MISSOURI HOSPITAL ASSOCIATION

Shifting from Shock to Solutions

2018 Missouri Oral Health Policy Conference

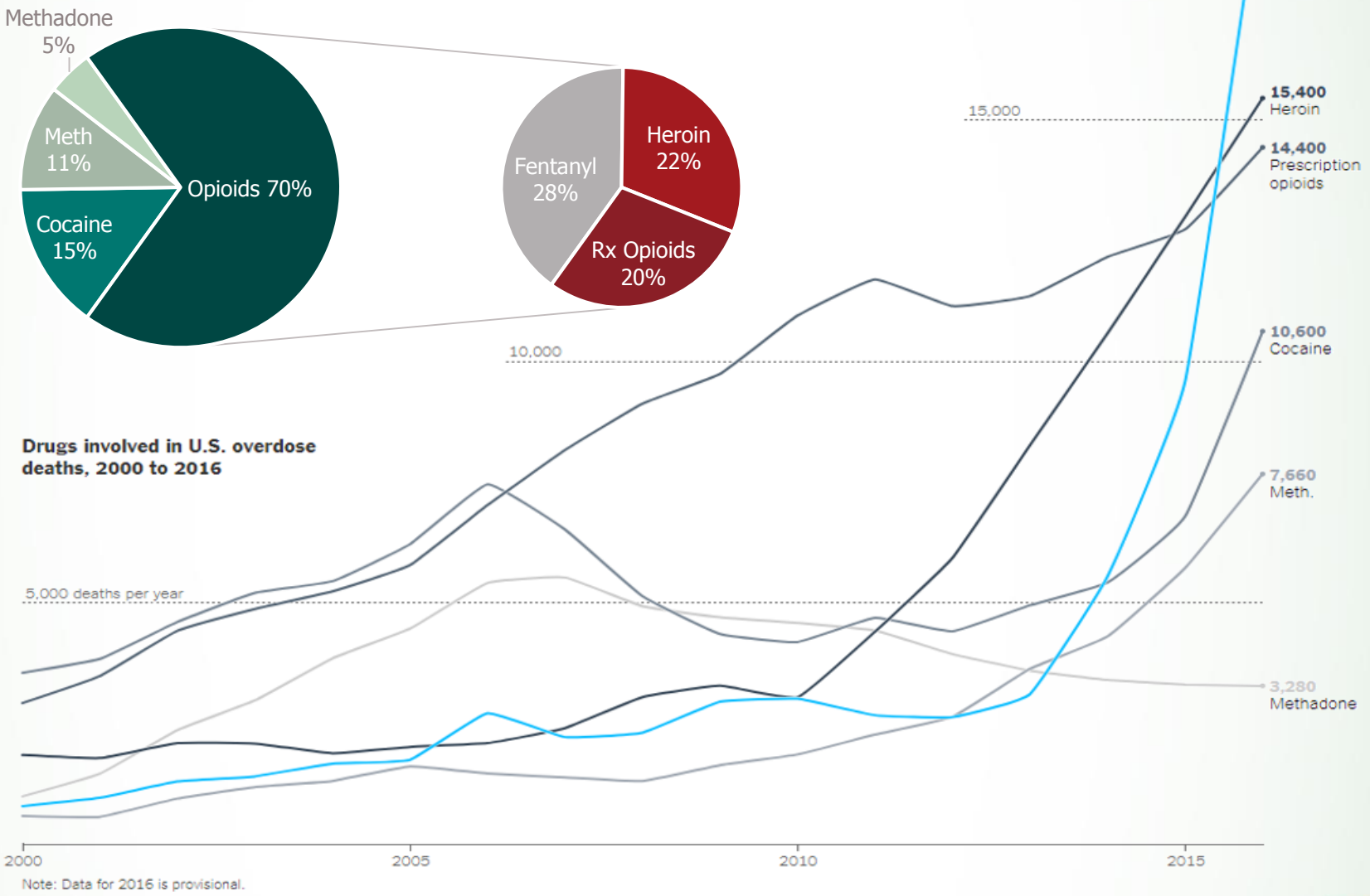
March 1, 2018

Causes of Death in the United States

- Opioids — 2016
  - 64,070 U.S. drug overdose deaths
    - 42,249 opioid-related overdose deaths
    - 1,400 in Missouri
    - 21 percent increase since 2015
    - 300 percent since 1999
- Influenza — 2010 to 2015
  - Annual range of excess deaths from influenza and pneumonia is 4,000 - 20,000
- Motor Vehicle Accidents — 2014
  - 33,736
- Firearms — 2014
  - 33,594

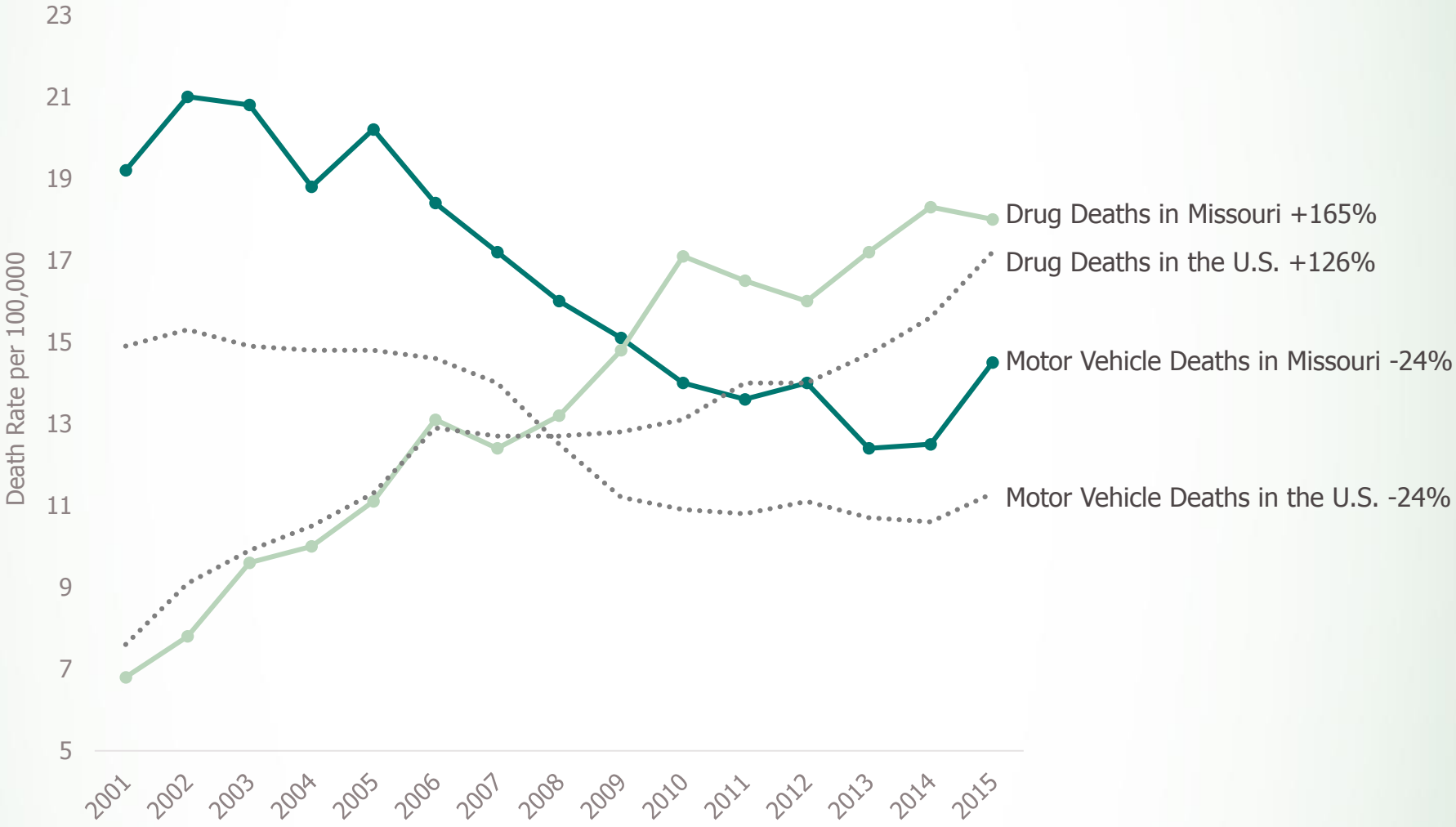
Sources: https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates
https://www.cdc.gov/flu/about/disease/2015-16.htm
https://www.cdc.gov/nchs/fastats/injury.htm

Distribution of Drug-Induced Deaths by Type in the U.S.



Source: *https://www.nytimes.com/interactive/2017/09/02/upshot/fentanyl-drug-overdose-deaths.html*

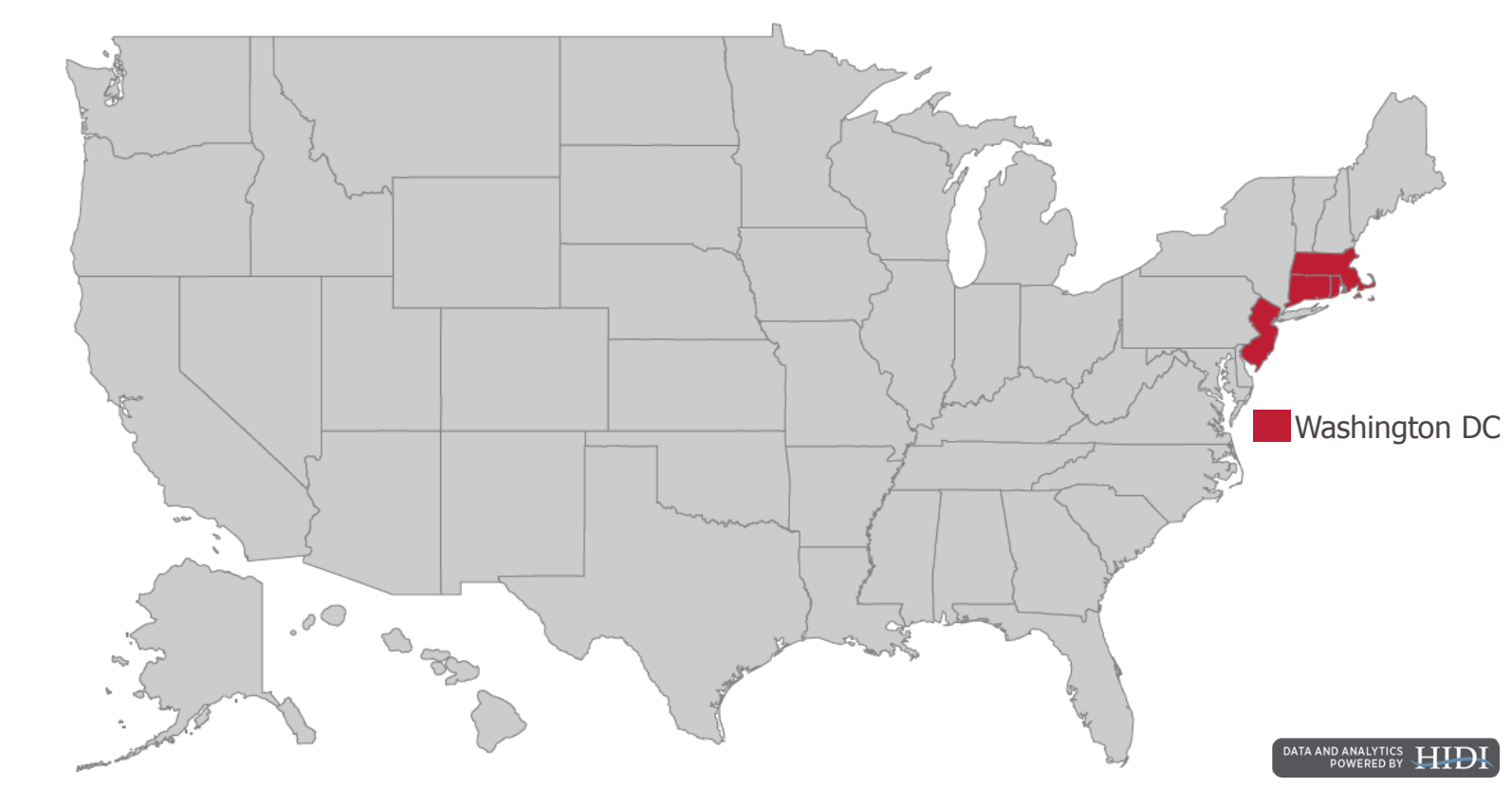
Drug-Induced vs. Motor Vehicle Death Rates in the U.S. and Missouri Over Time



Source: *Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015.*

States with More DRUG-INDUCED Than Motor Vehicle-Related Deaths

2001



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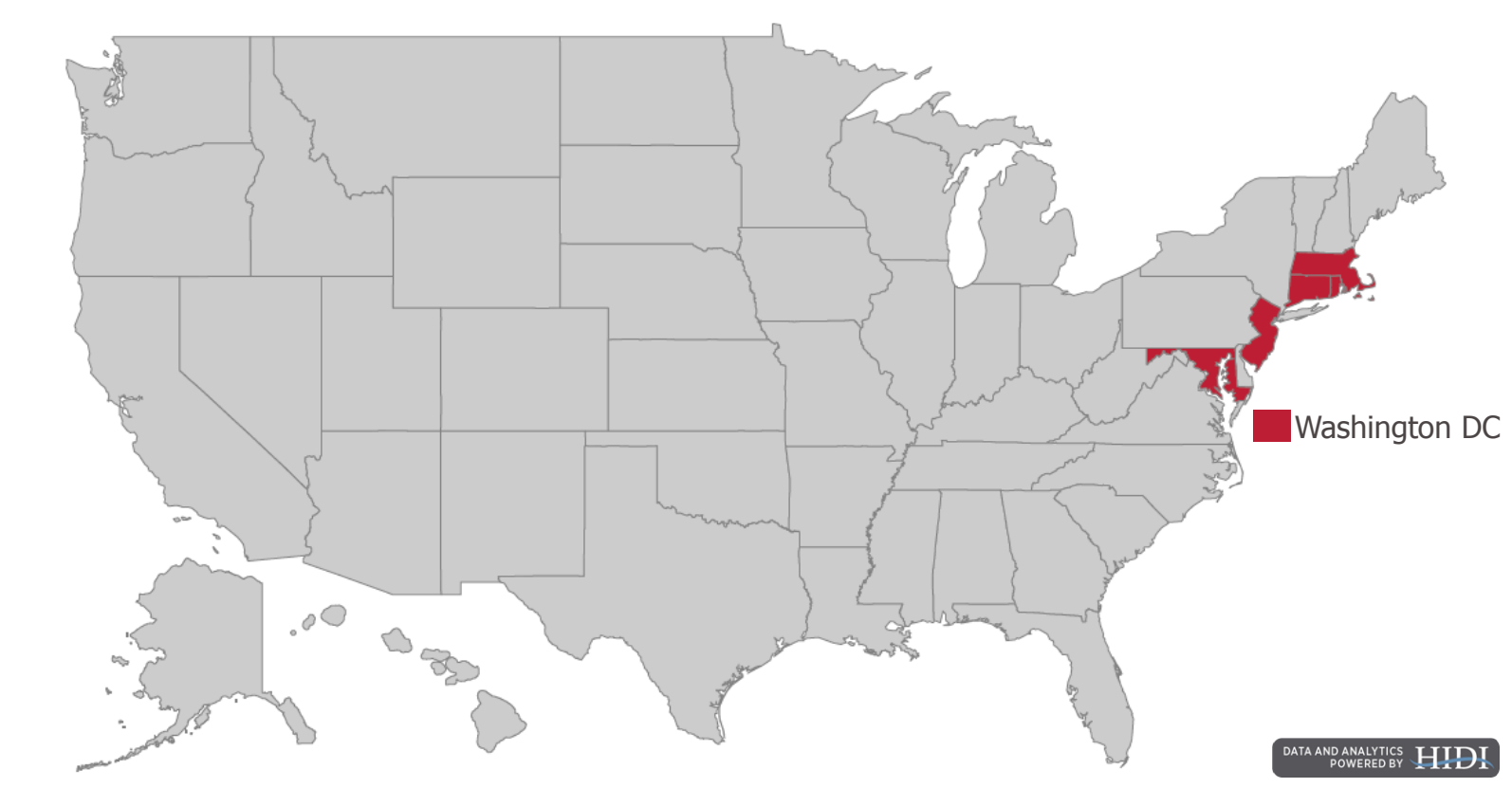

2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016

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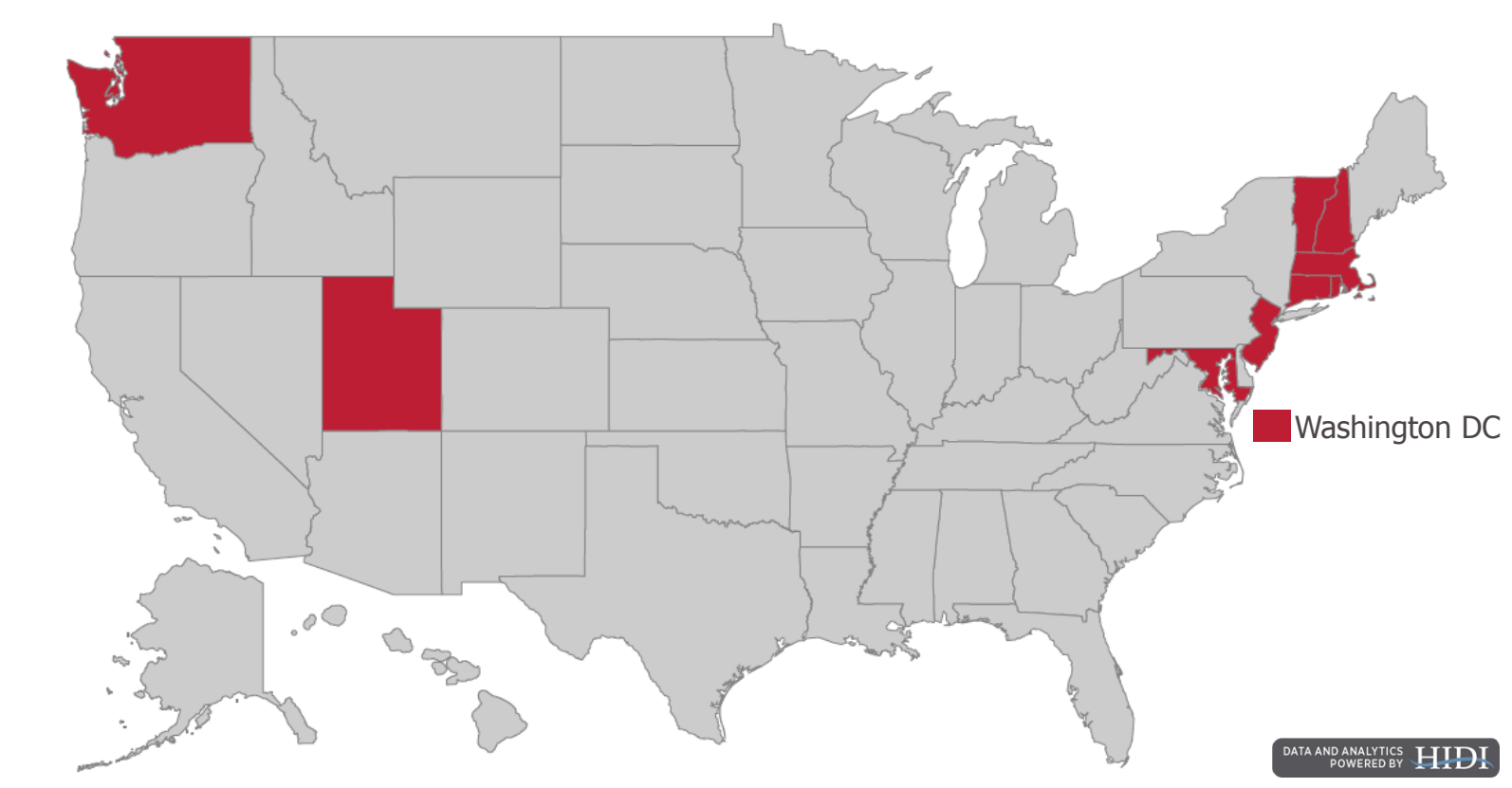

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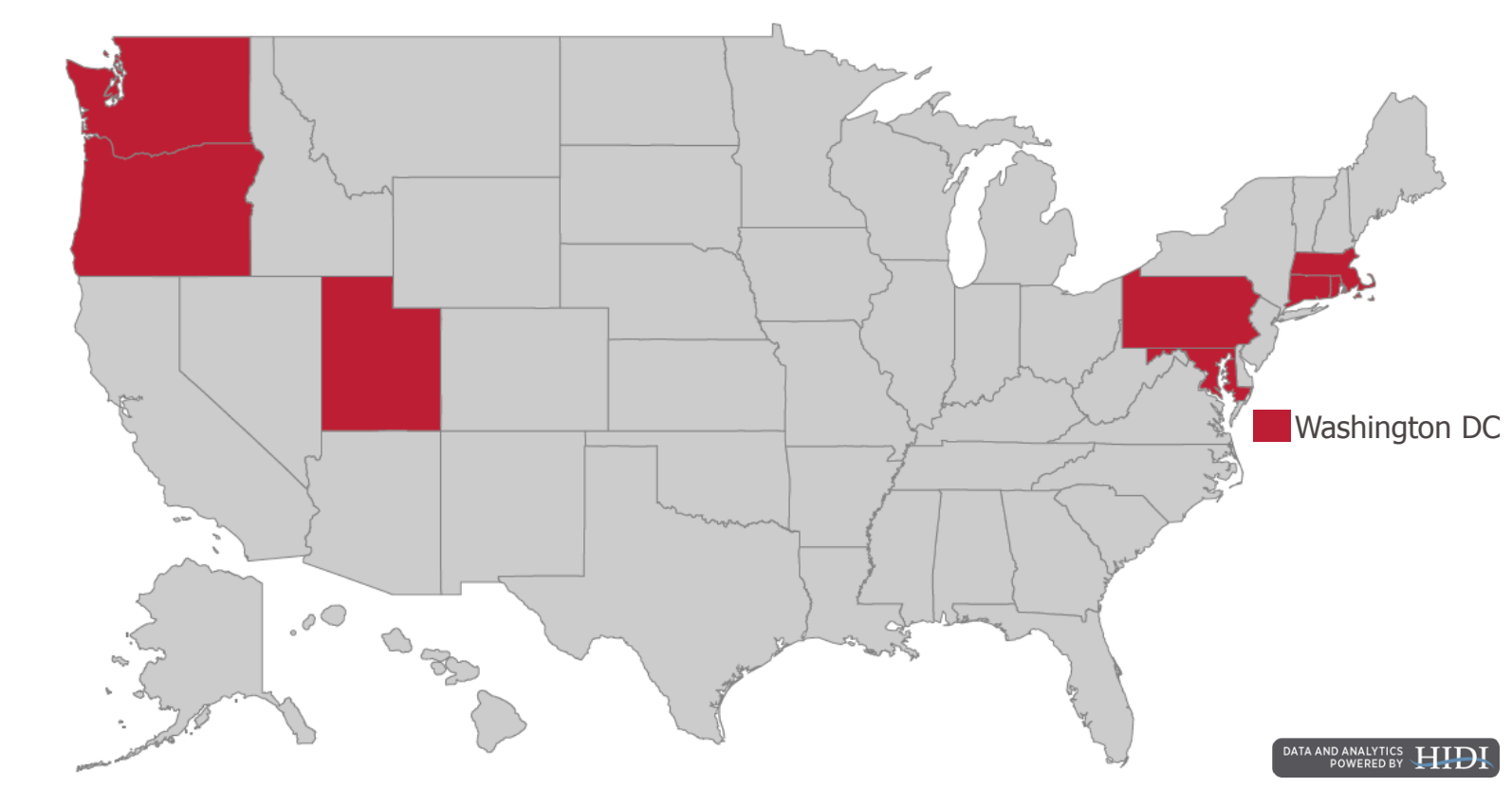

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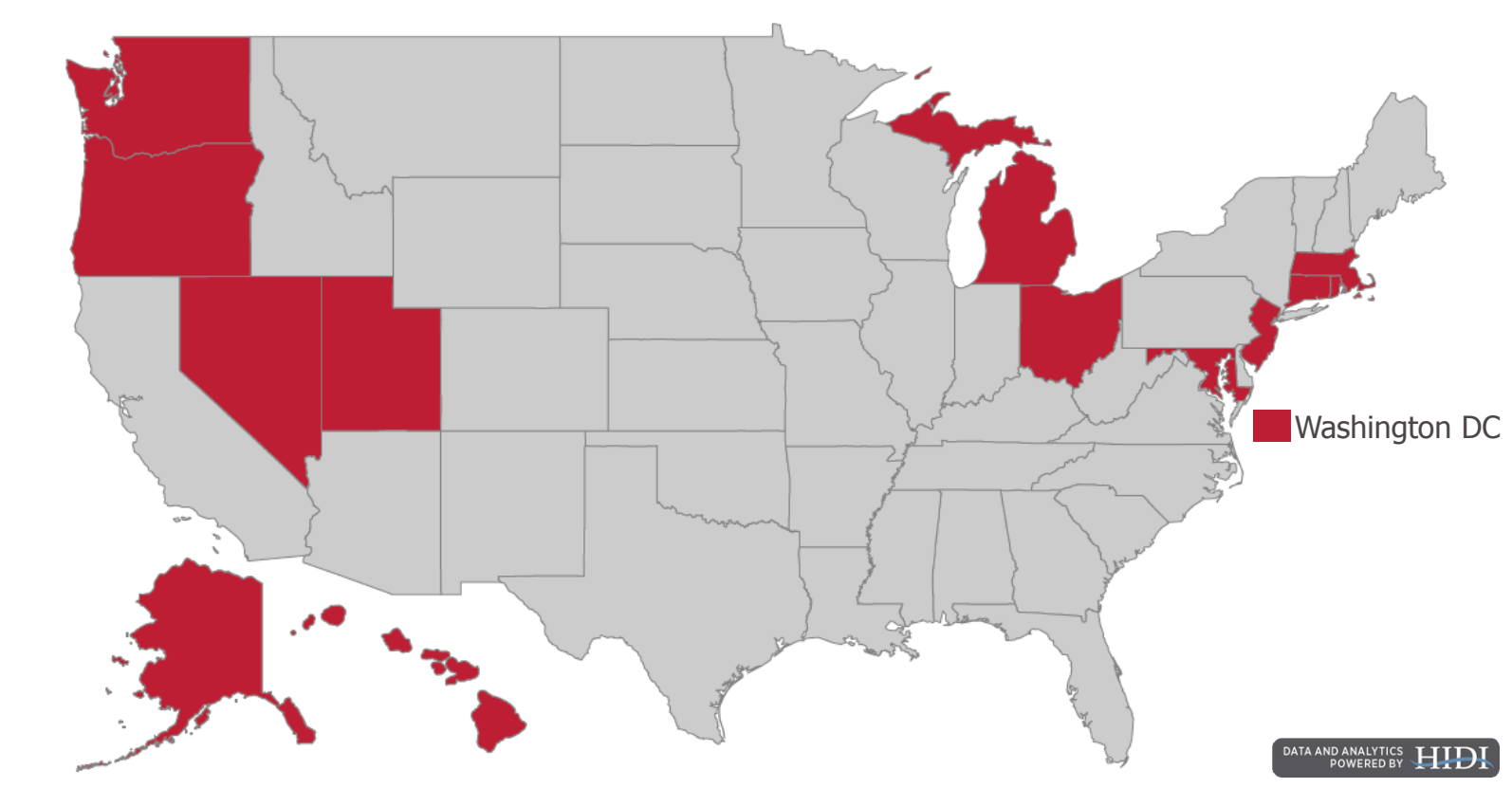

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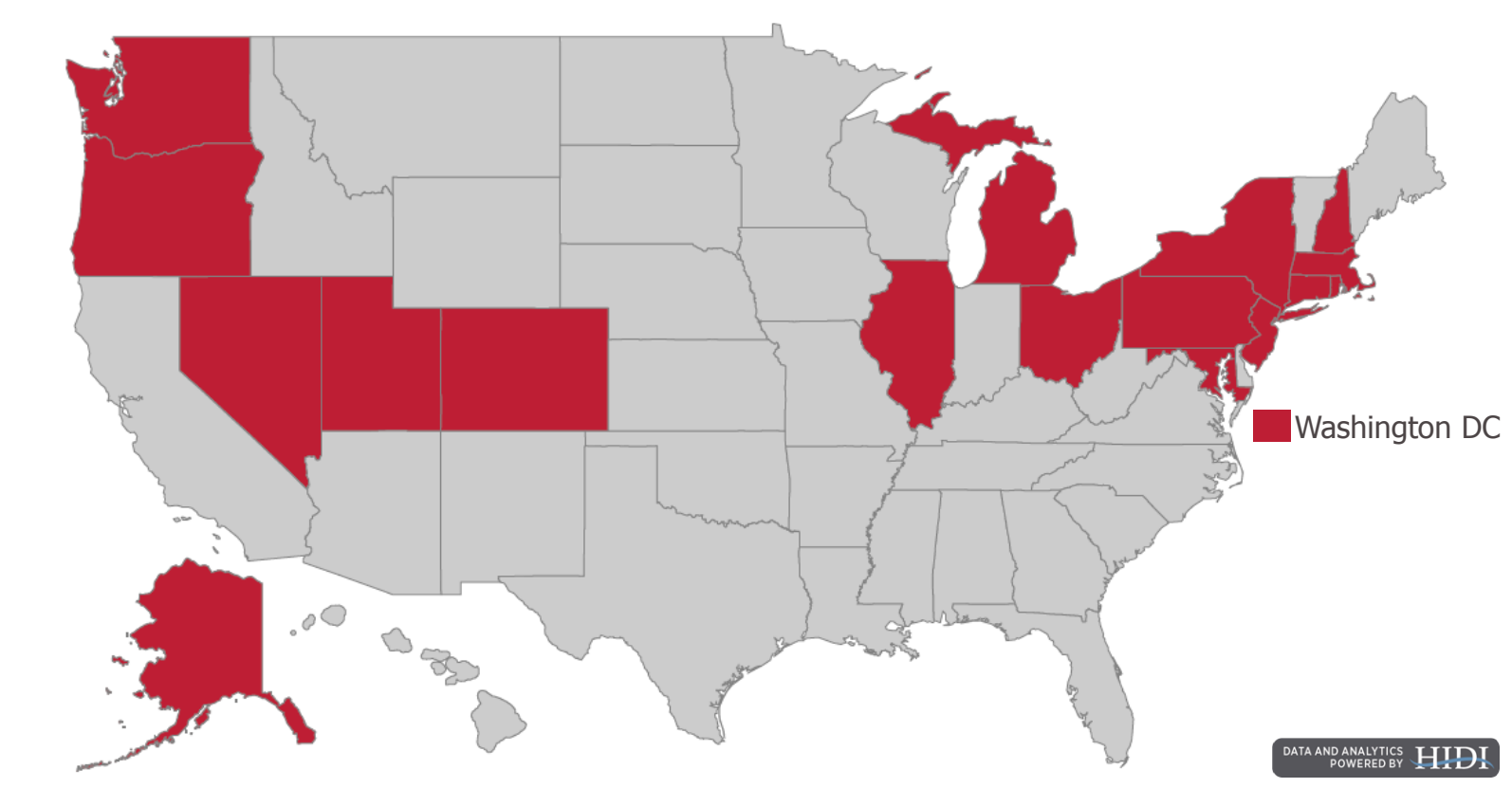

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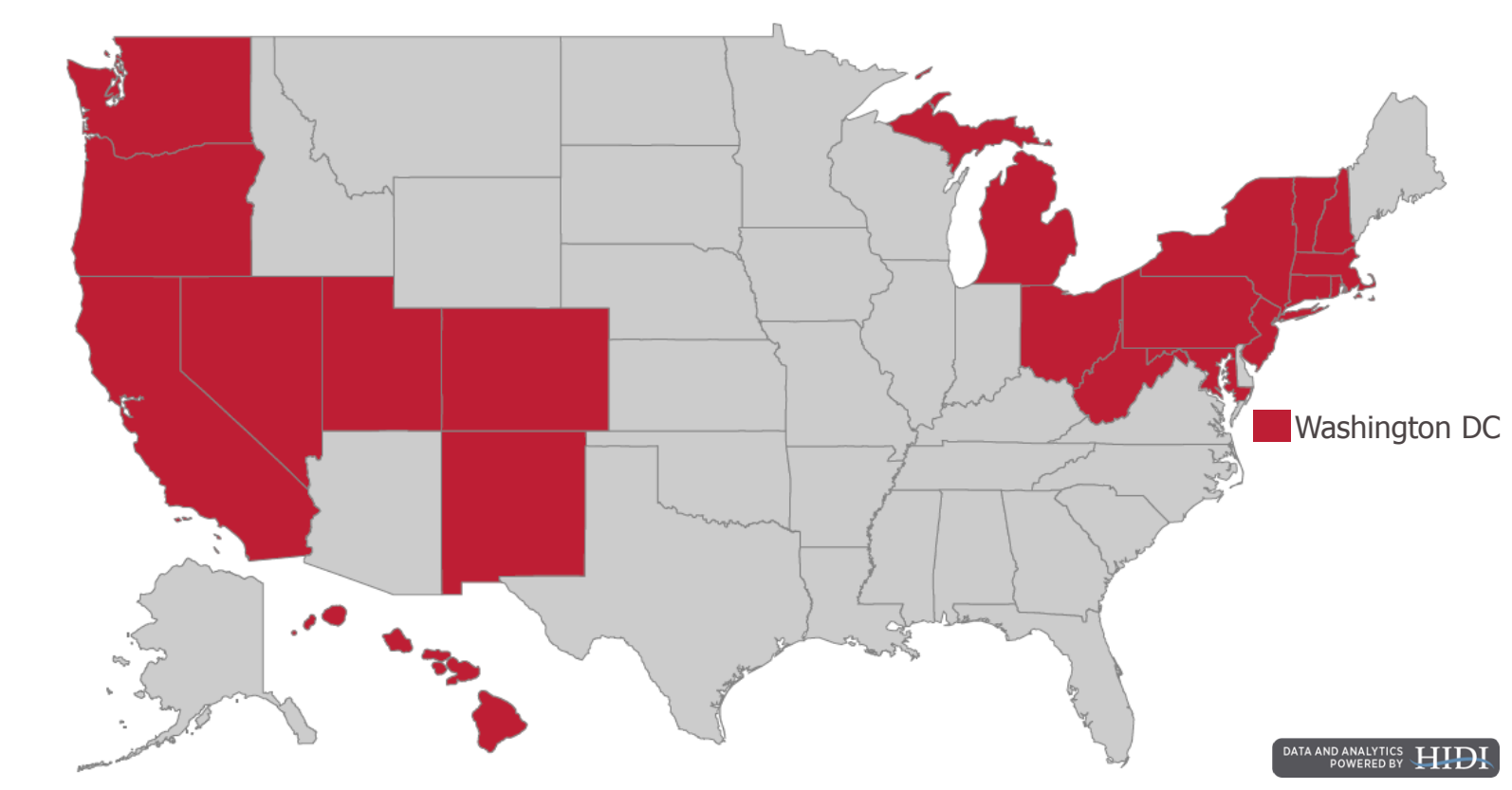

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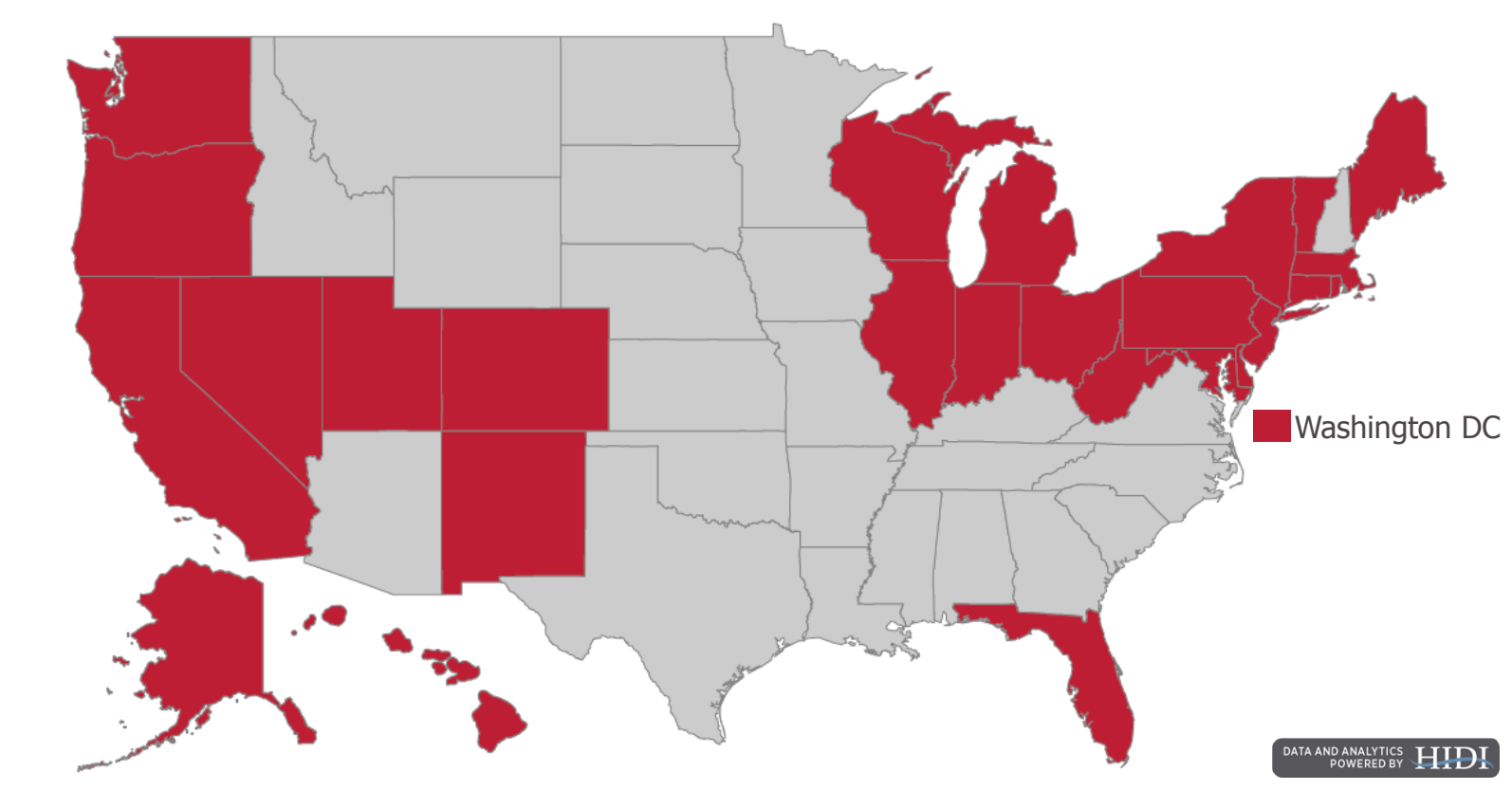

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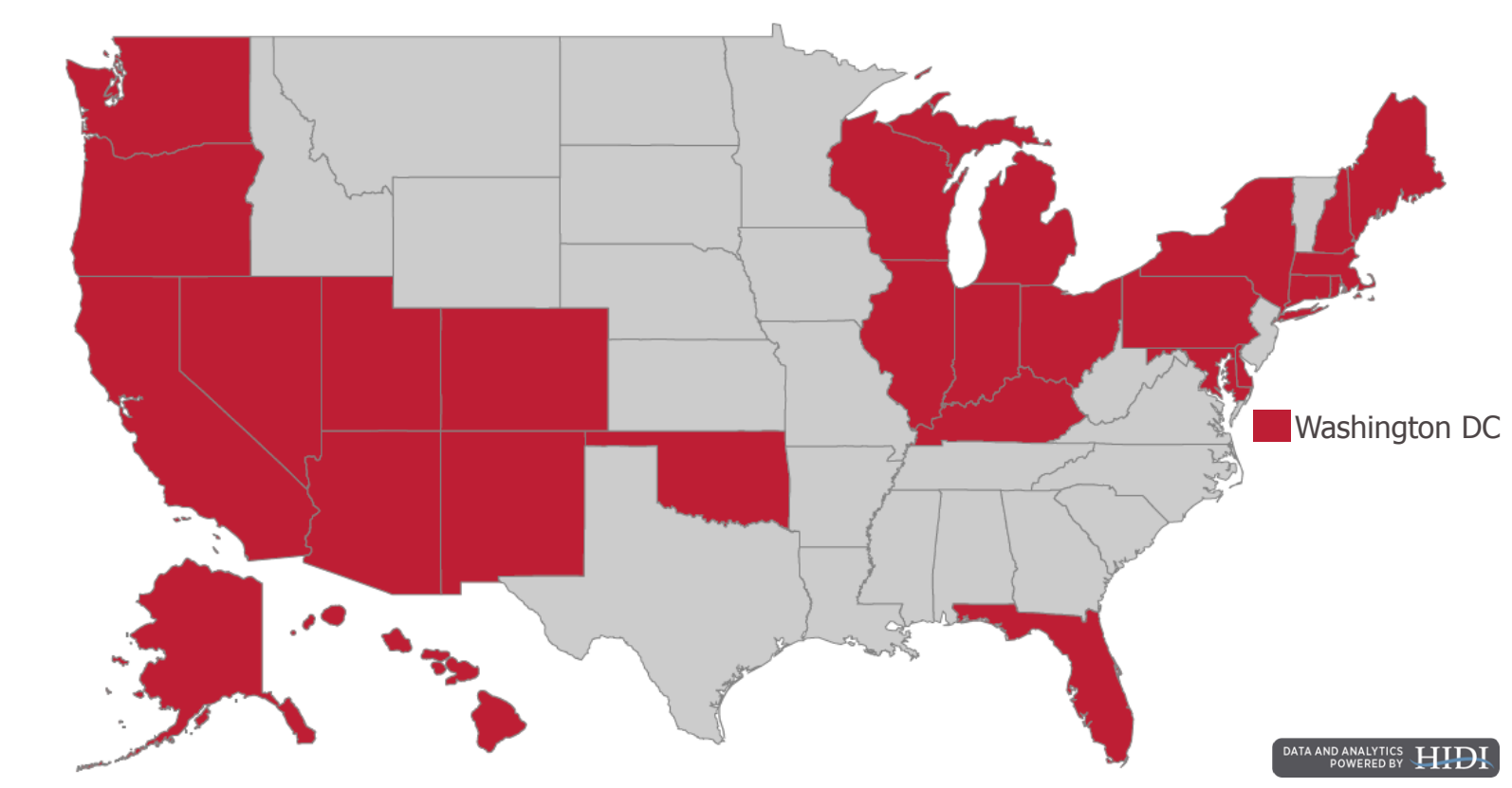

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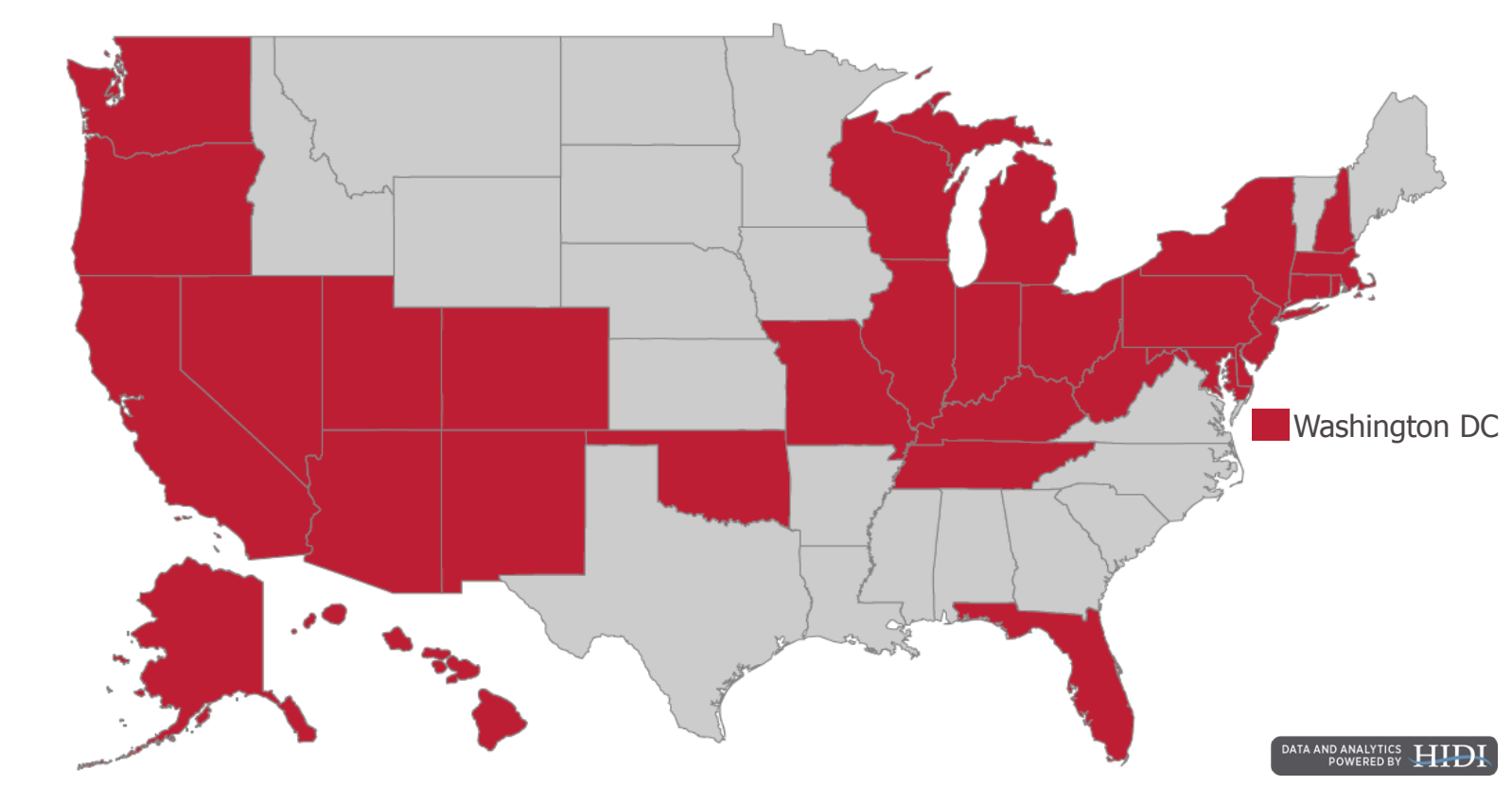

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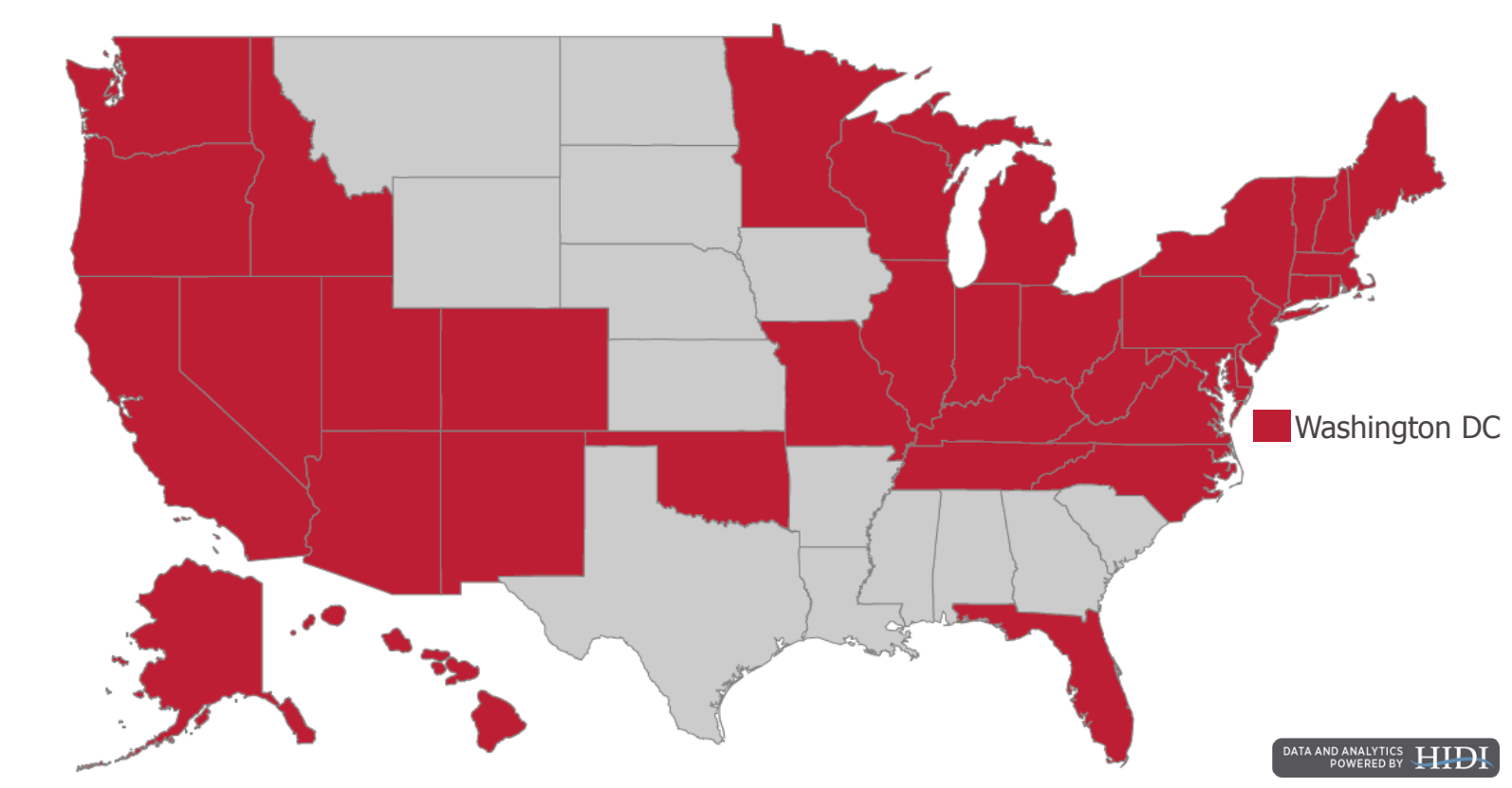

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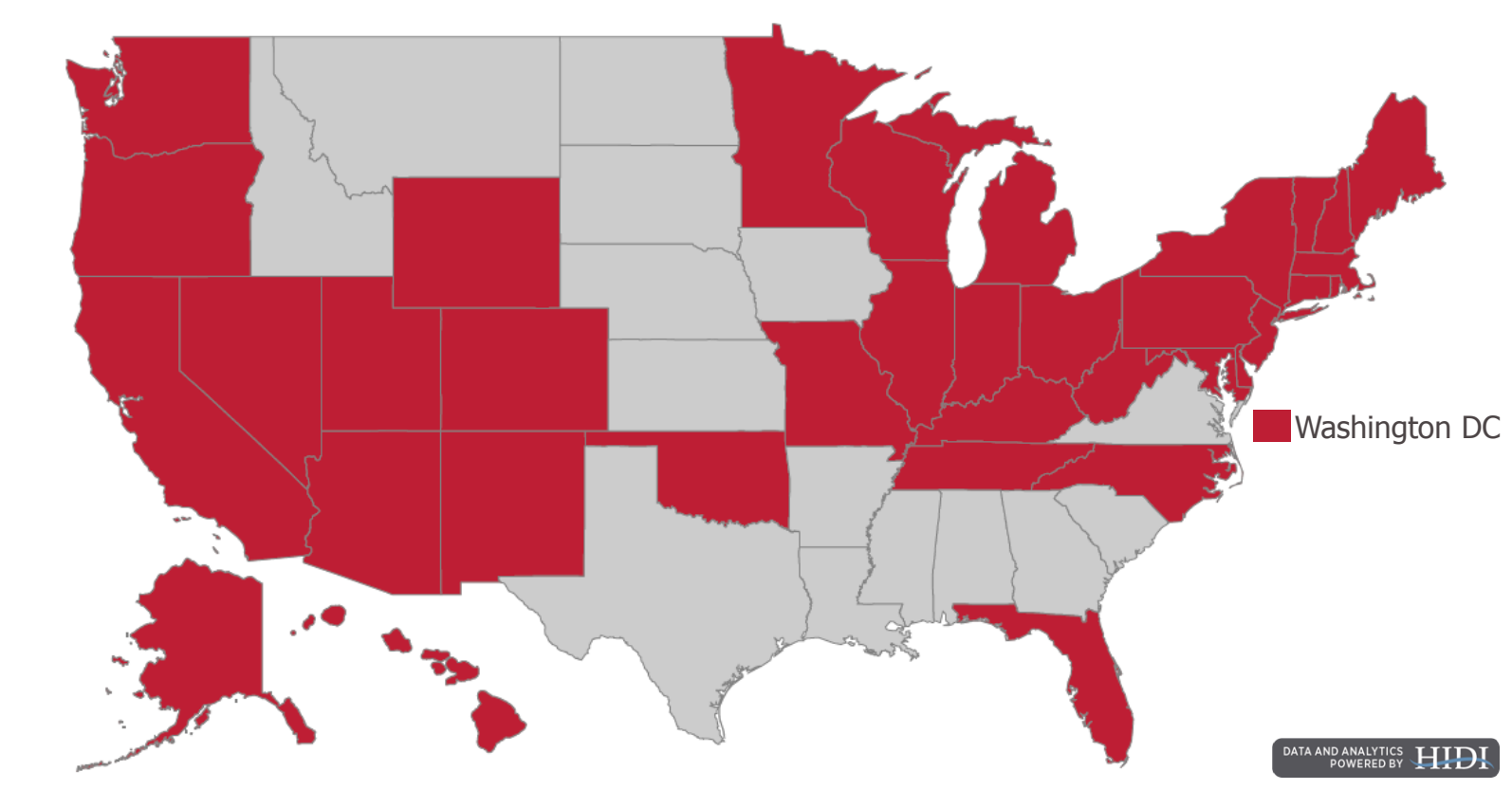

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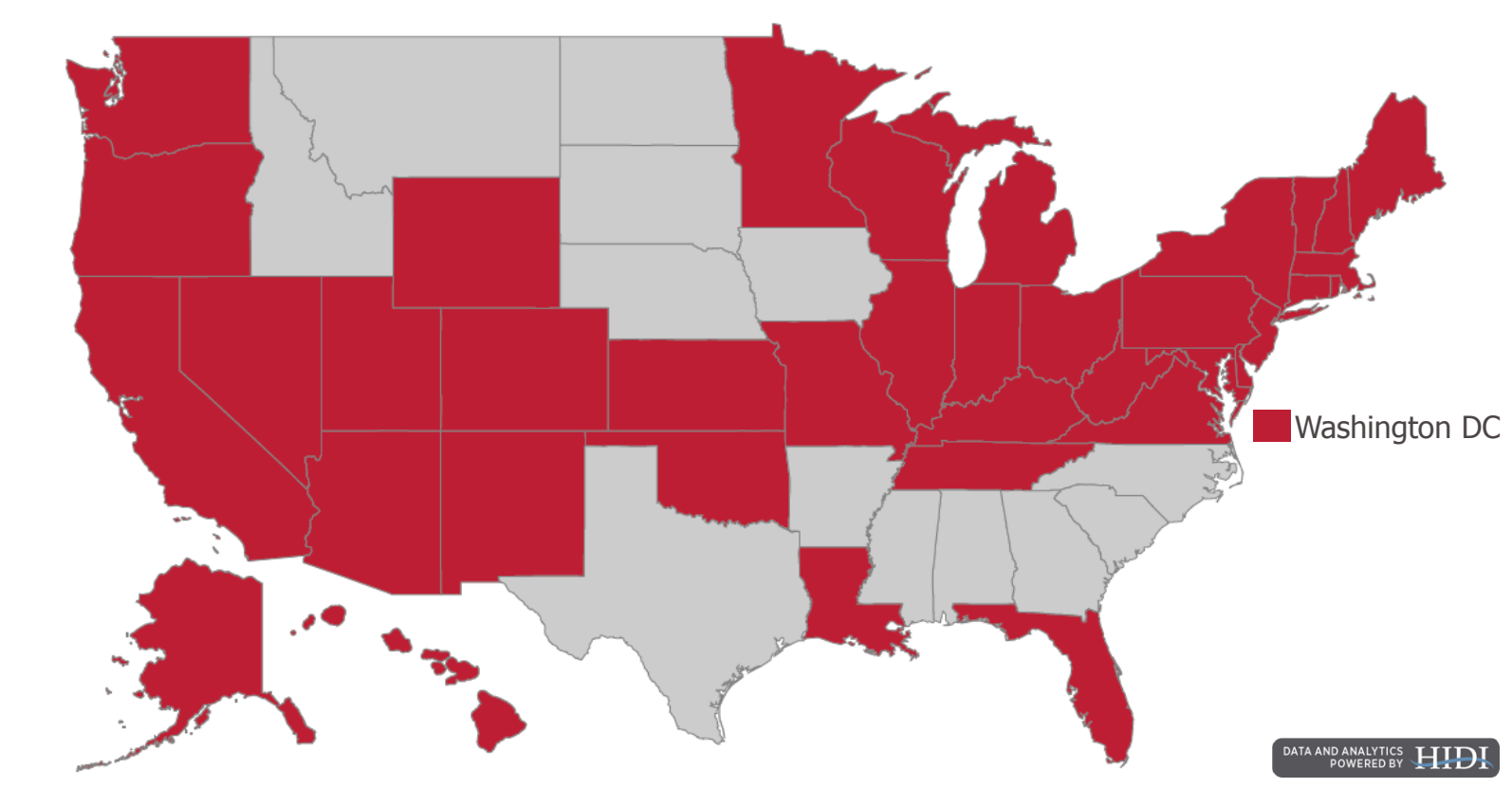

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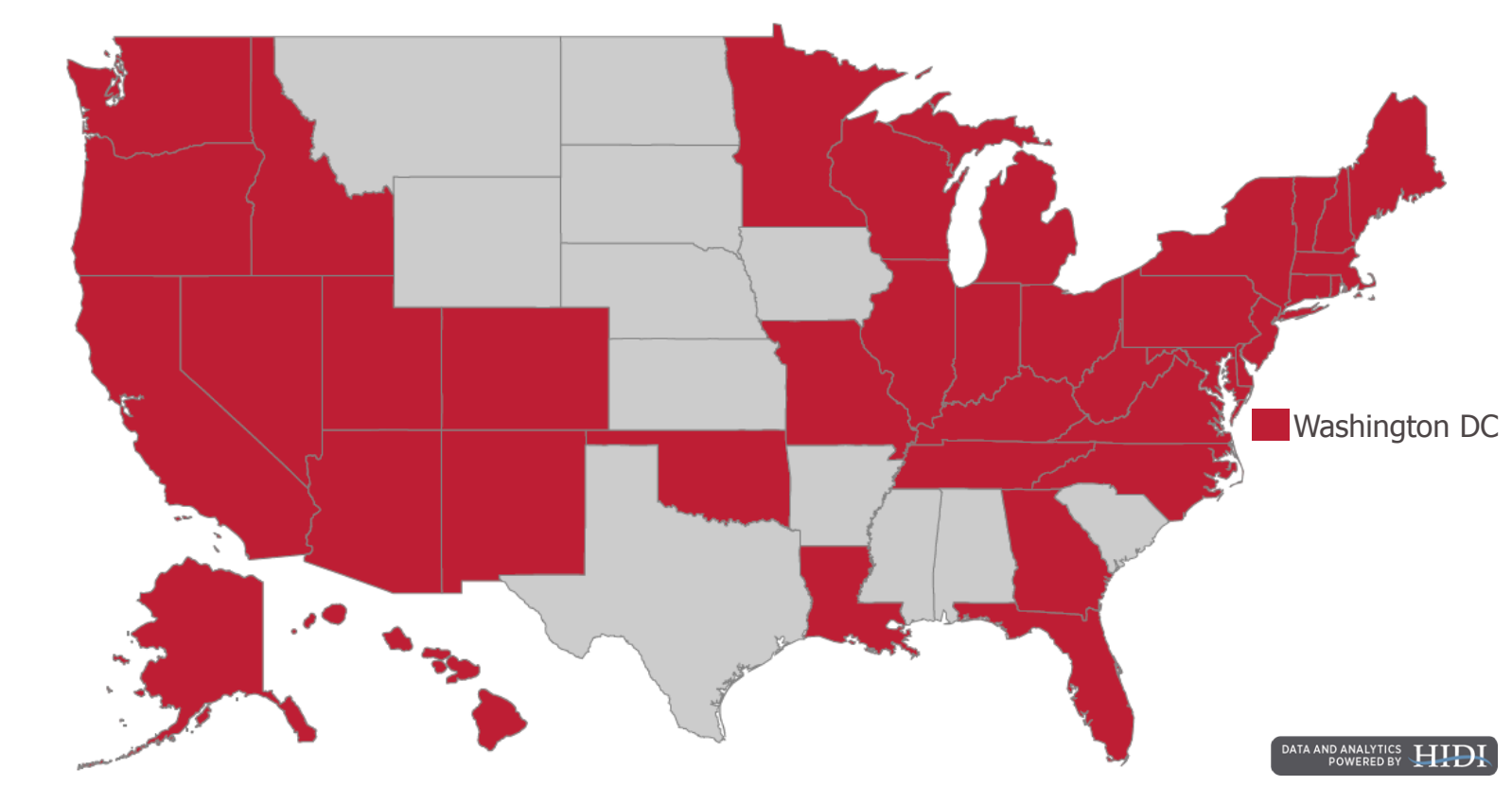

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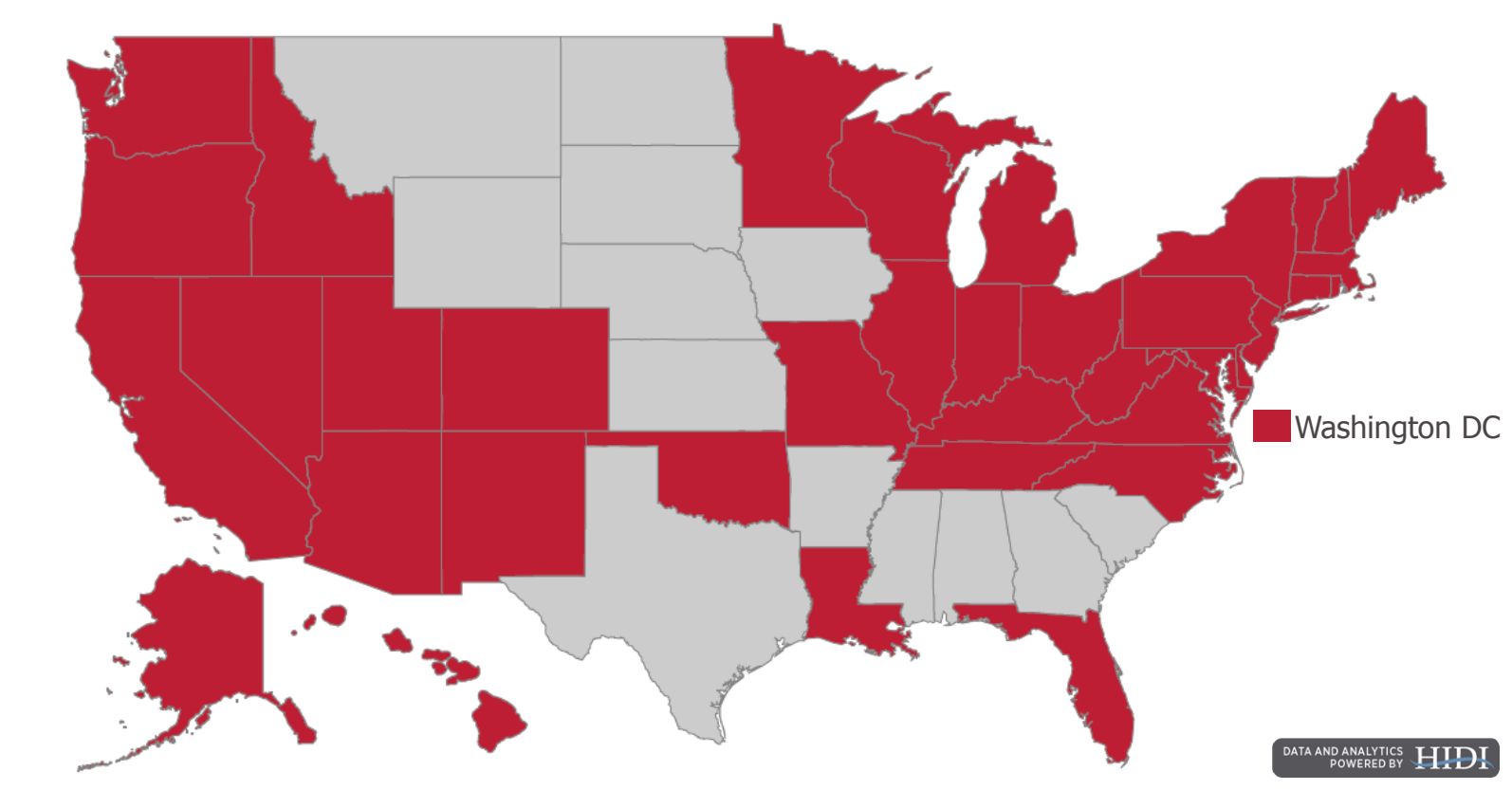

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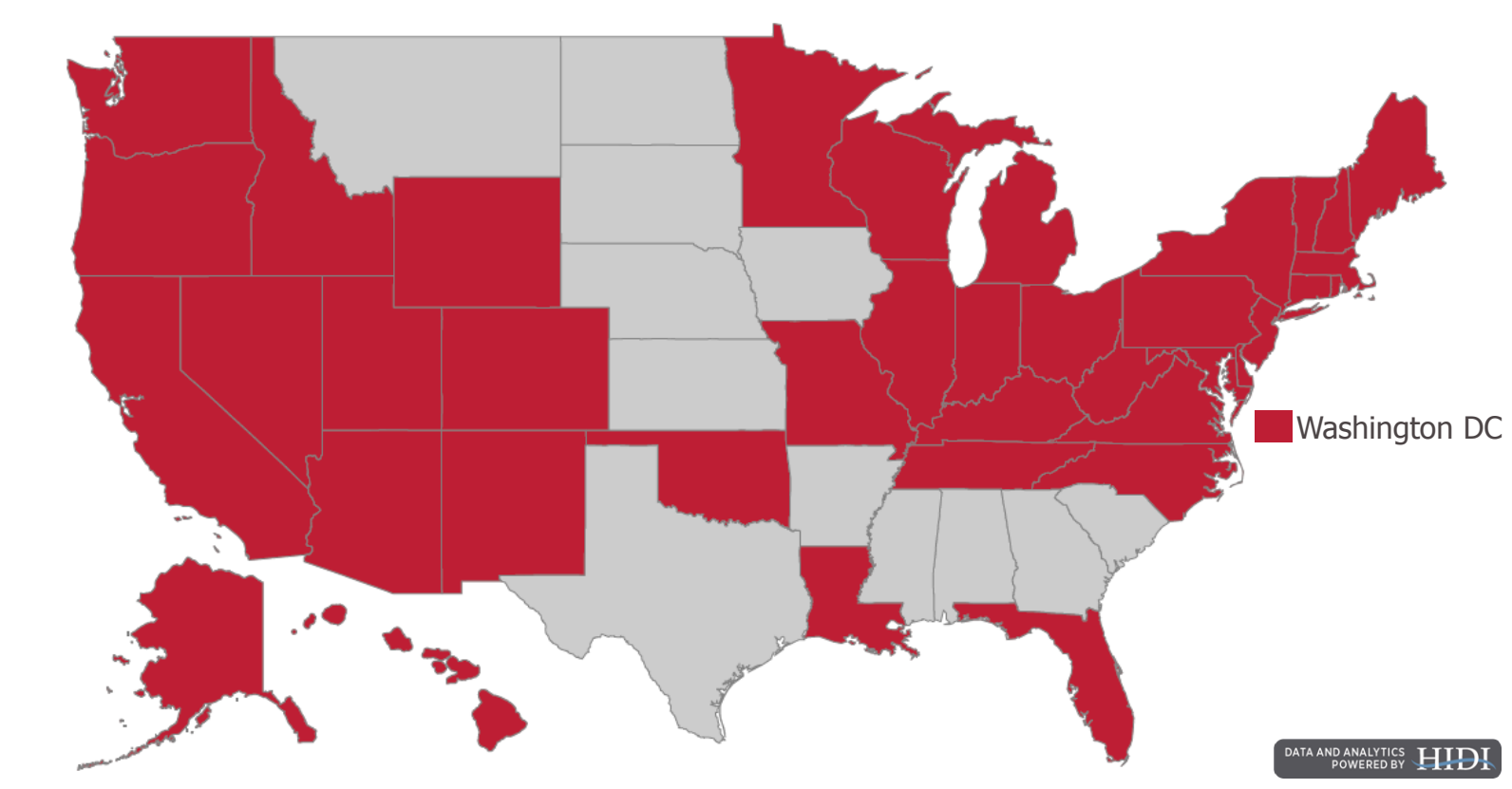

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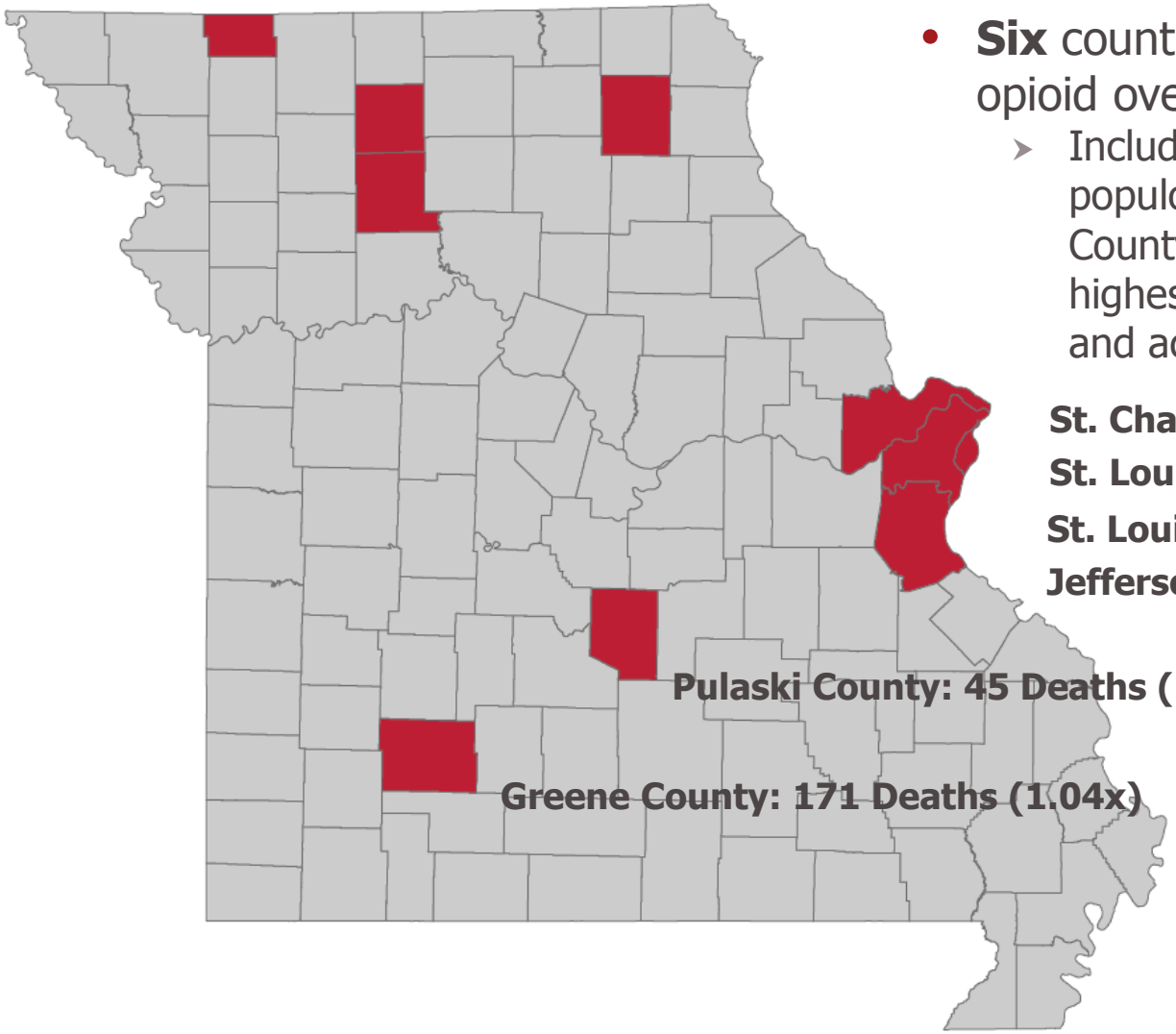
Source: *Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.*

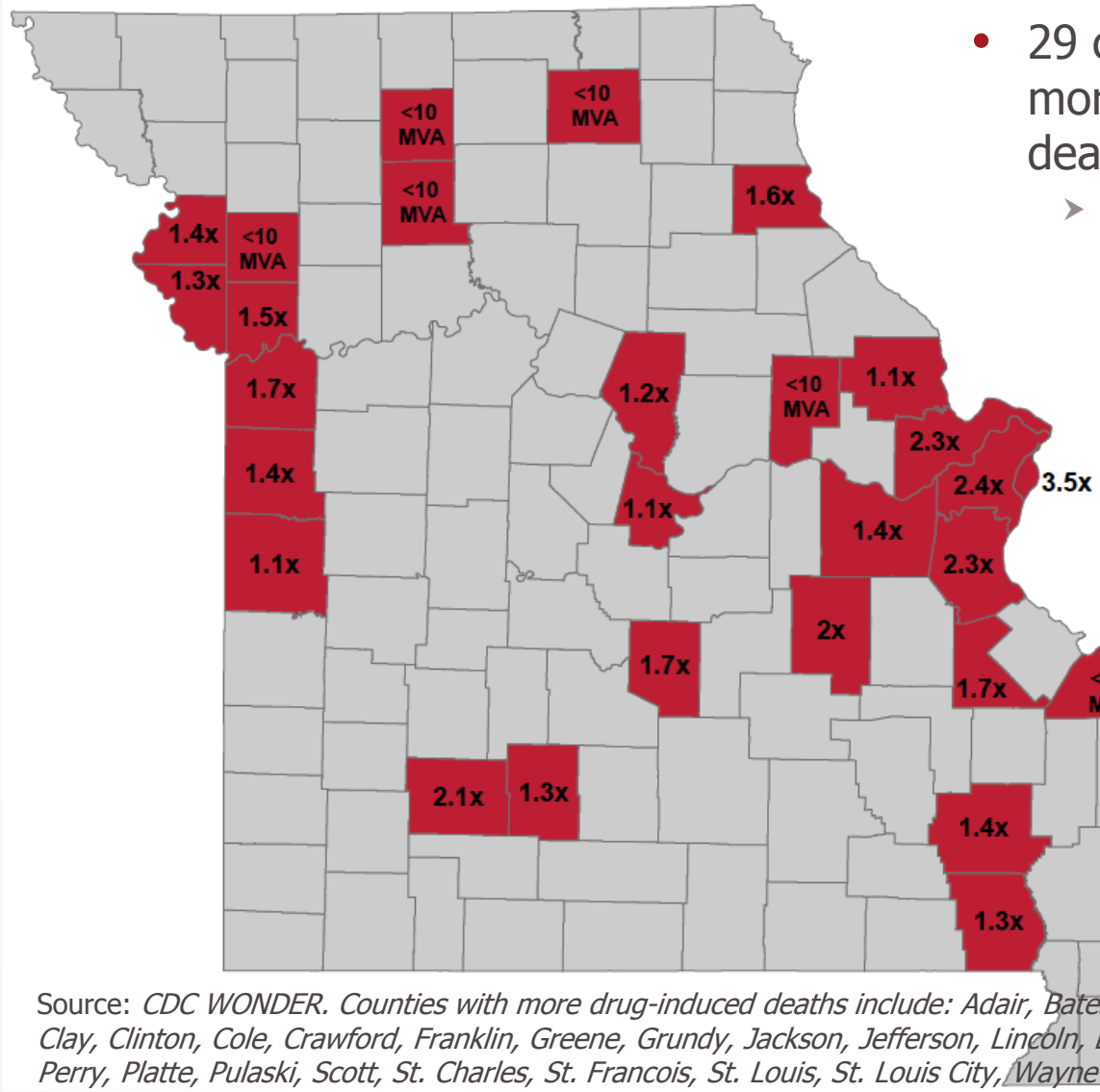
Counties with More Opioid Overdose Than Motor Vehicle Accident Deaths 2013-2015



- **Six** counties with significantly more opioid overdose than MVA deaths:
  - Includes five of our seven most populous counties and Pulaski County which has one of the state's highest concentration of veterans and active service members.

St. Charles County: 260 Deaths (2.2x)
St. Louis County: 798 Deaths (2.2x)
St. Louis City: 526 Deaths (3.2x)
Jefferson County: 302 Deaths (1.8x)

Counties with More Opioid Overdose Than Motor Vehicle Accident Deaths 2014-2016



- 29 counties with significantly more drug overdose than MVA deaths between 2014 and 2016
  - Includes nine of our 10 most populous counties and Pulaski County which has one of the state's highest volume of veterans and active service members.

Source: *CDC WONDER. Counties with more drug-induced deaths include: Adair, Bates, Boone, Buchanan, Butler, Cass, Clay, Clinton, Cole, Crawford, Franklin, Greene, Grundy, Jackson, Jefferson, Lincoln, Livingston, Marion, Montgomery, Perry, Platte, Pulaski, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Wayne and Webster*

Policy Changes

Missouri Government Action

- Senate Bill 501, signed into law
  - Grants immunity from arrest, prosecution or other penalties for certain drug-related crimes if seeking medical assistance for a drug or alcohol overdose
  - Permits the director of the Missouri Department of Health and Senior Services or physician designee to issue a statewide standing order for Naloxone
  - Revises standards for medication-assisted treatment of substance abuse
  - Allows the Board of Pharmacy to allocate funds for drug "take-back" programs
- Executive Order 17-18: "Multi-phase PDMP"
  - Retrospective data mining for prescribing variance from pharmacy benefit manager organizations and dispensers and through use of technology and software
- Proposed 2018 Legislation
  - Prescription drug monitoring program
  - Needle exchange programs
  - Expanded take-back programs
  - Patient refusal forms
- Governor's Budget
  - Fund Executive Order 17-18
  - Expand community treatment services to support medication-assisted treatment

Koon v. Walden and SLU (Mo. App. 2017)

HSG Healthcare Services Group
HSG Family of Companies

- Male with acute and persistent low back pain
- Treated with increasing doses of opioids — 2008-2012
  - 2008 — average daily dose was 49.67 MMEs (six pills daily)
  - 2009 — average daily does increased to 208 MMEs
  - 2010 — average daily dose doubled to 545.59 MMEs
  - 2011 — average daily dose reached 1,173.37 MMEs
  - 2012 — average daily dose was 1,555.94 when the patient and wife demanded help (40 pills daily)

Used with Permission. Opioid Prescribing, Healthcare Services Group, presented by Arvids Petersons, JD, MA, CMPE, CPHRM, January 2018

Jury Award

- Standard of care based on 2016 CDC guidelines for care delivered from 2008-2012
- Judgement for plaintiffs — Brian Koon and Michelle Koon. Jury awarded:
  - Brian Koon — $1.4 million
  - Michelle Koon — $1.2 million
  - Punitive damages — $15 million from Dr. Walden and SLU
- Total award — $17.6 million to plaintiffs
- SLU was vicariously liable for everything Dr. Walden did to cause Koon's injury.

Used with Permission. Opioid Prescribing, Healthcare Services Group, presented by Arvids Petersons, JD, MA, CMPE, CPHRM, January 2018

Plaintiff's Expert Testimony

- At trial, plaintiff's expert testified that "*everyone who is prescribing opioids must have training and systems in place to ensure that patients are not overprescribed and that the standard of care requires that 'prescribing healthcare providers have a medication management system in place to make sure patients do not receive excessive or too much dosage of opioids.'"*

Used with Permission. Opioid Prescribing, Healthcare Services Group, presented by Arvids Petersons, JD, MA, CMPE, CPHRM, January 2018

Standard of Care

1. Conduct a risk assessment with the patient before prescribing.
2. Risks and benefits should be re-assessed each time the opioid dose is increased.
3. Patient should be regularly monitored while on opioids.
4. Track the number of pills and dose the patient is taking.
5. All health care providers must have a medication management system.
6. Check for side effects and behaviors that suggest dependency or addiction.
7. If a doctor suspects the patient is addicted he should cease the opioids and wean the patient.
8. The risk assessment and monitoring results should be documented in the medical records.

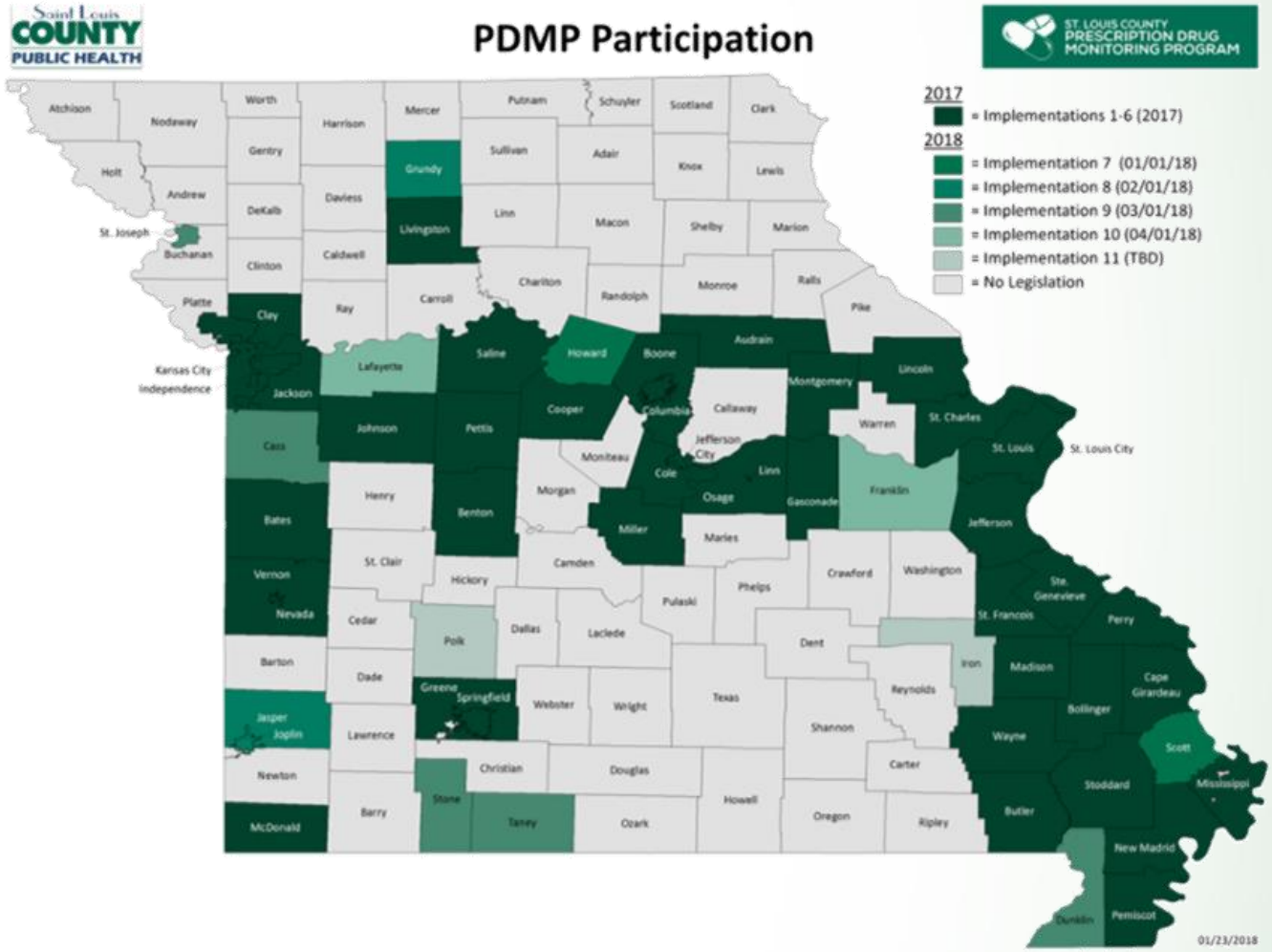
Used with Permission. Opioid Prescribing, Healthcare Services Group, presented by Arvids Petersons, JD, MA, CMPE, CPHRM, January 2018

Policy and Advocacy

Missouri State Medical Association

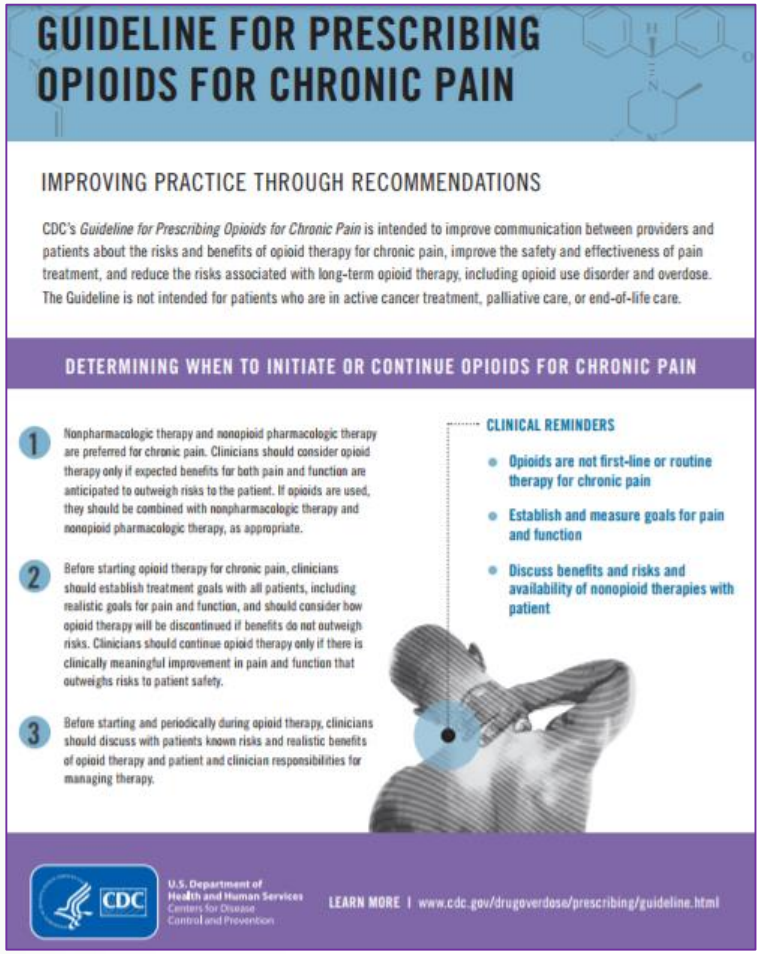
MAOPS established 1897
Missouri Association of Osteopathic Physicians & Surgeons

MHA
Missouri Hospital Association



Practice Changes

CDC Guidelines for Chronic Pain



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

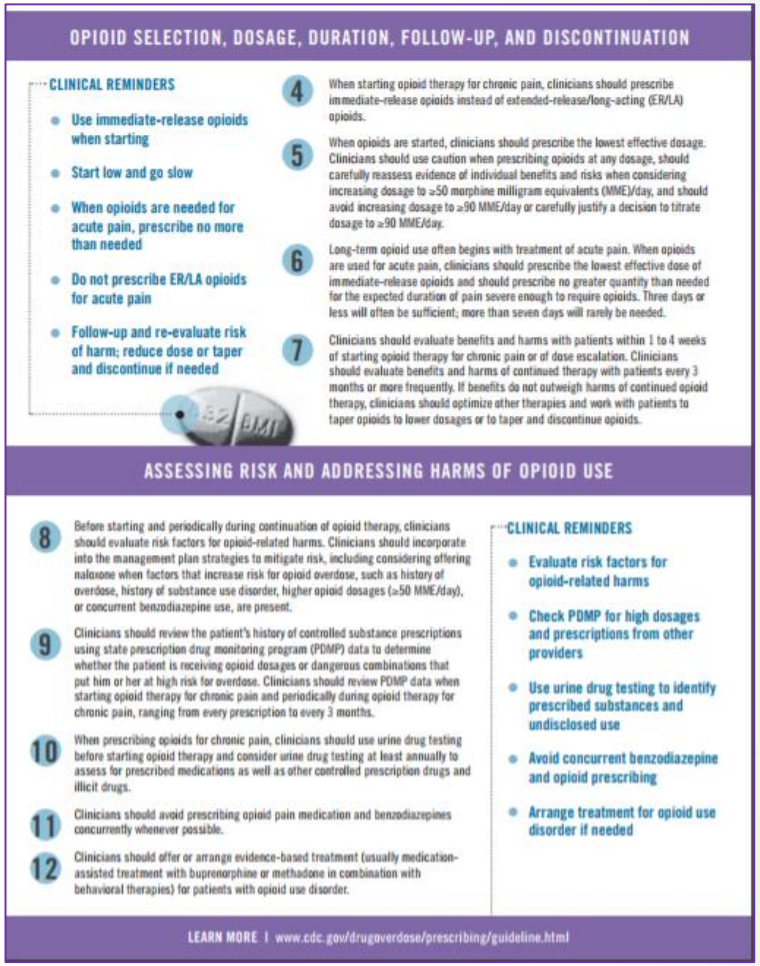
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html



OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

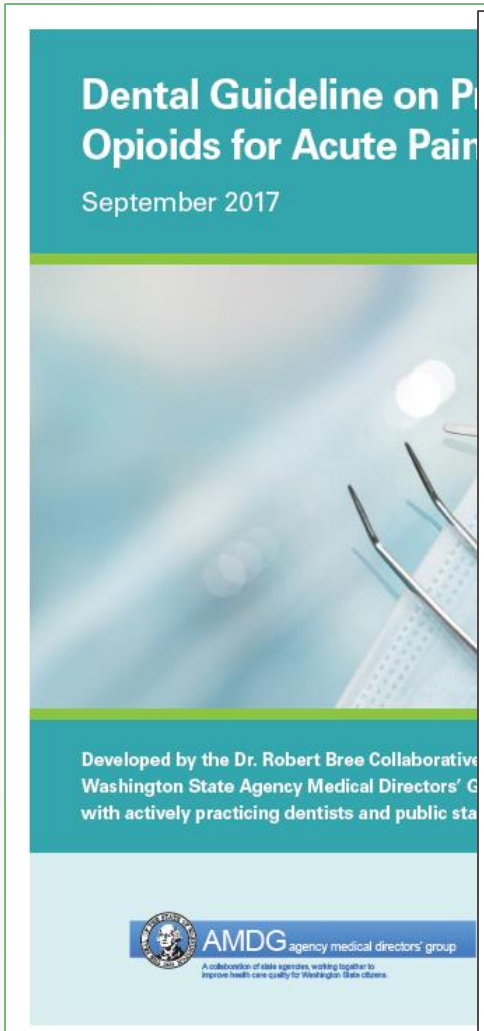
CLINICAL REMINDERS

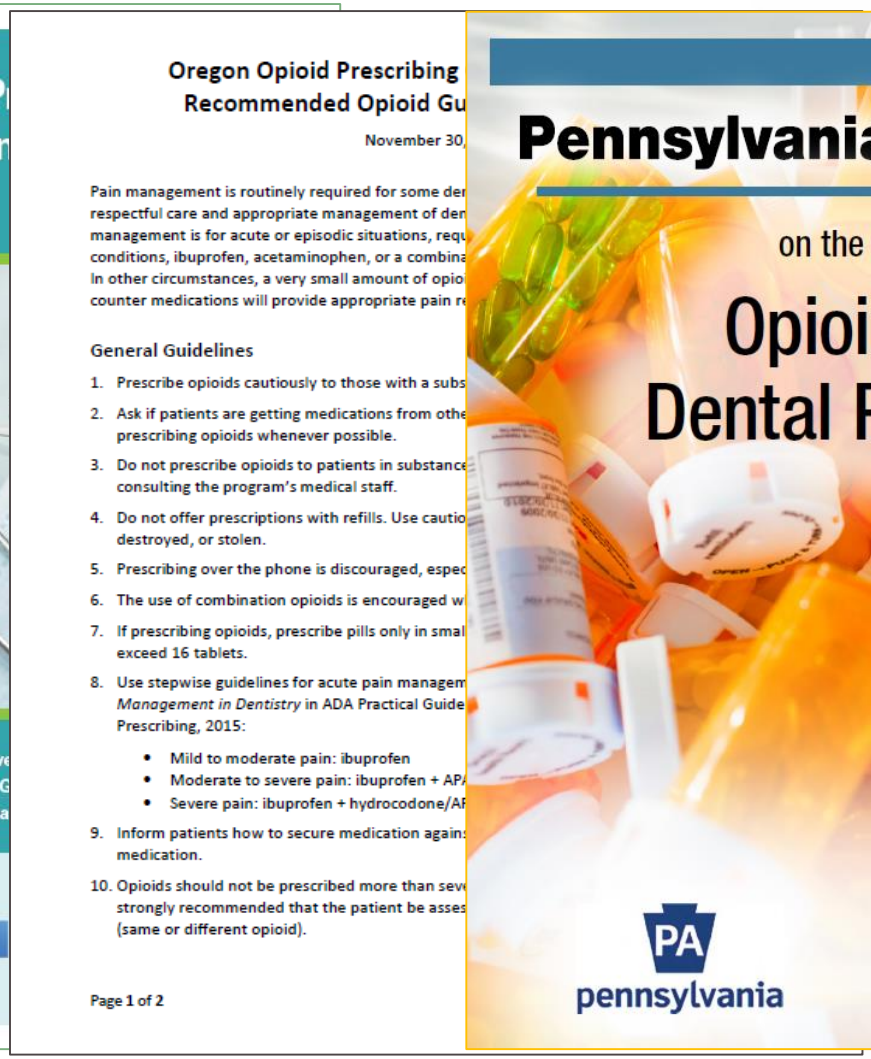
- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

Dental Practice Opioid Guidelines





Oregon Opioid Prescribing
Recommended Opioid Gu

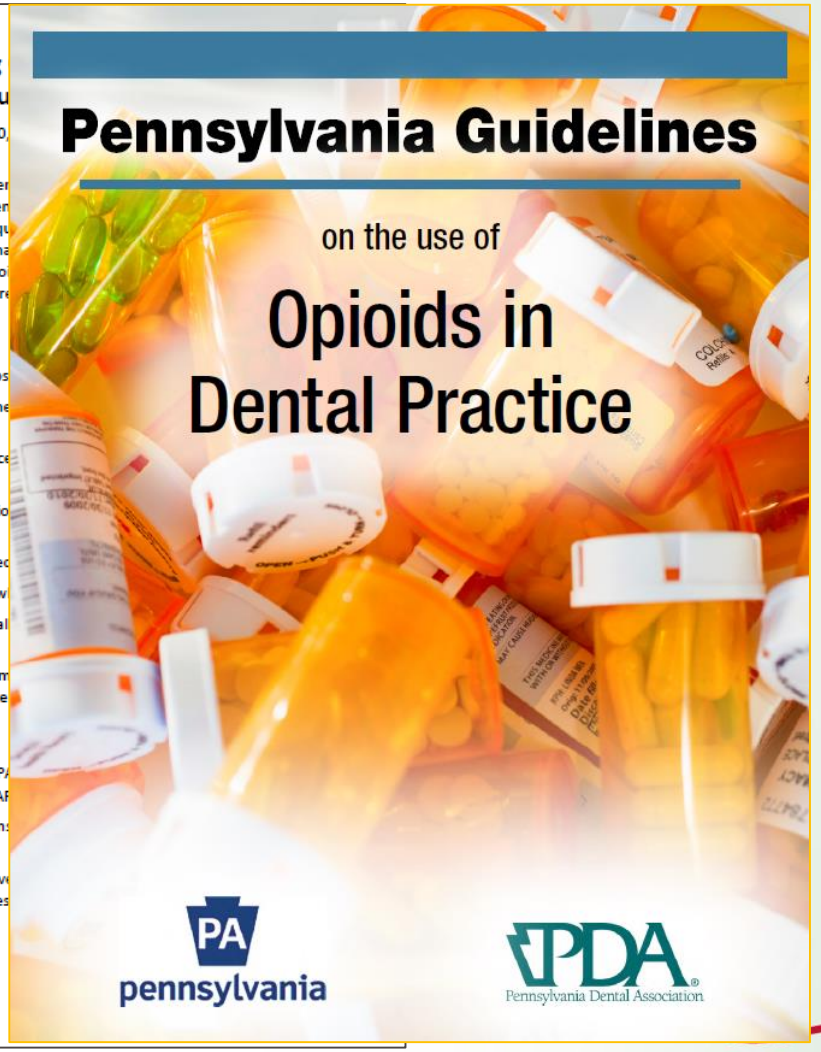
November 30,

Pain management is routinely required for some der
respectful care and appropriate management of der
management is for acute or episodic situations, requ
conditions, ibuprofen, acetaminophen, or a combina
In other circumstances, a very small amount of opio
counter medications will provide appropriate pain re

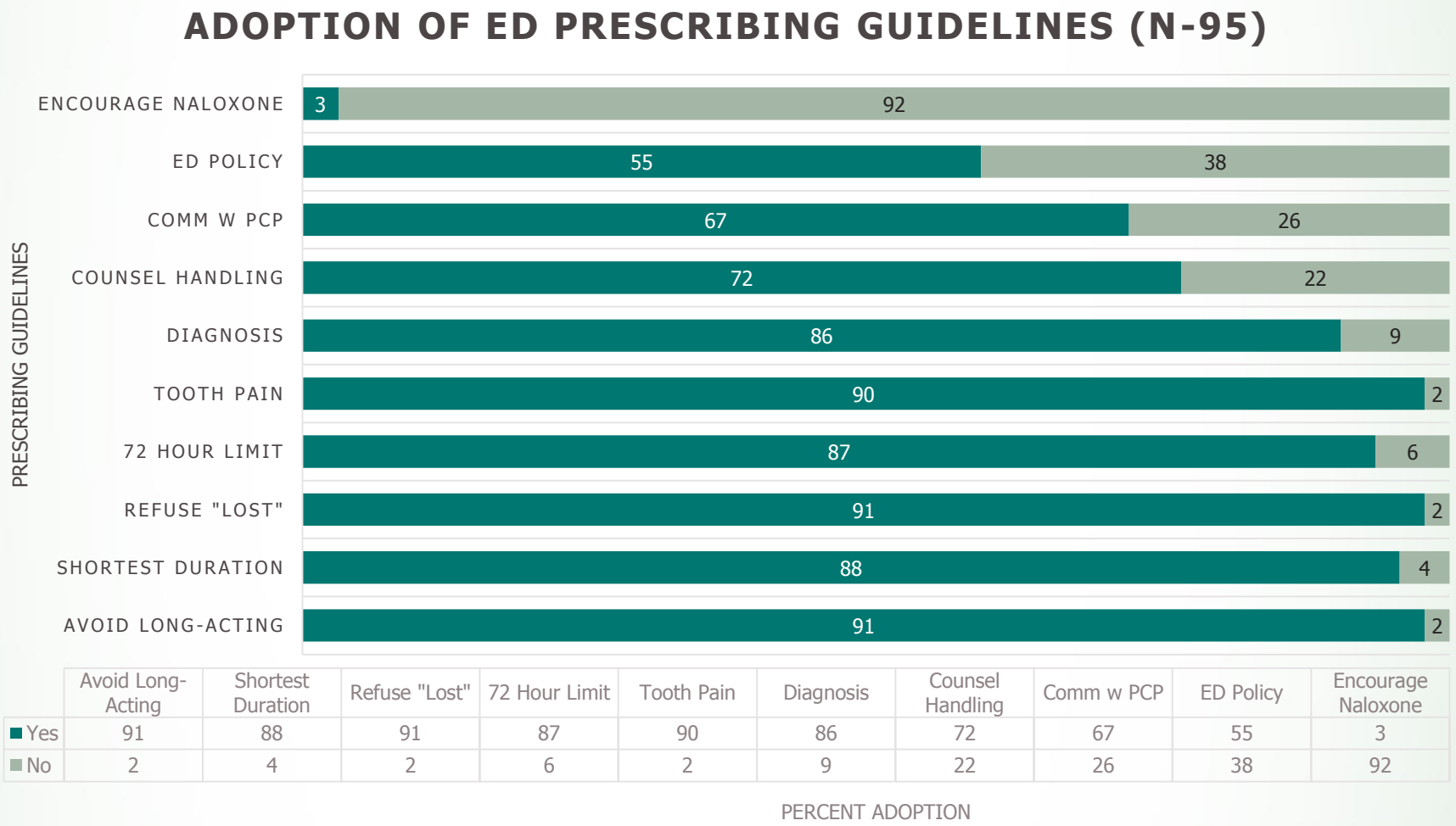
General Guidelines

1. Prescribe opioids cautiously to those with a subs
2. Ask if patients are getting medications from othe prescribing opioids whenever possible.
3. Do not prescribe opioids to patients in substance consulting the program's medical staff.
4. Do not offer prescriptions with refills. Use cautio destroyed, or stolen.
5. Prescribing over the phone is discouraged, espec
6. The use of combination opioids is encouraged w
7. If prescribing opioids, prescribe pills only in smal exceed 16 tablets.
8. Use stepwise guidelines for acute pain managem *Management in Dentistry* in ADA Practical Guide Prescribing, 2015:
   - Mild to moderate pain: ibuprofen
   - Moderate to severe pain: ibuprofen + APA
   - Severe pain: ibuprofen + hydrocodone/AP
9. Inform patients how to secure medication agains medication.
10. Opioids should not be prescribed more than sev strongly recommended that the patient be asses (same or different opioid).

Page 1 of 2



Practice Change: Adoption of ED Prescribing Guidelines for Opioids



	Avoid Long-Acting	Shortest Duration	Refuse "Lost"	72 Hour Limit	Tooth Pain	Diagnosis	Counsel Handling	Comm w PCP	ED Policy	Encourage Naloxone
Yes	91	88	91	87	90	86	72	67	55	3
No	2	4	2	6	2	9	22	26	38	92

Data: MHA Member Survey, June 2017

Practice Changes

2015 Guidance
- ED opioid prescribing
- 90 percent adoption of most guidelines

2016 Guidance
- Chronic pain
- Acute pain
- Naloxone distribution

2017 Education
- Neonatal abstinence syndrome
- Addiction as a condition

2018 Initiative
- Medication-assisted treatment with coordination of support and treatment services

Use of Naloxone in Response to Opioid Overdose

- Naloxone reverses the effects of an opioid overdose.
- As of August 28, 2017, anyone may access naloxone at a Missouri pharmacy via a statewide standing order.
- The MO-HOPE Project distributes naloxone and provides training on its administration.

Sources: https://opioids.mo.gov/naloxone
https://mohopeproject.org/

MO-HOPE Project

Medication-Assisted Treatment

- What Is It?
  - Medication-assisted treatment (MAT) incorporates the use of FDA-approved medications and behavioral therapy in the treatment of Opioid Use Disorder (OUD).
- Which Agencies Endorse MAT?
  - Substance Abuse and Mental Health Services Administration
  - American Medical Association
  - National Institute on Drug Abuse

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

"Medication First" Model

- Address withdrawal symptoms
- Reduce cravings
- Enable the patient to focus and engage in counseling and social support groups
- Increase treatment retention
- Supported by the Missouri Department of Mental Health
- Key component of the Opioid STR Grant

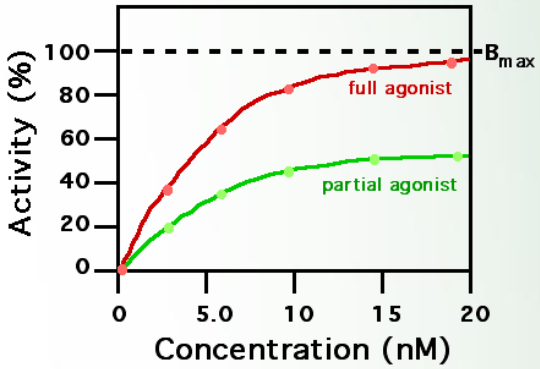
Source:
https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/59bab107f09ca461180d6429/1505407240927/Opioid+STR+Implementation+Guide_nonDMH.pdf

Obstacles to MAT

- Access
  - Need for more waiver-trained prescribers to use buprenorphine for treatment
  - Community services for support and treatment
- Funding
- Stigma
  - A shift from abstinence-models (12-step)
  - Lack of awareness of evidence-based treatment

Source: http://www.nejm.org/doi/full/10.1056/NEJMp1714529

FDA Approved Medications for Treatment of OUD



Medication	Action	Dispensing
Methadone	Full Agonist — Full agonists (like heroin, morphine, hydrocodone, and oxycodone) bind to opioid receptors and create a response proportional to the dose.	Opioid Treatment Program (OTP)
Buprenorphine	Partial Agonist — Partial agonists bind to opioid receptors, cause a limited reaction, and prevent the euphoric effect.	Any prescriber with waiver
Naltrexone	Antagonist — Antagonists bind to opioid receptors and block the receptors from being activated.	Any prescriber

Source: https://store.samhsa.gov/shin/content/SMA14-4852/SMA14-4852.pdf

Methadone

Components

- Long-established agonist treatment of OUD
- Medication used in combination with counseling and social support as part of MAT
- May only be dispensed via OTP certified by SAMHSA
- Addictive, but tightly controlled; only dispensed through an opioid treatment program

Missouri

- Methadone clinics in Missouri
- Breckenridge Hills, Cape Girardeau, Columbia, Hazelwood, Joplin, Kansas City, Poplar Bluff, Springfield, St. Joseph, St. Louis and West Plains

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

https://dmh.mo.gov/docs/ada/otpsinmissouri.pdf

Buprenorphine

- Partial agonist used in conjunction with counseling and social support as part of MAT
- Prescribed or dispensed in a physician's office
- Requires the prescriber to be waiver-trained
- Reduced potential for misuse by adding naloxone
- Trade names
  - Sublocade – monthly injectable
  - Subutex – buprenorphine
  - **Suboxone** – buprenorphine and naloxone

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

Research to Support MAT

Boston University

- Compared to inpatient detox protocol, hospital-based buprenorphine induction and follow-up with office-based buprenorphine treatment is effective in engaging OUD patients in treatment and reducing illicit opioid use at six months.
- Challenge — maintain engagement in treatment

Yale

- ED induction of buprenorphine was compared to brief intervention and referral.
- ED induction of buprenorphine increased engagement in treatment, reduced self-reported illicit opioid use, and decreased inpatient addiction treatment use.

Liebschutz, J., et al., BUP treatment for hospitalized, opioid-dependent patients: a randomized clinical trial. JAMA Intern Med (2014) 174:1369-1376.

D'Onofrio, G., et al., Emergency department-initiated BUP/ naloxone treatment for opioid dependence: a randomized clinical trial. JAMA (2015) 313:1636-1644.

Why is Waiver Training Required?

- **Harrison Narcotics Tax Act of 1914**: Physicians were allowed to prescribe narcotics to patients in the course of treatment except for the treatment of addiction.
- **Drug Addiction Treatment Act of 2000**: Waiver-trained physicians were allowed to prescribe buprenorphine as part of MAT.
- **Comprehensive Addiction and Recovery Act of 2016**: Buprenorphine waiver training was expanded to include nurse practitioners and physician assistants.

Missouri Buprenorphine Waiver Training

- Training requirements
  - Physicians — eight hours
  - Nurse practitioners and physician assistants — 24 hours
- Missouri Coalition for Community Behavioral Healthcare provides waiver training

Resources: https://www.mocoalition.org/medication-assisted-treatment (schedule)
https://katiehorst.wufoo.com/forms/z1fglcxq1u8h0fg/ (reimbursement)

Naltrexone

- Antagonist used in conjunction with counseling and social support as part of MAT
- Monthly injection available, trade name: Vivitrol
- May be prescribed by any health care provider who is licensed to prescribe without special training
- Blocks opioid receptors, thereby, negating misuse/diversion risk
- Challenge: patient must be opioid free for 7-10 days prior to administration of naltrexone

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

Buprenorphine and Naltrexone Comparison

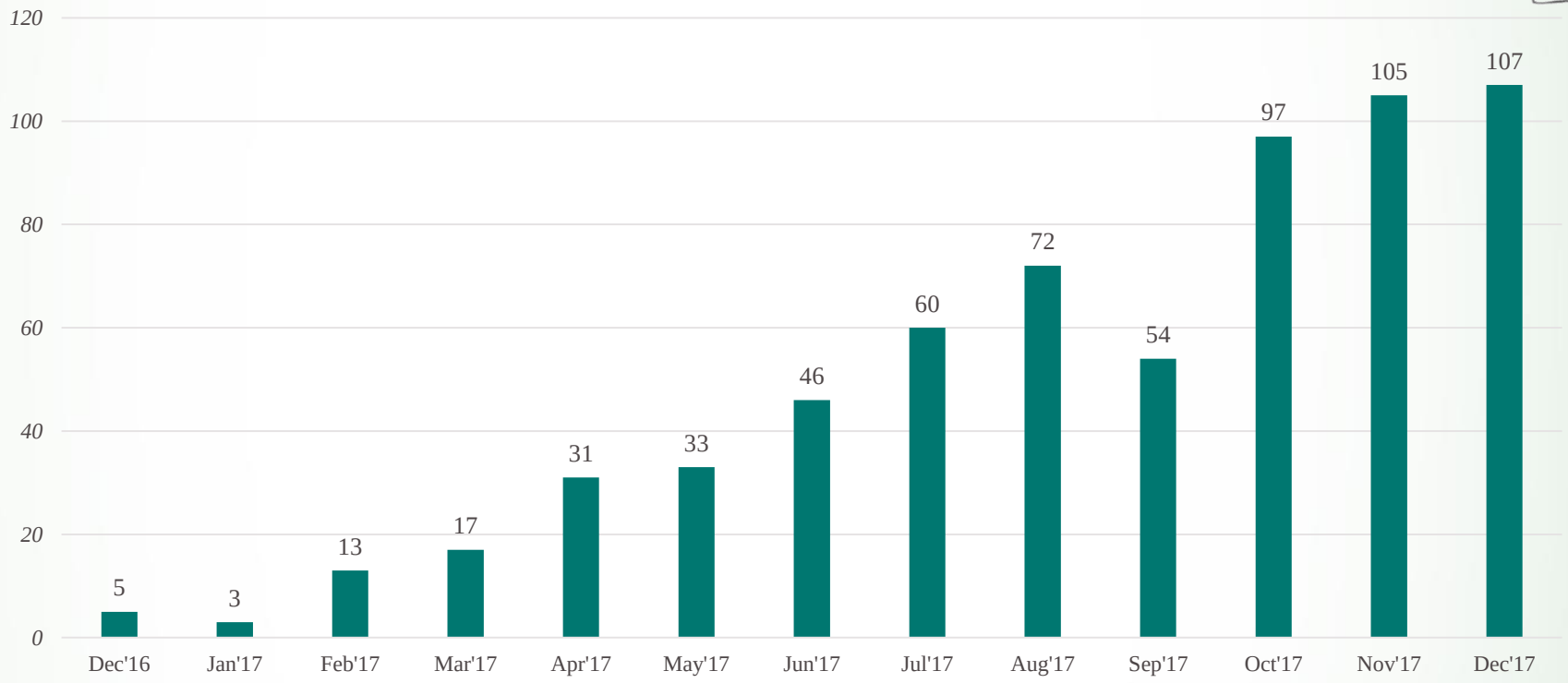
- NYU study compared effectiveness of buprenorphine-naloxone versus extended-release naltrexone for opioid relapse prevention.
- Findings demonstrated more difficulty initiating naltrexone (Vivitrol) compared to buprenorphine (Suboxone).
- Post initiation, both medications were equally effective.

Source: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32812-X/fulltext

Best Practice in Care Coordination — EPICC Project

- Patient overdoses and arrives in the ED.
- An ED buprenorphine-waivered physician is contacted.
- Buprenorphine induction occurs in the ED.
- A Recovery Coach is contacted and meets with the patient in the ED.
- The ED physician provides the patient with a bridge prescription of 3-5 days of buprenorphine.
- The Recovery Coach assists the patient with a timely referral to outpatient MAT, behavioral therapy, and support groups.

EPICC Project Results



Source: Behavioral Health Network (2018) EPICC Project, six-month report, July-December 2017

EPICC Demographic Profile

Active Opioid Overdose Clients (12/2016 – 12/2017; n=643)					
Gender	Male 42.3%	Female 57.7%			
Race	Caucasian 46%	African American 44%	Refused 10%		
Age	18-25 15%	26-35 42%	36-45 26%	46-64 15%	**>65** **2%**
Currently Enrolled in any Substance Use Tx?			Yes 2.1%	No 97.9%	
Client Reported as Homeless*			Yes 30%	No 70%	
Client Reported Active Insurance			Yes 33%	No 67%	
Narcan Provided through Recovery Coach			Yes 88%	No 12%	
Overdose Education Provided through Recovery Coach**			Yes 95%	No 5%	
Source: Data obtained from Efforts to Outcomes (ETO) database					

Source: Behavioral Health Network (2018) EPICC Project, six-month report, July-December 2017

Housing, MAT and Recovery

- Missouri partner: National Alliance for Recovery Residences
  - Missouri Coalition of Recovery Support Providers is an official affiliate of NARR
- NARR-accredited recovery homes in Missouri
  - Eastern region: two homes
  - Southwest region: one home
  - Western region: eight homes

Source: https://missouriopioidstr.org/recovery/

Missouri Recovery Community Centers

- Peer-based community centers
  - St. Louis Empowerment Center, St. Louis
  - Missouri Network for Opiate Reform and Recovery, St. Louis
  - Healing House, Inc., Kansas City
  - Springfield Recovery Community Center, Springfield

Source: https://opioids.mo.gov/node/56

Peer Support in Recovery

- March 2018 — DMH will recognize a single peer certification
- Certified Peer Specialists will be qualified to support individuals in recovery from substance use, mental health or co-occurring disorders.
- The Missouri Credentialing Board will oversee the credentialing process.

Source: www.missouricb.com

Contact Information

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