The Evolution of the Opioid Crisis: Where We Came From and Where We Are Going

Magellan Health Conference September 6 and 7, 2018

Jennifer Chambers, MD, MBA, FACP
Senior Vice President & Chief Medical Officer
Capital BlueCross
Declaration of Public Health Emergency

In October of 2017, President Trump declared that the opioid epidemic is a public health emergency.

“We are currently dealing with the worst drug crisis in American history. It’s just been so long in the making. Addressing it will require all of our efforts.”

~ President Donald Trump
The earliest references to opium come from Mesopotamia around 3400 BC.

In the late 1700s, it was common to use morphine and opium to treat a range of health issues; Overdosing was common due to the lack of guidance around side effects.

In 1898, Bayer Pharmaceutical Company began marketing morphine as a “Wonder Drug.”

Heroin was introduced to the public as being a safer and non-addictive way to treat the common cough as well as bronchitis and tuberculosis.
1914 Harrison Narcotics Act

- The Harrison Narcotics Act taxed the making, importing, and selling of any derivative of opium or coca leaves.
- Addiction was not considered a disease.
- Beginnings of an underground market.
- In 1918, the Secretary of the United States Public Services cautioned that the underground traffic in narcotic drugs was almost equal to the legitimate medical traffic and that law enforcement resources needed to be increased.
Government Push Back of 1924

- Heroin was classified as an illegal substance in 1924.
- Heroin started to outsell morphine on the black market.
“Addiction Rare in Patient Treated With Narcotics

To the Editor: Recently, we examined out current files to determine the incidence of narcotic addiction in 39,943 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.”

~ Jane Porter
Hershel Jick, MD
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

Resource: www.nejm.org
• Around 1986, Dr. Russell Portenoy observed 38 patients treated with opioids for noncancer pain.

• Although two of his patients developed an opioid addiction, Dr. Russell Portenoy concluded that “opioid maintenance therapy can be a safe, salutary and more humane alternative to surgery or to not treating a patient with chronic pain.”

• Dr. Portenoy’s findings were cited over 400 times to support the notion that opioids being used for pain management were not addictive.
In 1996, the American Pain Society (APS) recommended that healthcare providers evaluate patient’s pain as a 5th vital sign.

The phrase “pain as the 5th vital sign” was promoted to elevate the awareness among the healthcare community that pain treatment should be regularly checked.

“Vital Signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. Quality care means that pain is measured and treated.”

~ James Campbell, MD

Presidential Address, American Pain Society
November 11, 1996
• Veterans Health Administration introduced the pain intensity rating to all the healthcare facilities.
• The VHA recommended the use of the Numeric Rating Scale (NRS) for the rating of patient’s level of pain.
• Pain scores greater than four triggered a comprehensive pain assessment.
• After the assessment was completed, interventions were considered.
Late 1990s to Early 2000s

• In the late 90s and early 2000s, Purdue advertised OxyContin® as a safe, nonaddictive chronic pain medication due to the extended release of the medication.

• Per the Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse and the FDA website:

  “At the time of approval, FDA believed the controlled-release formulation of OxyContin® would result in less abuse potential, since the drug would be absorbed slowly and there would not be an immediate “rush” or high that would promote abuse. In part, FDA based its judgment on the prior marketing history of a similar product, MS Contin, a controlled-release formulation of morphine approved by FDA and used in the medical community since 1987 without significant reports of abuse and misuse.”

• As the price of the medication continued to increase, patients turned to heroin as a cheaper alternative with a similar effect.

NIH article:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940677
Three Waves of the Rise in Opioid Overdose Deaths

Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 2016, 64(50); 1378-82.
By 2002, there were 2.7 million new nonmedical users of opioid medications.

From 1999 to 2011:

- Hydrocodone use increased two fold.
- Oxycodone use increased five fold.
- Mortality due to opioids increased by four fold.
- ER visits, neonatal abstinence syndrome and opioid use disorder treatments all had statistically significant increases.
- Nonmedical used opioid pain relievers have cost health insurance companies around $72.5 billion dollars annually.
According to the CDC, “In 2014, nearly two million Americans either abused or were dependent on prescription opioid pain relievers.”

In order to help with the misuse of opioid medications, the CDC created the Guidelines for Prescribing Opioids for Chronic Pain.

The guidelines cover three main areas:

1. Determining when to initiate or continue opioids for chronic pain.
2. Opioid selection, dosage, duration, follow-up, and discontinuation.
3. Assessing risk and addressing harms of opioid use.
Determining when to initiate or continue opioids for chronic pain:

- Consider other methods of nonopioid treatment first.
  - Only use opioids if the benefits will outweigh potential risk.
- Consider combining opioid therapy with nonopioid treatment to lessen the amount of opioid usage.
- Be sure to set treatment goals with the patient when using opioid therapy including functional and discontinuation goals.
- Continually manage treatment and have regular interactions or follow-ups with the patient.
2016 – Congressional Action

July 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA).

This approach provided policies about prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal.

CARA and federal funding supported:

- Medicare and Medicaid services to improve the access to prevent and treat the opioid epidemic.
- Federal Substance Abuse and Mental Health Services Administration education to states and communities.
- US Food and Drug Administration developing alternative treatments to opioids.
• More than 115 people lost their lives due to an opioid overdose every day in the United States.

• 21-29 percent of patients prescribed opioids for chronic pain misuse the prescription.

• 80+ percent of injection drug users had abused prescription medications prior to using heroin.

• Substance abuse overdoses in 45 states increased 30 percent between July 2016 and September 2017.
• The Blue Cross Blue Shield Association (BCBSA), with the help from Blue Health Intelligence (BHI), studied the opioid prescription rates among the Commercially Insured Blue Population.

• In 2017, BCBSA reported the impact opioid use and opioid use disorders have on the Health of America.

For more information on how BCBSA is addressing America’s opioid epidemic:  [https://www.bcbs.com/the-health-of-america/addressing-americas-opioid-addiction](https://www.bcbs.com/the-health-of-america/addressing-americas-opioid-addiction)
Health of America Report

- 25 percent of BCBS commercially-insured members filled at least one opioid prescription in 2017.
- 493 percent increase from 2010 to 2016 on opioid use disorder diagnoses.
- Women age 45 and older have a higher rate of opioid use disorder than men.
BCBSA Opioid Prescription Rates

Total opioid prescriptions filled per 1,000 BCBS Members (2013-2017)

Percent of BCBS Members who filled at least one opioid prescription (2013-2017)

Opioid Prescription Fill Rate Decline By State (2013 to 2017)

Percent of BCBS members who filled their first opioid prescription by Dose and Duration in 2017

<table>
<thead>
<tr>
<th>Dose / Duration</th>
<th>MME &gt; 50</th>
<th>MME &lt; 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dose / Short duration</td>
<td>18%</td>
<td>67%</td>
</tr>
<tr>
<td>High dose / Long duration</td>
<td>2%</td>
<td>13%</td>
</tr>
<tr>
<td>1-7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8+ days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

241,900 BCBS members suffered from Opioid Use Disorder in 2017

Rate per 1,000 BCBS Members Diagnosed with Opioid Use Disorder in a Calendar Year (2013-2017)
• Estimated more than 4,600 individuals lost their lives from opioid misuse in Pennsylvania in 2016.

• More individuals in Pennsylvania lose their lives to substance abuse overdoses than fatal car accidents.

• Pennsylvania was rated 4th in the country in 2016 for the highest substance abuse overdoses 37.9 per 100,000 people.
Naloxone is a medication that can reverse an overdose that is caused by an opioid drug (i.e. prescription pain medication or heroin).

When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

Naloxone has been used safely by medical professionals for more than 40 years and has only one function: to reverse the effects of opioids on the brain and respiratory system in order to prevent death.

PA Opioid Command Center Update: Number of Naloxone’s doses provided by EMS from January 1- August 17: 7,981.

Source: PA.gov, CDC.
Medication Assisted Treatments (MAT)

- Refers to the use of medication as part of the treatment plan for those with substance use disorders.

- Intended to be used in combination with counseling and behavioral therapies.

- For those in treatment for opiate use, MATs work by producing the effect of an opioid in some capacity or blocking the effect of the opioid completely.

Methadone, buprenorphine, and naltrexone are the three commonly approved MAT medications, others include buprenorphine/naloxone or Suboxone.

Methadone is available in ingestible forms provided through opioid treatment programs.

Buprenorphine is available in ingestible and injectable forms through any prescriber with the proper certification.

Naltrexone is available in an injectable formulation through any health care provider with prescribing authority.
An “underused” form of treatment

- Barriers to MAT limit its scope of use; Common obstacles include policy, negative attitudes, and regulatory barriers.
- As a precaution, the federal government puts a cap on the number of patients doctors are allowed to prescribe MAT.
- Some providers are simply unwilling to provide MAT because it contradicts their idea of proper addiction treatment.
- The number of providers trained to provide MAT is inadequate to meet population needs.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114165/
https://www.samhsa.gov/medication-assisted-treatment/treatment
What are Blue Cross Blue Shield Companies Doing to Fight the Opioid Crisis?

- At the local and national level, we are collaborating with medical professionals, employers and communities to address the gaps in continuum of care.
- Blue Distinction Centers for Substance Use Treatment and Recovery will be established to ensure BCBS members have access to the best clinical thinking and evidenced-based approaches.
- A national hotline will be established by 2020 to direct all members and non-members to Blue Distinction Centers for Substance Use Treatment and Recovery.
What are Blue Cross Blue Shield Companies Doing to Fight the Opioid Crisis?

• BCBSA recently adopted a professional standard that opioids should not be prescribed as first or second lines of pain therapy in most clinical situations.

• Through collaborative research partnerships, BCBS companies are working to advance research to reduce addiction relapse rates and analyze current opioid prescribing patterns and policies.

• Capital BlueCross and all BCBSA companies cover non-opioid pain treatment options, as well as medication-assisted treatments.
“While we have made progress in combatting the heroin and opioid abuse crisis and drastically expanded Pennsylvania’s response, we are still losing far too many Pennsylvanians. I am taking this step to protect Pennsylvanians from this looming public health crisis, and I am using every tool at my disposal to get those suffering from substance use disorders into treatment, save more lives, and improve response coordination.”

~ Pennsylvania Governor Tom Wolf

Press Release, Public Health, Substance Use Disorder

January 10, 2018
Capital BLUE

Thank You

Dr. Jennifer Chambers

Jennifer.Chambers@CapBlueCross.COM