Frequent Flyers, Superutilizers and Drug Seekers

Kevin M Klauer, DO, EJD, FACEP
Chief Medical Officer, Emergency Medicine Physicians, Ltd.
Editor-In-Chief, ACEP Now
Speaker, ACEP Council

American Medical News
Kevin B. O'Reilly, amednews staff. Posted April 30, 2012.
American Medical News
Kevin B. O'Reilly, amednews staff. Posted April 30, 2012.

- 70% more likely to have poor mental health
- “The 8% of all patients who use emergency departments 4-plus times a year account for 28% of adult ED visits.”
- Spectrum Health System in Grand Rapids, Michigan
  - 950: 10 ED visits or more
  - 20,000 visits
  - $40 Million

Solution

- November 2011
- $1 Million multispecialty clinic
- Reduced ED visits in this group by 90%
Corey Waller, MD “Biopsychosocial Intervention of High Frequency Emergency Department Utilizers,” Annals of Emergency Medicine, October 2011

- 30 Pts
- 10 ED visits or more
- Intensive Medical and Case Management
- Insurer Costs Reduced by 90%
- 1-hour preliminary physician evaluation followed by 5 to 6 30-minute follow-up visits. The patients were also seen by medical social work at least 1 time and an average 3 times.
  - $1.1 million for 904 visits in 2007 to $129,792 for 104 visits in 2008

Reasons for Visits

- Inadequately treated chronic condition: 12
- Opiate addiction: 6
- Significant undiagnosed medical conditions: 5
- Lacked transportation to primary care physician: 5
- Prescription drug diversion: 2
- Undiagnosed schizophrenia: 1

- Frequent (7-17 visits): 9.9% of visits
- Highly Frequent (≥18): 3.6% of visits
  - Substance abuse more likely
    - Many more visits to primary care and specialists
- Long history: 70% v. 17.8%

**Percentage of patients with various conditions**
- Arthritis: 60%
- Depression: 60%
- Asthma: 38%
- Substance abuse: 36%
- Anxiety: 34%
- Ischemic heart disease: 31%
- Diabetes: 28%
- Dementia: 22%

---


- Higher severity of illness
- Older
- Fewer personal resources
- Chronically ill
- Present for pain-related complaints, and have
- Government insurance (Medicare or Medicaid)

- The 8% of users with 4 or more visits = 28% of all adult ED visits
- Independent association with frequent use
  - Poor health: OR 2.54
  - Poor mental health: OR 1.7
  - 5 or more outpt visits: OR 3.02
  - Family income below the poverty level: OR 2.36
  - No usual source of care: Less likely
- Health Insurance: 84%
- Usual source of care: 81%


- Patient centered intervention pilot
- Urban public hospital
- Ages 18-64: Identified as likely to be readmitted
- 19 Pts enrolled
- All male
- 18/19: Substance abuse
- 17/19: Homeless
- Admissions: 64 v. 40 (reduced 37%)
- ED visits decreased
“The Hot Spotters: Can we lower medical costs by giving the neediest patients better care?” The New Yorker, Jan. 24, 2011

The High Concentration of U.S. Health Care Expenditures
- Research in Action, Issue 19
- AHRQ 2011
- 2009
  - 1% accounted for 20% of healthcare costs
  - $90,000/pt
  - 5% accounted for 50% of healthcare costs
  - 50% accounted for only 3%
“Hot Spotters”

Doug Eby, M.D., vice president of medical services for the Southcentral Foundation, Anchorage Alaska

1. Chronic Mental Illness

2. Medically Fragile

3. “Socially Disintegrated”
   ♦ Self-Care
   ♦ Few family resources
   ♦ Dependent Personalities

Solutions
Robert Wood Johnson Foundation

• October 11 2012
• $2.1 Million
• Addressing costs of “super-utilizers”


• 11 studies (3 randomized controlled trials, 2 controlled and 6 noncontrolled before-and-after studies)
• Case management was the most commonly studied
• 6 of 8 before and after: Reduced ED visits
  ♦ 1 Increase
• Cost reduction in 3
• Homelessness reduced 3 of 3
• Clinical outcomes: Positive trend 2 of 3
The U.S. Drug Problem

- #1 reason for ED visits = Pain!
- 1,665 Pts
- 61.2%: Pain documented in the record
- 52.2%: Pain was the chief complaint


The Scope of Addiction

- Addiction
  - 3.27%
  - 0.19%: If screened for mental illness and prev addiction
- Physical dependence: Not a sign of addiction
- Tolerance: Not a sign of addiction
- Addiction rate: < 1% of those on long-term narcotics

  - Marian S. Grant, CRNP, Grace A. Cordts, MD, MPH, MS, Danielle J. Doberman, MD, MPH. Acute Pain Management in Hospitalized Patients With Current Opioid Abuse. Topics in Advanced Practice Nursing eJournal. 2007;7(1)
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical dependence</td>
<td>Normal physiologic adaptation defined as the development of withdrawal with abrupt dose reduction or discontinuation</td>
</tr>
<tr>
<td>Tolerance</td>
<td>Normal neurobiological process characterized by the need to increase the dose over time to obtain the original effect</td>
</tr>
<tr>
<td>Cross-tolerance</td>
<td>Tolerance to effects of medication within the same drug class</td>
</tr>
<tr>
<td>Substance dependence/addiction</td>
<td>Chronic neurobiological disorder defined as a pattern of maladaptive behaviors, including loss of control over use, craving and preoccupation with nontherapeutic use, and continued use despite harm</td>
</tr>
<tr>
<td>Pseudoaddiction</td>
<td>Behavior similar to those in patients with opioid addiction but is secondary to inadequate pain control</td>
</tr>
<tr>
<td>Drug-seeking behaviors</td>
<td>Directed or concerted efforts on the part of the patient to obtain opioid medication or to ensure an adequate medication supply, may be an appropriate response to inadequately treated pain</td>
</tr>
<tr>
<td>Opioid-induced hyperalgesia</td>
<td>A neuroplastic change in pain perception resulting in an increase in pain sensitivity to painful stimuli, thereby decreasing the analgesic effects of opioids</td>
</tr>
</tbody>
</table>


---

**narcotic legal definition**

**noun**

A drug that, by law, is illegal or designated a controlled substance.


• 20 Million use NSAIDs on a regular basis
• 1-2% complication rate
• 400,000 hospitalizations
• $4,000/pt
• $1.6 Billion annually

Budnitz DS, Pollock DA, Weidenbach KN, Mendelsohn AB, Schroeder TJ, Annes JL. National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events. JAMA. 2006;296(15):1858-1866

• 2004-2006
• 701,457: ADEs Tx
• 0.6% of all ED visits

Table 5. Number of Cases and Annual Estimate of Drugs Most Commonly Implicated in Adverse Events Treated in Emergency Departments—United States, 2004-2006

<table>
<thead>
<tr>
<th>Adverse Drug Events</th>
<th>Cases, No.</th>
<th>Annual Estimate, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>1577</td>
<td>55,819 (8.9)</td>
</tr>
<tr>
<td>Warfarin</td>
<td>1234</td>
<td>43,401 (6.5)</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>1022</td>
<td>35,158 (4.9)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>473</td>
<td>17,534 (2.5)</td>
</tr>
</tbody>
</table>
| Trimethoprim- 
  sulfamethoxazole   | 447        | 15,291 (2.2)             |
| Hydrocodone- 
  acetaminophen      | 420        | 15,812 (2.2)             |
| Ibuprofen           | 526        | 14,652 (2.1)             |
| Acetaminophen       | 467        | 12,832 (1.8)             |
| Cephalaxin          | 203        | 10,026 (1.5)             |
| Penicillin          | 270        | 8,275 (1.3)              |
| Amoxicillin-clavulanate | 274  | 86,506 (1.3)             |
| Azithromycin        | 265        | 87,794 (1.3)             |
| Levofloxacin        | 230        | 86,862 (1.3)             |
| Naproxen            | 245        | 86,341 (1.3)             |
| Phenytoin           | 234        | 79,977 (1.1)             |
| Oxycodone- 
  acetaminophen     | 227        | 73,326 (1.0)             |
| Metoclopride        | 179        | 86,787 (1.3)             |
“Because most opioids are prescribed by primary care physicians ...”
Improving Opioid Prescribing
The New York City Recommendations
JAMA, March 6, 2013—Vol 309, No. 9 879

- High School Seniors
- Non Medical Use
  - 36.9%: Leftovers (their own Rx)
  - Non Medical Use
    - Own Rx: Pain
    - Other source: Abuse
- Source of Prev Rx ED: 45%

Few Fla. doctors using prescription monitoring system: report Posted on October 8, 2012 by Erin Marie Daly

- Sept 2011-Oct 2012
- 48 Million Rx for controlled substances
- 2.5
- 2%
- 265%
Within months of opening in 2011, Mr. Gonzalez’s clinic, Southern Health Management Inc., was seeing up to 50 patients a day.

- GA: 125 Pain Clinics v. < 10 in 2010
- 8 States
- 42 States have monitoring programs
- 10 Share data
"efforts to crack down on pill mills become like a game of Whac-A-Mole—as soon as one disappears, another one pops up,"


“Chronic pain program”

  - Patient identification
  - Letters to patients and their primary care physicians regarding frequent ED visits and opioid rescue
  - Non-narcotics used in subsequent visits
  - Primary care follow up for alternatives suggested
- Decrease in ED and Primary care visits
Chronic Pain

- South Carolina Hospital Association

Our Emergency Department staff understands that pain relief is important when one is hurt or needs emergency care.

But......................

- The primary role of the Emergency Medicine provider is to look for and treat an emergency medical condition.
- You may be asked about a history of pain medication use, misuse, or substance abuse before prescribing any pain medication.
• We may ask you to show a photo ID, such as a driver’s license, when you check into the Emergency Department or receive a prescription for pain medications. We may also research the statewide prescription data base regarding your prescription drug use.
• We may only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medications with a lower risk of addiction and/or overdose when possible.

For your safety, we do not:

– Give pain medication shots for sudden increases in chronic pain, or aggravation of chronic pain syndromes.
– Refill lost or stolen prescriptions for medications. You must obtain refill prescriptions from your primary care provider or pain clinician.
– Prescribe missed methadone doses, or provide prescription refills for chronic pain management.
– Prescribe long-acting pain medications, such as OxyContin, MSContin, fentanyl patches, or methadone for chronic, non-cancer pain.
– Prescribe pain medications if you already receive pain medication from another doctor or emergency department.
CMS Response
Thank you for your inquiry of January 18, 2013 regarding proposed notices that hospitals have considered posting in ED waiting rooms or ED patient examination rooms regarding “Prescribing Pain Medication in the Emergency Department”.

(e)(1) The term “emergency medical condition” means (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) . . . . (emphasis added).

42 CFR 489.24 (b) defines “Emergency medical condition” as (1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) (emphasis added).

42 CFR 489.24 (d) (4) (iv) states that Hospitals may follow reasonable registration process... . However “Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation”. (emphasis added). Furthermore, hospitals should not deny emergency services based on Accordingly, the language regarding “Prescribing Pain Medication in the Emergency Department” which to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations.

Thank you!