

**Opioid Crisis: South Carolina Responds**  
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 Medical University of South Carolina



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**Obama administration announces grants to fight opioid epidemic, urging more funds for treatment**  
By Stephanie Scalet  
Updated 10/26/17 at 10:00 AM

**Trump declares opioid epidemic a national public health emergency**  
By Stephanie Scalet  
Updated 10/27/17 at 10:00 AM

**FACT SHEET: Obama Administration Announces Prescription Opioid and Heroin Epidemic Awareness Week**  
Released 10/26/17 at 10:00 AM

**President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis**  
October 26, 2017  
For Immediate Release

**Opioid Crisis: A Mounting National & State Problem**

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**What are Opioids?**

- Drug class of narcotics that be naturally, synthetically or semi-synthetically made that interact with the brain's opioid receptors.
- Can relieve acute and chronic pain
  - Can cause euphoria, nausea/vomiting, constipation, impaired decision making, respiratory depression, addiction
- Examples: hydrocodone (Norco, Lortab, Vicodin), oxycodone (OxyContin, Percocet), morphine (MScontin, Kadian, Avinza), hydromorphone (Dilaudid), meperidine (Demerol), propoxyphene (Darvon, Darvocet), codeine (Tylenol 3), fentanyl, heroin, methadone
- Come in various forms: capsule/pill/tablet form, patches, liquid, syrup, powder, lollipops, suppositories
  - Can be swallowed, absorbed through the skin, dissolved and absorbed through the oral mucosa, sniffed/snorted, injected
  - Extended release and immediate/short acting formulations
- NOT opioids: cocaine, amphetamines, benzodiazepines

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Overview:  
 > How did we get here?

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## History of Opioid Epidemic

- Studies done in the 1980s strongly denounced the link between opioids and addiction potential.
- Americans consume tenfold the amount of opioids other countries do.
- In under 20 years, the rate of opioid-related deaths has more than quadrupled.
- Joint Commission: pain as a fifth vital sign, linking patient pain satisfaction with reimbursement, little provider education about management of pain, addiction or opioids
- 4 out of 5 new heroin users start with prescription opioids.
  - It is estimated those addicted to prescription opioid painkillers (when compare to alcohol, marijuana or cocaine) are **40x more likely to become addicted to heroin.**

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**Addiction Rate in Patients Treated with Narcotics**

Research, we conducted a cohort study to determine the incidence of opioid addiction in 20,000 non-addicted patients who were treated with opioids. Although there were 17,000 patients who received at least one narcotic prescription, from 2000 to 2010, the rate of addiction and subsequent hospitalizations increased significantly. The patients who remained opioid-free in only one hospital. The 10,000 patients who were hospitalized for opioid addiction in one or more hospitalizations were hospitalized for an average length of 10 days. The development of addiction is seen in medical patients with no history of addiction.

John F. Taylor  
 Director, Opioid Abuse  
 Director, Opioid Abuse Program, Boston University Medical Center, Boston, MA  
 2016

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The problem:

➤ Where has this gotten us?

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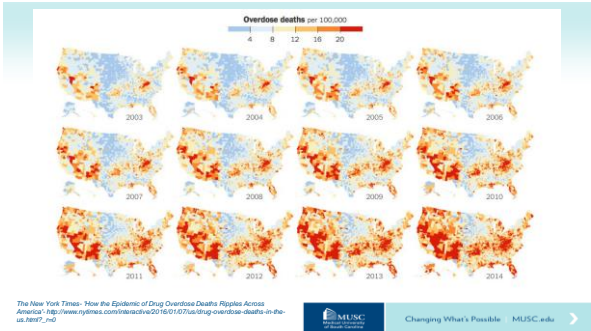
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### "Epidemic" of Opioid Deaths

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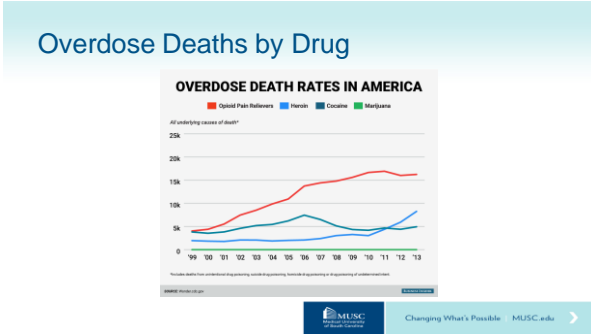
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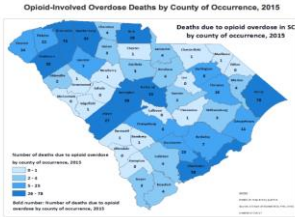
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## 2015 Opioid Involved Overdose Deaths by County of Occurrence



SC DHEC, 2015



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Prevention, Screening & Diagnosis

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Opioid Use Disorder

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## Prevention

- Societal shift from "0/0" pain to learning to live or cope with a degree of pain
- Promote, pay for and utilize evidence based pain management alternatives: physical & occupational therapy, psychological counseling, stress reduction
- Continue research of alternative pain management options: acupuncture, chiropractic adjustment, marijuana, hypnosis, massage, yoga, biofeedback
- Controversial, although worth multidisciplinary conversation and research: prescriber regulation of dose, quantity, frequency
- Patient centered approach: history, screening tools



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### For Those Already on Opioids...

- Universally screen for addiction
- Explore and fund alternative options such as pain rehabilitation, injections
- Decrease stigma surrounding addiction
- Increase access to and funding for "evidence based" life saving addiction treatment
- Prescription drug monitoring program
- Harm reduction: naloxone reversal kits, needle exchange programs, opioid recycling programs, drug checking
- "Firing" the patient is not the answer




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### Addiction and Dependence: There is a difference

#### Addiction in Opioid Use Disorder

- Withdrawal
- Loss of control
- ↓ in function
- Use despite negatives
- Compulsive use
- Craving



#### Dependence

- Tolerance
- Withdrawal
- No loss of control
- Functioning well




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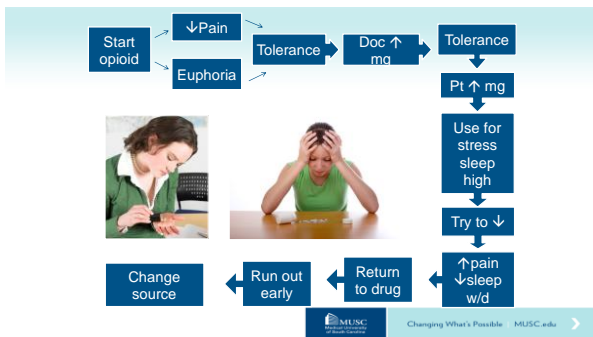
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### Stigma of Addiction



- Contributes to social isolation
- Reduces help-seeking
- Undermines long term recovery
- "The historical stigma attached to methadone and... MAT has denied patients the status of recovery and left them isolated from mainstream community life, existing in limbo between cultures of addiction and cultures of recovery." *William White, 2012*




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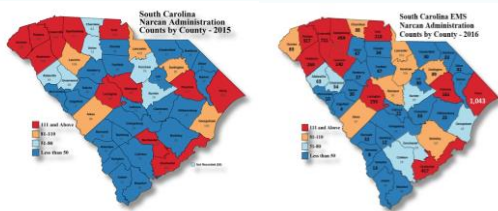
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### South Carolina Narcan Administration by County: 2015 & 2016



SC DHEC, 2017




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### Chart of Evidence-Based Screening Tools for Adults and Adolescents



Screening Tool	Substance Type	Patient age		How tool is administered	
		Alcohol (Drug)	Adults	Adolescents	Self-administered
Heroin					
NIDA Drug Use Screening Test: Quick Screen	X	X	X	See AHS Attached 2014 ASSIST tools	See BHS Attached 2014 ASSIST tools
COMET (DWA&A)*	X	X	X	X	X
Alcohol Use Disorders Identification Test - C (AUDIT-C) (PHQ-9, PHQ-4)	X	X	X	X	X
Drug Use Risk Tool (DURT) (ASRS)	X	X	X	X	X
Brief Screener for Alcohol, Tobacco, and Other Drugs (BESTO)	X	X	X	X	X
Screening to Brief Intervention (S2BI)	X	X	X	X	X

<https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-heroin-coastal-evidence-based-screening-tools-adults>




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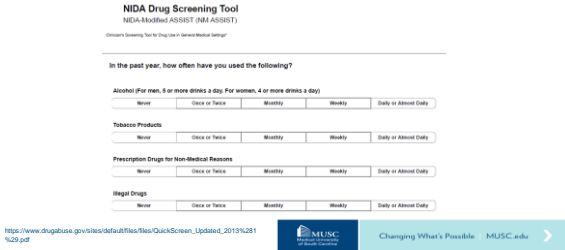
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# NIDA Drug Use Screening Tool: Quick Screen




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# DSM-5 Criteria for Opioid Use Disorder (OUD)

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least **two** of the following, occurring within a 12-month period:

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - A markedly diminished effect with continued use of the same amount of an opioid. (Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.)
- Withdrawal, as manifested by either of the following:
  - The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
  - Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms. (Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.)




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# Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

- A best practice, cost-effective intervention that saves lives and money.
- Should include co-occurring psychosocial treatment.
- Methadone and buprenorphine (Subutex, Sublocade, Probuphine) or buprenorphine/naloxone (Bunavail, Suboxone, Zubsolv) are FDA approved to treat OUD
- Opioid agonists or partial opioid agonists
- Opioid treatment program (OTP) vs primary care availability
- Extended release injectable (Vivitrol) or oral naltrexone are FDA approved for the prevention of relapse to OUD following detoxification
- Opioid antagonist
- Requires complete withdrawal with 7-10 days of abstinence




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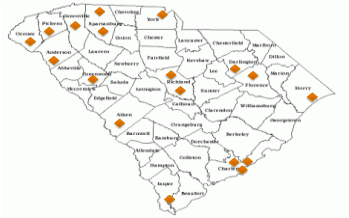
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### South Carolina Methadone Treatment Centers, 2017



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### South Carolina Buprenorphine Waivered Providers by County, 2017



SAMHSA, 2017

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### Solutions: Proceed with Caution...

- Promoting or incentivizing potential solutions without a strong evidence base
  - Recall how we got here...
- Regulation of prescribers
- Cutting off supply without adequate solution
- Excluding critical roles in solution mapping
  - Team should include multispecialty prescribers, patients, insurers/payers, regulatory bodies, health economists, public health experts, medical ethicists
- Realistic expectations
  - We did not get here overnight
  - One size does to fit all

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### What's Next?

- Work to decrease personal and peer stigma and bias surrounding addiction
- Commit to routine screening of all patients for opioid abuse and misuse
- Obtain DATA 2000 DEA X waiver to prescribe buprenorphine
  - Free waiver trainings offered online through AANP/SAMHSA & locally face-to-face in SC
- MUSC Opioid Use Disorder Project ECHO: 1<sup>st</sup> & 3<sup>rd</sup> Friday

[www.scmataccess.com](http://www.scmataccess.com)




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### Sources and Additional Information

- American Society of Addiction Medicine (ASAM)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Center for Disease Control (CDC)
- National Institute of Health (NIH) & National Institute for Drug Abuse (NIDA)
- American Association of Addiction Psychiatry
- Additional sources available upon request




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