Alternatives to Opioids Initiative

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Alternatives to Opioids Initiative

• Discuss the historical context and current state of the “opioid crisis” facing the US
• Describe the appropriate use of alternatives to opioids in the ED
• Discuss opioid reduction process implemented at SMC modeled after Colorado Opioid Safety Pilot
As physicians, we are on the front lines of an opioid epidemic that is crippling communities across the country. We must accept and embrace our professional responsibility to treat our patients’ pain without worsening the current crisis. These are actions we must take as physicians individually and collectively to do our part to end this epidemic.

Stephen Stack, MD, AMA, President & Emergency Physician (2016)
THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016...

116
People died every day from opioid-related drug overdoses

11.5 m
People misused prescription opioids¹

42,249
People died from overdosing on opioids⁵

2.1 million
People had an opioid use disorder⁴

948,000
People used heroin¹

170,000
People used heroin for the first time¹

2.1 million
People misused prescription opioids for the first time¹

17,087
Deaths attributed to overdosing on commonly prescribed opioids²

19,413
Deaths attributed to overdosing on synthetic opioids other than methadone⁸

15,469
Deaths attributed to overdosing on heroin²

504 billion
In economic costs³

Sources: ¹ 2016 National Survey on Drug Use and Health, ² Mortality in the United States, 2016 NCHS Data Brief No. 293, December 2017, ³ CEA Report: The underestimated cost of the opioid crisis, 2017
Dramatic Increases in Overdose Deaths in Every State

Estimated Age-Adjusted Death Rates for Drug Poisoning by County, United States in Every State

1999 vs 2016
Opioid overdoses went up 30% from July 2016 through September 2017 in 52 areas in 45 states.

The Midwestern region saw opioid overdoses increase 70% from July 2016 through September 2017.

Opioid overdoses in large cities increased by 54% in 16 states.

Opioid overdose ED visits continued to rise from 2016 to 2017.

Detecting recent trends in opioid overdose ED visits provides opportunities for action in this fast-moving epidemic.

SOURCE: CDC’s Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent change from July 2016 through September 2017.
2018: How Did We Get Here?

1. Pain Being Designated The Fifth Vital Sign
2. Under Appreciation of Addictive Potential of Prescription Opioids
3. Aggressive Marketing of Prescription Opioids to Clinicians
4. Clinicians Who Ran Pill Mills that Profited from Over Prescribing
5. Sophisticated Actions of Drug Traffickers to Open New Heroin Markets
6. Potency and Ease of Making, Trafficking, and Profiting from Illicit Fentanyl and Fentanyl Analogs
ED’s, ED Providers and Others have Stepped Up in Many Ways:

- I-Stop Program
- Limiting Prescription Duration
- Initiating Suboxone Treatment
- Widespread Narcan Availability
- Bridge Clinics
- Community Treatment Links to ED
- ALTO Use in ED
Proof of Concept

- 10 participating EDs
  - voluntary
  - region
  - urban/rural status
- Based on Colorado ACEP guidelines
- Launched and administered by the Colorado Hospital Association (CHA)
- Aim: Reduce administration of opioids by 15% measured in morphine equivalent units (MEUs) over the 2017 6-month pilot period, as compared with the same 6-month baseline period in 2016.
Figure 6: Analgesic Treatment (ALTO vs. Opioid Percent of Total Unique Visits) by Medical Condition

- **Kidney Stones**
  - 2016: 31% Alto, 69% Opioid
  - 2017: 53% Alto, 47% Opioid

- **Back Pain/Lumbago**
  - 2016: 35% Alto, 65% Opioid
  - 2017: 61% Alto, 39% Opioid

- **Headaches/Migraine**
  - 2016: 58% Alto, 42% Opioid
  - 2017: 80% Alto, 20% Opioid

- **Arm/Leg Fractures & Dislocations**
  - 2016: 17% Alto, 83% Opioid
  - 2017: 23% Alto, 77% Opioid

- **Unspecified Abdominal Pain**
  - 2016: 23% Alto, 77% Opioid
  - 2017: 50% Alto, 50% Opioid

- **Malignant Neoplasms**
  - 2016: 7% Alto, 93% Opioid
  - 2017: 16% Alto, 84% Opioid
Goal 1: Master the CO-ACEP Guidelines

4 Pillars of Care

- How can we address the opioid epidemic in the ED?
  - Limiting Opioids from the ED
  - Alternatives to Opioids for Painful Conditions (ALTO)
  - Harm Reduction
  - Treatment of Addicted Patients and Referral

Colorado Hospital Association
ALTO Principles

1. Non-opioid medications first
2. Opioids as rescue therapy and not used liberally
3. Multimodal and holistic pain management
4. Specific pathways exist
   - Kidney stones
   - Low back pain
   - Fractures
   - Headache
   - Chronic abdominal pain
5. Requires more patient engagement:
   - Discuss realistic pain management goals with patients
   - Discuss addiction potential and side effects with using opioids

www.coacep.org
ALTO and CERTA – Putting Science Back In Pain Control

http://www.propofology.com/infographs/certa-concept-of-analgesia
ALTERNATIVE TREATMENTS TO OPIOIDS FOR PAINFUL CONDITIONS (ALTO)

How many of us prescribe alternatives for pain?

- Ketamine
- Toral/ol
- Haldol
- Gabapentin
- Trigger-point injections
- Lidocaine drips/Lidoderm patches
- DDAVP
- Nitrous oxide
- Nerve blocks
Lidocaine

- Acts on central and peripheral voltage dependent sodium channels, G protein-coupled receptors and NMDA receptors

- Used **topically**, **intravenously** or as **trigger point injections**
  - When used at low doses, IV lidocaine is generally benign
  - **Caution** should be used when giving IV to patients with a severe cardiac history

- MSK, migraines, renal colic, abdominal, neuropathic

- Lidocaine patches are great for pain!

- Lidocaine IV doses ≤ 1.5 mg/kg over 10-60 min may be given in non-ICU areas (max 200 mg/dose)
Ketamine

- NMDA receptor antagonist
- When used at low doses, it is generally benign
- Used *intranasally* or *intravenously*
- Should not be used in patients with PTSD
Ketamine

- Ketamine effect is dose-dependent
- May be used for analgesia at doses ≤ 0.2 mg/kg via slow IV or 0.1 mg/kg/hr infusion
  - May be given in non-ICU areas
  - Slow administration rate (≥ 10 min) = less adverse effects
- Ketamine 50 mg IN can also be given
  - No IV access
- Can be used adjunctively with opioids to reduce opioid requirements
Other Options

- **Ketorolac**
  - 15 mg for everyone (IV or IM)
    - No difference in pain reduction with 30 vs. 15 mg
  - Great for many pain indications including musculoskeletal pain and renal colic

- **Haloperidol**
  - Low dose (2.5-5 mg IV)
  - Great for nausea
    - Cannabinoid induced hyperemesis
Other Options

- Dicyclomine
  - Antispasmodic and anticholinergic agent that acts to alleviate smooth muscle spasms in the GI tract
  - 20 mg PO/IM (NOT IV!)
  - Great for abdominal pain
  - Caution in elderly
Trigger Point Injections

Indications:
- Myofascial Pain Syndrome
- Headaches - tension and migraines
- Musculoskeletal back pain
- Torticollis
- Trapezius strain

Concerns:
- Infection
- Hematoma
- Arterial injection (Bupivacaine)
- PTX on chest
OVERVIEW: IHA Opioid Alternative Project

**WHAT**
Pilot program with the primary goal of reducing opioid usage in Upstate NY EDs through physician and hospital collaboration to administer alternative opioid pain treatments

**WHO**
15-20 Acute Care EDs
Mix of designated Urban and Rural hospitals

**WHERE**
Upstate New York – IHA Region
In 1 or more geographic sub-regions

**WHEN**
April 1, 2018 – March 31, 2019 (NYS fiscal year)
Includes data collection
1. Non-opioid medications first
2. Opioids as rescue therapy and not used liberally
3. Multimodal and holistic pain management
4. Specific pathways exist
   1. Kidney stones
   2. Low back pain
   3. Fractures
   4. Headache
   5. Chronic abdominal pain
5. Requires more patient engagement:
   1. Discuss realistic pain management goals with patients
   2. Discuss addiction potential and side effects with using opioids
Musculoskeletal

Ibuprofen PO 600 mg OR
Ketorolac 15 mg IV/30 mg IM
Lidoderm Patch

Spasm

Cyclobenzaprine 5 mg PO OR
Diazepam 5 mg PO

Ketamine
Gabapentin
Trigger Point Injections
Ketorolac
Dexamethasone
Headache

- Prochlorperazine 10 mg PO / IV OR Metoclopramide 10 mg IV
- Ketorolac 15 mg IV OR 30 mg IM
- Sphenopalatine block, occipital block, or Trigger Point Injection
- Acetaminophen 1000 mg PO + Ibuprofen 600 mg PO
- 1 L 0.9% NS + high-flow oxygen
- Sumatriptan 6 mg SC

Diphenhydramine and 2nd dose of Metoclopramide at provider's discretion

- Lidocaine IV
- Caffeine
- Ketamine
- Promethazine
- Dexamethasone
- Haloperidol
- Magnesium
- Valproic acid
- Propofol
Abdominal Pain

- Haloperidol 5mg IV
- Acetaminophen 1000mg PO OR
- Ketorolac 15 mg IV OR 30mg IM
- Metoclopramide 10 mg IV
- Prochlorperazine 10 mg IV
- Diphenhydramine 25 mg IV
- Dicyclomine 20 mg PO/IM

(Cannabinoid Hyperemesis)
Capsaicin Cream

- Haloperidol
- Ketamine
- Lidocaine

Repeat First Approach drugs and diphenhydramine as secondary medication at provider’s discretion
Renal Colic

Acetaminophen 1000 mg PO or IV
Ketorolac 15 mg IV OR 30 mg IM

1 L NS Bolus and Antiemetic as needed

Lidocaine IV AND/OR Ketamine
Dental Pain → Acetaminophen 1000 mg PO
Ketorolac 30 mg IM
Dental Block
Questions