Governor Raimondo’s Task Force on Overdose Prevention and Intervention
July 10, 2019

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SENIOR ADVISOR TOM CODERRE; OFFICE OF GOVERNOR GINA M. RAIMONDO
WELCOME & ANNOUNCEMENTS
Rhode Island Levels of Care Implementation Update

Emergency Department Naloxone Distribution, Behavioral Counseling, and Referral to Treatment

Elizabeth A. Samuels, MD, MPH, MHS
Governor’s Overdose Prevention and Intervention Task Force
July 10, 2019
1. Rhode Island Levels of Care
2. Implementation Review
3. Primary Outcomes:
   - Naloxone Distribution
   - Behavioral Counseling
   - Referral to Treatment
4. Emergency Department (ED) Buprenorphine
5. Next Steps
Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder
Rhode Island Levels of Care

Level 1
Able to initiate, stabilize, and maintain patients on medication for opioid use disorder

Level 2
1. Conducts comprehensive, standardized substance use assessments
2. Has addiction specialty services

Level 3
1. Follows discharge planning law
2. Standardized substance use disorder screening
3. Patient education on opioid storage and disposal
4. Dispenses naloxone
5. Offers peer recovery support services
6. Referral to community providers
7. 48-hour overdose reporting
8. Laboratory fentanyl drug screening on overdose patients
Rhode Island Levels of Care

Sept 2017- June 2018
10 Hospitals Certified

Level 1:
Our Lady of Fatima
Roger Williams
The Miriam
Rhode Island
Newport
Kent

Level 3:
Landmark
Women & Infants
South County Health
Westerly
Monthly Opioid Overdose ED Visits, February 2016-May 2019

Source: 48-Hour Overdose Reporting System, Rhode Island Department of Health
NARCAN NASAL SPRAY
4 mg
(naloxone HCl)
FOR USE IN THE NOSE ONLY
NDC 6547-303-02
Proportion of ED Patients Discharged with Take-Home Naloxone After An Opioid Overdose, 2016-2018
Proportion of Patients Offered and Given Take-Home Naloxone After An ED Visit for Opioid Overdose, 2016-2018

- ~80%
- ~50%

Quarters since LoC certification

% of OD visits

Offered naloxone
Discharged with naloxone
Discharged Opioid Overdose ED Patients Given Take-Home Naloxone by Hospital Level of Care, 2016-2018

% of OD visits

Quarters since LoC certification

Level 1  Level 3

~50%
Proportion of ED Overdose Patients Receiving Behavioral Counseling 2016-2018

% Discharged opioid overdose patients

- Baseline
- post-DC legislation
- Certified

Any Level
Level 3
Level 1
Proportion of Patients Offered and Provided Behavioral Counseling During an ED Visit for Opioid Overdose, 2016-2018

- Offered Counseling: ~80%
- Received Counseling: ~30%
Discharged Opioid Overdose ED Patients Receiving Behavioral Counseling by Hospital Level of Care, 2016-2018

% of OD visits

Quarters since LoC certification

-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4

~30%

Level 1 Level 3

RHODE ISLAND DEPARTMENT OF HEALTH
Proportion of ED Patients Referred to Treatment After An Opioid Overdose 2016-2018

- **Any Level:**
  - Baseline: 20%
  - post-DC legislation: 30%
  - Certified: 40%

- **Level 3:**
  - Baseline: 10%
  - post-DC legislation: 30%
  - Certified: 50%

- **Level 1:**
  - Baseline: 10%
  - post-DC legislation: 20%
  - Certified: 30%
Proportion of Discharged Patients Referred to Treatment After an ED Visit for Opioid Overdose, 2016-2018

Proportion of OD visits

Quarters since LoC certification

% of OD visits

~40%
~20%
Discharged Opioid Overdose ED Patients Referred to Treatment by Hospital Level of Care, 2016-2018

- % of OD visits
  - Level 1: ~20%
  - Level 3: ~30%

Quarters since LoC certification

~20%
~30%
ED Buprenorphine
ED Buprenorphine
Sept 2017- June 2018
10 Hospitals Certified

Level 1:
- Our Lady of Fatima
- Roger Williams
- The Miriam
- Rhode Island
- Newport
- Kent

Level 3:
- Landmark
- Women & Infants
- South County Health
- Westerly
ED Buprenorphine

ED Patients Treated After an Opioid Overdose
ED Patients Ready to Start Medication for OUD
ED Buprenorphine

- ED patients treated after an opioid overdose
- ED patients ready to start medication for OUD
STAGES OF CHANGE

PRE-CONTEMPLATION
no intention on changing behaviour

CONTEMPLATION
aware a problem exists but with no commitment to action

ACTION
active modification of behaviour

MAINTENANCE
sustained change; new behaviour replaces old

PREPARATION
intent on taking action to address the problem

RELAPSE
fall back into old patterns of behaviour

UPWARD SPIRAL
learn from each relapse
“We can’t push or pull people into recovery; however, **we can remove barriers** so when people are ready for recovery, recovery is ready for them.”

- Dr. James McDonald, Medical Director; RIDOH
Naloxone Offered and Received

Counseling Offered and Received
Take Home Points

- Naloxone distribution increasing over time
- Behavioral Counseling: Offering ~80% visits, ~30% receive
  - Greatest increase at Level 3 sites
- Referral to Treatment ~20-30% visits
  - Initial increase with decline over time
  - Greatest increase at Level 3 sites
Next Steps

- Address barriers and identify opportunities to improve:
  - Naloxone distribution
  - Behavioral counseling
  - Referral to treatment
  - ED buprenorphine initiation

- Develop new strategies for ED treatment navigation
Next Steps: *Levels of Care 2.0*

- One set of hospital treatment standards
- Adolescent and Pregnancy-specific recommendations
- ED buprenorphine support guide
- Home inductions
- Pilot ED overdose engagement specialists
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Number Needed to Harm (NNH) from Opioid Prescribing

Luke Barré, MD, MPH
Governor Raimondo’s Overdose Prevention and Intervention Task Force
July 10, 2019
Rhode Island’s Updated Acute Pain Management Regulations [216-RICR-20-20-4]

• Section 4.4: Initial Prescriptions
  • Initial prescriptions for acute pain be limited to 20 doses and no more than 30 Morphine Milligram Equivalents (MMEs) per day;

• Long-acting or extended-release opioids for initial prescriptions for acute pain – like methadone- are prohibited for initiates.
In a representative sample of opioid naïve, cancer-free adults who received a prescription for opioid pain relievers, the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day, with the sharpest increases in chronic opioid use observed after the fifth and thirty-first day on therapy, a second prescription or refill, 700 morphine milligram equivalents cumulative dose, and an initial 10- or 30-day supply. The highest probability of continued opioid use at 1 and 3 years was observed among patients who started on a long-acting opioid followed by patients who started on tramadol.
New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

Chad M. Brummett, MD; Jennifer F. Waljee, MD, MPH, MS; Jenna Goesling, PhD; et al


Key Points

Question  What is the incidence of new persistent opioid use after surgery?

Findings  In this population-based study of 36,177 surgical patients, the incidence of new persistent opioid use after surgical procedures was 5.9% to 6.5% and did not differ between major and minor surgical procedures.

Meaning  New persistent opioid use is more common than previously reported and can be considered one of the most common complications after elective surgery.

Abstract

Importance  Despite increased focus on reducing opioid prescribing for long-term pain, little is known regarding the incidence and risk factors for persistent opioid use after surgery.

Objective  To determine the incidence of new persistent opioid use after minor and major surgical procedures.
Risk Factors and Pooled Rate of Prolonged Opioid Use Following Trauma or Surgery: A Systematic Review and Meta-(Regression) Analysis.

Mohamadi A, Chan J, Lian J, Wright CL, Marin AM, Rodriguez EK, von Keudell A, Nazarian A.

RESULTS: Thirty-seven studies with 1,969,953 patients were included; 4.3% (95% confidence interval [CI] = 2.3% to 8.2%) of patients continued opioid use after trauma or surgery. Prior opioid use (number needed to harm [NNH] = 3, odds ratio [OR] = 11.04 [95% CI = 9.39 to 12.97]), history of back pain (NNH = 23, OR = 2.10 [95% CI = 2.00 to 2.20]), longer hospital stay (NNH = 25, OR = 2.03 [95% CI = 1.03 to 4.02]), and depression (NNH = 40, OR = 1.62 [95% CI = 1.49 to 1.77]) showed some of the largest effects on prolonged opioid use (p < 0.001 for all but hospital stay [p = 0.042]). The rate of prolonged opioid use was higher in trauma (16.3% [95% CI = 13.6% to 22.5%]; p < 0.001) and in the Workers' Compensation setting (24.6% [95% CI = 2.0% to 84.5%]; p = 0.003) than in other subject enrollment settings. The temporal trend was not significant for studies performed in the U.S. (p = 0.07) while a significant temporal trend was observed for studies performed outside of the U.S. (p = 0.014).
Drug overdose deaths decline in R.I.

While the number of drug overdose deaths in the United States increased steadily from 2009 to 2017 (2018 numbers are not yet available), Rhode Island drug deaths declined in 2017 and again in 2018.

U.S. drug overdose deaths

<table>
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<th>Year</th>
<th>2009</th>
<th>'10</th>
<th>'11</th>
<th>'12</th>
<th>'13</th>
<th>'14</th>
<th>'15</th>
<th>'16</th>
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<td>Deaths</td>
<td>37,004</td>
<td>56,388</td>
<td>64,353</td>
<td>69,556</td>
<td>70,237</td>
<td>70,237</td>
<td>70,237</td>
<td>69,556</td>
<td>NA</td>
<td>70,237</td>
</tr>
</tbody>
</table>

R.I. drug overdose deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>'10</th>
<th>'11</th>
<th>'12</th>
<th>'13</th>
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<th>'15</th>
<th>'16</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>336</td>
<td>336</td>
<td>336</td>
<td>336</td>
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<td>336</td>
<td>336</td>
<td>336</td>
<td>314</td>
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</tr>
</tbody>
</table>

SOURCE: National Vital Statistics System
Rhode Island Department of Health

THE PROVIDENCE JOURNAL
Rhode Island Data on Opioid Prescription Pain Medications

Number of Opioid Prescriptions (2017 - 2019)

- 2017: 152,378
- 2018: 115,373
- -24% decrease since Q1 2017
Rhode Island Data on Opioid Prescription Pain Medications

New opioid prescriptions can lead to addiction in some people

Some people inherit a gene that makes them more likely than others to become addicted to an opioid prescription pain medication even after a few doses. Healthcare providers are looking into new ways to manage pain, since opioid medications are not always the right answer. Non-pharmacologic therapies like exercise, physical therapy, chiropractic care, acupuncture, and cognitive behavioral therapy are also effective options for treating pain. Learn more about non-opioid pain management therapies for treat pain.

Number of People Receiving New Opioid Prescriptions (2017 - 2019)

Note: A new opioid prescription is one that starts 60 or more days after the last opioid prescription ends.
Opioid Naïve Patients and Persistent Opioid-Use

Long-term opioid use with initial script duration:
- < 8 day initial, 6% have long-term opioid use.
- ≥ 8 day initial, 13.5% have long-term opioid use.

**Number Needed to Harm (NNH) is 14 (13.3)**

In other words:
- Giving 14 patients eight or more days’ supply initially, (versus < 8 days), will result in one additional, long-term opioid user.
- Compared to Rituximab and PML the NNH is 28,571.
- Compared to gastrointestinal bleeding in patients taking dual antiplatelet therapy (aspirin and Plavix), the NNH is 91.
Initiate Prescriptions of Eight or More Days by Month, 2017

The monthly average decreased by 1,557 opioid prescriptions.
• The monthly average decreased by 1,557 opioid prescriptions.

• There was no significant change in the total number of new opioid prescriptions in 2017.

• Since the NNH is 14 (13.3), there would be a theoretical decrease of 111 new, long-term opioid users per month.
Percent >30 MME for Initiates, 2017

January: 39.96%
February: 39.96%
March: 39.96%
April: 22.07%
May: 22.07%
June: 22.07%
July: 13.39%
August: 13.39%
September: 13.39%
October: 13.39%
November: 13.39%
December: 13.39%
Former US drug czar says national focus on opioid epidemic is overlooking real culprit

William Bennett, the nation’s first drug czar, said Monday that the debate about the opioid overdose epidemic wrongly focuses on prescription drugs.

While the government’s opioid crackdown has involved reducing the supply of legal opioids and reducing painkiller prescription rates, black market opioids such as illicit fentanyl and heroin actually have been the driving force of the epidemic in recent years,
Prescription Opioid Use among Acute Gout Patients Discharged from the Emergency Department

Deepan S. Dalal, Nadine Mbuyi, Isha Shah, Steven Reinert, Ross Hilliard, Anthony Reginato

Almost one-third of ED patients with gout are prescribed opioids

Conclusions

Despite the availability of effective treatments, opioids are commonly used for the management of acute gout. The study highlights an opportunity to curb the opioid epidemic among gout patients
Rheumatologic conditions are a major cause of chronic, non-cancer pain.

- i.e., rheumatoid arthritis, gout, vasculitic neuropathies.

- In the past, opioids were given to patients:
  - Only to mask pain; they were not disease-modifying.
  - Uncontrolled inflammation leads to further morbidity.

- In the future of medicine, we will try to control a patient’s underlying inflammation with medications that target the underlying disease, and if necessary, use alternative analgesic regimens.
Briefing on Substance Use Disorder (SUD)-Related Legislation in 2019

Presentation to Governor’s Overdose Prevention and Intervention Task Force

Sen. Josh Miller, Chairman of Committee on Health and Human Services, Rhode Island Senate

July 10, 2019
In Budget

- **Article 13 - Opioid Stewardship Fund - $5 million**
  - Establishes requirement for pharmaceutical manufacturers, distributors, and wholesalers in Rhode Island to pay an “Opioid Stewardship Fee.”
  - Fee is based on market share from opioid sales in Rhode Island
  - Restricted receipt account where funds are deposited by December 31st every year starting in 2019
  - Uses include opioid treatment, recovery, prevention, education services, and other related programs, subject to appropriation by the general assembly
  - Approval required by RIDOH and BHDDH directors
Legislative Session in Review: SUD Legislation

Passed

- **S 139 / H 5383 - Comprehensive Discharge Planning**

- **S 291 / H 5184 – Pharmacies – Warning Notices**
  - **Sponsor:** Sen. Bridget Valverde / Rep. Justine Caldwell

- **S 409 / H 6086 - Health And Safety Of Pupils**
  - **Sponsor:** Sen. Valerie Lawson / Rep. Jose Serodio

- **S 799 / H 6184 - Life Insurance Policies and Naloxone**
  - **Sponsor:** Sen. Dominick Ruggerio / Rep. Justine Caldwell

- **S 953 / H 5536 - Good Samaritan for HOPE Initiative**
  - **Sponsor:** Sen. Dominick Ruggerio / Rep. Nicholas A. Mattiello
Passed, cont’d

- **S 1032 / H 5253** – Info to student about mixing opioids/alcohol
  - **Sponsor:** Sen. James Seveney / Rep. William W. O’Brien
- **S 962 / H 6164** – Creates a Superior Court diversion program
  - **Sponsor:** Sen. Michael McCaffrey / Rep. Robert Jacquard

Commissions

- **H 5751** – To study the efficacy of involuntary inpatient treatment
  - **Sponsor:** Rep. Stephen Casey
- **S 1038** – To study the impact of insurer payments
  - **Sponsor:** Sen. Josh Miller
Unfinished Business / Next Session

- Reclassification of Possession to Misdemeanors (Attorney General)
- Excluding possession of buprenorphine from criminal penalties
- Harm Reduction Center Advisory Committee and Pilot Program
- Removing Preauthorization for Medication Assisted Treatment (MAT)
- Justice Reinvestment initiatives

Action by Governor

- After all bills are transmitted to the Governor, she will likely hold a ceremonial event to sign the legislation.
PUBLIC COMMENT