January 29, 2016

Opioid Abuse and How It Will Impact Physicians

One of the largest issues that the healthcare industry is facing, which no one wants to really deal with,is the addiction to opioids in the United States. In 2014, an estimated 2 million people in the United States were addicted to opioids. In 2013, the United States became the biggest global consumer of Hydrocodone, accounting for more than 100 percent of the world's use, and Oxycodone use in the U.S. accounted for 81 percent of the use in the world. As a result, this has more than tripled visits to the emergency room with individuals looking for opioids or withdrawing from opioids or heroin, increased the use of heroin across the United States, and increased the overdose deaths in the United States four times more than 20 years ago.

While most individuals believe that is entirely created by pain clinics and it is just pain clinics prescribing opioids, they are wrong. Stanford University recently released information showing that the largest group of opioid prescribers is general practitioners. Another myth about opioid abuse is that it is only impacting lower class citizens or patients on Medicaid. While there is a very large population of individuals on the Medicaid program that are struggling with this addiction,

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it has now reached everyone. There are many middle class and upper class citizens who are just as addicted to opioids as lower class citizens; no one is immune to this epidemic.

One of the largest impacts of opioid abuse that tends to get brushed under the rug is the impact it is having on our unborn children. Children who are born addicted are born with a disease called Neonatal Abstinence Syndrome (NAS). In 2012 an estimated 21,732 babies were born addicted, which is a five-fold increase since 2000, and those numbers will rise for 2013, 2014, and 2015. Within two to three days of birth, these children begin having withdrawal symptoms just like an adult would. These children are sent to NICU for six weeks where they are given drugs like Morphine to help taper them down and to control the withdraws, but it doesn't end here for these children. Although little research has been done on the impact this disease has on these children, they do know that it does cause the front lobes of the brain to atrophy. This impacts the child's behavior and motors skills, and it can seriously delay a child in the ability to learn.

Why is this important to your practice? Recently, President Obama signed into law the Protecting Our Infants Act of 2015 (H.R. 2462). The highlights of the law are below.

(Sec. 3) This bill requires the Agency for Healthcare Research and Quality to report on prenatal opioid abuse and neonatal abstinence syndrome (symptoms of withdrawal in a newborn). (An opioid is a drug with effects similar to opium, such as heroin or certain pain medications.) The report must include:

- *an assessment of existing research on neonatal abstinence syndrome;*
- *an evaluation of the causes, and barriers to treatment, of opioid use disorders among women of reproductive age;*

- *an evaluation of treatment for pregnant women with opioid use disorders and infants with neonatal abstinence syndrome; and*
- *recommendations on preventing, identifying, and treating opioid dependency in women and neonatal abstinence syndrome.*

(Sec. 4) The Department of Health and Human Services must review its activities related to prenatal opioid use and neonatal abstinence syndrome and develop a strategy to address gaps in research and programs.

(Sec. 5) The Centers for Disease Control and Prevention must provide technical assistance to states to improve neonatal abstinence syndrome surveillance and make surveillance data publicly available

This bill is essential because it is the start of really digging into how many opioid prescribers there are and it will begin shifting the "blame" for NAS from the patient to the prescriber - not necessarily because of what was discussed at the beginning of this article but because of the cost. On average, it costs $66,700 to take care of these children just while they are in the NICU for an average of 16.9 days. A normal newborn spends 2.1 days on average in the hospital. Also, keep in mind that most of these kids end up in state custody and stay on the Medicaid program either through a certain age or for life because they become disabled due to the long-term impacts NAS can have.

So, how do practitioners treat a patient's pain while being conscious of what President Obama calls an epidemic of opioid use and protect themselves? Here are several steps practices can take to prevent NAS and overdose deaths and keep them out of trouble. Keep in mind this should qualify for anyone who is on more than a PRN dose (1x as need

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per day) for more than 30 days.

1. Do not give the patient more than a one-month supply of medications. Do not let them come in for two months after the initial visit just to pick up a script. If they need a narcotic refill, they need to be seen. This is a great policy to adopt and will also assist in increasing revenue.
2. Drug test on every single visit. Physicians can purchase point-of-care cups and if they come back positive, they can send them to a lab for a confirmation - and yes, physicians can bill for doing a POC cup.
3. Pregnancy test women of childbearing age unless they can provide medical proof of a hysterectomy. The patient should sign a pregnancy waiver form or this should be a part of a pain contract if the clinic is a pain clinic.
4. OBGYN pregnancy tests every pregnant woman you have monthly. (Studies have shown if the mom gets off the drug or on to Methadone or Suboxone before the third trimester, the child's withdrawal symptoms will not be as bad). Yes, you may lose a couple of patients, but if all OB physicians work together, then many lives can be turned around and saved.
5. Check your state laws. Some states now make it mandatory to report a child born with NAS or a mom that is pregnant and on opioids. Some state laws are now very strong on imposing civil penalties and even criminal charges for not reporting.
6. Even if your state does not have a law making it a requirement to report the patient to DCS/CPS, they will follow the mom and make sure she gets the care she needs and also see that the child gets the care he/she needs after being born. Keep in mind, once a mom or a child is in the DCS/CPS system, it is very hard for them to get out of it.
7. If your state has a database showing that a patient filled a scheduled drug prescription, use it to make sure the

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patient is not doctor shopping. This system is not just for pain clinics or pain doctors; it is for everyone. Every time the patient comes in, this report should be pulled and reviewed.

8. If the patient fails a drug screen or has a bad state report, offer to refer the patient to a treatment center, give them a 30-day supply of the medication (unless they just received medications in the same drug class from another physician), and discharge them as a patient.
9. Document everything. This is extremely important. Even if you discharge the patient, document that the patient was discharged due to a failed toxicology or a failed state report and that a 30-day supply of medication was given and the patient was either offered or was referred to a treatment center.

As we move forward and more attention is being drawn to this topic, physicians will come under more scrutiny for prescribing opioids. The CDC is currently creating prescribing guidelines for scheduled drugs. As a physician, keep in mind that the CDC states there are no long-term benefits from using opioids and that patients should receive three or fewer days of opioid treatment for most non-traumatic pain not related to major surgery. This will be an important statement as we continue to battle such a huge problem in the United States.

This Week's Tip Provided By:

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