

HEALTH MANAGEMENT ASSOCIATES

Battling Opioid Addiction: Public Policy and Healthcare Strategies for an Epidemic

Speakers:

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Moderator:

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September 29, 2015

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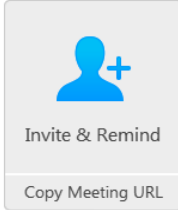
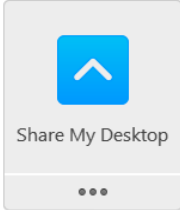
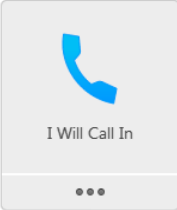
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▼ Participants (1)

Speaking:

▼ Panelists: 1

 **HMA Events** (Host, me) 


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▼ Chat

Send to: All Panelists


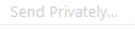
Select a participant in the Send to menu first, type chat message, and send...





▼ Q&A

All (0)

Select a question, and then type your answer here. There is a 256 character maximum.

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Panelists: 1

HMA Events (Host, me)

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Chat

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Select a participant to send a message to:

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- All Participants
- Select an Attendee...

Select a question, and then type your answer here. There is a 256 character maximum.

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Chat

Send to: All Panelists

Type your question here

Send

Q&A

All (0)

Select a question, and then type your answer here. There is a 256 character maximum.

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"The CDC is proposing that it is better to put millions to a slow and torturous death rather than risk overdose. You might as well plan a genocide for true pain patients." — Reader comment

Modern Healthcare

The leader in healthcare business news, research & data

CDC: Opioid prescribing has 'primed' Americans for heroin addiction

Groups unite against curbing painkillers
Industry, doctors, patients lobby over opiate laws



The New York Times
OxyContin Is Not for Kids

theguardian

Rapid rise of heroin use in US tied to prescription opioid abuse, CDC suggests

Times Gazette

Doctors have a role in opioid addiction epidemic: CDC



Aimee Bee Brooks

Learning Objectives

- Importance of provider education
- Understand harm-reduction and patient-safety programs
- Potential unintended consequences of laws and policies
- Crafting policies and protocols that emphasize a coordinated approach

**DRUGS LEAD TO ADDICTION,
JAIL, END OF LIFE..
END OF STORY!!**

call Jodi at 949.831.5430 for help and she will refer you to a professional

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MIKE MELIMAN DEAD AT 27	JOHN MURPHY DEAD AT 26	JAMIE BARNER DEAD AT 25	MIKE RUTTO DEAD AT 24	RYAN WYTER DEAD AT 26
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National Impact

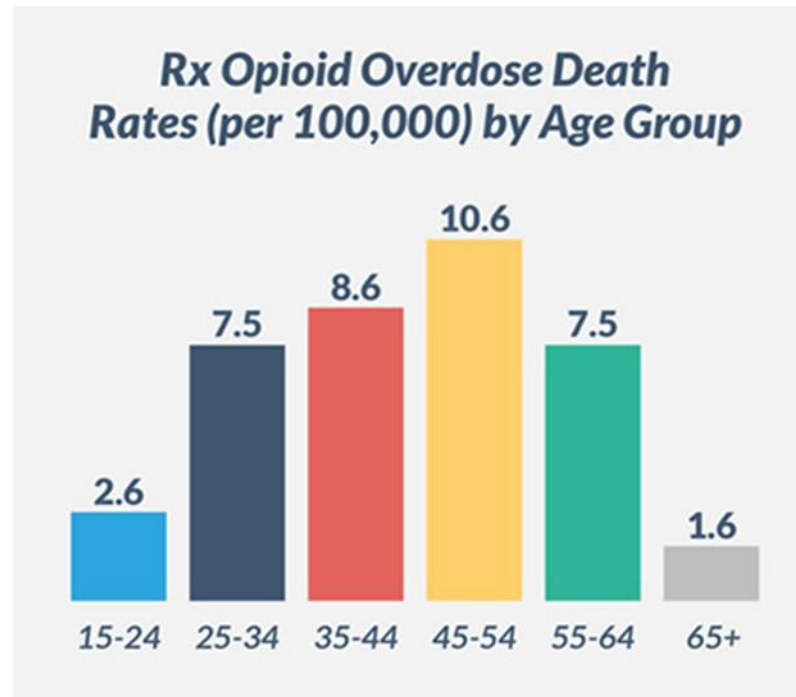
- Drug overdose was the leading cause of death due to injury in 2013
- In 25-64 age group, drug overdose caused more deaths than motor vehicle accidents
- >40,000 drug overdose deaths in the US in 2013
- Combination of benzodiazepines and opioid painkillers is often found at death

National Impact

- Drug misuse and abuse caused >2 million emergency department visits in 2011
- Two million Americans either abused or were dependent on opioid painkillers in 2013
- Prescription opioid abuse costs were greater than \$55 billion in 2007

Demographic

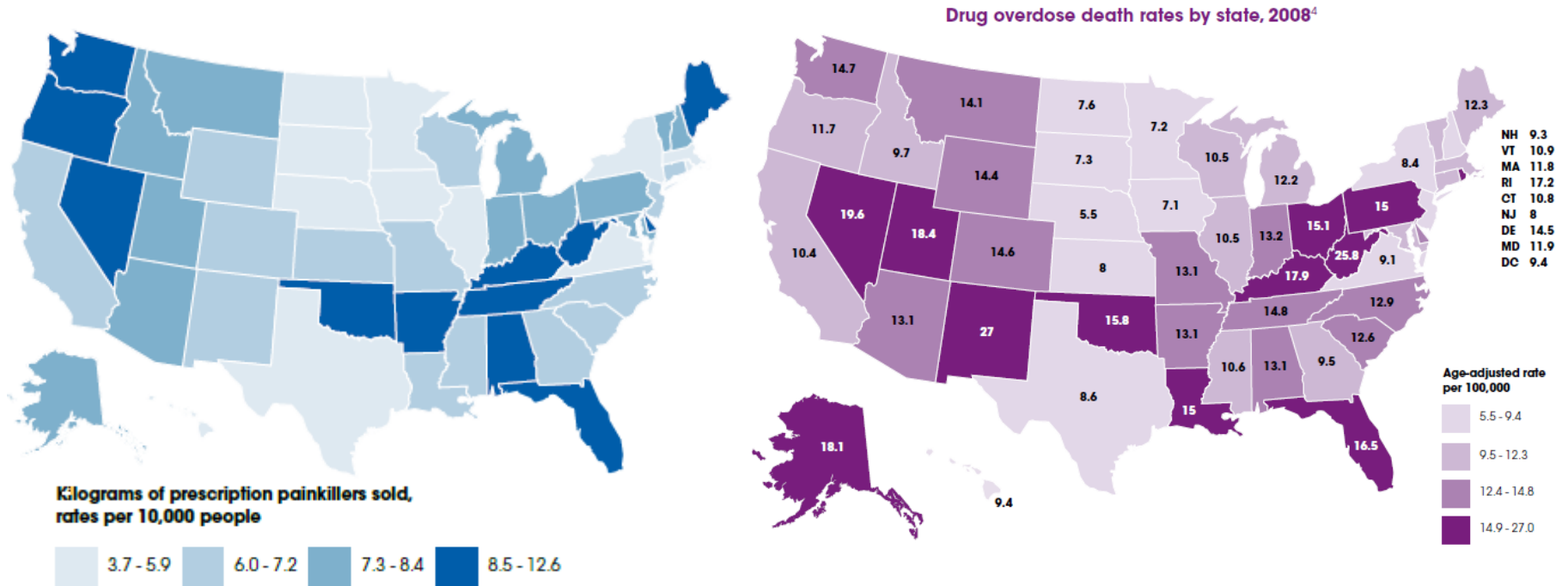
44 people die of prescription related OD every day



State Variability in Prescribing and Deaths

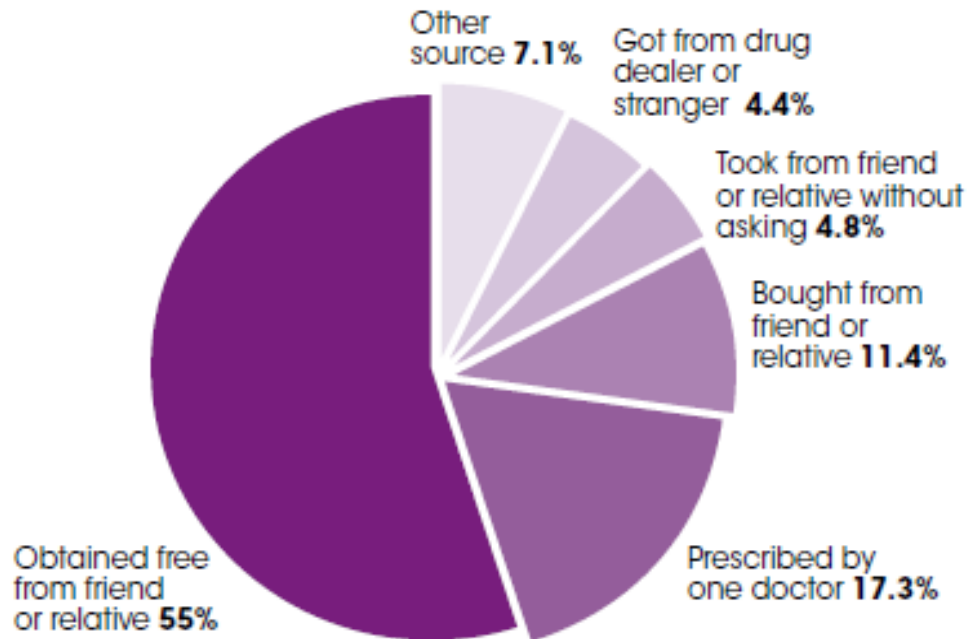
- Providers in the highest-prescribing state wrote 3 times as many opioid prescriptions/person
- Causes of pain do not vary
- Factors influencing prescribing rates

Prescriptions Sold: Drug Overdose Deaths



Source of Prescription Painkillers

**People who abuse prescription painkillers
get drugs from a variety of sources⁷**



How Did We Get Here?

An Iatrogenic Epidemic ?

- Physicians understood opioid pain medication role better
- Understood potential for adverse effects
- Change in culture

Federal and State Response

- Making misuse difficult
- Reclassification of drugs
- Prescription Drug Monitoring Programs (PMPs or PDMPs)
- Drug take-back programs
- Prescribing Guidelines
- Funding *Prevention* programs
- Harm Reduction programs
- Public Education Campaigns

Outcomes

Federal and State Response

- Florida
- North Carolina

Are there Unintended Consequences to Federal and State Response?

- Prescribed opioids and link to heroin
- ED admissions
- *What is clear is that our problems with opioids continue at full throttle*

People Most at Risk

- Obtain multiple prescriptions from multiple providers
- Take high daily dosages
- Misuse multiple prescription drugs
- Are low-income and live in rural areas
- Are on Medicaid
- Are prescribed painkillers at twice the rate of non-Medicaid patients
- Are six times more likely to overdose
- Have a mental illness and/or history of substance abuse

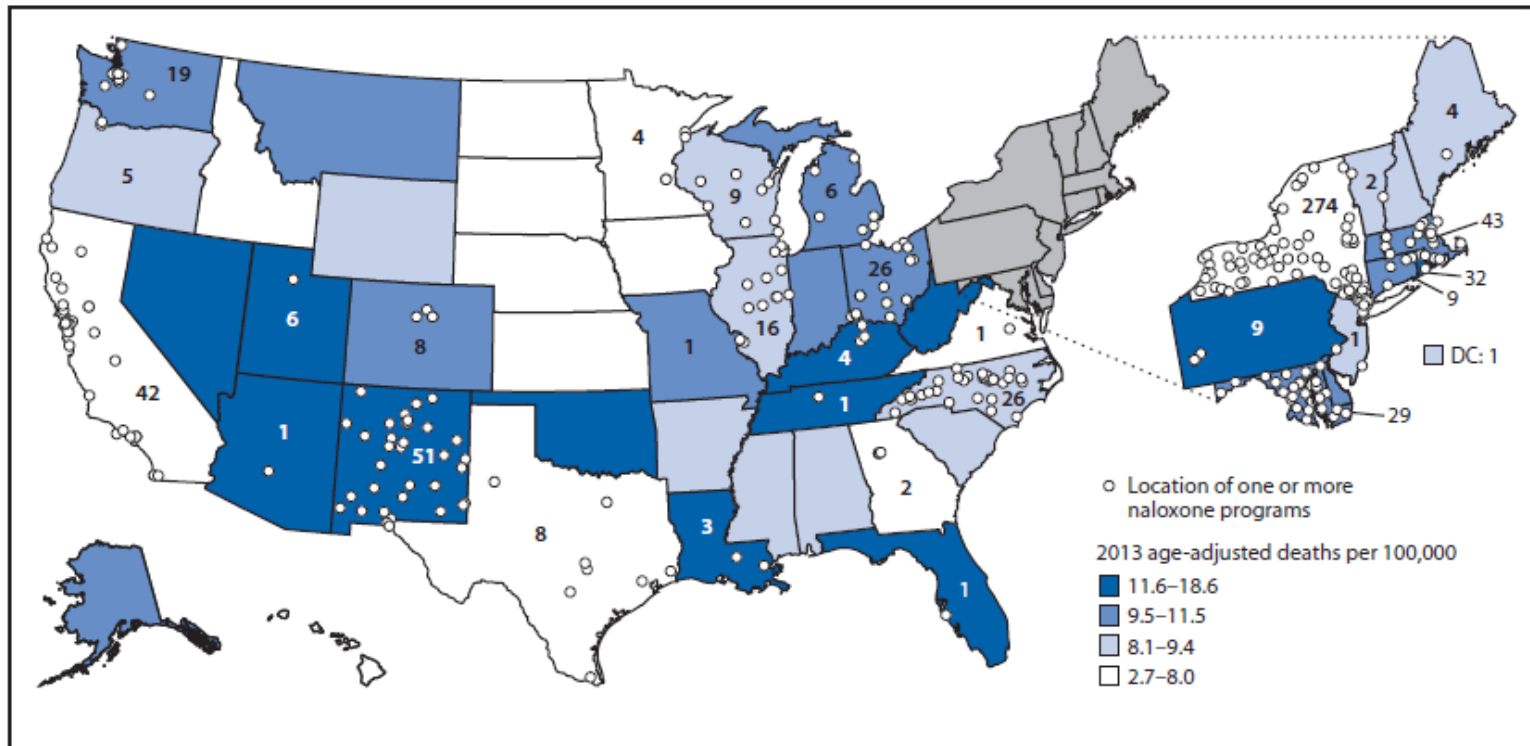
What are States Doing?

- Prescription Limits
- Identification Laws
- Laws Related to Prescription Drug Overdose Emergencies
- Pain Management Clinic Regulation

Strategies For Managing the Epidemic:

- Harm Reduction Strategies
- Improved Access to Substance Abuse Treatment
- New Options for Medication Assisted Treatment
- Provider Education Efforts
- Public Policy
- Public Awareness and Education
- Shift toward treating substance abuse as a chronic disease

Harm Reduction Strategies: Naloxone



Harm Reduction Programs-- Naloxone

- Distribution of naloxone began at syringe exchanges
- Now expanded to other venues
- 20 states still lack opioid overdose prevention programs that distribute naloxone

Massachusetts OEND: Overdose Education and Naloxone Distribution



DOPE PROJECT

Drug
Overdose
Prevention
Education

prevention | point | pittsburgh

The Evolution of Community Pharmacy Collaboration

Provider Level Strategies

- EB Consensus guidelines
- Financial incentives
- Involving medical-legal community
- Requiring training
- Providing practice re-design tools
- Frequent and varied opportunities for learning or adopting tools

Common Recommendations for Prescribing Opioids (CDC draft recommendations)

- Conducting thorough history and physical exam
- Conducting drug testing
- Considering all treatment options
- Starting patients on the lowest effective dose
- Implementing pain treatment agreements
- Monitoring progress
- Using safe and effective methods for discontinuing opioids
- Using data from PDMPs

Provider Education Tools: NYC Department of Health and Mental Hygiene



City Health Information

CHI goes paperless—
see back for details

December 2011

The New York City Department of Health and Mental Hygiene

Vol. 30(4):23-30

PREVENTING MISUSE OF PRESCRIPTION OPIOID DRUGS

- Physicians and dentists can play a major role in reducing risks associated with opioid analgesics, particularly fatal drug overdose.
- For acute pain:
 - If opioids are warranted, prescribe only short-acting agents.
 - A 3-day supply is usually sufficient.
- For chronic noncancer pain:
 - Avoid prescribing opioids unless other approaches to analgesia have been demonstrated to be ineffective.
 - Avoid whenever possible prescribing opioids in patients taking benzodiazepines because of the risk of fatal respiratory depression.

NYC Department of Health and Mental Hygiene: Provider Newsletter

Note: The use of brand names does not imply endorsement of any product by the New York City Department of Health and Mental Hygiene. Please consult prescribing information for complete safety information, including boxed warnings.

FIGURE. OPIOID RISK TOOL

		Mark each box that applies	Item score if female	Item score if male
1. Family history of substance abuse	<ul style="list-style-type: none"> • Alcohol • Illegal drugs • Prescription drugs 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 2 4	3 3 4
2. Personal history of substance abuse	<ul style="list-style-type: none"> • Alcohol • Illegal drugs • Prescription drugs 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 4 5	3 4 5
3. Age (mark box if 16-45)		<input type="checkbox"/>	1	1
4. History of preadolescent sexual abuse		<input type="checkbox"/>	3	0
5. Psychological disease	<ul style="list-style-type: none"> • Attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia • Depression 	<input type="checkbox"/> <input type="checkbox"/>	2 1	2 1

Total Score _____ Risk Category _____

Low Risk: 0 to 3

Moderate Risk: 4 to 7

High Risk: 8 and above

Source: Webster LR, Webster R. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Med.* 2005;6(6):432.

NYC Department of Health and Mental Hygiene: Provider Newsletter

BOX 5. CALCULATING CUMULATIVE MORPHINE-EQUIVALENT DOSES (MED)

Approximate equivalent doses for 30 mg morphine¹¹:

Hydrocodone: 30 mg

Oxycodone: 20 mg

If a patient takes 6 hydrocodone 5 mg/acetaminophen 500 mg and 2 oxycodone 20-mg extended-release tablets per day, the cumulative dose is calculated as:

Hydrocodone 5 mg x 6 tablets/day = 30 mg/day
= 30 mg MED/day

Oxycodone 20 mg x 2 tablets/day = 40 mg/day
= 60 mg MED/day

Cumulative dose = 30 mg MED/day + 60 mg MED/day
= 90 mg MED/day

BOX 6. CONSIDERATIONS FOR OPIOID DOSING

- **Acetaminophen warning with combination products.** Liver damage can result from prolonged use or doses in excess of the recommended maximum total daily dose of acetaminophen, including over-the-counter products¹¹:
 - Short-term use (<10 days): 4000 mg/day
 - Long-term use: 2500 mg/day
- **For long-acting opioids.** Monitor for adequate pain relief and for breakthrough pain at least until the long-acting opioid dose is stabilized. When calculating the starting dosage, be sure to include any short-acting opioids; consult with a pain management specialist for guidance.¹¹
- **Dosing caution.** Doses ≥ 100 mg MED per day are associated with higher risks of overdose; the lowest possible effective dose should be prescribed at all times. If dosing reaches 100 MED per day, thoroughly reassess the patient's pain status and treatment plan and reconsider other approaches to pain management.

Always monitor for adverse effects (respiratory depression, nausea, constipation, oversedation, itching, etc).¹¹

Medication Assisted Treatment

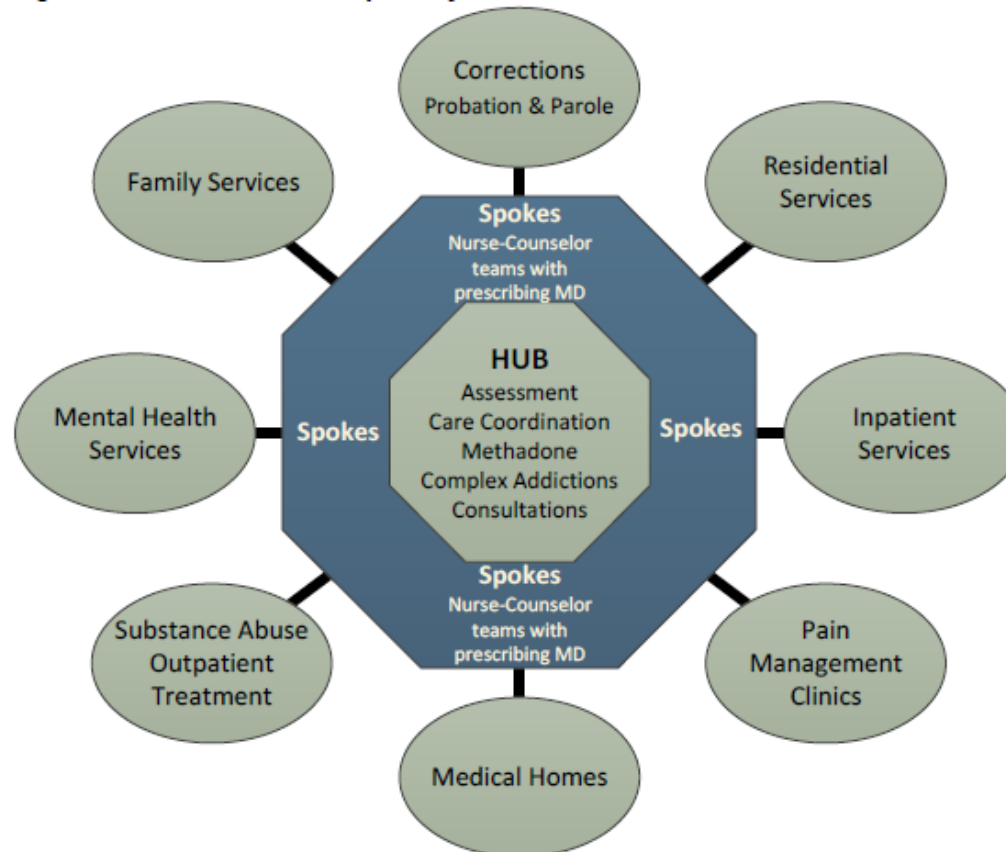
- Use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach
- Premised on concept of Opioid addiction as a chronic disease

Maryland: A Comprehensive Approach to Increasing Access to Individualized Addiction Treatment with Buprenorphine and Counseling

- Collaborative initiative with FQHCs
- Medicaid reimbursement
- Guidelines and protocols
- Physician training
- Monitoring

Vermont: Establishing a More Robust and Connected Substance Abuse Treatment System

Figure 2. Vermont Hub and Spoke System



Note: Adapted from Vermont Agency of Human Services (2012)

Massachusetts: Nurse Care Management Model for Buprenorphine

“Nurse Management” Program to address
the problem

- Assessment, education, referral, adherence monitoring, paperwork
- Allows the physicians to manage a larger group of patients

Improved Access to Substance Use Disorder Treatment

Barriers Exist:

- Institution for Mental Diseases (IMD) exclusion in Medicaid
- Separate systems for treating mental health and substance use disorders

CMS 1115 Waiver Opportunity

- For States pursuing “broad and deep” systems transformations
- Addressing adults and youth with SUD
- Pursuing full continuum of
- Adopting new payment mechanisms
- Performance quality initiatives encouraged
- Ability to coordinate with other sources of funding
- Addressing prescription and opioid addiction

CMS Goals

- Promote SUD as a primary, chronic disease
- Aligning Medicaid policy with Medicare and commercial plans
- Comprehensive continuum of care
- Adding coverage of EB and promising practices
- Having Medicaid partner with drug courts and juvenile justice systems
- Payment reform strategies
- Data for evaluation

CMS Expectations:

- Comprehensive, evidence-based benefit
- Appropriate standards of care
- Network development and resource plan
- Care coordination design
- Integration of physical health and SUD
- Program integrity safeguards
- Benefit management
- Community integration
- Strategies to address prescription drug abuse
- Strategies to address opioid use disorder
- Services to adolescents and youth
- Reporting of quality measures
- Collaboration between Medicaid and Substance Abuse Authority

California: Drug Medi-Cal Organized Delivery System

Ambitious plan to improve mental health services and substance use treatment

- Integrated safety-net delivery system
- Coordinated continuum of services
- Based on the American Society for Addiction Medicine criteria
- Offer counties contracting options
- Provides more administrative oversight

Policy and Benefit Design

- Lifetime limits
- Schedule III medications
- Prior authorization (PA) requirements

Effects of Prior Authorization on Medication Use and Costs

- Limited research on medications for alcohol and opioid use disorders
- Research exists for other chronic illnesses
- Formulary restrictions

Removing Barriers

- Payers are moving toward a system of real-time, standardized prior authorization at the point of care
- One example is the electronic prior authorization system now being used by CVS Caremark (<http://www2.caremark.com/epa>)
- Medicaid benefits can be designed to increase access to substance abuse medications by eliminating lifetime limits

SUMMARY

Substance Use Disorder is a problem for the US

- It is a costly problem
- It is a deadly problem
- It is a treatable problem

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Q & A

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