Addressing A Crisis: A Health System’s Response to the Opioid Crisis

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CME Disclosure

- We do not have any financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

Agenda

- Overview of MaineHealth
- Nature of the Problem
- System Response
  - The Work
  - Strategies
  - Organizational Model
- Challenges and Benefits

Who We are….

- Maine's largest non-profit integrated healthcare system with 8 member and 3 affiliate acute care general hospitals and a 100- bed psychiatric hospital
- **Maine Behavioral Healthcare, the state's largest <u>behavioral health provider,</u> is an integrated member of the system, providing a comprehensive array of inpatient, crisis and outpatient behavioral health services throughout the footprint**
- An ACO with over 1,500 independent and employed physicians and over 400 primary care physicians
- **Social workers embedded in each primary care Patient Centered Medical Home promote integrated model**
- A behavioral health service line assures alignment of services and best practice dissemination across members and affiliates

MaineHealth's Vision: Working Together so Our Communities are the Healthiest in America

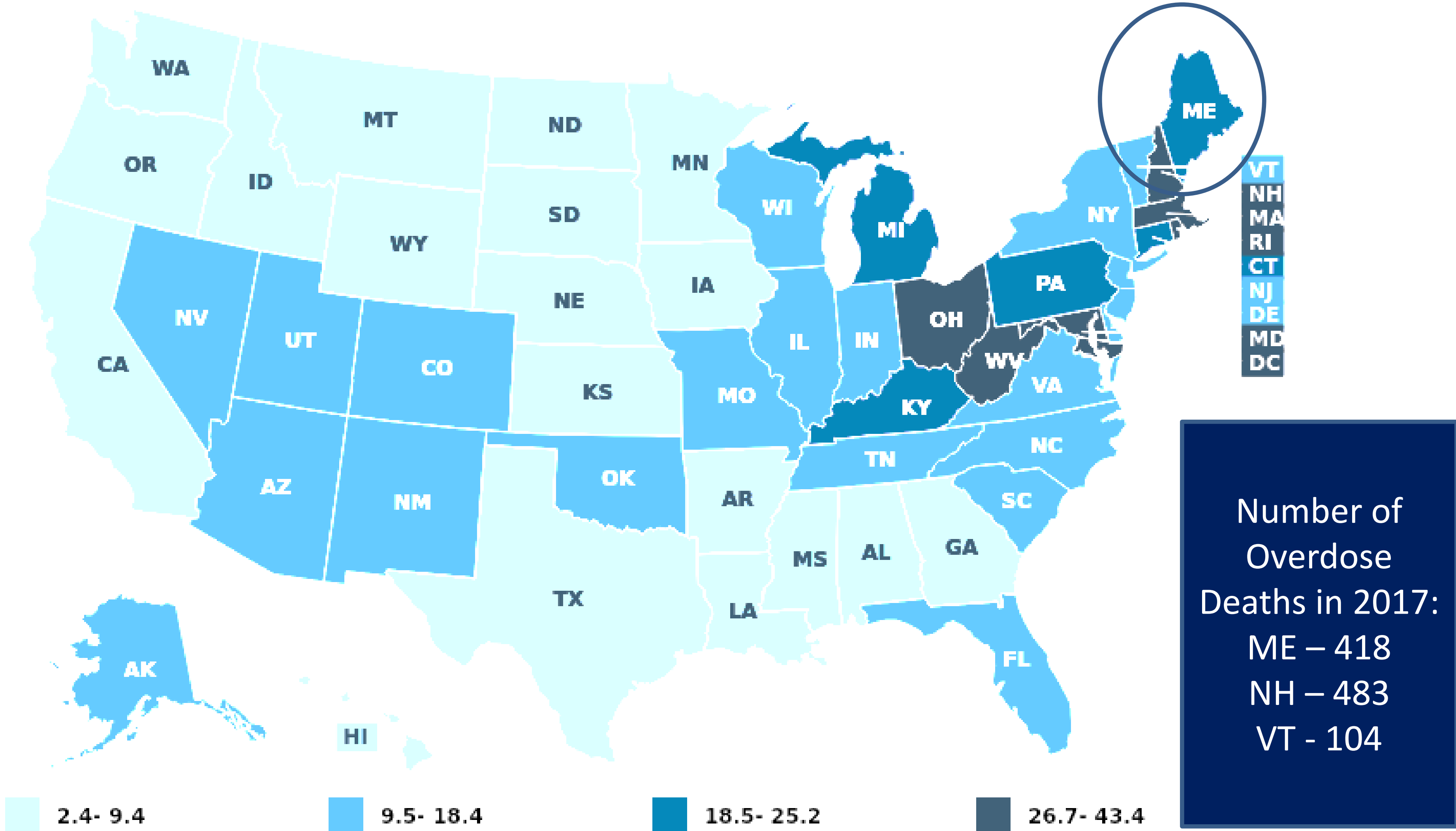
The Opioid Epidemic by the Numbers

- US Overdose Deaths
  - Drug overdoses killed **630,000** people between 1999-2016
    - That is half the population of Maine or New Hampshire– and greater than the entire population of Vermont
    - Opioids were involved in 5 time more deaths in 2016 than 1999
    - It's the leading cause of death under age 50
    - Opioids (prescription, heroin, fentanyl) comprise 2/3 of the total overdose deaths

"A group of middle-aged whites in the US is dying at a startling rate" NY Times, Josh Katz, September 3, 2017

"We know of no other medication routinely used for nonfatal conditions that kills patients so frequently." NEJM: 374; 16 4-21-16

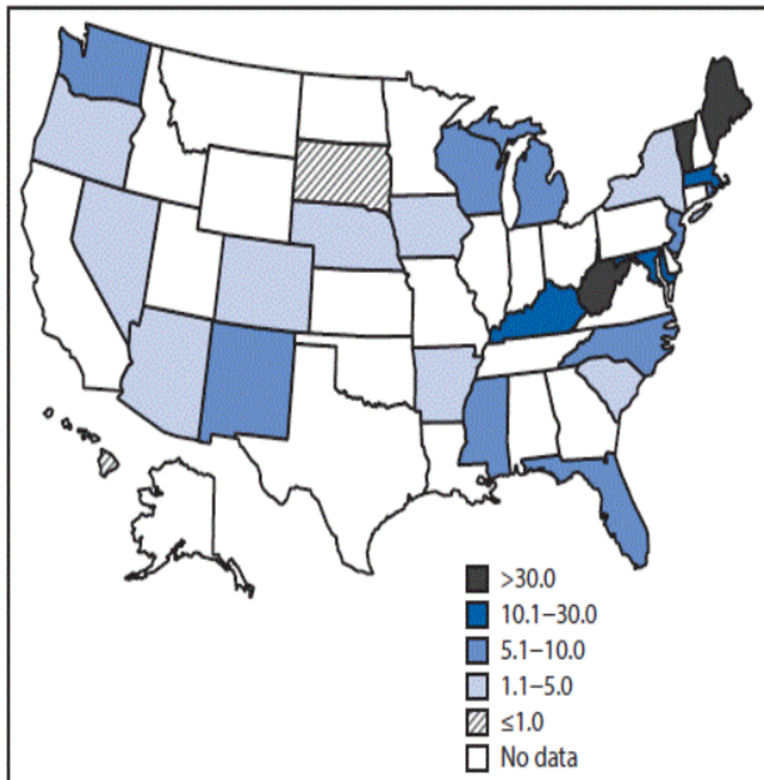
The Opioid Epidemic By the Numbers - 2016



Number of Overdose Deaths in 2017:
ME – 418
NH – 483
VT - 104

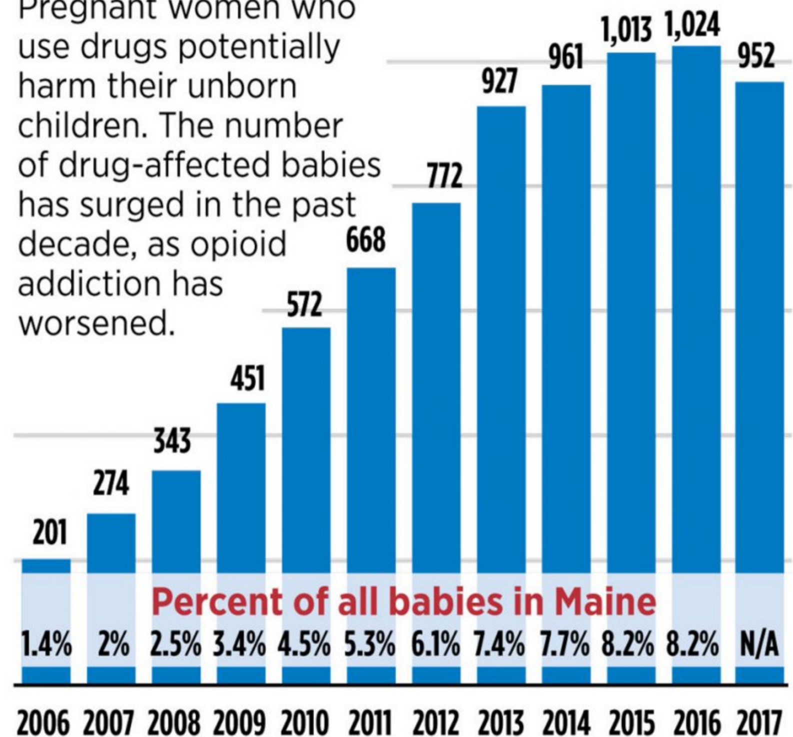
The Opioid Epidemic By the Numbers
Drug-Affected Babies

FIGURE. Neonatal abstinence syndrome (NAS) incidence rates* — 25 states, 2012–2013



Source: State Inpatient Databases, Healthcare Cost and Utilization Project.

* NAS cases per 1,000 hospital births.



Downstream Financial Cost of Untreated Addiction

- Medical Costs
  - $500,000 per inpatient stay for related medical conditions
    - » 8-12 patients on any given day at MMC for related medical conditions
  - Emergency Department Utilization
  - A Washington State study reported a 50% decrease in medical costs for individuals who received substance use treatment
- Corrections and Societal Costs
  - Have yet to quantify impact on future generations

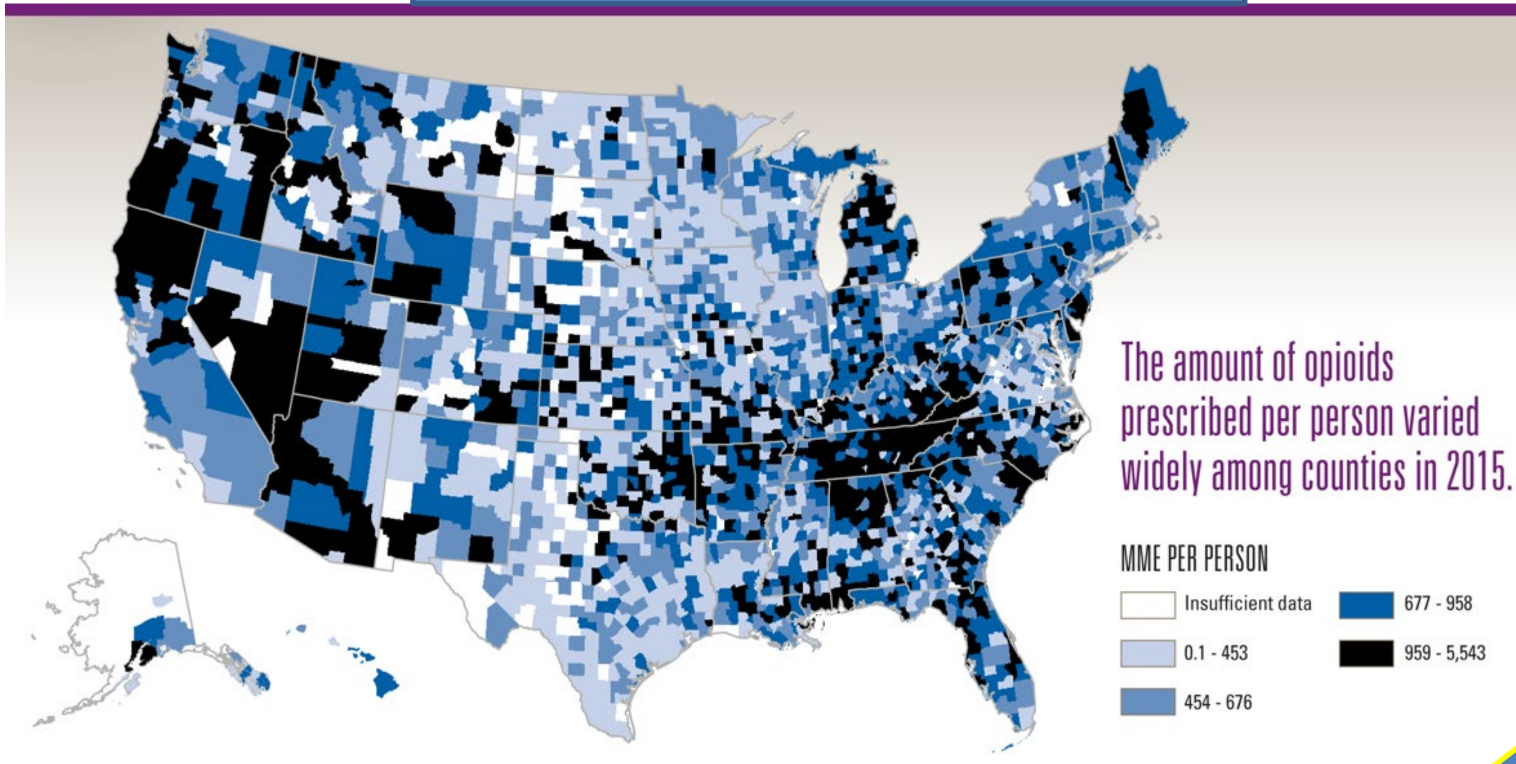
How Did We Get Here?

- 3400 BC – Opium poppies were cultivated in lower Mesopotamia. The poppy was known as the "joy plant"
- 1827 – E. Merck & Co. of Germany begins commercial manufacturing of morphine (active opium ingredient)
- 1898 – Heroin is created and introduced commercially. **It is marketed as a cure to morphine addiction.**
- 1903 – 1905 Heroin addiction rises significantly. US Congress bans opium but it has gained a foothold as a black market drug.
- **1916 – First synthesis of oxycodone with goal it would retain analgesic effects of morphine with less dependence**
- **1996 – Purdue Pharma begins marketing of OxyContin in "Partners Against Pain" campaign claiming addiction risk is small. By 2001 it is best-selling narcotic in U.S.**
- **1999 -- Promotion of pain as "5th Vital Sign" by VA intended as quality measure for pain management; became Joint Commission standard in 2001**
- **"Rate pain management" continues as key question on patient experience surveys**
- **1999 to 2010 – Opioid related deaths increased by a factor of 4**

This is the first public health crisis that was created, in part, by the health care system

Excerpts taken from
www.pbs.org/wgbh/pages/frontline/shows/heroin/etc/history.html

How Did We Get Here?



Some characteristics of counties with higher opioid prescribing:

- Small cities or large towns
- Higher percent of white residents
- More dentists and primary care physicians
- More people who are uninsured or unemployed
- More people who have diabetes, arthritis, or disability

The amount of opioids prescribed per person in the US increased by **350%** between 1999-2015

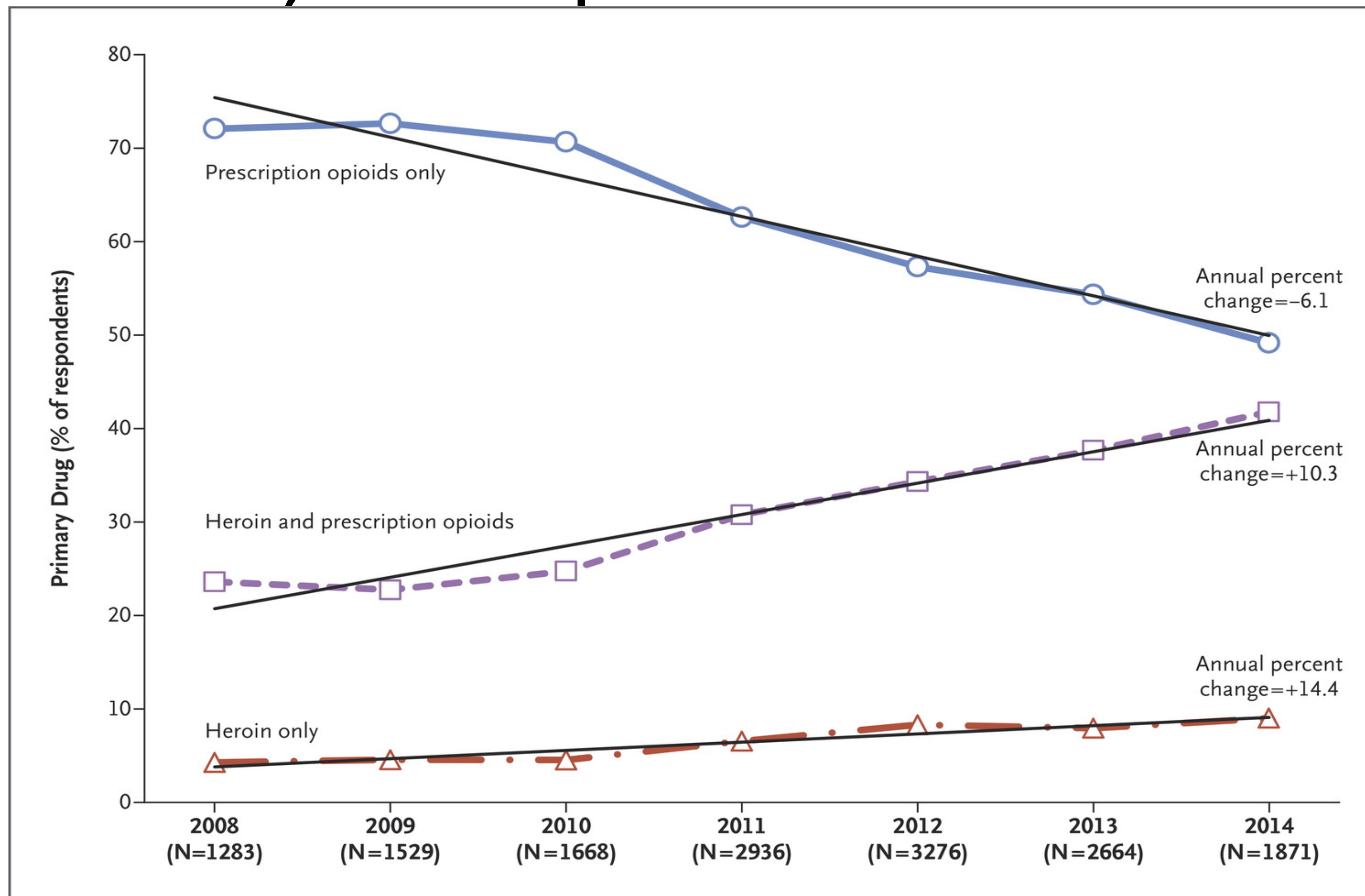
- **Federal: Comprehensive Addiction and Recovery Act (CARA)**
  - Minimal funding for Maine included to support its implementation
- **State:**
  - **Public Law Chapter 488**
  - **Task Force to Address the Opioid Crisis in the State**
  - **$6.7 Million to Treat Uninsured Patients**
  - **Opioid Health Homes Initiative**

Maine: Prescribing Law Enacted

- Implements Strict Prescribing Limits
  - 7 days acute pain and 30 days chronic pain
  - Cap of 100 MMEs
- Mandates Electronic Prescribing
- Mandates Prescription Monitoring Program Checks
  - For opioids and benzodiazapines
  - Upon initial prescription and every 90 days thereafter
  - Certain exemptions
- Prescription Monitoring Program Improvements
- Licensed prescribers will be required to complete 3 hrs. of CMEs about opioids every 2 years

The first time in memory in which the medical community asked for legislative involvement in a clinical issue

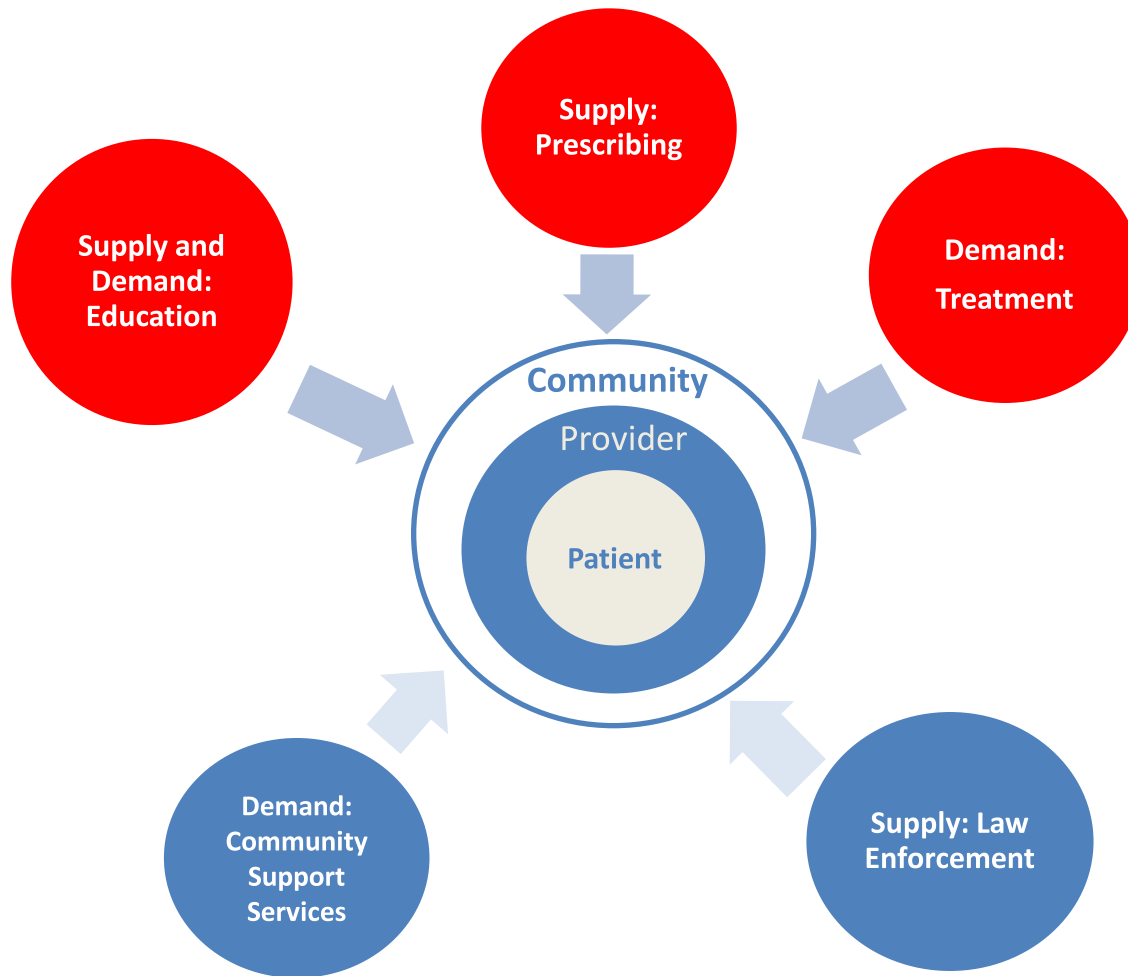
As prescription opioid drug supply wanes, illicit opioid use increases. . .



SOURCE: R. HAFFEJEE, DECEMBER 7, 2016. NATIONAL ABUSE RATES AMONG 15,227 ABUSERS. CICERO TJ ET AL. N ENGL J MED 2015;373:1789-1790.

The MaineHealth System Responds

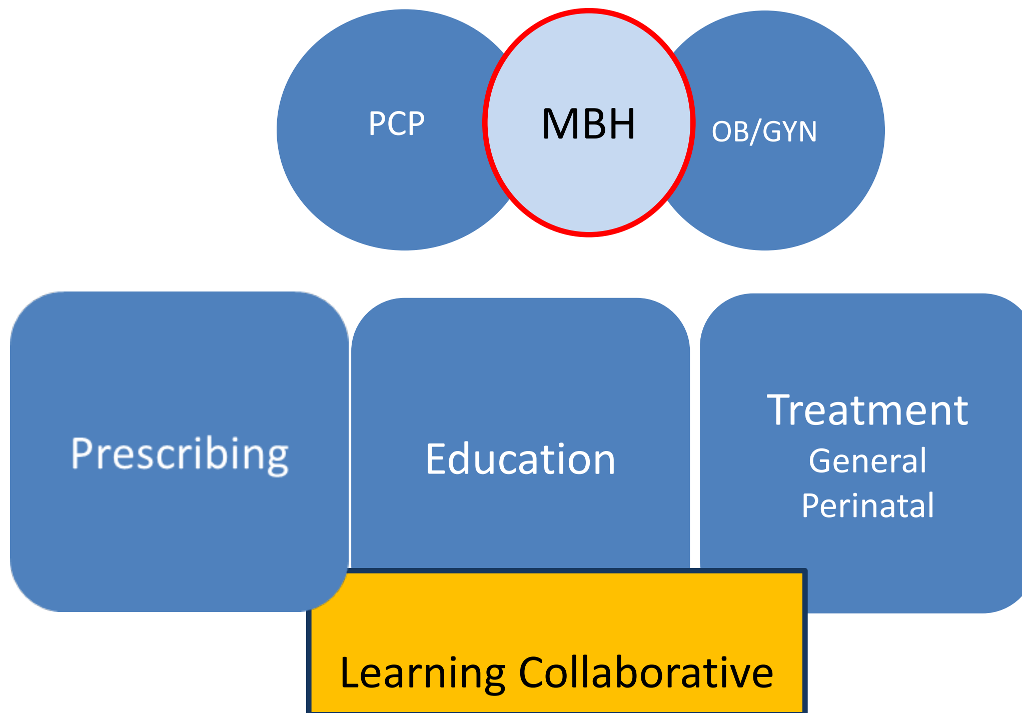
Multi-Faceted Response Required



- **Purpose:** To lead the development of a system-wide response to the urgent community need surrounding the opioid epidemic.
- **Scope:** To identify those facets of prevention and treatment for which health care providers can be influential and accountable.
- **Participants:**
  - Physician and administration leaders from each MaineHealth local service area and
  - Maine Behavioral Healthcare
- **Subgroups:**
  - Prescribing for Acute and Chronic Pain
  - Opioid Use Education
  - Treatment for Dependent and Addicted Patients
  - Treatment for Pregnant Women and Babies

Medical Community Responds
MaineHealth: An Integrated Approach

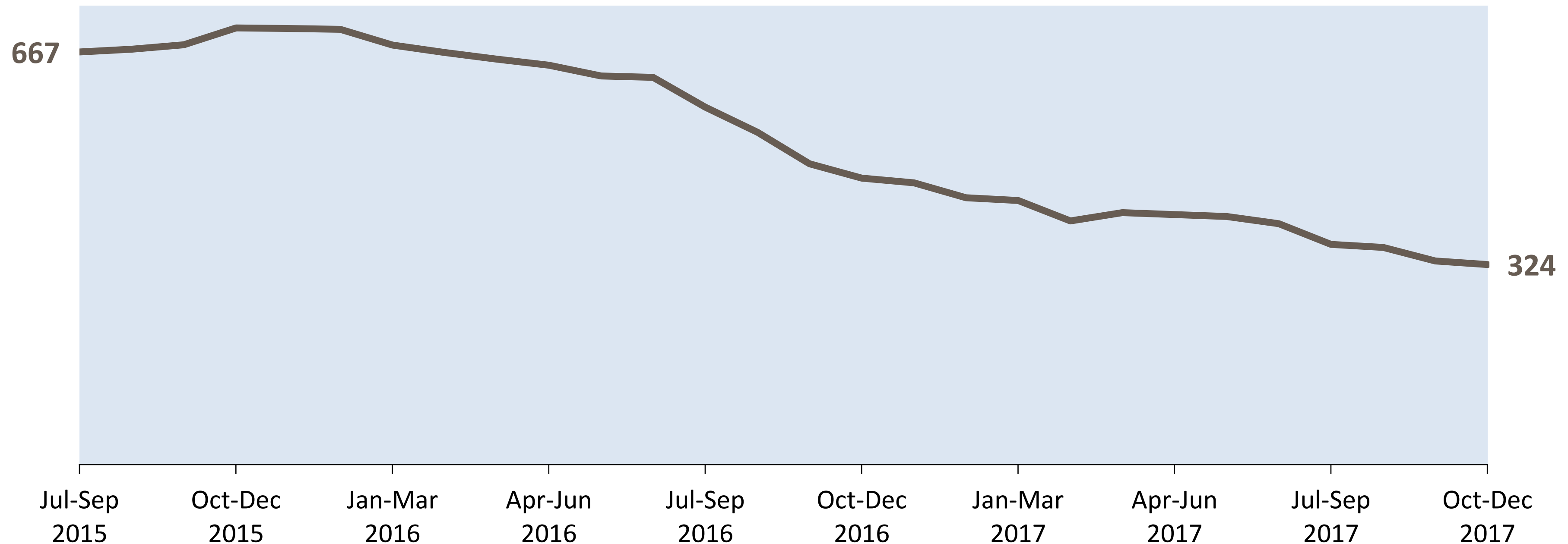
- **Goal:** Develop a system-wide response to the urgent community need surrounding the opioid epidemic.
- **Scope:** Identify those facets of prevention and treatment for which health care providers can be influential and accountable



Unanimously approved by the CMO Council and supported by the Board, this model integrates prevention, education and treatment through a collaboration between providers of different specialties.

Progress: Focus on Unnecessary Opioid Prescribing

- # Patients with ≥100 MME* per day at MaineHealth Member-Owned Practices**
- MaineHealth Epic Electronic Medical Record (2015 – 2017) *3-year rolling averages*



*MME=Morphine milligram equivalents
**Data from practices at Franklin Community Health Network, Memorial Hospital and Southern Maine Health Care are not included, because these practices were not using the EPIC electronic medical record during the whole time period presented (July 2015 – December 2017).

Progress: Education & Communications

- 110 providers trained to provide Medication Assisted Treatment
- Training about Opioid Use Disorder, prevention and treatment for clinical teams
- Conference attended by 130 clinicians focused on IMAT
- Patient education materials

Treating Your Pain Without Opioids

Treating your pain

The goal for pain management is to reduce your pain so that you can live your life as normally as possible. Opioids are one option for treating your pain out of many other options. When choosing how best to treat your pain, your healthcare team will talk about the potential benefits and risks of both opioid and non-opioid treatment options.

Your healthcare team may recommend that you try treating your pain with medicines other than opioids, or with a mix of different treatments.

Treatment may be different from person to person

People can respond differently to treatment and pain medicines. Sometimes pain can be hard to treat, especially if you have had it for a long time (chronic pain). You may need a few types of medicines and/or other therapies to reduce your pain. Combining different therapies with opioid medicines may work better for your pain. This might help you use a lower dose of opioids for your pain or can shorten the amount of time you need to be on opioids.

Examples of non-opioid treatment choices

On page 2 is a chart showing some of the common non-opioid pain medicines your doctor might recommend. It is important to remember to read the instructions and ingredients in each of these medicines carefully because taking too much can hurt your body. Be sure to tell your doctor if you are taking any medicines that don't require a prescription. In this chart, you will find what type of pain they treat best and other things you should know about these medicines.

On page 3 is a chart showing some treatment options your doctor might recommend in addition to or instead of pain medications. These treatments have been shown to help many people reduce their chronic pain.

Talk with your doctor:

It is important for you and your healthcare team to keep track of your pain levels, how your pain responds to treatment, and to follow up with you to make sure you are taking your medicine correctly and that your pain is being taken care of.

How to Safely Store and Get Rid of Medicines

Store your medicines safely.

Here are some tips for safe storage of opioid medicines:

- Keep track of your medicines and check expiration dates
- Lock your medicine in a safe place
- Take your medicine as needed and as prescribed by your doctor
- Never share your medications with others
- Keep your medicine in the original containers, even when traveling

Unused medicines can harm those in your home and community.

Keeping unused medicines in your home does more than just take up space in your medicine cabinet. Unused medicine can be a danger to children, seniors and pets. Every minute of every day, a poison control center answers a call about a young child that has swallowed a medicine by mistake. Having unused prescription opioids in your home may also contribute to the opioid epidemic. More than 70% of people misusing opioids are getting them from family and friends.

Flushing or throwing medicines in the trash is not safe.

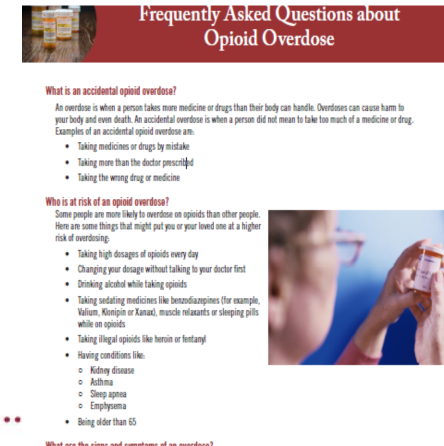
Many people think that flushing used medicines down the toilet or simply throwing the bottle in the trash are safe ways to get rid of medicines. While this may remove the medicine from your home, it does not remove it from the environment.

Use local medicine disposal programs.

Here are some ways to safely get rid of opioid medicines:

- Bring them to your local police station
- Search for any community collection events or programs such as "drug take-back days" in your area
- Visit DisposeMyMeds.org for a list of pharmacies in your community that will safely get rid of your unused medicines
- Contact your local waste management authorities to learn about community solid waste programs

If you are unsure of how to dispose of your medicine, contact your pharmacist.



Frequently Asked Questions about Opioid Overdose

What is an accidental opioid overdose?

An overdose is when a person takes more medicine or drugs than their body can handle. Overdoses can cause harm to your body and even death. An accidental overdose is when a person did not mean to take too much of a medicine or drug. Examples of an accidental opioid overdose are:

- Taking medicines or drugs by mistake
- Taking more than the doctor prescribed
- Taking the wrong drug or medicine

Who is at risk of an opioid overdose?

Some people are more likely to overdose on opioids than other people. Here are some things that might put you or your loved one at a higher risk of overdosing:

- Taking high dosages of opioids every day
- Changing your dosage without talking to your doctor first
- Drinking alcohol while taking opioids
- Taking sedating medicines like benzodiazepines (for example, Valium, Klonipin or Xanax), muscle relaxants or sleeping pills while on opioids
- Taking illegal opioids like heroin or fentanyl
- Having conditions like:
  - Kidney disease
  - Asthma
  - Sleep apnea
  - Emphysema
- Being older than 65

What are the signs and symptoms of an overdose?

MaineHealth Board's Focus on Treatment

"By Sept. 30, 2017, and with support from Maine Behavioral Health, every MaineHealth local health system will actively provide Medication Assisted Treatment in one or more adult primary care practices for patients with opioid use disorder."

"By Sept. 30, 2018, MaineHealth members will have served 900 patients with OUD through hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area."

By Sept. 30, 2019, MaineHealth members will have served **700** new patients with OUD through hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area.

System Buy-In: Key Messages

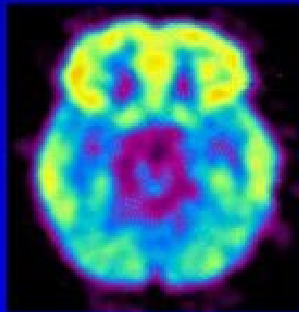
- **Our message: This epidemic requires a comprehensive health system response**
  - Community Health Needs Assessments
  - MaineHealth Board calling for plan of action
  - Partnership between primary care and behavioral health required
  - These are our patients
  - Health care practitioners asking for support
- **MaineHealth's structure supports a scalable, evidence-based model**
  - **Maine Behavioral Healthcare provides continuum of services**
    - Limited substance use treatment experience
  - Behavioral Health Clinicians integrated into all primary care offices
- **Nascent in developing standardized care models**

Addiction is Like Other Diseases…

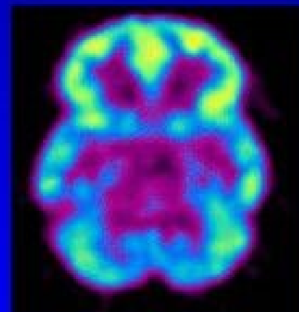
- It is preventable
- It is treatable
- It changes biology
- If untreated, it can last a lifetime

Decreased Brain Metabolism in *Drug Abuser*

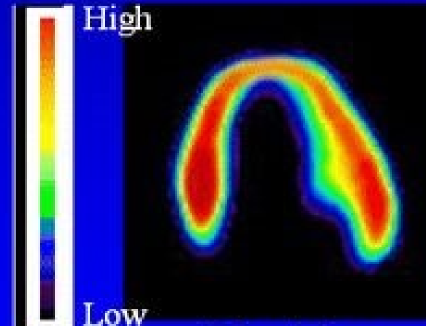
Decreased Heart Metabolism in *Heart Disease Patient*



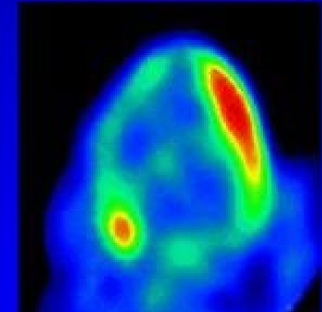
Healthy Brain



Diseased Brain/ Cocaine Abuser



Healthy Heart



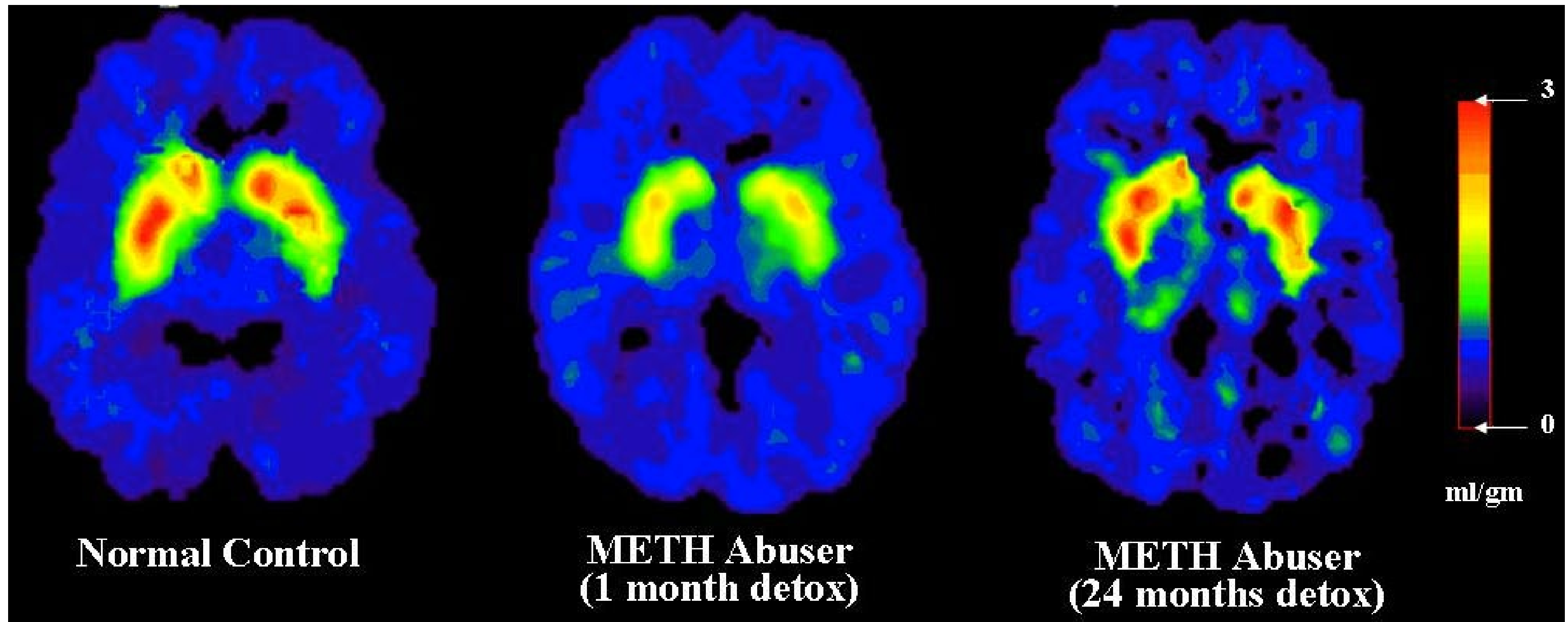
Diseased Heart

Research supported by NIDA addresses all of these components of addiction.

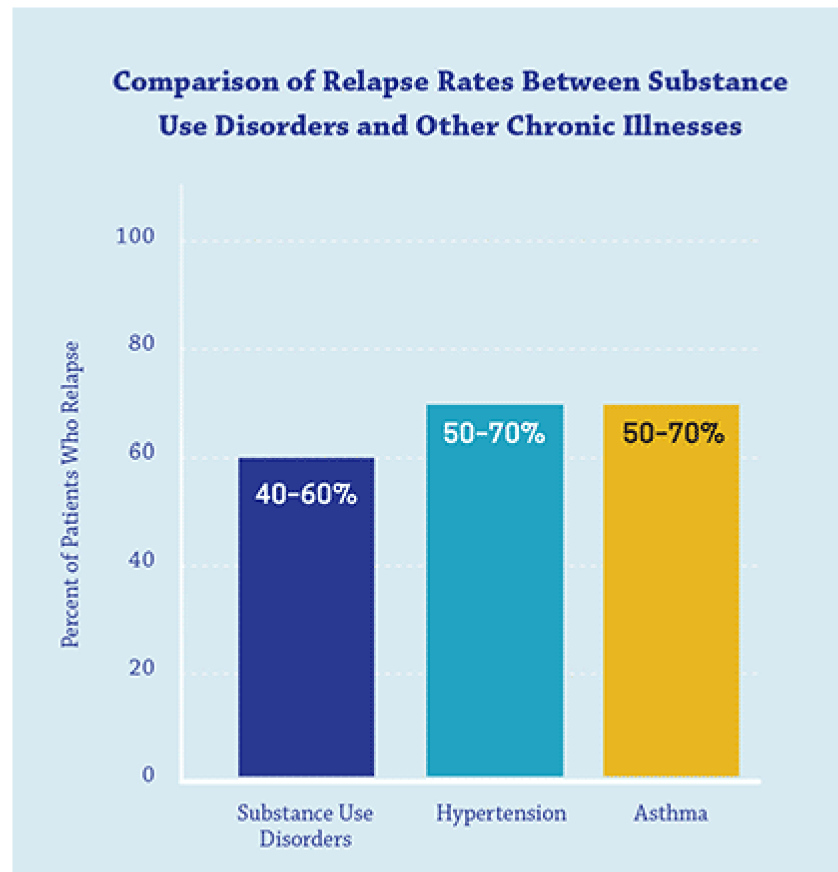
NIDA

Treatment Works

- **Addiction** can be treated
- **Partial recovery** with protracted abstinence



Affected Individuals Behave Similarly



Source: JAMA, 284:1689-1695, 2000.

Relapse rates for people treated for substance use disorders are compared with those for people treated for high blood pressure and asthma. Relapse is common and similar across these illnesses. Therefore, substance use disorders should be treated like any other chronic illness. Relapse serves as a sign for resumed, modified, or new treatment.

Chronic Disease Model Applies

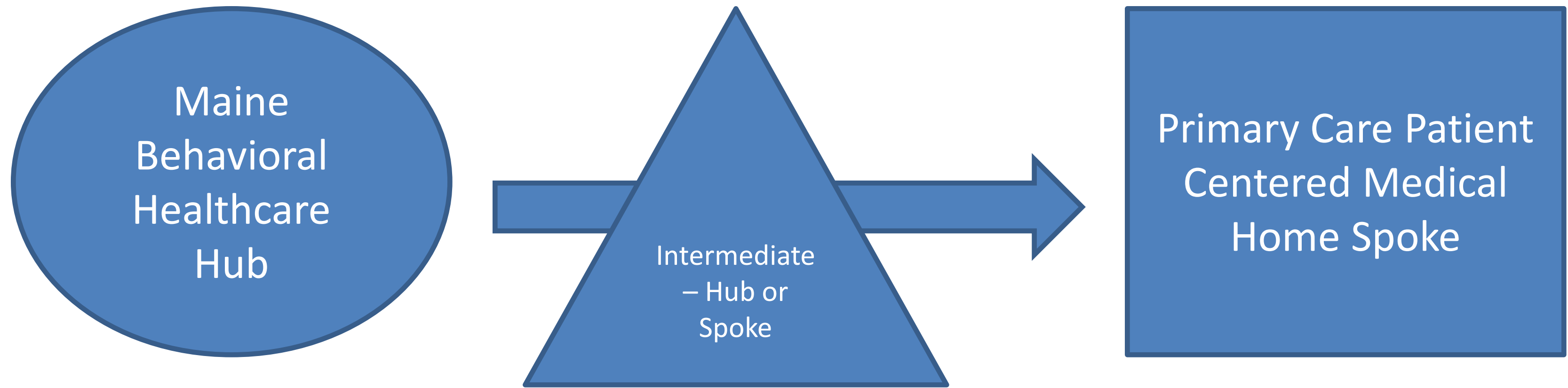
Health Systems Role – Medical	Health Systems Role- Psychological	Community Role: Social Determinants
Medication	Counseling Coping Skill Development Mental health treatment Peer Support	Safe Housing Employment Communication & Conflict Resolution Somatic Health Family & Friends

“The opposite of addiction is connection”

Barriers:

- Stigma
- Lack of Insurance
- Lack of Providers
- Transportation
- Childcare
- Lack of Social Supports
- Safe housing needs

MaineHealth Hub and Spoke Model Overview



Scalable model that incorporates specialty treatment with primary care

MaineHealth's Treatment Model: Primary Care + Specialty Substance Use Services

Hubs:
- Biddeford
- Springvale
- Portland
- Damariscotta
- Augusta
- Lewiston
- Brunswick
- Farmington
- Rockland

Intermediate:
North Conway
Norway
Belfast

Patient Centered Medical Homes throughout the service area will provide treatment for stable patients

Intensive Hubs

Community-based behavioral health centers:

- Medical Evaluation & Screening
- Induction of IMAT
- Intensive Outpatient Treatment
- Stabilization Treatment
- **Specialty Treatment**
- Consultative Support for Intermediate& Primary Care Practices.

Intermediate:

Primary care offices & integrated behavioral health clinicians:

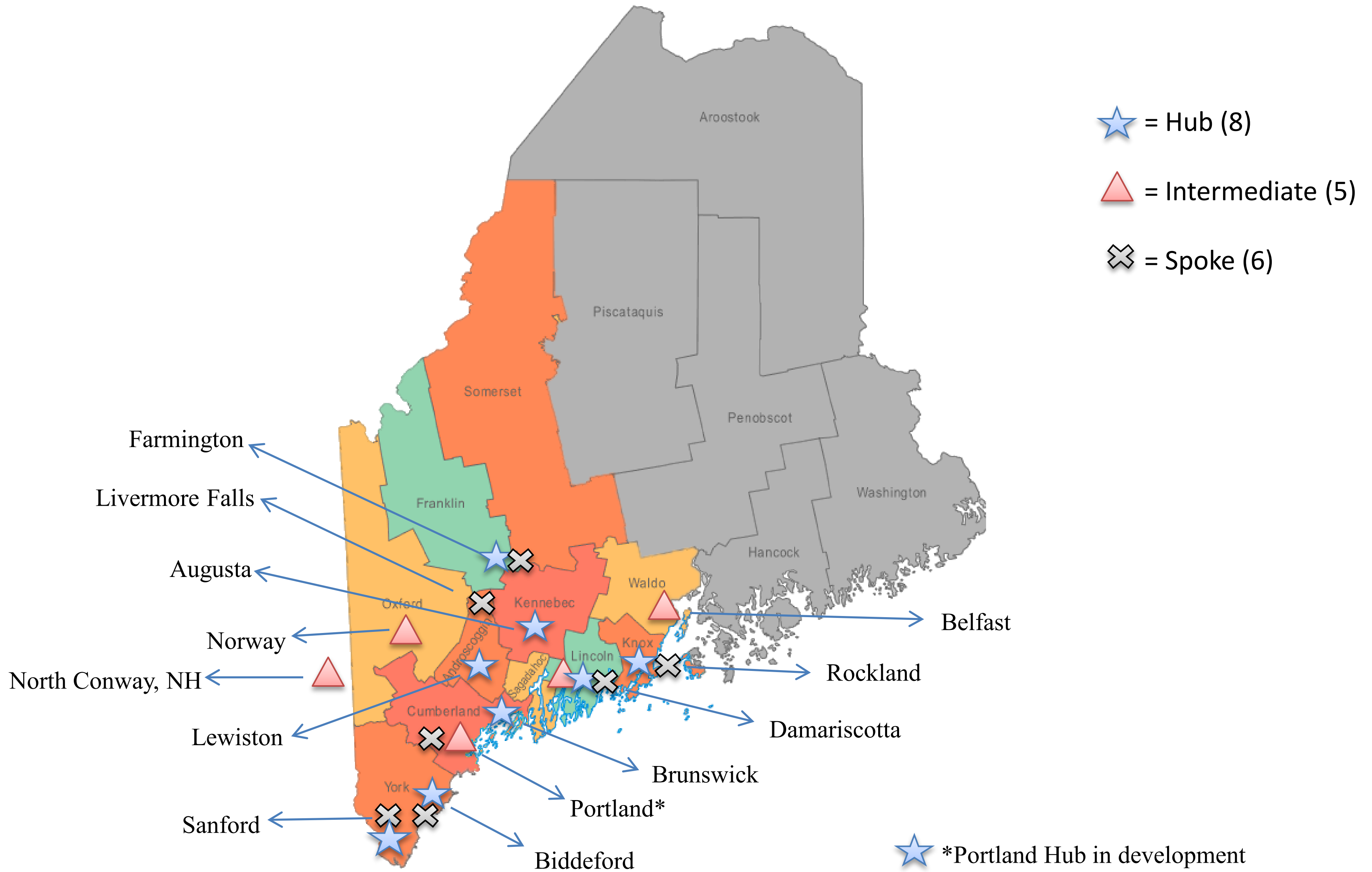
- Screening
- IMAT inductions & treatment
- Ongoing treatment for stabilization & maintenance phases

PCMH Spokes:

Patient Centered Medical Homes provide MAT and supportive behavioral health services for patients in maintenance phase and with support from behavioral health.

Goal: Ensure that any patient within the MaineHealth service area has access to evidence-based treatment for Opioid Use Disorder.

MaineHealth Member and Affiliate Hub, Spoke, and Intermediate Locations



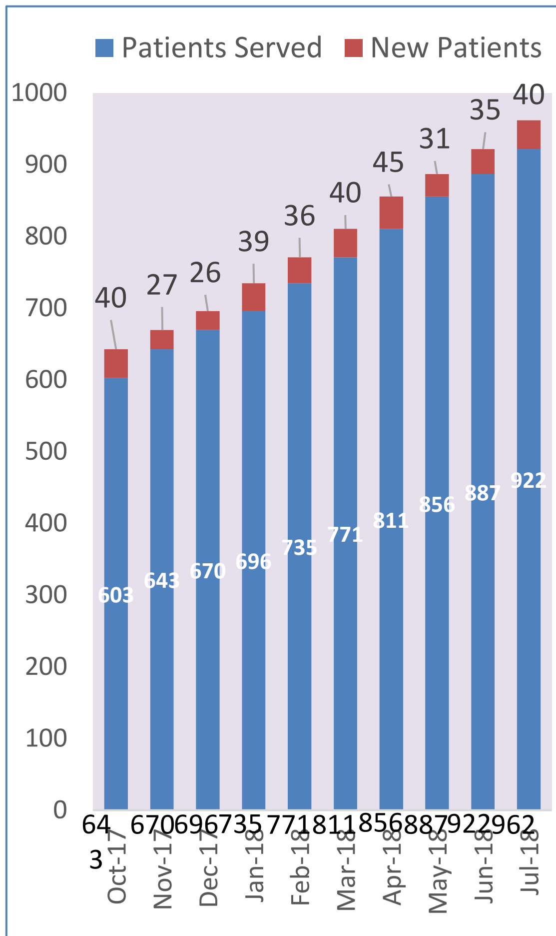
MaineHealth

Focused Goal: Population Health

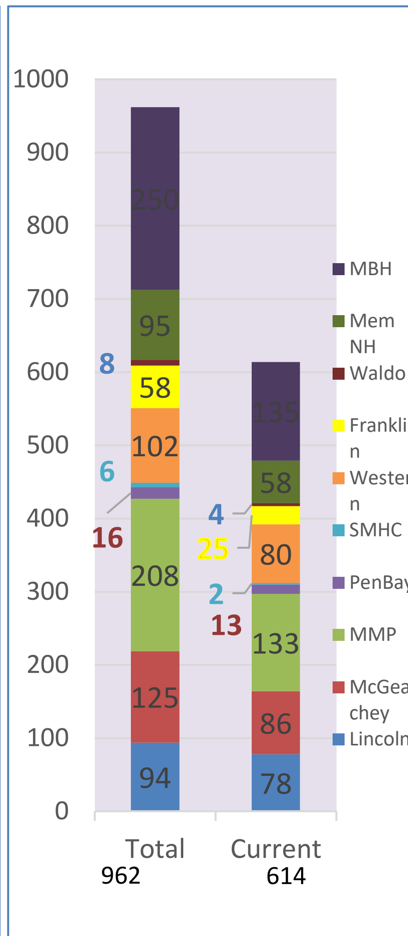
By September 30, 2018, MaineHealth members will have served 900 patients seeking treatment for Opioid Use Disorder though hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area.

As Of July 31st 2018

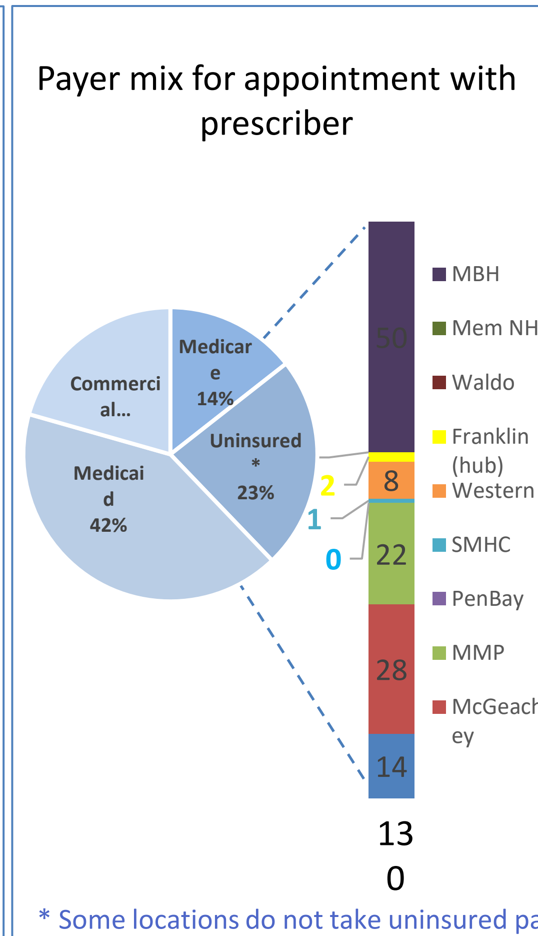
Total Patients Served



Patients By System

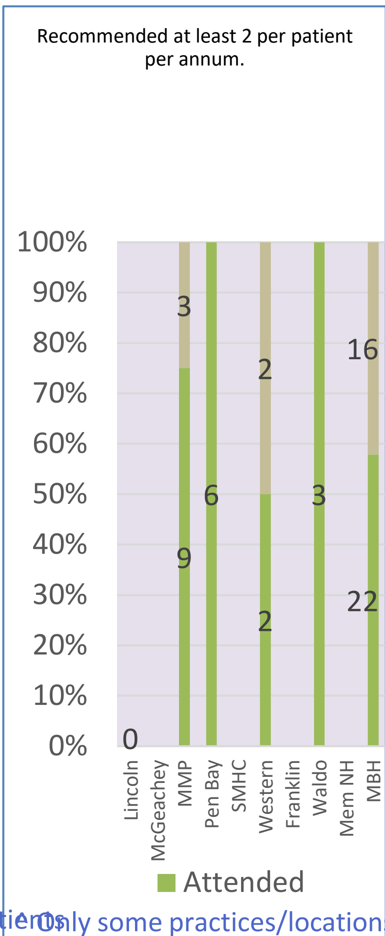


Current Month Payer Mix



* Some locations do not take uninsured patients

Random Checks^



^Only some practices/locations

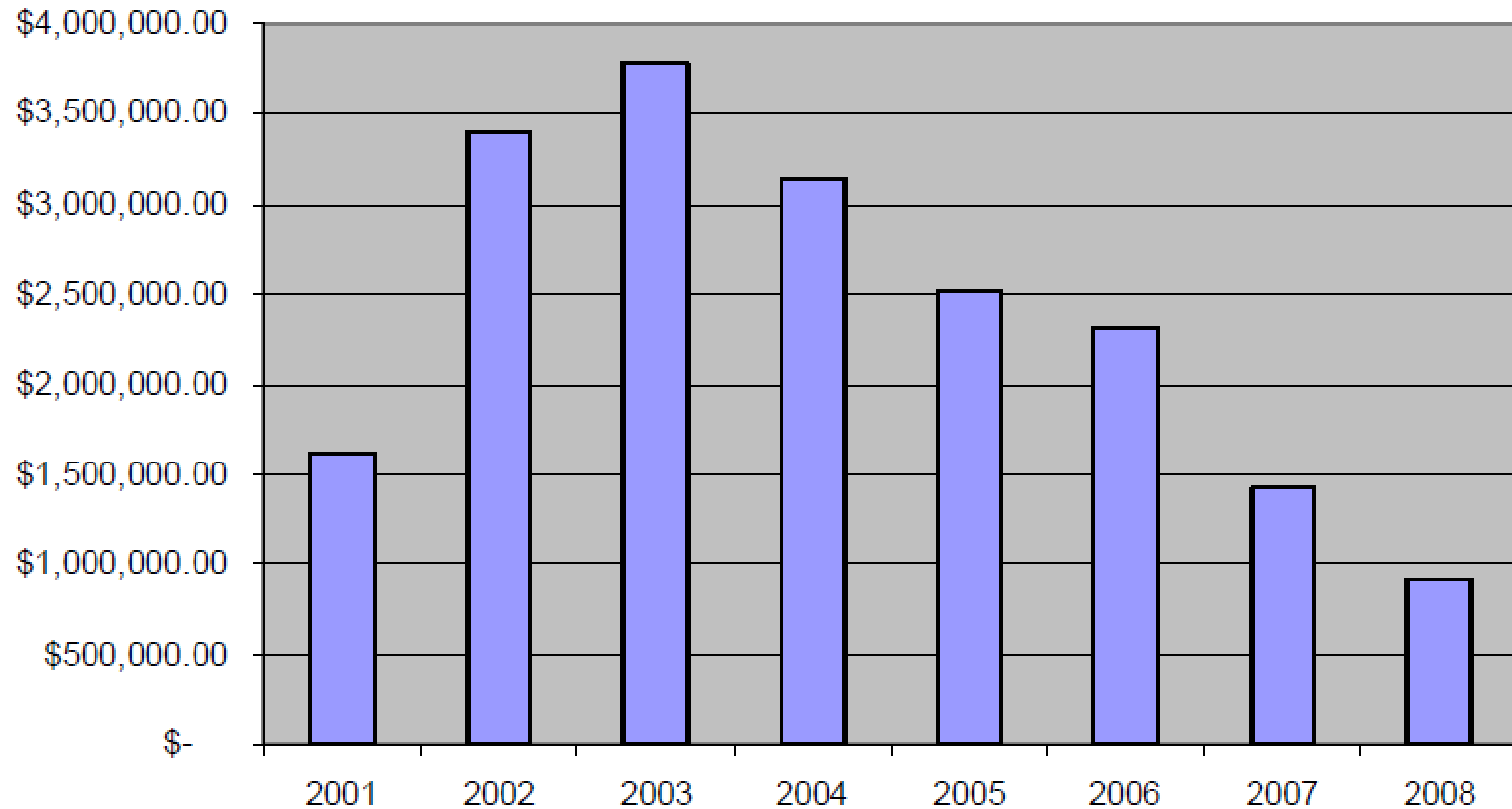
Challenges Remain – and Policy Makers Can Help!

Stigma Impacts All Facets of the Solution

- **Funding**
  - **81% of patients are uninsured or enrolled with government payors**
  - **Cost per unit of service exceeds revenue = unsustainable**
  - **Key elements of recovery model not covered by payors**
    - **Peer/recovery coaches**
    - **Recovery housing**
    - **Transportation for uninsured**
    - **Vocational Services**
- **Deconstructing Siloes and Regulatory Barriers**
  - CMS and SAMHSA
    - Commercial insurer carve outs
    - **Federal Privacy Law - 42 CFR Part 2**

MaineHealth

A Case to be Made: The Financial Return on Investment



Cost-Savings as a Result of Implementing a Recovery-oriented System

SAMHSA "Briefing on Substance Use Treatment and Recovery in the United States."

Can You Tell Who Is In Recovery from Opioid Use Disorder?

For More Information:

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- https://mainehealth.org/healthcare-professionals/clinical-resources-guidelines-protocols/opioid-use-treatment-resources