Meeting the Opioid Challenge: Tackling the Opioid Epidemic in Rural Minnesota

Thursday, October 24, 2019

A Statewide Performance Improvement Project

MN Health Plans Collaborative

BlueCross BlueShield Minnesota

Hennepin Health

HealthPartners

MEDICA

PrimeWest HEALTH

SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

ucare SM

Provider Toolkit

Meeting the Challenges of Opioids and PAIN:

PATIENT EDUCATION ON PAIN AND OPIOID PRESCRIPTIONS

ADDRESSING OPIOID PRESCRIPTION PRACTICES

IDENTIFYING SAFE AND EFFECTIVE PAIN MANAGEMENT PROTOCOLS

NONPHARMACOLOGIC AND NON-OPIOID PHARMACOTHERAP ALTERNATIVES

[Reducing Chronic Opioid Use – Provider Toolkit]

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Opioid Abuse Epidemic: A Rural Health System Tackles a Crisis

Erin Foss, RN

Catholic Health Initiatives

Imagine better health.℠

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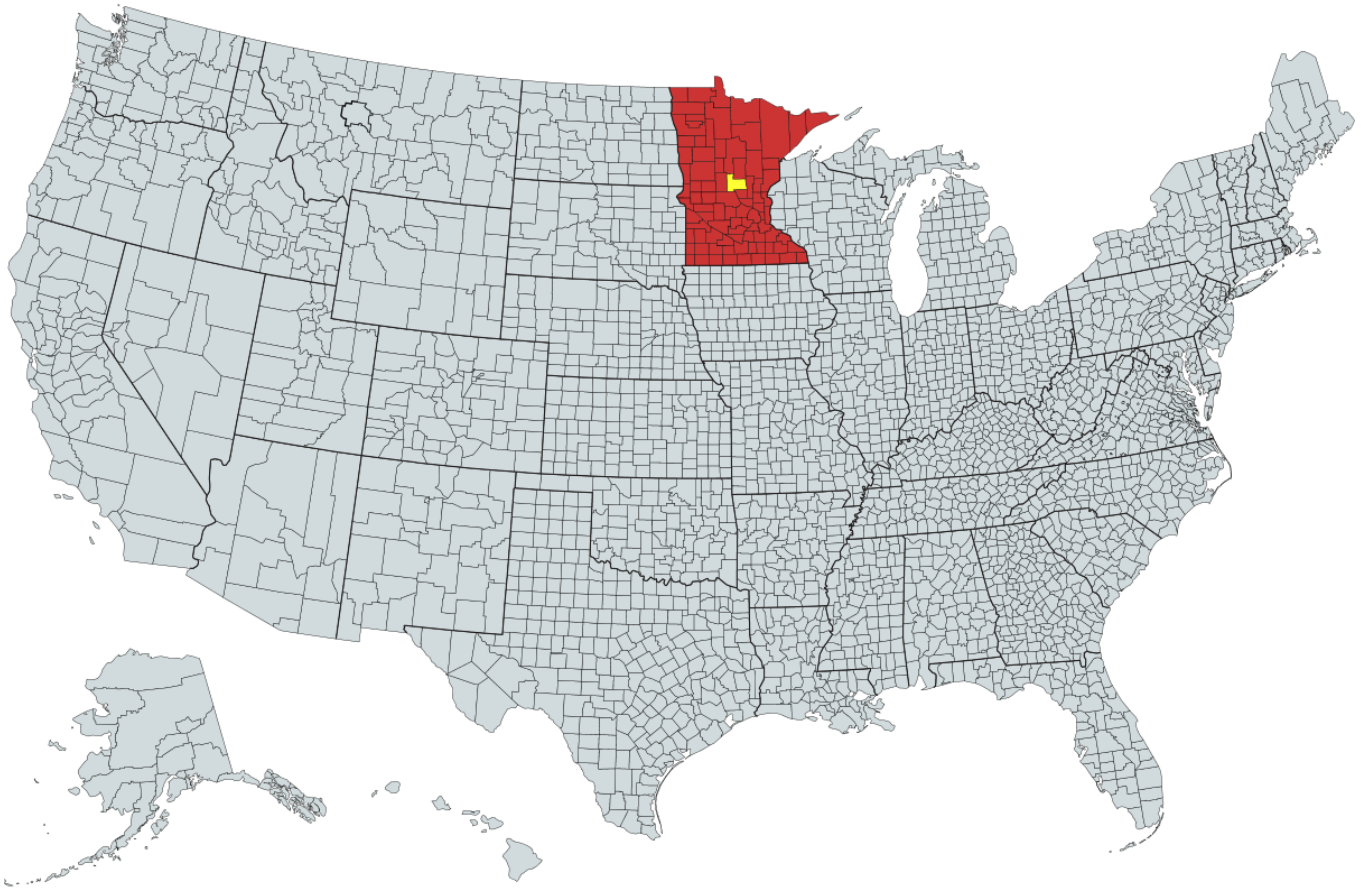
Where are we?



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Morrison County Statistics:

- **Population:** 32,821
- **Little Falls Population:** 8,689
- **Race:** 97.3% white alone
- **Persons without Health Insurance, Under 65:** 5.8%
- **Percentage of County on Medical Assistance:** 22% (7,278 residents)
- **Median household income:** $51,456

https://www.census.gov/quickfacts/fact/table/morrisoncountyminnesota/PST045217

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Community issues require community collaboration.

In 2014, the Morrison County Prescription Drug Task Force formed.

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Prescription Drug Task Force functions:

- Information sharing
- Community education
  - Community forums
  - School Programs
  - Coffee with a Cop
- Drug take-back events

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Our pharmacy data showed **100,000 narcotic pills** were coming out of our local pharmacies each month. (Jan 2015)

The task force could not solve this issue.

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State Innovation Models Initiative (SIM) Grant Recognition

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In 2015, a Controlled Substance Care Team (CSCT) was formed within our primary care clinic.

SIM (State Innovation Model) grant received for $360,000 helped fund efforts.

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Key Partnerships

CENTRAL MN VIOLENT OFFENDER TASK FORCE

POLICE LITTLE FALLS MINNESOTA LAND OF LINDBERGH

COBORN'S PHARMACY

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Funding Sources for Program Sustainment

- Payer Contracting, Quality and Performance Targets
- MDH Medical Home Certification
- Billable Care Coordination :
  - Medicaid Reimbursement ($12 - $30 per month/enrollee)
  - Medicare complex Care Management


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Heather Bell, MD

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Kurt DeVine, MD

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The number of emergency room visits attributable to pharmaceuticals alone

increased 97%

between 2004 and 2008.

SOURCE: U.S. Drug Enforcement Administration

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The number one cause of death for Americans <50 years old

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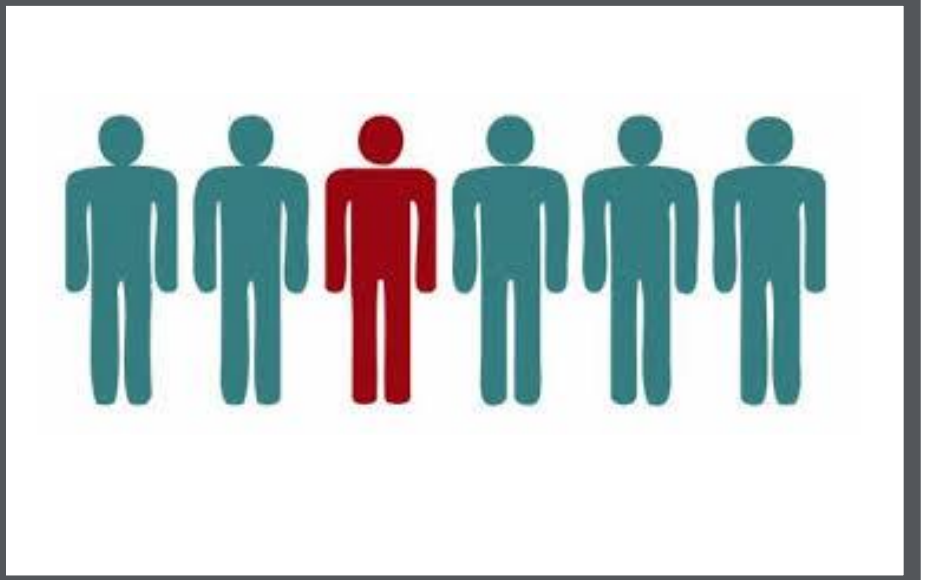
More than

50 million Americans

have admitted to **abusing prescription drugs**



SOURCE: CBS Evening News

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Approximately 30,000 Americans died from an overdose last year, with at least half of these deaths related to the improper use of legal, controlled substances.

SOURCE: CBS Evening News

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Opioid Use

An American Epidemic

4.6%
of the world's population

Consuming
80%
of the global opioid supply

SOURCE: Pain Physician 2010: 13:401-435

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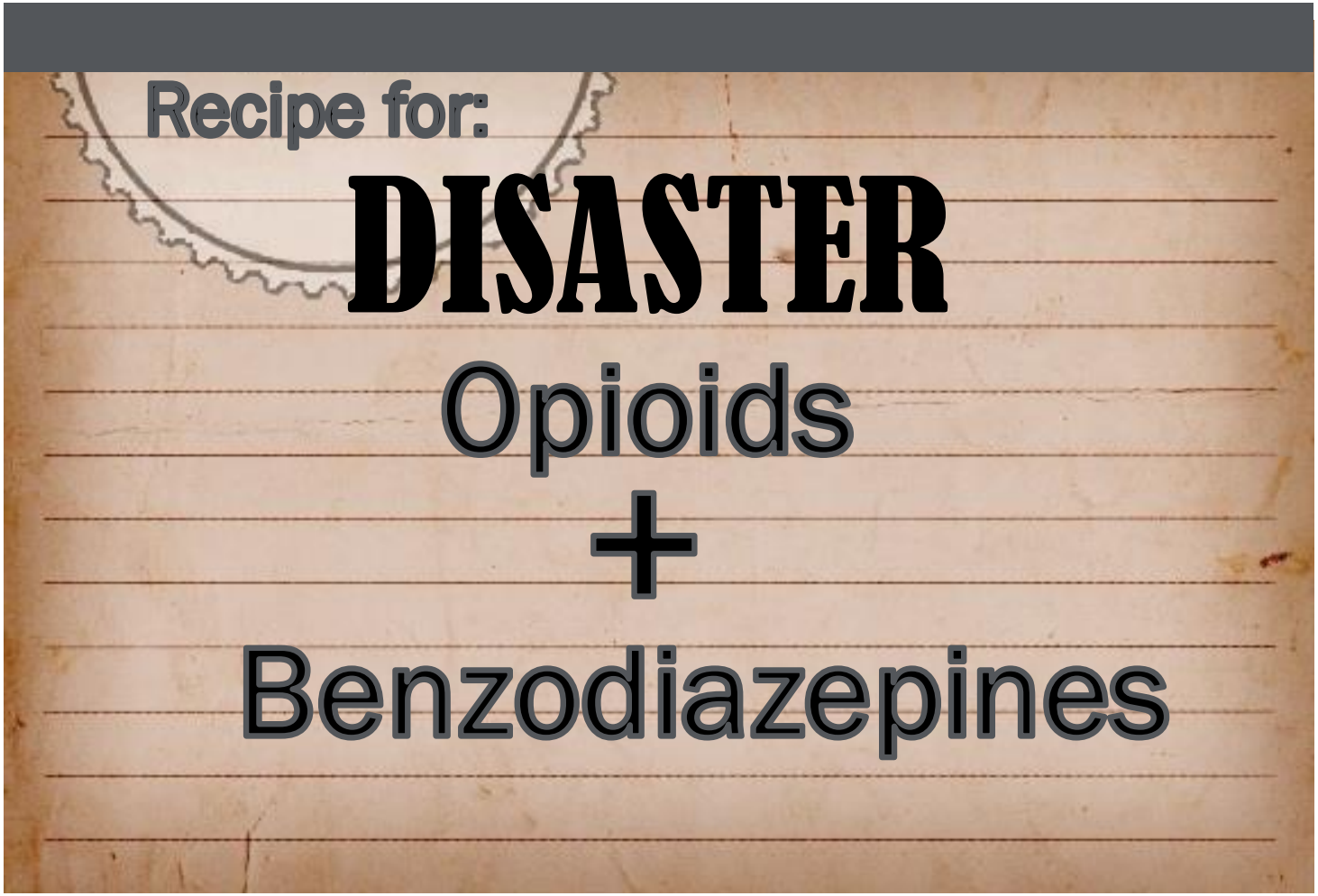

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Benzodiazepines are often found in the blood of overdose victims.

50-80%

Heroin Overdose Deaths

40-80%

Methadone Deaths

30-69% due to prescription opioids were individuals who were also prescribed benzodiazepines

SOURCE: CDC Report

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Dr. Portenoy co-wrote a seminal paper arguing opioids could be used in people without cancer.

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"We conclude that opioid maintenance therapy can be safe, salutary, and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse."

Pain, 1986 May 25 (2) 171-86

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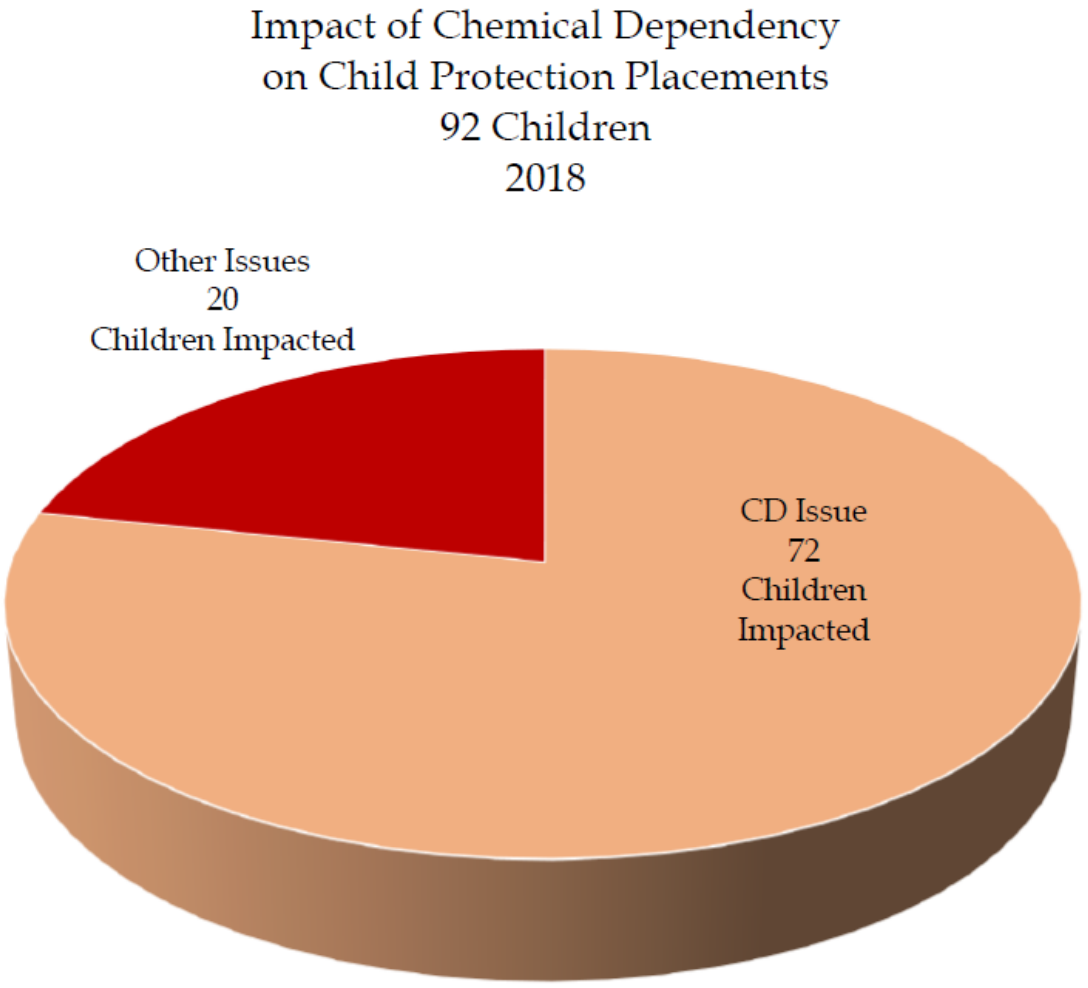

Chemical Dependency (CD) issue means heroin, methamphetamine or other drug or alcohol use that impacts child's return home.

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The American Pain Society trademarked the slogan, “Pain: The Fifth Vital Sign.”

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This same year (1996), Purdue Pharma released OxyContin, the most widely used narcotic pain killer today.

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"If pain were accessed with the same zeal as other vital signs, it would have a much better chance of being treated properly."

Dr. James Campbell, MD, President of the American Pain Society

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The Veterans Health Administration made pain a "fifth vital sign." The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) did the same.

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Throughout the late 1990's, groups such as the American Pain Foundation urged tackling the epidemic of untreated pain.

Physicians were falsely educated that the risk of addiction was less than 1%.

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Less than 1%?

Study 1: Porter and Jick

Only four (4) of 11,882 patients became addicted.

Source: New England Journal of Medicine 1980; 302:123

Study 2: Perry and Heidrich

Management of pain during debridement

Zero (0) of 10,000 patients became addicted.

Source: Pain 1982; 13: 267-280

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The problem: these studies reflect patients treated for acute pain, not daily chronic pain.

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Multiple studies from 1991 to 1997 showed addiction rates from 3-43% in patients on chronic daily narcotics, research Purdue Pharma chose to ignore.

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The Federation of State Medical Boards released a recommended policy reassuring doctors they would not face regulatory action for prescribing even large amounts of narcotics.

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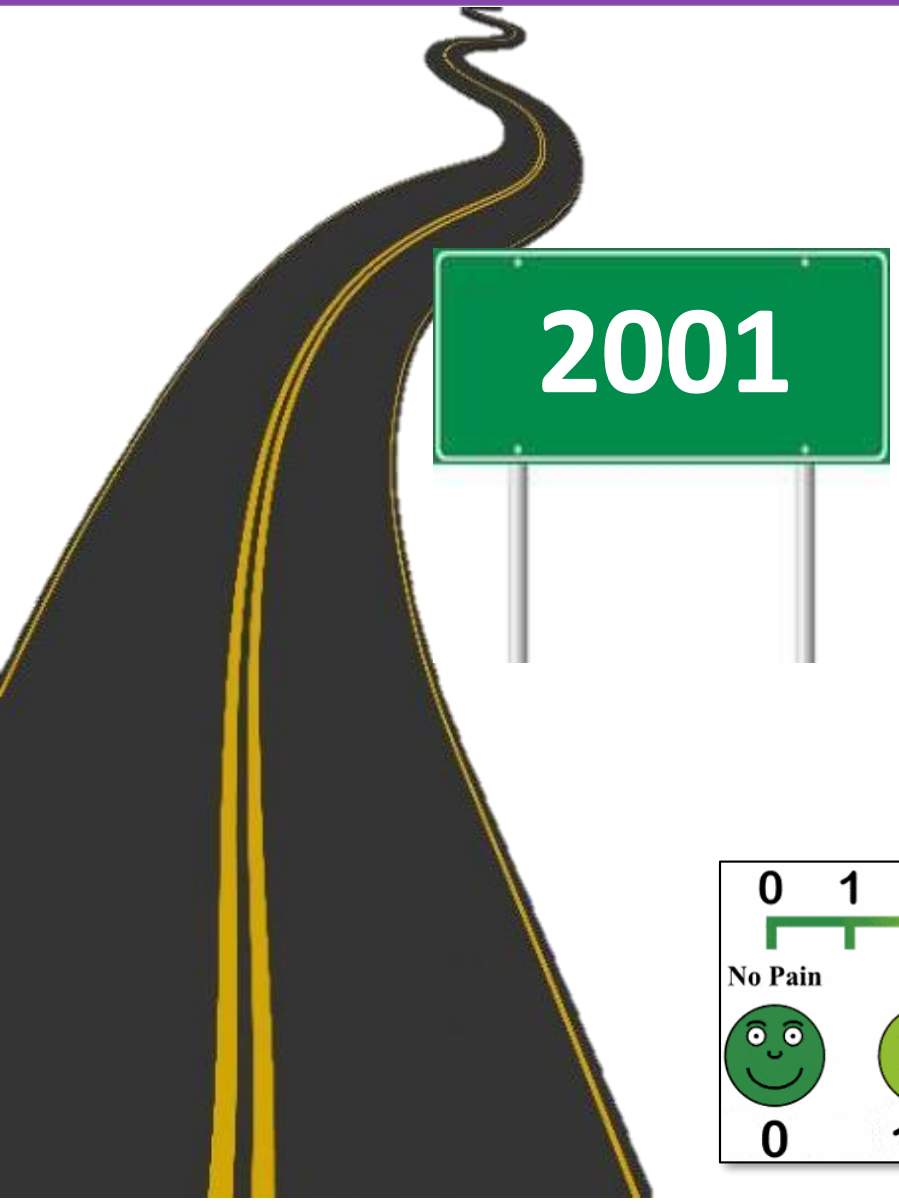
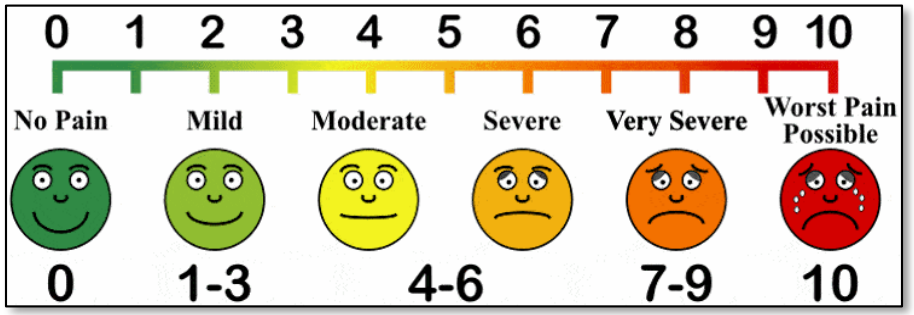


The JCAHO issued new standards telling hospitals to regularly ask patients about pain and to make treating it a priority.



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Rethinking the way we talk about pain

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The Federation of Medical Boards called on state medical boards to make under-treatment of pain punishable.

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"Untreated pain or undertreated pain is as serious a departure from the standard of care, and as serious a violation of the Minnesota Medical Practice Act as is excessive prescribing of controlled substances or prescribing of controlled substance for non-therapeutic purposes."

Minnesota Board of Medical Practice controlled substance work group, November 10, 2007

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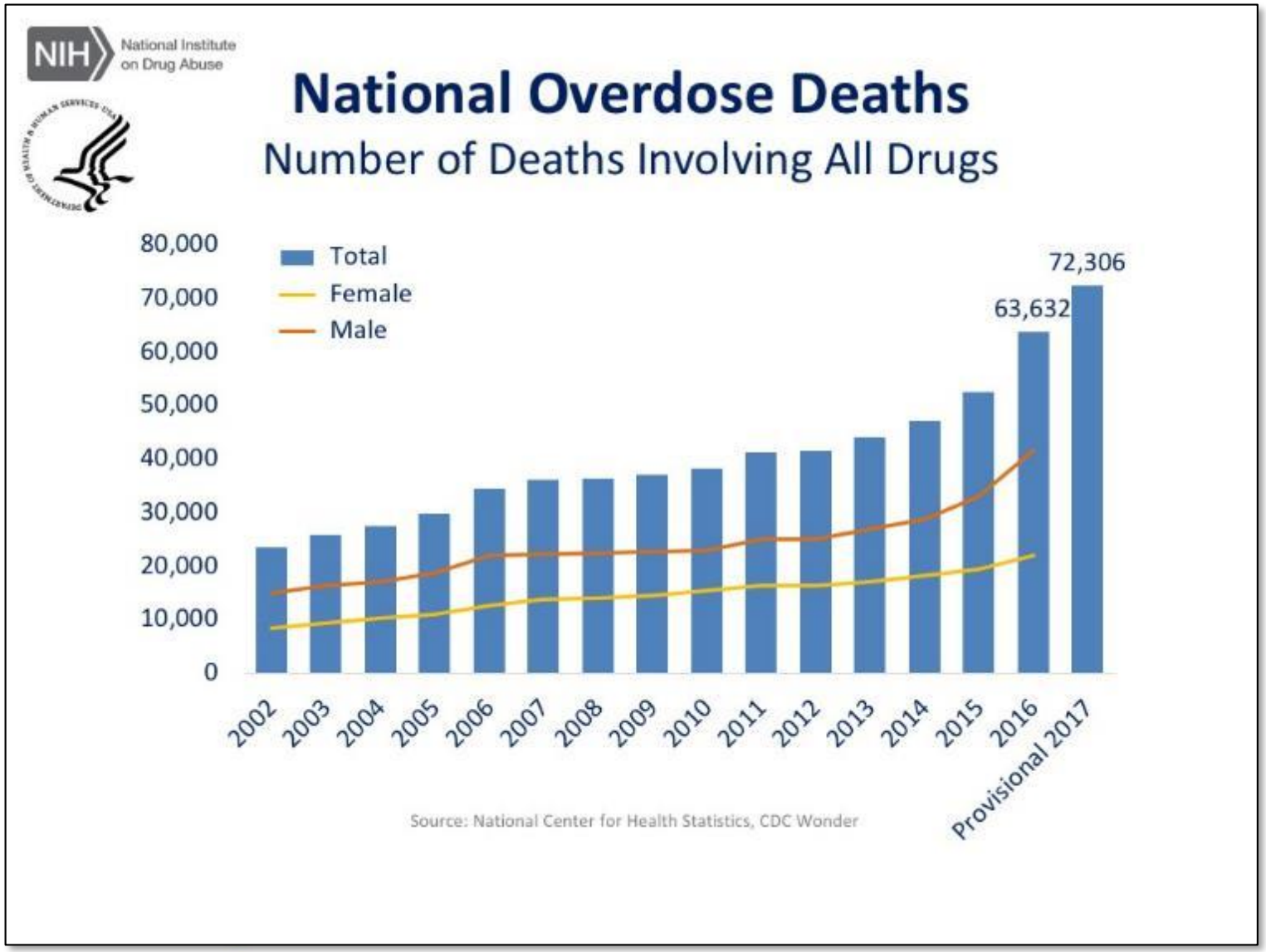

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Opioid overdose deaths surpass car accidents as the leading cause of accidental death, a

4-time increase in deaths from 1999.

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What caught our attention in our community?

- On call narcotic refills
- Emergency room visits
- Police concerns
- Overdose deaths

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Our initial focus:

Decreasing the narcotics leaving clinics and hospitals.

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Most patients addicted to heroin started on pills, and many times first exposure was legally prescribed.

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Initial Goals

- Avoid early refills
- Encourage doctors to sign up for Prescription Drug Monitoring Program (PDMP)
- Review patient charts
- Ensure urine screens and pill counts are completed
- Support providers by establishing care plans for all patients on controlled substances

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Program Planning & Early Workflow Development

- One physician
- RN Care Coordinator
- Administrator

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Top 3 Things Physicians Love to Hear:

1. More documentation
2. More time required (care plans)
3. Told how to manage their patients

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Team Advancement:

- Patient Centered Medical Home Physician
- Recovery Corp Peer Support Specialist
- Social Worker
- Program Coordinator
- Nurse Practitioner
- Outreach Coordinator

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Getting Started

- Data gathering
- Making the “list”
- Working the “list”

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Criteria for the List

- Narcotics
- > 3 months consecutive prescriptions

Initial Evaluation

- Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker
- Care plan signed
- UDAS

Information Gathering

- **Drug-related convictions**

- **Facebook**
- Mental health concerns
- Medication interaction
- ER visits
- Work history
- Diagnosis for medication

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MD Recommendations

CSCT REVIEW

Dr._____, Date: _____

The CSCT has reviewed the following patient:

Patient Name: _____ DOB: _____ MRN: _____

Diagnosis: _____

_____

Medication Agreement/Care plan signed: Y/N, Date: _____

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N,_____

Mental Health Provider/Therapist: _____

Current Medications of Concern:

_____

_____

_____

Images Reviewed: Y/N_____

Other Modalities attempted: _____

_____

UDAS in past year: Y/N, Date of most recent UDAS: _____

UDAS Findings:

- _____
- _____
- _____

Pill Counts: _____

PMP Reviewed: Y/N, Findings: _____

Social History: _____

_____

Social Needs identified:_____

Recommendations: _____

_____

Form scanned in to EMR: Y/N

Signed: _____

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CSCT Review Form

Evaluated at weekly meetings by physicians.

Review Includes

- Previous work-ups
- Scans
- Previous treatments

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Components of Recommendations

- Discussed with primary provider
- Implementation by primary doctor
- +/- guidance/tapers from CSCT

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Components of Recommendations

- Physical therapy or occupational therapy
- Taper if medical condition doesn't warrant pain medication
- Discontinued if proven diversion or no if no evidence that the patient is taking the medication

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Priority Patients

- Provider or nurse referral
- Drug refill issues (RN reviews)
- Police information
- Pharmacy concerns
- Slowly working the “list”

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Changing Physician Culture: Slow and Ongoing

- Unexpected urine testing
- "Good" patients with unexpected findings
- Overdoses and overdose deaths
- Police information
- CDC guidelines
- State Board interest in this issue
- Minnesota State Prescribing Guidelines, 2018

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What does the board expect?

- Evaluate patient history and physical
- Document treatment plan
- Check the PDMP
- Informed consent and medication agreement
- Periodic review-functional improvement?
- Consultation/referral if appropriate
- Medications-attempt to decrease and pill counts, drug screens

Minnesota Board of Medical Practice

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Outcomes

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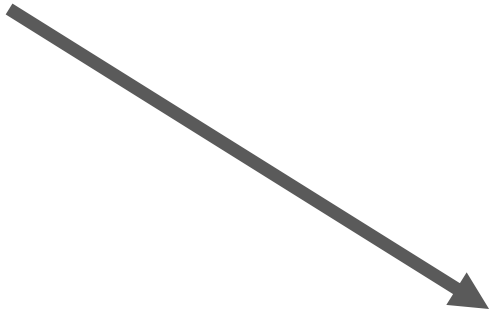
#1

In 2014, the #1 Emergency Department diagnosis was therapeutic drug monitoring



↓#20

As of Nov. 2015, Emergency Department diagnosis for therapeutic drug monitoring is no longer on the top 20 list

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668 patients had opioids, benzodiazepines, or stimulants discontinued by a Controlled Substance Care Team intervention.

These patient tapers account for **724,776** fewer pills/units prescribed in a year.

383,952

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668 total taper patients (narcotics, stimulants, or benzodiazepines)

- Average decrease= **60,398** units/month no longer prescribed

Patient Needs/Support Referrals

- 2016: 146
- 2017: 336

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Reasons for Tapers:

- Dose too high
- Diverting
- No diagnosis/reason for medications
- “Other” – urine drug screen results, self medicating, etc.

These patients are still treated for their conditions but with other methods

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Medication-Assisted Treatment

Medication-Assisted Treatment

- FDA- approved medications with:
  - Counseling
  - Behavioral therapies

Holistic Approach

https://www.samhsa.gov/medication-assisted-treatment

MAT is Not a Drug for a Drug

- Long-term opioid use alters brain chemistry
- Abstinence based treatment not effective

86%

Medications Approved for the Treatment of Opioid Use Disorder

- Agonist- Methadone
- Partial Agonist- Buprenorphine
- Antagonist- Naltrexone
- Detox
  - Give and quickly taper methadone/buprenorphine

Our choice for MAT

- Buprenorphine-Naloxone
  - Partial agonist
  - Good safety profile
  - Proven effectiveness
  - Easily dosed and available
  - Can be prescribed by primary care *(with waiver)*

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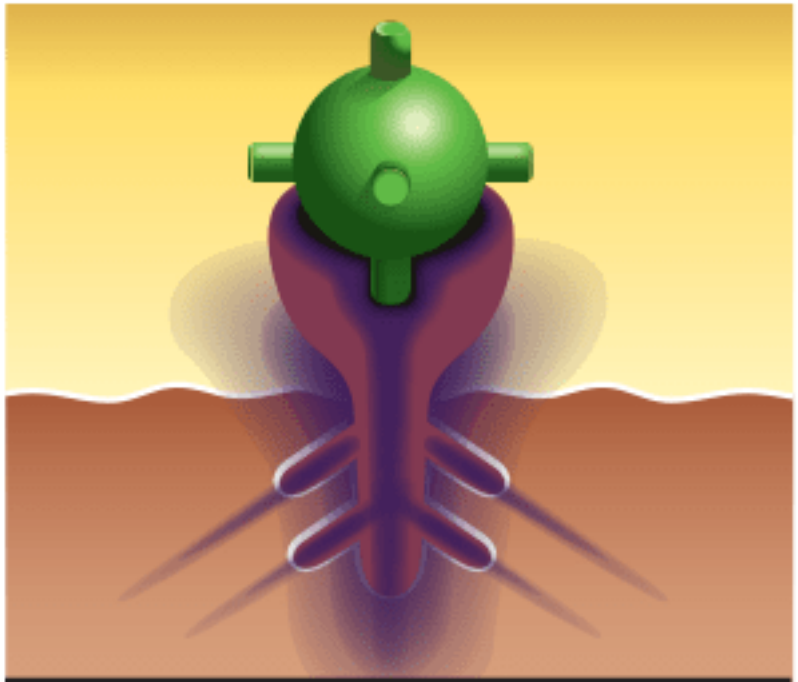
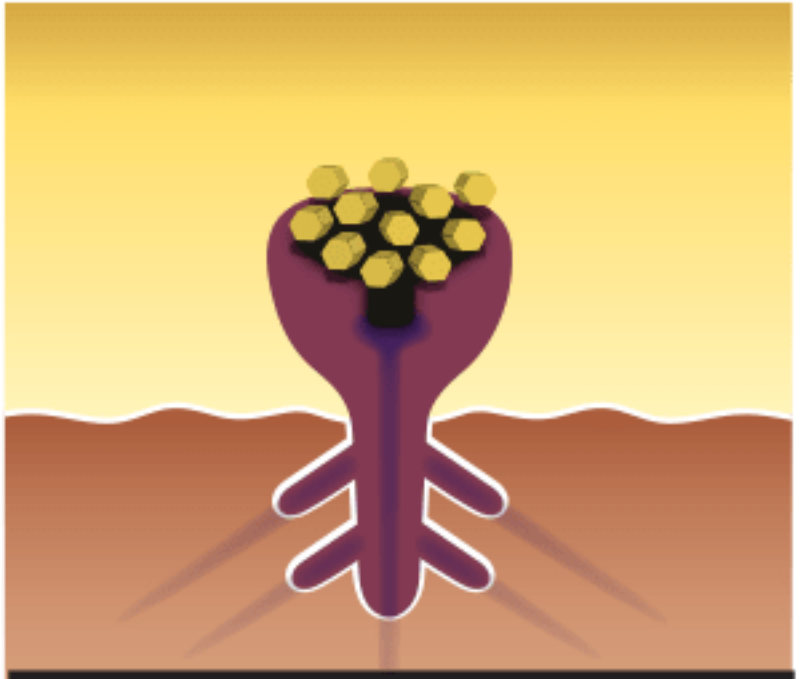


Full Agonist Opioid.
Perfect receptor fit.
Maximum intrinsic activity (opiate effect).



Partial Agonist Opioid
(Buprenorphine). Imperfect Fit.
Less intrinsic activity (opiate effect).

Rural Barriers to Treatment

- Distance
- Accessibility
- Stigma
- Accessibility of medication in pharmacy

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Why start an MAT program in a rural clinic?

- Patients with underlying opioid use disorder are unable to taper from narcotics
- Large population of patients using heroin
- Overdose deaths
- Standard of care
- Patients like to be treated in their local clinic

Reduce Potential for Relapse

- Behavioral intervention alone- 80% relapse within 2 years
- Methadone and buprenorphine 60% retention in program
- One small study with buprenorphine showed a 1 year retention of 75%, patients on placebo had a retention rate of 0% with 4 deaths at 1 year.

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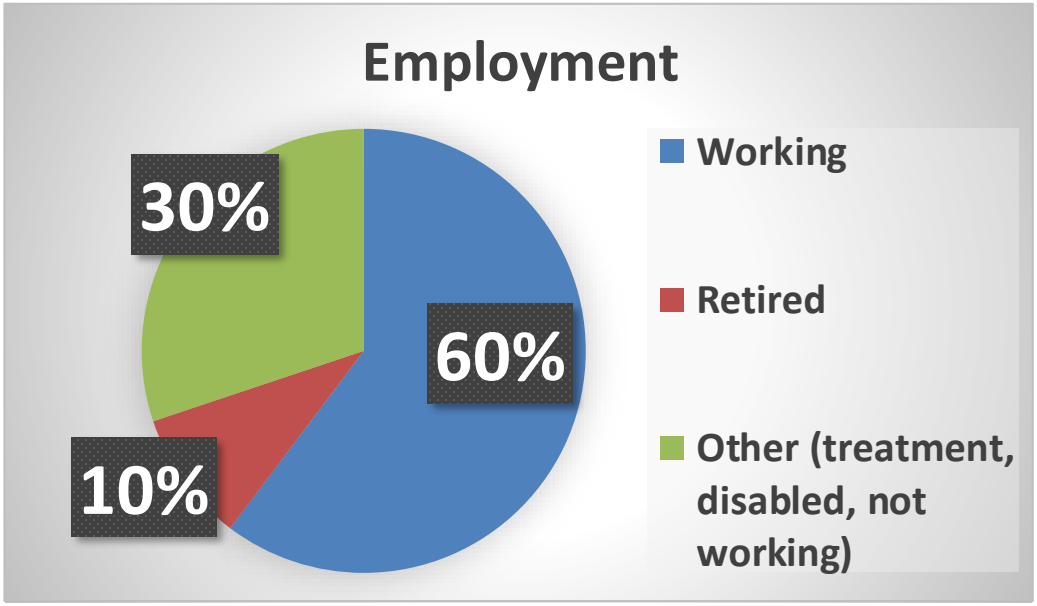
Improving Employment

- We feel buprenorphine has greatest potential to get people back to work
  - Convenient monthly visits- not daily
  - Overall cost likely less
- Anecdotally: less fatigue and increased motivation



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MAT and Criminal Justice

- Research based on randomized controlled studies with greater than 3 month follow up show buprenorphine/naloxone is as effective as methadone in:
  - Decreasing opioid use and re-arrest
  - Increase treatment retention
  - Inmates were more likely to report to continued community treatment upon release

– Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury Afshar. An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals. Illinois Criminal Justice Information Authority. July 18, 2017

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Pregnancy

- Safe in pregnancy
- Better compliance with prenatal visits
- Can’t use other meds/narcotics
- Can deliver in home hospital

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Getting into "our program" …

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Our Workflow

Patient calls clinic and talks with nurse care coordinator or social worker

- **Drug history**
- **"Story"**

Doctors review

Patient scheduled

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Ultimate Goal:

- Seeing the patient when they are motivated to change
- Treating the condition like it is an emergency

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Our Buprenorphine Program Success Thus Far

- Currently Active: 84
- Inactive: 69
- Transferred: 4

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Jail Program

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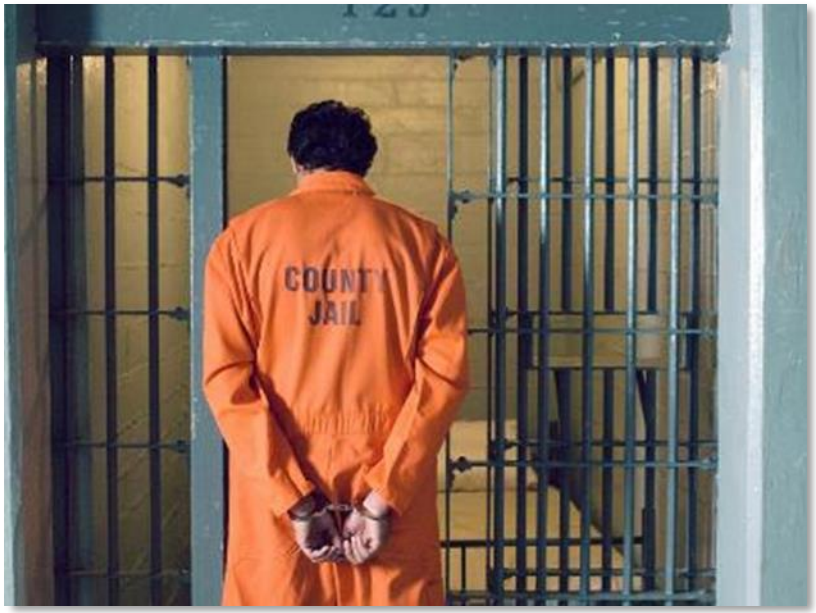
What happened?

Initiating and Maintaining MAT

- Maintain stable patients if jail time is <30 days
- In withdrawal and want help, initiate MAT
- Recidivism problem: $120/day for jail vs $8.10/day for buprenorphine

Barriers

- Significant cost to county
- Waivered doctor/training
- Staff education
- Strict protocols



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Convened a county panel

- Judge
- Sheriff
- Jailor
- Social Services
- Jail doctor
- County attorney
- Drug court
- Probation

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Typical Process

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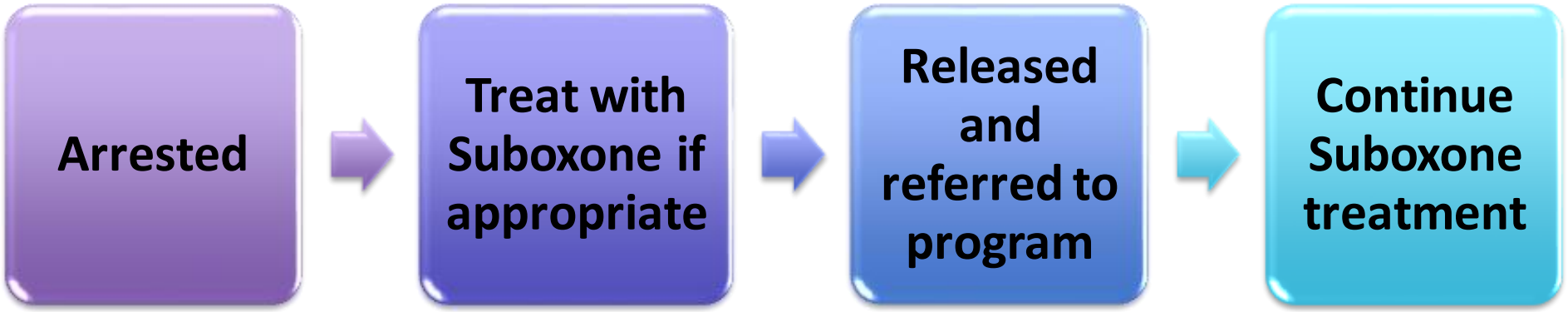
New Process



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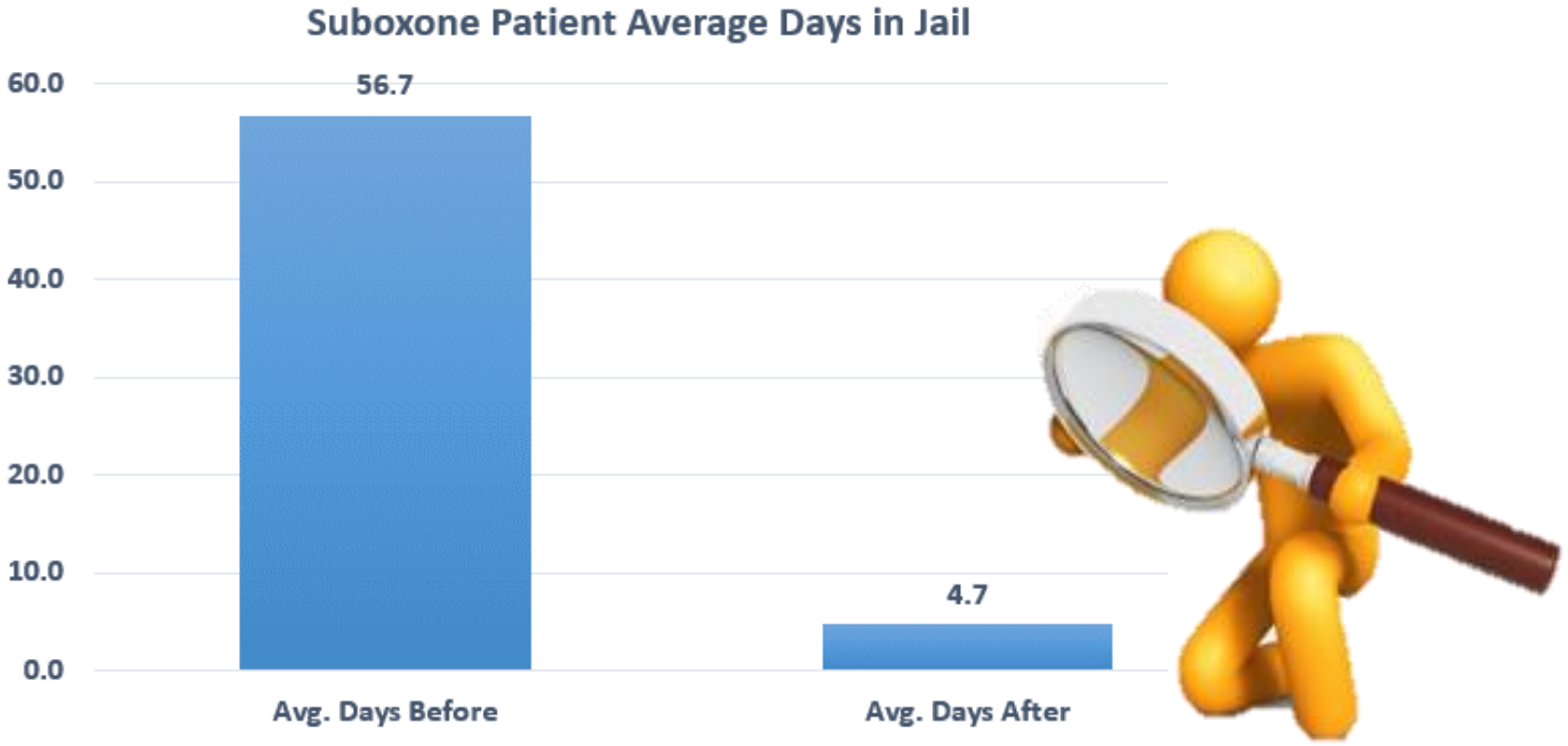

Average Days Spent In Jail Prior to Buprenorphine vs. After Buprenorphine- 83 patients surveyed

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Emergency Department

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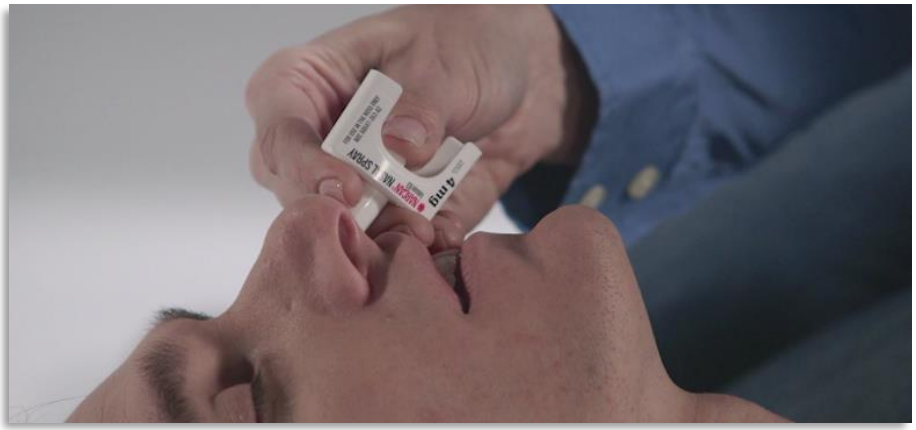
Goal: Point of care intervention

- Treat like emergency, point of care
- Not about tying up a bed with “these people”
- Just as “standard of care” as ACLS/ATLS
- More common than car accidents



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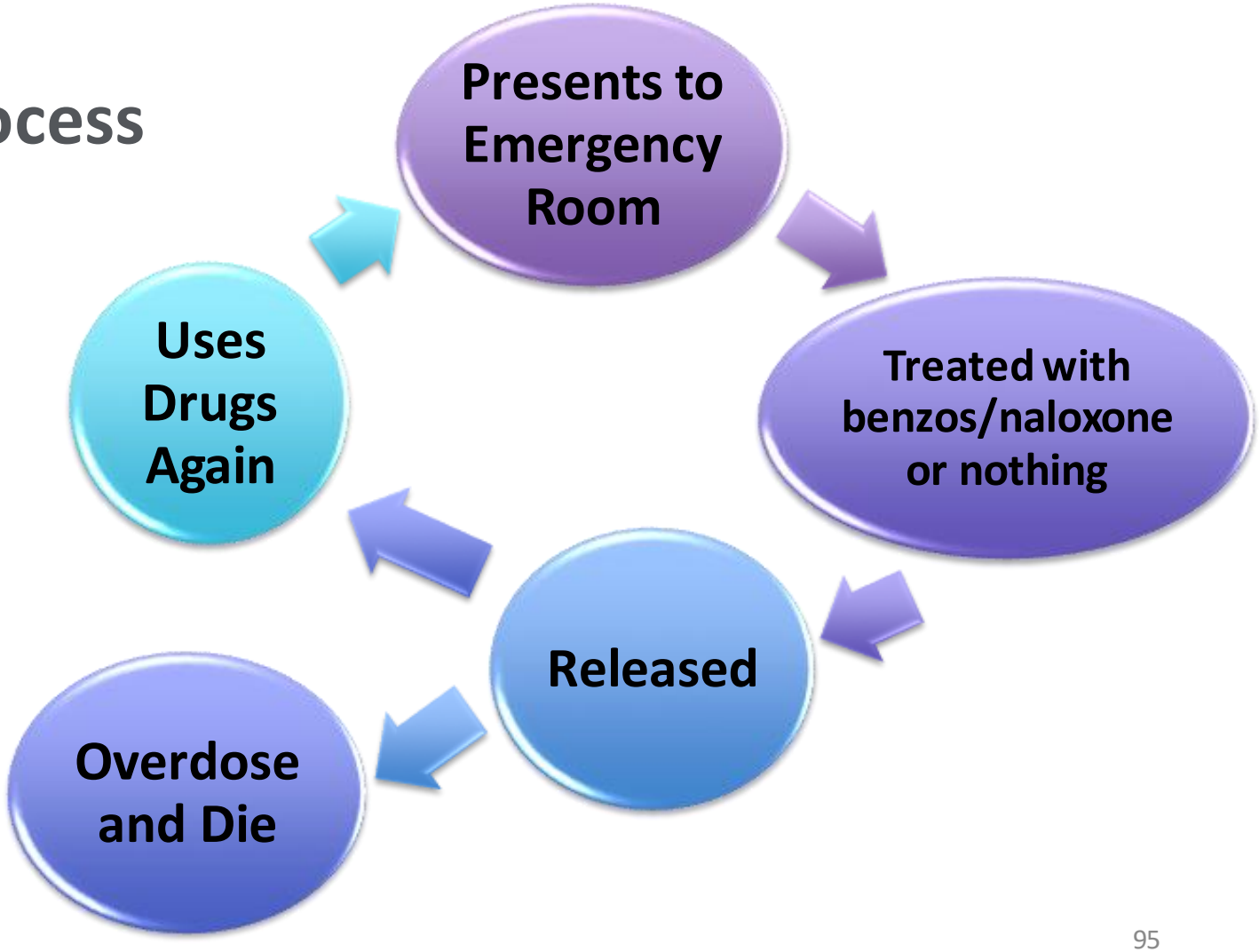
Typical Process



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ED Initiated Suboxone – OVERNIGHTS AND WEEKENDS

1. Dx- Opioid Use Disorder, Severe
2. Assess opioid type and last use
3. Complete DSM5

COWS
(In EPIC Flowsheets)

Contact:
Dr. Heather Bell (320) 630- 5607
OR
Dr. Kurt Devine (320) 630-2507

0-7 Mild Withdrawal

- DO NOT GIVE BENZOS
- Observation with COWS 1x per hour

>8 Mild to Severe Withdrawal

- DO NOT GIVE BENZOS
- Administer 4mg Suboxone SL
- Observe 45-60 minutes
- Repeat COWS
- Administer 4mg Suboxone SL
- Observe 45-60 min
- Repeat COWS

Discharge Criteria

1. COWS score decreased
2. Call Dr. DeVine or Dr. H. Bell (numbers listed above) for discharge instructions and to place referral

ED Initiated Suboxone – WEEKDAYS AND CLINIC HOURS

1. Dx- Opioid Use Disorder, Severe
2. Assess opioid type and last use
3. Complete DSM5

COWS
(In EPIC Flowsheets)

0-7 Mild Withdrawal

>8 Mild to Severe Withdrawal

DO NOT GIVE BENZOS

Contact:
Controlled Substance Care Team at 631-7000 to alert them to come to ER to complete Suboxone Induction Packet

CSCT will provide guidance as to further treatment

>8 Mild to Severe Withdrawal

- Administer 4mg Suboxone SL
- Observe 45-60 minutes
- Repeat COWS
- Administer 4mg Suboxone SL
- Observe 45-60 min
- Repeat COWS

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Duplicating our Program

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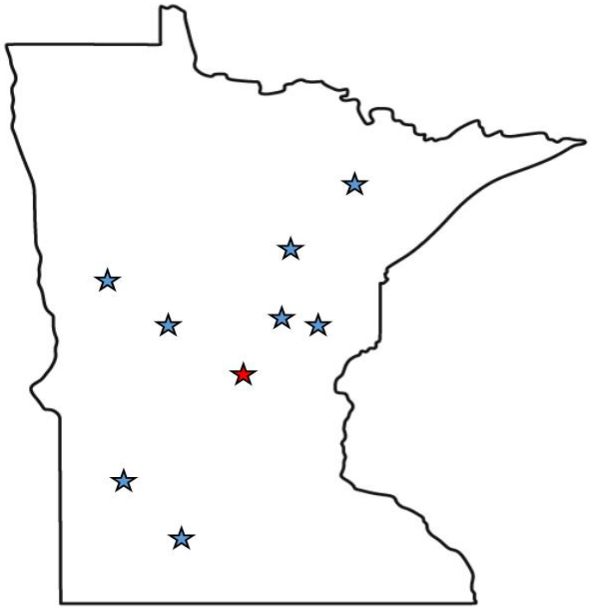
Replicating our program began in May 2018 with $1.2 million in legislative grant money

- Each community received $75,000-$100,000
- Money to hire nurse care coordinator
- Physician lead



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What the Communities Need To Do

- Monitor prescribing
- Assemble county task force
- At least one buprenorphine waivered physician
- CSCT

DEPARTMENT OF HEALTH

Can our program work in other communities?

Following our guidelines and model, other communities are seeing decreases in pills:

- Community 1: 258,036/year
- Community 2: 167,472/year
- Community 3: 276,843/year

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Duplicating Program

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Our communication throughout our state and further.

Project ECHO®

Moving Knowledge Instead of Patients and Providers

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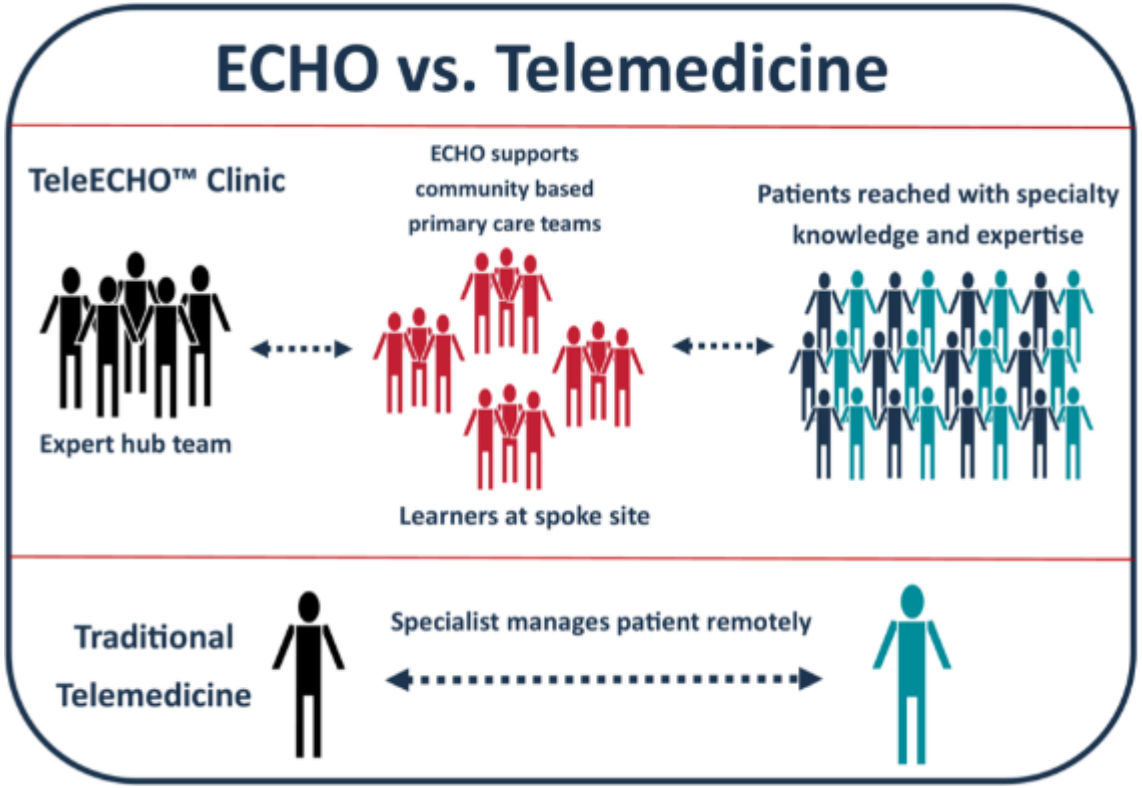

ECHO model is not "traditional telemedicine."
Treating physician retains responsibility for managing patient.

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DEPARTMENT OF HUMAN SERVICES

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Goals of our ECHO:

- Increasing general knowledge of opioids and addiction
- Demonstrating how to implement our program in rural primary care

ECHO Clinic Format

- Attendance
- Didactic
- Case discussion/reviews
- Specialist partners
  - Addiction specialist
  - Pain doctor
  - Toxicologist

Topics Covered

- Care Plans
- Task Force Components
- Care Team Functions
- Marijuana Overview
- Patient Centered Medical Homes
- Lumbar Pain
- Mis-Prescribing

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Presenters:

- Family physicians
- Maternal Fetal Medicine Specialist
- Prescription Drug Monitoring Program Administrator
- Director of Minnesota DHS
- Addiction Medicine physician
- Women's treatment center president
- LADC

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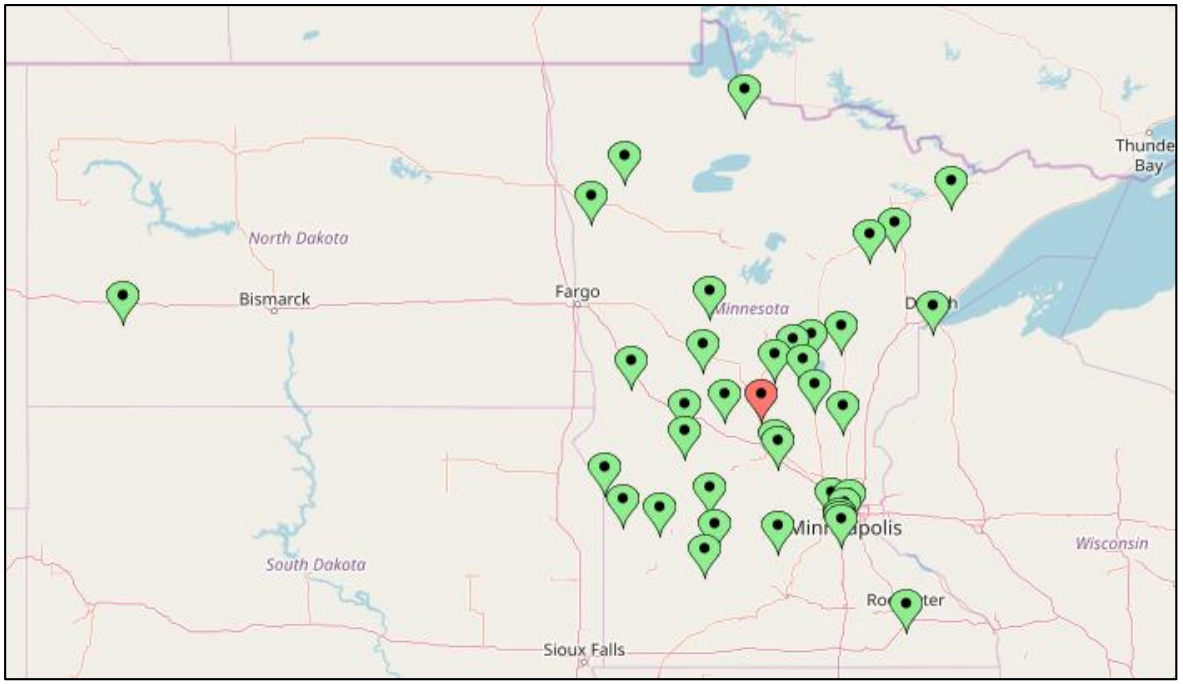
Little Falls Hub

ECHO Spoke Locations



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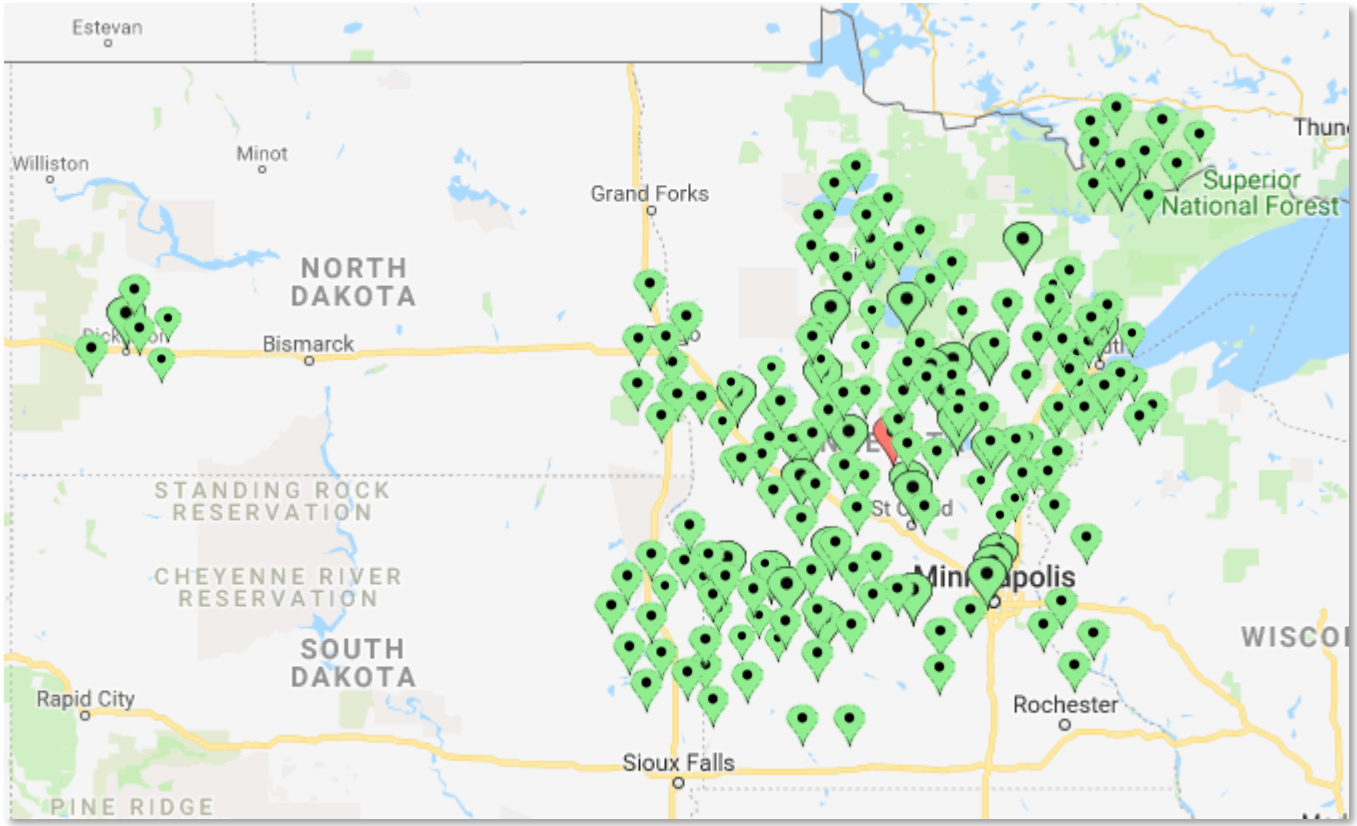
Little Falls Hub

ECHO Participants



Together
We're Stronger

A Rural Response

2nd ECHO Program

Partnering with the University of Minnesota Rural Physician Associate Program (RPAP)

- Nine-month, community-based educational experience
- For third-year medical
- Hands-on learning
- Physician preceptor 17 week curriculum

UNIVERSITY OF MINNESOTA

Together
We're Stronger

Buprenorphine Program: Defining Success

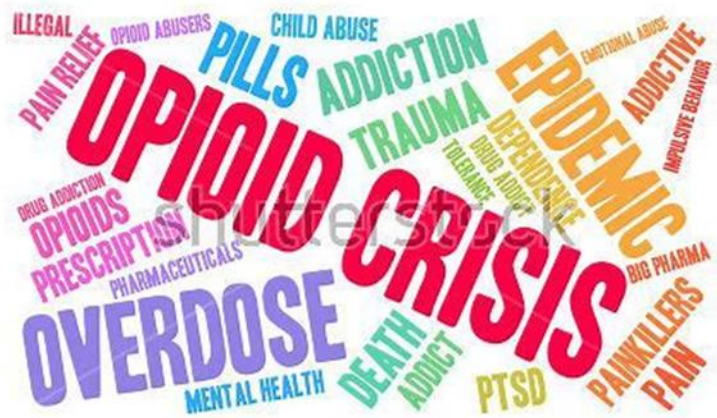
- Time
  - Sobriety
  - Past point of brain healing
- Employment
- Repaired relationships
- Parenting

The Opioid Crisis in Farm Country

Minnesota Farm Bureau Foundation

The Minnesota Farm Bureau is a 501C3 Foundation that provides opportunities and programs focused on supporting active farmers and agriculturalists, better connecting agriculture to consumers AND serving rural communities.

Minnesota Farm Bureau Foundation
Ruth Meirick
Foundation Director



farmtownstrong.org

Quick Story

Minnesota Farm Bureau Foundation has partnered with RALI Minnesota *to promote* ***farmtownstrong.org*** *the website.*

It's our job to bring awareness and resources to rural Minnesota that help combat the opioid crisis.

We believe strongly that we must be at the table communicating our story with all those who will listen.

Minnesota Farm Bureau Foundation
Ruth Meirick
Foundation Director

farmtownstrong.org

Why?

We have a crisis happening in our rural communities.

We must all believe it is our duty to keep our farm families and rural communities safe and healthy.

Together, we'll overcome the opioid epidemic through strong farmer-to-farmer support and the resilience of our communities.

Minnesota Farm Bureau Foundation
Ruth Meirick
Foundation Director

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Identified Problem

The Minnesota and the American Farm Bureau wanted to address the staggering statistics that were indicating that rural America had an opioid crisis.

- *74% of farmers and farmworkers say they have been directly impacted by the opioid epidemic.*
- *3 in 4 farmers say it is easy to access large amounts of opioids without a prescription.*

Minnesota Farm Bureau Foundation
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How we are approaching it and what we are doing…

- **Set up outreach meetings and participated in events to build awareness**
  - National Health & Safety Conference
  - IDEAg -- Farmfest
  - MN Farm Bureau LEAP Conference
  - MN Farm Bureau Annual Meeting
  - Care Coordinators Conference
  - Minnesota Association of Counties – Opioid Summit
  - County Farm Bureau Outreach meetings

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Foundation Director

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Overview of Steps to Achieve Solution

- *Identify opportunities to communicate and share*
- *Find opportunities to partner*
  - *Hospice*
  - *National Night Out*
  - *Local Social Services Offices*
  - *County Farm Bureaus*
  - *4-H & FFA*
  - *Veterinarians*
  - *Law Enforcement*
  - *Care Coordinators*

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Our results

- *Created conversations that there are avenues of help.*
- *Educated others on safe and affordable ways to dispose of opioids, and why that is important.*
- *Provided opportunities for others to share their stories and learn from each other.*
- *Created conversations with decision makers.*

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