The Opioid Epidemic:  
What's the Medical Staff's Role?
The Opioid Epidemic: 
What's the Medical Staff's Role?

Presented by
James B. Hogan, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
I. History

- 1800s: 2 opium wars in China
- 1839-1842: British exporting Opium to China
  China destroyed 1,400 tons
- 1856-1860: Britain + France vs. China
- 1886-1929: Coca Cola
- 3000 B.C.: Opium poppy – "The Joy Plant"
I. History

• 1980s: Heroin, Dilaudid, Cocaine
• 1990s: Cocaine, Crack, Methamphetamine, Vicodin
• 2000s: Methamphetamine, Oxycontin
• 1990-2011: Opioid prescriptions tripled
  1996 Oxycontin $48M U.S.
  2012 Oxycontin $2.4B U.S.
• Today: Oxymorphone (Opana)
I. History

• Opioids Weaker than Morphine
  – 7-4x Codeine
  – 7-10x Meperidine (Demerol)
  – 10% Tramadol

• Opioids Equivalent to Morphine
  – Hydrocodone (Vicodin, Narco, Lorcet)
I. History

• Opioids Stronger than Morphine
  150% x Oxycodone (Oxycontin, Percocet, Percodan)
  3 x Methadone
  5-10 x Hydromorphone (Dilaudid)
  2-5 x Heroin
  10 x Oxymorphone (Opana)
  100 x Fentanyl
  10,000 x Carfentany
I. History

• 1995: Purdue pharma approval for Oxycontin
• 2007: Paid $634 million fine lying re Oxycontin
  Addictive property
• 2010: Introduced abuse resistant form
  – New Heroin epidemic
  – Synthetic opioid epidemic
    » Fentanyl, Opana
II. Today

• 2016: 63,000 U.S. drug overdose deaths
  – 174/day

• 141,000,000 Medicare beneficiaries prescribed opioids
  – 460,000 – Average dose over
    120 mg/day x 3 months
  – 58,000 over 240 mg/day x 1 year
  – 15,000 beneficiaries – Doctor shopping
II. Today

- Austin, Indiana – 4,100 population, 2.5 square miles
- December 2014 – Largest HIV outbreak in U.S. History
  - % approached Sub-Saharan Africa
- 1980s: Employer left (Morgan Packing, Co.)
  Unemployment 16.9% (vs. U.S. 5.6%)
- Today: Median income $33,000 (vs. Ind. $48,000)
  25% in poverty
II. Today

• Austin: Everyone knows everyone, all sharing needles
  – One needle a month, 10 times a day
  – $3,500 Opana in less than 5 hours

• 2016: 4,100 residents
  – 35,358 prescriptions
  – 8.6 prescriptions per resident
  – If average is 30 tablets/prescription
    • 1,060,740 tablets
    • 258 tablets/resident
### Indiana Opioid Prescribing Rate by County (2016)

<table>
<thead>
<tr>
<th>County</th>
<th>Rate</th>
<th>Prescr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott</td>
<td>149</td>
<td>35,358</td>
</tr>
<tr>
<td>Vanderburgh</td>
<td>138</td>
<td>250,412</td>
</tr>
<tr>
<td>Lawrence</td>
<td>133</td>
<td>60,448</td>
</tr>
<tr>
<td>Floyd</td>
<td>132</td>
<td>101,550</td>
</tr>
<tr>
<td>Knox</td>
<td>130</td>
<td>48,916</td>
</tr>
<tr>
<td>Howard</td>
<td>123</td>
<td>101,311</td>
</tr>
<tr>
<td>Jasper</td>
<td>123</td>
<td>40,955</td>
</tr>
<tr>
<td>Fountain</td>
<td>117</td>
<td>19,289</td>
</tr>
<tr>
<td>Fayette</td>
<td>116</td>
<td>26,971</td>
</tr>
<tr>
<td>Starke</td>
<td>115</td>
<td>26,437</td>
</tr>
<tr>
<td>Jefferson</td>
<td>114</td>
<td>36,924</td>
</tr>
<tr>
<td>Morgan</td>
<td>111</td>
<td>77,295</td>
</tr>
<tr>
<td>Madison</td>
<td>110</td>
<td>142,355</td>
</tr>
<tr>
<td>Martin</td>
<td>109</td>
<td>11,066</td>
</tr>
<tr>
<td>Ripley</td>
<td>108</td>
<td>31,096</td>
</tr>
<tr>
<td>LaPorte</td>
<td>106</td>
<td>116,506</td>
</tr>
<tr>
<td>Orange</td>
<td>106</td>
<td>20,476</td>
</tr>
<tr>
<td>Perry</td>
<td>105</td>
<td>20,066</td>
</tr>
<tr>
<td>Clark</td>
<td>105</td>
<td>121,600</td>
</tr>
<tr>
<td>Grant</td>
<td>104</td>
<td>69,748</td>
</tr>
<tr>
<td>Vigo</td>
<td>104</td>
<td>112,032</td>
</tr>
<tr>
<td>Dubois</td>
<td>103</td>
<td>43,701</td>
</tr>
<tr>
<td>Wayne</td>
<td>102</td>
<td>67,567</td>
</tr>
<tr>
<td>Delaware</td>
<td>99</td>
<td>114,909</td>
</tr>
<tr>
<td>Montgomery</td>
<td>99</td>
<td>37,541</td>
</tr>
<tr>
<td>Jennings</td>
<td>98</td>
<td>27,258</td>
</tr>
<tr>
<td>Sullivan</td>
<td>98</td>
<td>20,365</td>
</tr>
<tr>
<td>Henry</td>
<td>97</td>
<td>47,259</td>
</tr>
<tr>
<td>Clay</td>
<td>95</td>
<td>24,941</td>
</tr>
<tr>
<td>Pike</td>
<td>95</td>
<td>11,760</td>
</tr>
<tr>
<td>Fulton</td>
<td>94</td>
<td>19,011</td>
</tr>
<tr>
<td>Wabash</td>
<td>94</td>
<td>29,920</td>
</tr>
<tr>
<td>Greene</td>
<td>94</td>
<td>30,278</td>
</tr>
<tr>
<td>Whitley</td>
<td>94</td>
<td>31,342</td>
</tr>
<tr>
<td>Bartholomew</td>
<td>94</td>
<td>76,111</td>
</tr>
<tr>
<td>Gibson</td>
<td>93</td>
<td>31,276</td>
</tr>
</tbody>
</table>
III. Role of Overprescribing

• Two types public health crisis
  – Naturally occurring disease and byproduct of medical care
    • 1918 Spanish Flu
  – Opioid epidemic "self-inflicted wound"
  – Too many patients leaving with too much medication
    • Number of tablets
    • Dosage
III. Role of Overprescribing

• Elective laparoscopic cholecystectomy
  – Post-op: 30-60 opioids, 5-10 mg every 4-6 hours
    • 90 MME day ≈ 2x over threshold for risk abuse

• The top 5% of opioids prescribers write 40% opioid prescriptions
  – Internists, family physicians, dentists
III. Role of Overprescribing

• EMR: Default prescription
  – "30 tabs" vs. 10
    • Non-narcotic alternatives, progressive strategy
  – Physician limited training in pain management
  – Patient satisfaction scores
III. Role of Overprescribing

- Indiana: 83.9/100 people vs 66.5/100 (U.S.)
- Scott County: > 112.5/100 persons

* 10,509 prescriptions written for 1,827 patients by 787 practitioners
  - Primary nurse practitioners?
  - Theft of CSR/DEA numbers?
IV. The Regulatory Response

• Standardizing – MME-Morphine milligram equivalent
  – Equalizes opioids strengths for comparison

\[
\text{MME} = \text{Strength per unit} \times \text{quantity} \times \text{conversion} \\
\text{days supply}
\]

\[
\times \text{daily MME} = \text{total pills} \times \text{dose} \\
\text{days supply}
\]
IV. Regulatory Response

- High dose – Average daily MME dose > 120 mg x 90 days
- Extreme dose – Average daily MME dose > 240 mg x 90 days
IV. Regulatory Response

- Indiana Medical Licensing Board – Opioid Rx Rules
  - > 60 opioid containing pills > 3 consecutive months
  - MME > 15 mg/day > 3 consecutive months
  - Mandatory periodic patient visits for evaluation
  - Review patient INSPECT report
  - Written treatment agreement
IV. Regulatory Response

• Treatment Agreement
  – Goals of treatment
  – Patient consent to periodic testing
  – Description of physicians prescribing policies
  – Consent to random pill counts
  – Retained as part of patient medical record
IV. Regulatory Response

• **Visits**
  – Face-to-face patient visit at least every 4 months
  – If change to regimen needed, visit every 2 months

• **INSPECT**
  – At outset + at least annually, physician to run INSPECT report on patients
IV. Regulatory Response

• PDMPs: 49 states
  – Statewide electronic database
  – Summarizes controlled substances
• Prescribed to patients, who prescribed them and pharmacy where they were obtained
V. Medical Staff/Hospital Role

- Two potential legal relationships
  - Employment – Contract
  - Medical Staff – Membership, privileges
V. Medical Staff/Hospital Role

• Employment
  – Policy – Opioid prescribing limits
    • Delineate pain management scope for practitioners
      * Certain practitioners
      * When refer?
      * Limit # pills, refills, dosage, certain drugs

• Contract – Grounds for termination
V. Medical Staff/Hospital Role

• Employment
  – PDMP (INSPECT)
    • At hiring
    • Annual review
  – Compile system metrics for comparisons
  – Oversight of non-physician practitioners
  – Educational (CME) requirements
V. Medical Staff/Hospital Role

• Medical Staff
  – Initial application
  – Reaplication > PDMP query

• Issues likely to be at office vs. hospital
  – Legal authority over private practice?
  – Hospital will see private patients in the ED

• Report to Licensing Board?

• Delineate qualifications for pain management privileges
V. Medical Staff/Hospital Role

- Liability for employed physicians?
  - Insurance coverage available

- Liability for medical staff members?
  - Physician liability for supervised NPs

- Establish rules (CDC)
  - Prescribe opioids only when benefits outweigh risks
    - Consider non-narcotics first
  - Fewer day supply
    - 3 days vs. 30 days
  - Lowest effective dosage
  - Regular reassessments of long-term patient use
V. Medical Staff/Hospital Role

- Pharmacy inquiries – Patient medical records
- Payor screening of physicians – PDMPs
- Hospital internal reviews
  - Regularly audit volume, prescribers, shifts
  - Confirm compliance with wastage policies
  - Witnesses
  - Subsequent patient pain complaints
V. Medical Staff/Hospital Role

- Limited access to treatment programs for patients
- Establish referral relationships in advance
- Patient dismissal policies
- No narcotics at practice sites – samples
- Physician/practitioner education
Please visit the Hall Render’s blog at [http://blogs.hallrender.com](http://blogs.hallrender.com) for more information on topics related to health care law.

James B. Hogan
317.633.4884
jhogan@hallrender.com