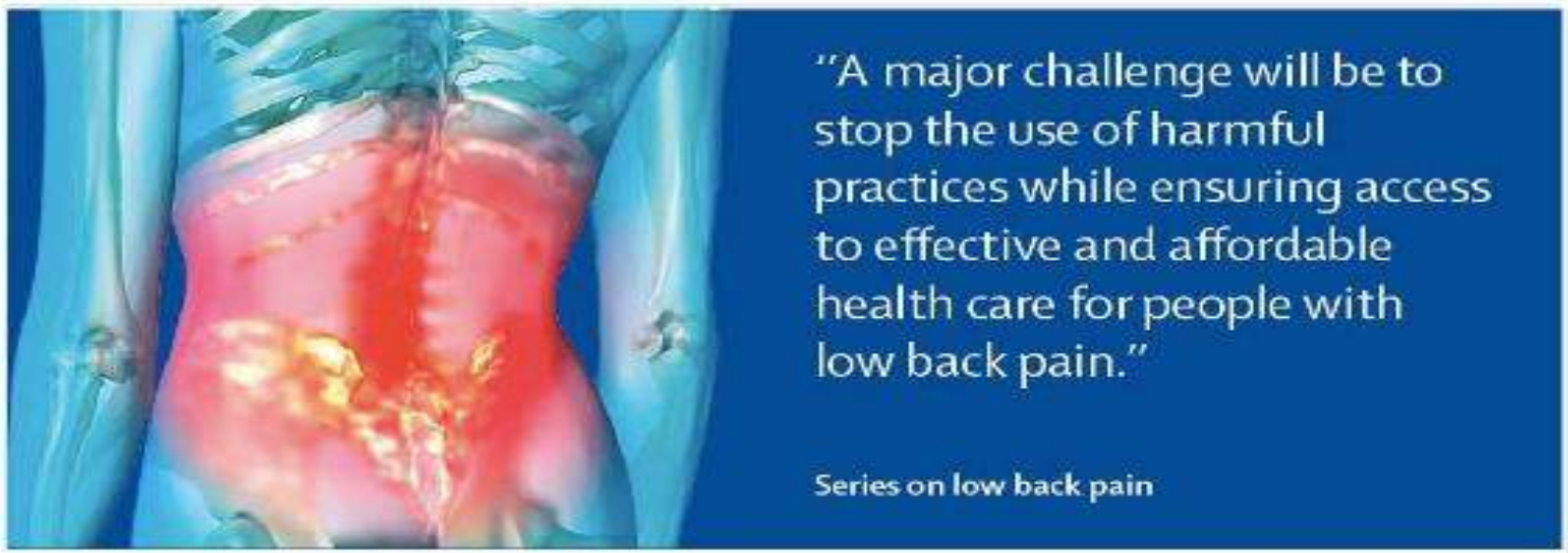
How do prescribers implement “non-pharmacologic” treatment of pain?

- Chiropractors, Physical Therapists, and other providers must reach out to the primary care community
  - Increase prescriber knowledge of non-pharmacologic approaches
  - Primary care need to know how, when and who to refer to
    - Most importantly – what to expect
  - Cooperation between DCs and PTs needed
- Outreach at national, state and local level
- Evidenced-based information
  - Become the expert in latest research!

The Lancet
@TheLancet

Follow

Low back pain affects 540 million people worldwide, but too many patients receive the wrong care — new series on #LowBackPain hubs.ly/H0bnWfs0



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The Lancet: Low Back Pain

March 22, 2018

- *The reduced emphasis on pharmacological care is shown by the US guideline, which recommends non-pharmacological care as the first treatment option ...These guidelines endorse the use of exercise…and a range of other non-pharmacological therapies, alone and in combination, such as massage, acupuncture (and) spinal manipulation.*
- Lancet
  - Exercise, activity, and work
  - Limited use of radiography
  - First choice is non-pharmacological, including spinal manipulation
  - Electrical physical modalities ineffective
  - Very limited role for invasive procedures and surgery

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Social Determinants of Health

Virginia Department of Health Professions

Questions?

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