Addressing Opioid Abuse - The Wisconsin Strategy

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This reflects a maturing of the addictive process.
CDC: “From 1999 to 2013, the amount of prescription painkillers prescribed and sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report.”

http://www.cdc.gov/drugoverdose/data/index.html
Accessed February 26, 2016
Why Opioids Don’t Work for Chronic Pain: Mu Receptor Physiology

This is the basis for opioid tolerance and hyperalgesia. Initially, opioids help pain; later, they tend to worsen it.

- **Unbound State**
- **Initially Bound State**
- **Eventual State**

![Diagram](Image)
Clinical Studies Confirm Lack of Benefit

Multiple meta-analyses on opioids in chronic pain have been done:

<table>
<thead>
<tr>
<th>Months</th>
<th>Evidence of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Good</td>
</tr>
<tr>
<td>2-6</td>
<td>Weak</td>
</tr>
<tr>
<td>&gt; 6</td>
<td>None</td>
</tr>
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~15%, less than patients consider effective

No decent studies > 6 months

Longer studies < 6 months tend to have less benefit
What Level of Improvement is Meaningful?


20-30% ↓ necessary (20-30/100 points) before patient finds treatment worthwhile
AmeriTox data: 12 months, 400,000 urine drug tests
61% showed aberrant behavior:
* 38% - Prescribed drug not present
* 31% - Non-prescribed controlled substances
* 13% - Illicit drugs
* 17% - Levels more than 2 standard deviations from expected

And these tests were done when patients knew they could be tested!

Direct effect on reward center: positive reinforcement
Euphoria may counteract misery of pain
Linus’ blanket
Reverse placebo effect
Some patients may genuinely benefit
Opioids directly stimulate the dopamine-driven reward centers. With chronic use, changes in these structures can be identified on MRI. This occurs whether they are taken for abuse or for pain. This causes the brain to confuse the primal drive to take more with pain relief.
Numerous large-scale studies show this is not true.

Patients on high doses have:

- More pain, disability, psychological distress
- Worse quality of life
- Lower probability of recovering from chronic pain

(NOTE: These studies have selection bias, but they all show that opioids are not effective at what they are being prescribed to do)

More than linear ↑ in annualized mortality:

at 100 MMEs, risk ratio 8.8 x normal
at 200 MMEs, risk ratio 24 X normal

(NOTE: Vioxx risk ratio was 1.9 x normal, and it was taken off the market!)
Goals

1. Stop creating addiction
   1. Much more evidence-driven prescribing
   2. Pain is not a narcotic deficiency disease
   3. Encourage effective non-narcotic treatments

2. Treat those already addicted
   1. Train practitioners to identify and address addiction
   2. Dramatically expand addiction treatment services
* Federal Regulatory Efforts

* PROP Act - US Senator Johnson (R WI)
* CARA Act - US Rep. Sensenbrenner (R WI)
* CARA Act (Title IX) - US Senator Baldwin (D WI)
The Wisconsin Strategy for Prescription Opioid Reform

* Collaboration and involvement of the medical community from the beginning outward
* Ownership of the solutions from within the health systems and providers themselves
* Coalition of stakeholders and health systems to share best practice and workflow ideas
Wisconsin State Coalition for Prescription Drug Abuse Reduction

Coalition Structure and Collaborative Impact Model

MEB and other Exam Boards

Rep Nygren Legislature

Attorney General Schimel

Associations

Public Insurers  Hospital Assoc  Medical Society  Nursing Assoc  Pharmacy Society

Private Insurers  Tribal Assoc  Medical Groups + Health Systems  Dental Assoc  Other Assoc......

These Groups Bring:
1) Constituencies
2) Competencies
3) Resources

To Engage, Impact and Guide

Insurers  Prescribers  Patients  Law Enforcement
Employers  Communities  Education  Etc......
The WI Strategy #1: Improve and Increase Use of the PDMP

Dramatically simplify access: 1 button click to data
Shorten time to reporting: best quality real-time data
Improved interface, user friendly
Alerts for concerning behaviors
Physician profiles available
Medical director function
Provide licensing board access to concerning prescriber data
Patterned after CDC Guidelines

Primary goals:
* Focus on treatment of the underlying problem
* Maximize non-narcotic treatments
* Avoid chronic opioids if possible, and minimize dose
* Avoid dangerous opioids like oxycodone, methadone
* Look closely for signs of developing addiction
* If addiction develops, *do not* just fire the patient: either treat them yourself or refer to a center
The WI Strategy #3: Mandatory CME

* CME to be determined by each licensing board
* 2 hours of Continuing Medical Education specifically developed under the supervision of the Medical Examining Board
* Specifically explains Guidelines
  * Reasons why each was implemented
  * How to apply each in medical practice
* All physicians must complete in 2017 in order to renew their licenses
The WI Strategy #2: Treatment of Addiction

- Develop coalition of all major healthcare organizations
  - Collaborative efforts at developing Best Practices
  - Incentivizing practitioners to participate
  - Develop Behavioral Health resources
- Work with academics at researching optimal recruitment practices
- Work with legislators on funding pilot projects
- Work with insurers to improve payment
- Work with law enforcement to expand drug courts