Dr. Brian J. Browne – Defeating Fentanyl: Addressing the Deadliest Drugs Fueling the Opioid Crisis

Questions for the Record

Questions from Senator Coons

1. *Wilmington's News Journal, reported that between Friday, April 6, 2018, and Monday, April 9, 2018, 36 Delawareans overdosed statewide. In 2016 alone, 154 Delawareans died from opioid-related overdoses, which is a rate of 16.9 deaths per 100,000 persons and higher than the national rate. Delaware is not alone in facing this epidemic. Based on your experience with the opioid epidemic, what are some best practices Delaware should consider implementing?*

a. Opioid Crisis Task Force

- Public health officials in Delaware could consider creating a multidisciplinary task force like the one organized by Dr. Leana Wen, MD, the Commissioner of the Department of Health and Mental Hygiene (DHMH) of Baltimore. She has made the opioid epidemic the number 1 priority for her department. She has brought together a multi-disciplinary committee to share information and coordinate efforts to approach this public health issue.
- **The Fentanyl Task Force** consists of top leaders from the Baltimore Police Department, the Baltimore Fire and EMS Department, the Baltimore City Council, the Mayor's Office, the Department of Health and Mental Hygiene, trial judges, prosecuting attorneys, the Justice Department, the DEA, the FBI, the Attorney General's Office, the directors of all the emergency departments in Baltimore including Johns Hopkins and University of Maryland, representatives from the state legislature and the Governor's Office, and the Greater Baltimore Committee (business leaders).

b. Provider Prescribing Practices

- As a first step, track and analyze physicians' opioid prescription practices and create an inventory of alternative therapies. Today, all hospitals have electronic health records, making it easy to track and sort data indicating which opioids are being prescribed, at what strength, exactly how many, how often, for which patients, for what conditions, on which medical service (the unit or department), by which providers. This is powerful information that can be fed back to the providers in an effort to bring their prescribing practices within safer boundaries.
- Most physicians follow a routine regarding opioid prescriptions. They believe their practice is safe and conforms to standards of care. But they might be surprised to learn how their own practices compare with those of their colleagues, to realize what alternatives exist, and to understand that they can modify these practices without compromising care.
- This information can greatly improve how safer practices can be targeted to the right physicians. Some providers prescribe large quantities of very strong analgesics for pain management, to cancer patients, and to postoperative patients. Practices can be modified even under these circumstances when the physicians become aware of alternatives or are given guidelines.
- Tracking the prescribing practices of physicians in community hospitals is as important but more difficult to achieve.

- Instituting a prescription drug monitoring program and health information exchange like the Chesapeake Regional Information System for Our Patients (CRISP) will greatly assist physicians in determining how many prescription opioids a patient is receiving.[1]
- At the UMMC, we have integrated opioid-prescribing educational programs into new residents' orientation, residents' credentialing processes, and faculty re-credentialing processes.

c. Legislation

- Another possible step is enacting legislation like Maryland's **Heroin and Opioid Prevention (HOPE) Act**.[2] The HOPE Act, passed in 2017, provides support for peer counselors, crisis centers, a 24-hour hotline, substance abuse treatment programs, and prison-based treatment programs. It also requires hospitals to create discharge plans for patients at risk for opioid overdose.
- Maryland legislators passed a **Good Samaritan Law** in 2015 that provides protection from arrest and prosecution to those who assist in an emergency overdose situation.[3]
- Rhode Island's Hospital/Emergency Department Certification Program provides very good guidelines for organizing an emergency response to the ED patient with an opioid problem. A similar measure is being considered by DHMH for the hospitals in Maryland. The Maryland Hospital Association, however, has expressed concern over the cost of implementation.
- We recommend asking the officials at your state health department to write a standing order for naloxone, allowing anyone to obtain it from any pharmacy in the state without a prescription. Dr. Howard Haft, DHMH Deputy Secretary for Public Health, wrote Maryland's statewide standing order for naloxone. (Please refer to Appendix B of the report we submitted on April 11 for more information.)

d. Increase Access to Naloxone

- The University of Maryland started a system-wide effort to increase the amount of naloxone we prescribe.
- **Naloxone-To-Go:** Kaleo Pharmaceuticals provided several hundred EVZIO naloxone injectors, free of cost. They were distributed to patients seen in the UMMC ED who were at risk for opioid overdose.
- **Baltimore EMS** increased its budget to cover 2000 doses of naloxone per month.
- **Baltimore Police** now carry naloxone.
- **Don't Die Campaign:** Increases naloxone's availability in Baltimore through the standing order, paired with physician teaching videos and patient educational programs.

e. Treatment Programs – Emergency Department Screening and Intervention Programs

- **SBIRT:** Our peer recovery coaches conduct Screening, Brief Interventions, and Referral to Treatment (SBIRT) evaluations on all emergency department patients automatically, parallel to the reason for the visit or the physician request.
- **Overdose Survivor Outreach Program:** This program is for patients who survived an overdose but are not willing to get treatment at the time of the ED visit. Our peer recovery coaches follow up with them and encourage them to go into a treatment program or cut down their use.
- **Buprenorphine Induction:** Our emergency physicians can give buprenorphine

(Suboxone) to patients in withdrawal and arrange next-day placement in substance abuse treatment clinics. A word of caution, however, about these new medications. The treatment of opiate addiction is not another drug. This approach works best in the context of a treatment program. These drugs must be distributed carefully. They can easily be abused themselves. There already exists a strong black market for these drugs because of their ability to ward off withdrawal symptoms. Users might not be sincere in stopping at all. They just need time to find another opportunity to score more narcotics.

- **Stabilization Center:** Mainly targeted at alcoholism, this center provides a place for patients who are intoxicated in a public place to sober up safely as an alternative to the ED and to access substance abuse and community resources.

f. Surveillance

- **Surveillance:** "Bad Batch" is a free app that sends out text messages when an overdose spike is detected (http://www.badbatchalert.com).
- **Fentanyl Testing:** Fentanyl is not part of the standard drug screen in most EDs and hospitals. But, because of the current epidemic, it is now routine at UMMC and should be everywhere.
- Providing funds to state and local agencies to detect and track changing drug use trends will help us understand where a substance is being used, measure the effectiveness of public health interventions, and make lawmakers aware of new threats as they appear.

2. *According to a report on alcohol, drugs, and health by the Surgeon General, "Implementation of evidence-based interventions . . . can have a benefit of more than $58 for every dollar spent; and studies show that every dollar spent on substance use disorder treatment saves $4 in health care costs and $7 in criminal justice costs." How would you recommend allocating funding to best combat the scourge of opioids and specifically fentanyl?*

- We support increasing the availability of naloxone. A standing order is one method of making it more available to more people.
- We also believe there should be wider support for outpatient and inpatient substance abuse programs and peer counselors who are able to screen and refer any patient visiting an emergency department, regardless of complaint. The goal should be for patients to be able to enter treatment at any time of day.
- Illicit fentanyl and other synthetic opioids do not show up on standard drug screens, so there is little information about what drugs are being used at any given time, what drugs are causing overdose spikes, and the burden these users place on the medical system. We suggest that funding be allocated to support medical examiners, public health officials, and hospitals as they discover and track emerging drug use patterns.

3. *According to a 2017 Drug Enforcement Administration briefing guide for first responders, "[t]here is a significant threat to law enforcement personnel, and other first responders, who may come in contact with fentanyl and other fentanyl-related substances through routine law enforcement, emergency or life-saving activities."*

- *Based on your medical experience and knowledge, what happens to an individual who comes in contact with trace amounts of fentanyl (for instance, when a person, such as a first responder, uses his/her bare hands to brush fentanyl remnants off his/her clothes)?*

1. Based on the potency of these drugs, there is a conceivable exposure risk to first responders in a scenario involving fentanyl and related substances. We found one

report in our state news related to this risk.[4] In our clinical practice, we have not seen any first responders suffer from "contact overdose" in our emergency departments. In an informal poll, Baltimore City paramedics, who see several thousand non-fatal overdoses annually, reported that they have not personally seen or heard of any paramedics or police officers with contact overdose. In most cases, the person has already ingested the substance they bought, so there isn't any left to endanger first responders when they arrive.

2. The exception is when entering a house or building from which the drugs are being distributed. In that case, the facility is considered not safe for paramedics. They are trained to wait until the scene is deemed safe by police.

3. The drug must be internalized to be effective. Most of the time there is no exceptional danger. Aerosolized fentanyl can be very dangerous, but it is very uncommon. Care must be taken not to exaggerate the dangers.

- *What steps would you recommend that first responders take to protect themselves from health risks associated with fentanyl contact?*

  1. First responders are trained to respond to medical emergencies arising from hazardous materials exposure; fentanyl contact is no different.

  2. First responders should use universal precautions (wearing gloves, washing hands, etc.) at all times. Advanced personal protective gear (masks and contamination suits) should be available to them, just as it would be when responding to a chemical spill.

- *Would personal protective equipment reduce the risk to officers in these situations.*

  1. Yes.

4. *How effective is naloxone in treating opioid overdoses when administered by a layperson, and would training on the use of naloxone increase its effectiveness?*

- Naloxone is safe and effective when given by laypersons. Many of our patients state that they either have been saved or have saved the life of someone else by administering naloxone.

- Similar to basic life support training, naloxone administration education helps laypersons identify the signs of overdose and enables them to respond earlier and more effectively in a medical emergency.

5. *Would you recommend making naloxone more readily available, for example, over-the- counter at pharmacies?*

- Yes

6. *From a physician's perspective, how well do you think we do as a nation of tracking pharmacy prescriptions to ensure that patients aren't getting more than the supply they need?*

- We have made great strides toward tracking prescription opioids, but there is room for improvement. The technology needed to create robust prescription drug monitoring programs has been created. In Maryland, emergency physicians have access to Chesapeake Regional Information System for Our Patients (CRISP), which provides excellent prescription data.[1] Many other states have similar programs. Unfortunately, not all medical care providers in Maryland have access to CRISP and others do not check to see what medications a patient has received before writing a prescription. Overall, each state should have a repository of prescribing information that is easily accessible to all physicians. Once such a database in place, physicians should be made aware of it and instructed on how to use its data.

7. *How often are you seeing patients who are finding illicit drugs through other sources and do you believe that we should create some kind of federal clearinghouse, perhaps through DEA, to track diversion?*

- Physicians have certainly played a role in fueling the current opioid crisis. Numerous publications in the 1990's described physician's attention to pain relief as inadequate. The Joint Commission (formerly JACHO) and even CMS included pain relief in their patient satisfaction evaluations that were ultimately tied to reimbursement. Regulations made pain a "fifth vital sign" and pressured physicians to treat pain more aggressively and with stronger options. The pharmaceutical organizations used deceptive marketing tactics about the dangers of opioid medications, their side effects, and their addictive qualities in order to boost prescriptions. Clearly, some physicians became motivated to eliminate the experience of pain altogether. Prescriptions for opioids tripled almost immediately.
- I am not certain where my patients get their drugs, but I believe most are illicit transactions.
- I believe a robust surveillance system would help us tailor better interventions.

8. Finally:

- I am an emergency medicine physician, currently the Professor and Chairman of Emergency Medicine at the University of Maryland School of Medicine. I have been in practice for 34 years. I have spent my entire career at our flagship hospital, the University of Maryland Medical Center (UMMC), located in downtown Baltimore. The citizens of Baltimore have struggled with opioid abuse and its ramifications for decades, but the depth and severity of the current opioid crisis have shocked even me. This is the worst drug crisis I have ever seen.
- While this current opioid crisis is a national problem, downtown Baltimore has been hit particularly hard. Our small community of West Baltimore already suffers from very low income, high numbers of families below the poverty line, a low high school completion rate, and high rates of unemployment and violent crime. To those challenges is added the high rate of complications from drug abuse, including destroyed families. Further, the community carries an enormous burden of chronic disease, diabetes, hypertension, heart disease, lead toxicity, HIV, and trauma. The infrastructure is failing and many buildings are abandoned and crumbling. Businesses are boarded up and meaningful employment opportunities are severely lacking. This very same community experienced civil unrest and rioting a couple of years ago. Could anything make matters worse? Yes, and it's called fentanyl. Its impact on Baltimore has been crushing.
- To be fair, many good social programs, health programs, educational programs, family support programs, financial assistance programs, and alcohol and drug treatment programs are already up and running. By design, they are targeted at certain populations within the community and all enjoy a certain limited success. Our community would be much worse without them. They all deserve to be supported, developed, and even expanded appropriately because of the current crisis. But I believe these programs will achieve only limited success because it's actually the entire community that is "sick" and troubled. Adding the opioid crisis to all the other problems is just too much for it to bear. The community lacks a critical mass of resources and cannot recover on its own. Any real long-term solution must include an economic component—a restructuring of the community itself with a comprehensive, coordinated, collaboration of existing programs with a new major business development initiative, a Free Enterprise Zone that would create real meaningful employment, providing the dignity of work, not just a money hand-out. Without employment, there is no ladder for individuals to climb out of poverty to improve their lives. Without a comprehensive economic solution, there is no way for the community to recover.

- At the Senate Subcommittee Hearing on April 11, I learned that Senator Graham championed, and Congress authorized, $1 billion in aid for treatment programs this year, with another $6 billion on the way next year. Thank you! I am very grateful, along with millions of others. It has been an honor to be asked to participate in this process.

References

[1]Chesapeake Regional Information System for Our Patients (CRISP), found at: https://www.crisphealth.org/

[2]Heroin and Opioid Prevention Efforts (HOPE) and Treatment Act of 2017, SB967/HB1329, found at: http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&tab=subject3&id=hb1329&stab=01&ys=2017RS

[3]Criminal Procedure – Immunity – Alcohol- or Drug-Related Medical Emergencies, SB654/HB 799, found at: https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Maryland-2015-SB654-Chaptered.pdf

[4]McDaniels AK, Butler E. *Deputy, Two EMS Providers Treated for Overdose Symptoms Responding to Call*. Baltimore Sun, May 23, 2017, found at: www.baltimoresun.com/health/bs-md-harford-opioid-exposure-20170523-story.html