Minnesota Hospital Association

Community-Based Care Collaboration Prevents Opioid Abuse

Speakers: Kurt DeVine, M.D., Heather Bell, M.D. and Charles Strack
Friday, Jan. 12, 2018
4:20 – 5:20 p.m.
Northland Ballroom

Kurt Devine, M.D.

Dr. Kurt DeVine has been a full spectrum family medicine physician for more than 26 years. As a practicing physician in Rural Minnesota, he has faced many unique challenges caring for patients in the primary care setting amid evolving care delivery models demanding forward-thinking and creative strategies for change. As opioid use and its attributing issues became increasingly apparent, he became more engaged and involved with the local community task force assembled to address concerns of opioid use and dependency within the county. He quickly discovered the importance of guiding change with a strong provider champion and building impactful community partnerships. His leadership has enabled grant funding to be put to practical use, demonstrating positive outcomes both financially and from a patient care perspective. Recently, he has begun medication-assisted addiction treatment, introducing the use of buprenorphine as part of his primary care practice. As he continues to provide ongoing support and education to his colleagues, Dr. Devine has been a change agent, creating a culture shift within his practice. It is through his remarkable leadership that a small rural clinic has made significant progress related to the treatment of opioid misuse that is recognized across the country.

Dr. Heather Bell

In 2012, Dr. Heather Bell began her family medicine practice in rural MN. With her visionary leadership, Dr. Bell has been influential in redesigning the primary care delivery model across the clinic by adopting whole person-centered care and instituting guiding principles which led to the clinic earning recognition by the state of Minnesota as a Medical Home. As an emancipated minor, Dr. Bell's childhood brought many challenges. Losing a mother as an early teen and coping through family chemical abuse and addiction instilled the strength of perseverance, courage and desire to make a difference through the practice of medicine. As opioid use and related issues became increasingly apparent, Dr. Bell identified that the whole-person care approach of the medical home model was most appropriate for re-engineering the approaches to care**.** Dr. Bell became very active in the Controlled Substance Care Team within the clinic setting and recently introduced medication-assisted addiction treatment using buprenorphine as part of her primary care practice. Her leadership and perseverance are transforming the clinic practice, demonstrating success in both cost savings and patient care outcomes.

Charles Strack

Charles Strack is a detective at the Little Falls Police Department and the police chief in Randall, Minnesota. Strack began working part-time as a police officer in 1994 for the city of Little Falls before being hired full time as a patrolman in 1998. He is a narcotics K-9 officer and was sergeant of the Little Falls Police Department for nine years. Strack has worked with other members of the Prescription Drug Task Force including Sheriff Wetzel, Police Chief Greg Schirmers, members of local pharmacies, area doctors and nurses from the Family Medical Center, St. Gabriel's Hospital and Little Falls Orthopedics. He assists in the Drug Take-back program where prescription drugs are dropped off at local police departments and then destroyed as to get dangerous narcotics out of homes.

CHI St. Gabriel's Health

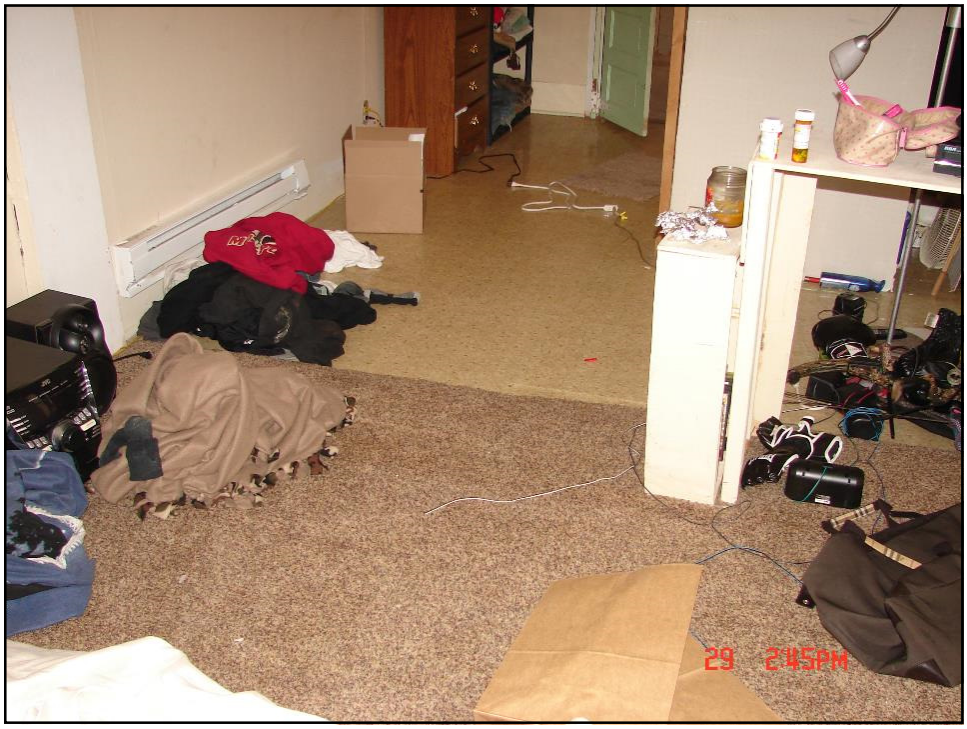
Imagine better health.℠

Morrison County Opioid Program

Dr. Kurt DeVine
Dr. Heather Bell
Charles Strack, Detective

COBORN'S
DEDICATED
ACLIGRIP

NDC 0781-7113-55
Five (75 mcg/h) Systems
Fentanyl Transdermal System
75 mcg/h
LONGBELLA DRUG STORE
PHONE (218) 994-8761
APPLY & CHANGE 1 PATCH EVERY 72 HOURS - May Cause Dizziness. For External Use Only
FENTANYL PATCH 75MCG
NO REFILLS LEFT
ONLY
for pain requiring opioid medicine around-the-clock
2009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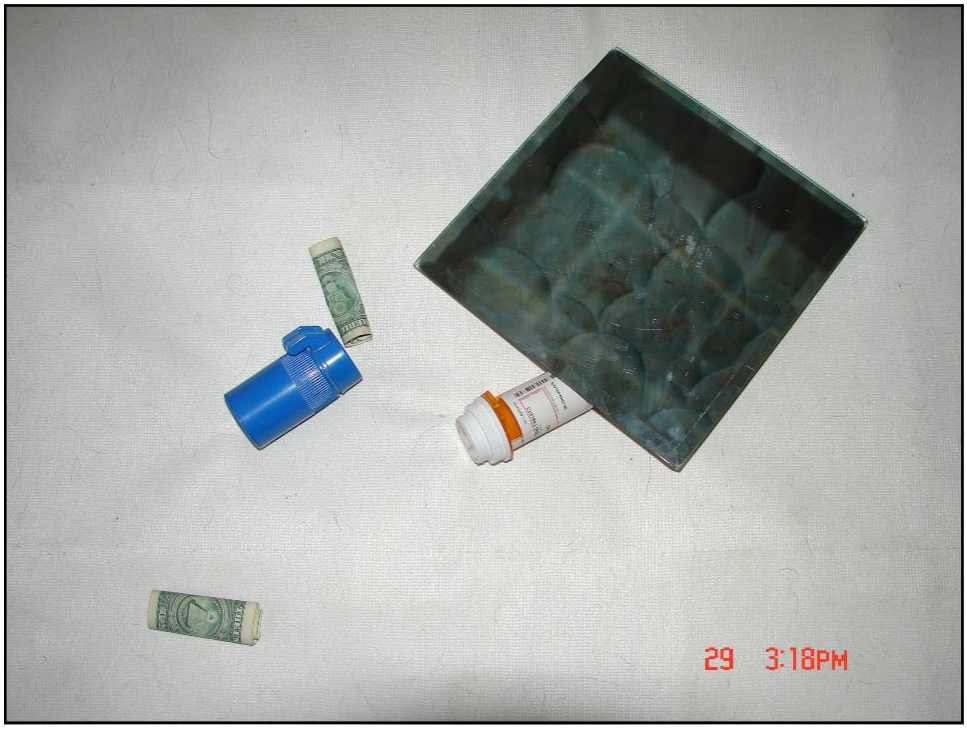
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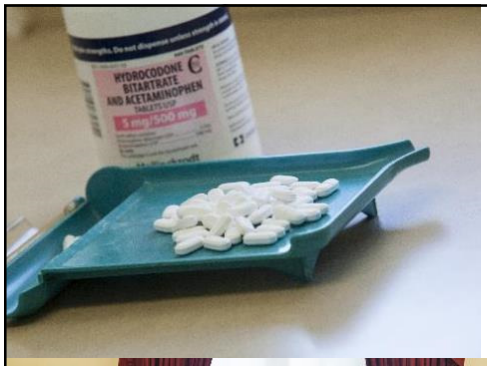
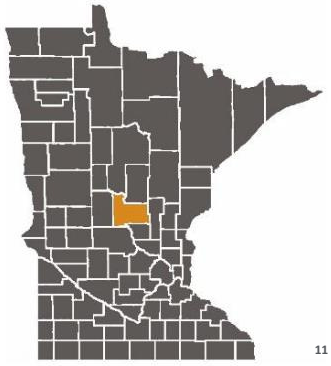


Opioid Abuse

A call to action



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Opioid Abuse

The call to action.

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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Opioid Abuse
The call to action.

The **number one cause of death** in 17 states is prescription drug abuse, surpassing motor vehicle accidents

SOURCE: Centers for Disease Control and Prevention

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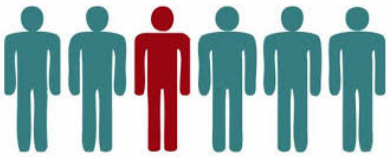
Opioid Abuse
The call to action.

More than **50 million Americans** have admitted to **abusing prescription drugs**

SOURCE: CBS Evening News



= 1 out of 6 people

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Opioid Abuse
The call to action.

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.

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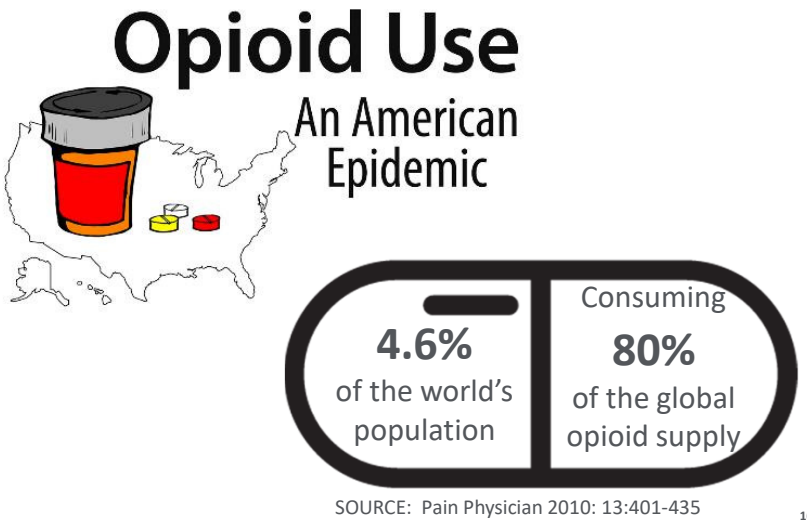
Opioid Abuse
The call to action.



SOURCE: Pain Physician 2010: 13:401-435

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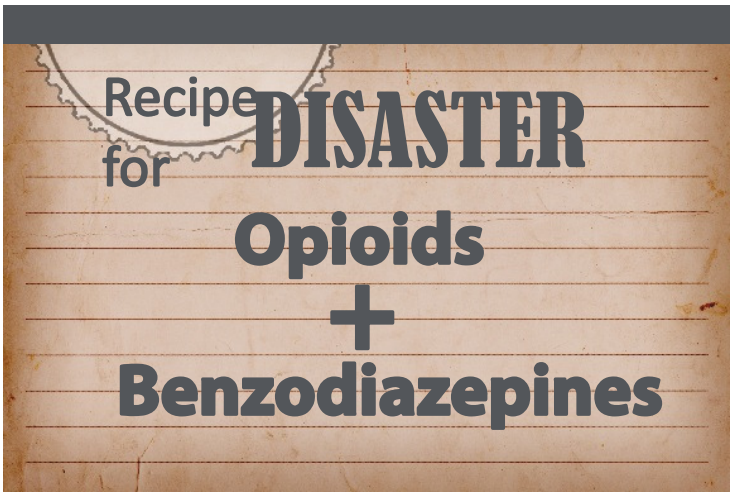
Opioid Abuse
The call to action.



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Opioid Abuse
The call to action.

Benzodiazepines are often found in the blood of overdose victims.

50%– 80% of heroin overdose deaths.
40% – 80% of methadone deaths.
30% – 69% of deaths due to prescription opioids were individuals who were also prescribed benzodiazepines.

SOURCE: CDC Report

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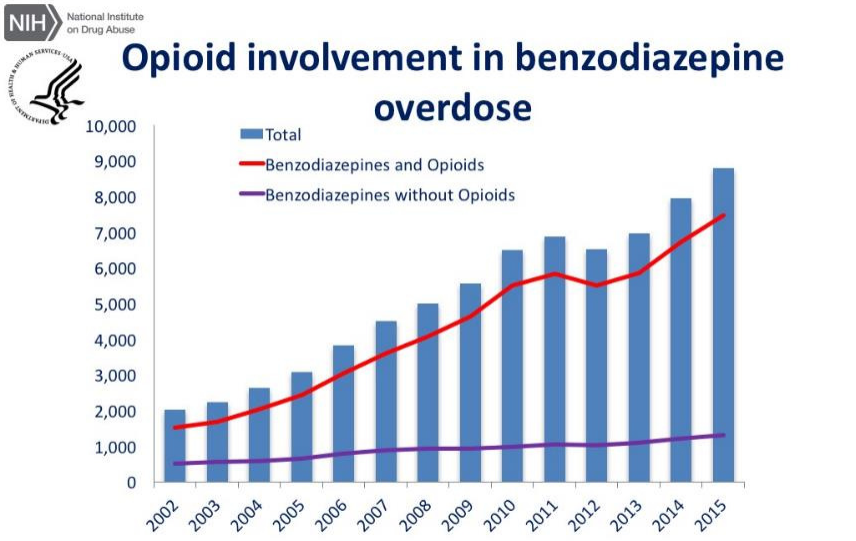
Opioid Abuse
The call to action.



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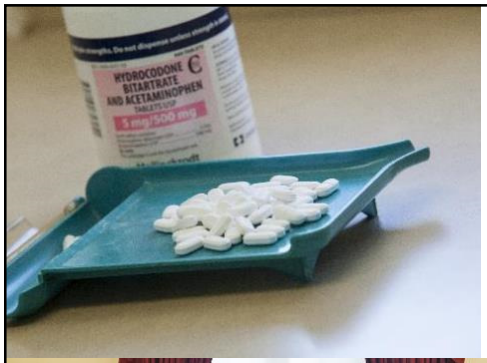
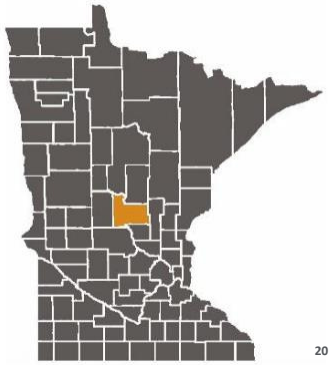


Opioid Abuse

Roadmap to Disaster



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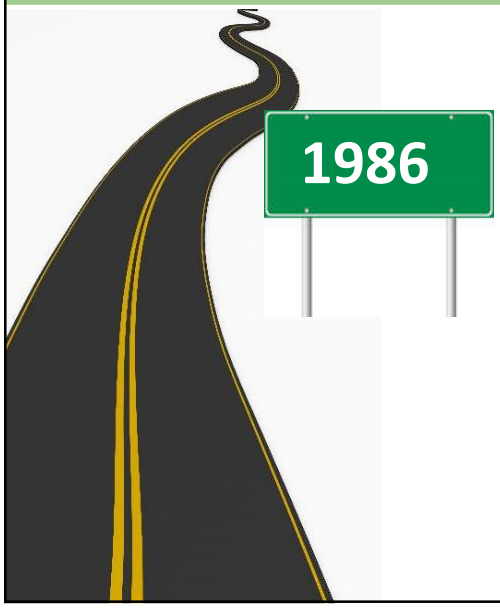
Opioid Abuse
Roadmap to disaster.



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

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Opioid Abuse
Roadmap to disaster.

"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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Opioid Abuse
Roadmap to disaster.

The American Pain Society trademarked the slogan "Pain: The Fifth Vital Sign."

Pain
the 5th vital sign™
American Pain Society

23

Opioid Abuse
Roadmap to disaster.

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

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Opioid Abuse
Roadmap to disaster.

"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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Opioid Abuse
Roadmap to disaster.

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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Opioid Abuse
Roadmap to disaster.

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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Opioid Abuse
Roadmap to disaster.

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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Opioid Abuse
Roadmap to disaster.

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

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Opioid Abuse
Roadmap to disaster.

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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Opioid Abuse
Roadmap to disaster.

Also in 1998, 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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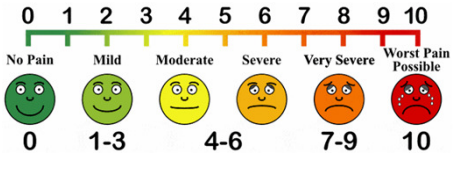
Opioid Abuse
Roadmap to disaster.

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



Opioid Abuse
Roadmap to disaster.

"Some clinicians have inaccurate and exaggerated concerns" (about addiction, tolerance and risk of death). *"This attitude prevails despite the fact there is no evidence that addiction is a significant issue when persons are given opioids for pain control."*

Guide published by JCAHO, sponsored by Purdue Pharma, 1991

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Opioid Abuse
Roadmap to disaster.

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

34

Opioid Abuse
Roadmap to disaster.

"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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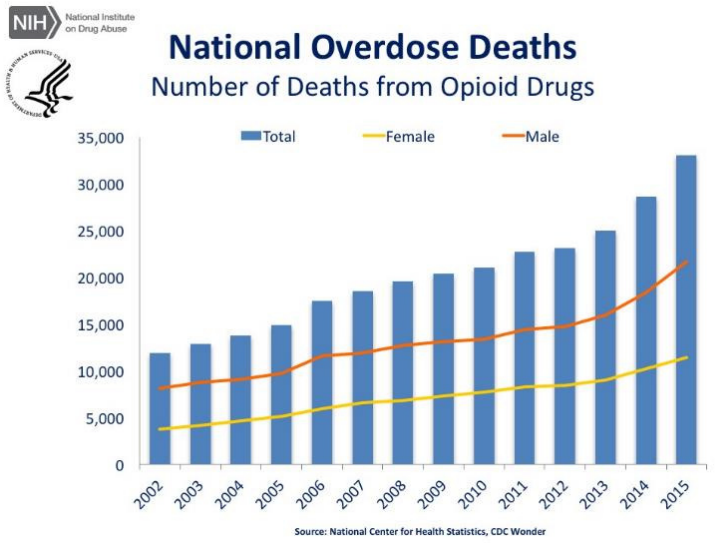
Opioid Abuse
Roadmap to disaster.



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Opioid Abuse
Roadmap to disaster.

Purdue Pharma and execs pleaded guilty to "misbranding" the drug as less addictive and less subject to abuse than other pain medications.

Paid $645 million in fines.

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Opioid Abuse
Roadmap to disaster.

Are narcotics really necessary?

- Opioids are useful for up to 8 weeks for acute pain.
- Pain relief is modest.
- No evidence to suggest it is effective beyond 2 months.
- Dose escalation to maintain analgesia occurs.

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Opioid Abuse
Roadmap to disaster.

259 million prescriptions are written for opioids.

Sales of opioid painkillers total more than **$9 billion per year.**

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Opioid Abuse
Roadmap to disaster.

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
- Overdoses in the community
- Police concerns

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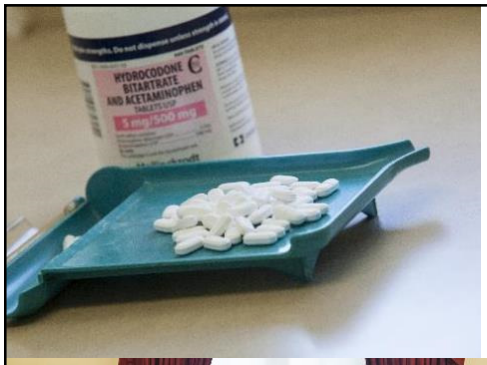

Opioid Abuse

A real solution

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Opioid Abuse
A real solution.

Community issues require community solutions.

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

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Opioid Abuse
A real solution.

CENTRAL MN VIOLENT OFFENDER TASK FORCE

MORRISON COUNTY

SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

COBORN'S PHARMACY

CHI St. Gabriel's Health
Imagine better health.℠

NORTHERN PINES Mental Health Center

HORIZON HEALTH INC.
We serve where you live.

POLICE LITTLE FALLS MINNESOTA LAND OF LINDBERGH

STAND UP 4U coalition

St. Otto's Care Center
Little Falls, MN

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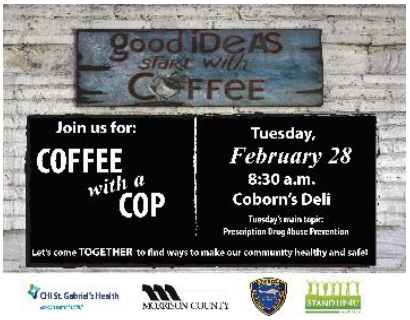
Opioid Abuse
A real solution.

Prescription Drug Task Force functions:

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



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Opioid Abuse
A real solution.

- Task forces
- Narcan
- Drug Treatment
- Medical Assisted Treatment

These are NOT solutions to the opioid epidemic and addiction, rather these are reactions to the problem.

Opioid Abuse
A real solution.

Our pharmacy data showed
100,000 narcotic pills were coming out of our local pharmacies each month.

The task force alone was not the solution!

47

Opioid Abuse
A real solution.

The solution?

Decreasing the narcotics leaving clinics and hospitals.

Our goal:

Put drug treatment centers, and the manufacturers of Methadone, Suboxone, and Narcan out of business.

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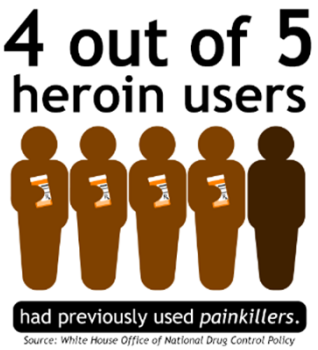
Opioid Abuse
A real solution.

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



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Opioid Abuse
A real solution.

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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Opioid Abuse
A real solution.

Initial Goals

- Avoid early refills
- Encourage doctors to sign up for Prescription Drug Monitoring Program (PDMP)
- Review patient charts

51

Opioid Abuse
A real solution.

Initial Goals

- Ensure urine screens and pill counts are completed
- Support providers by establishing care plans for all patients on controlled substances

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Opioid Abuse
A real solution.

Early Workflow Development

- One physician
- RN
- Administrator

A social worker and Medical Home physician were added in an effort to address all the patient's needs.

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Opioid Abuse
A real solution.

Getting Into the "Program"

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

54

Opioid Abuse
A real solution.

Initial Evaluation

Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker.

55

Opioid Abuse
A real solution.

Information Gathering

- Past medication history
- Substance abuse history
- Drug-related convictions
- PMP
- Family history
- Pharmacy review (if necessary)
- Review of appropriate dosing

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Opioid Abuse
A real solution.

Information Gathering

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

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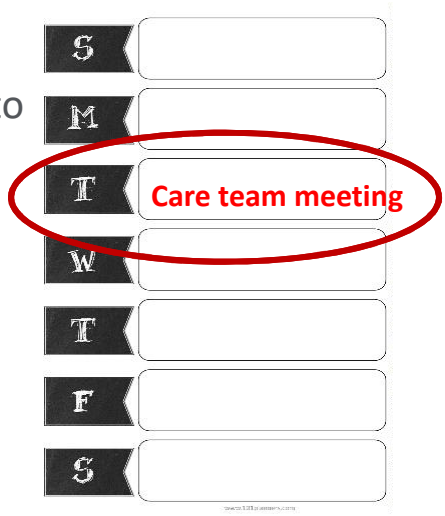
Opioid Abuse
A real solution.

Weekly meetings began to review patient cases one at a time.



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Opioid Abuse
A real solution.

Entrance Form

Reviewed at weekly meetings by physicians.

Review includes:
- Previous work-ups
- Scans
- Referrals to occupational therapy, physical therapy, or pain clinics

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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: _____

_____

_____

_____

Scanned in EMR: Y/N

Signed: _____

60

Opioid Abuse
A real solution.

Recommendations

- Formulated based on review
- Reviewed with primary provider

61

Opioid Abuse
A real solution.

Components of Recommendations

- Dose reductions
- Further work-up or updated work-up
- Discontinuation of other medication due to risks (benzodiazepines)

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Opioid Abuse
A real solution.

Components of Recommendations

- Physical therapy or occupational therapy
- Taper if medical condition doesn't warrant pain medication
- Discontinued if obvious diversion

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Opioid Abuse
A real solution.

Outcomes

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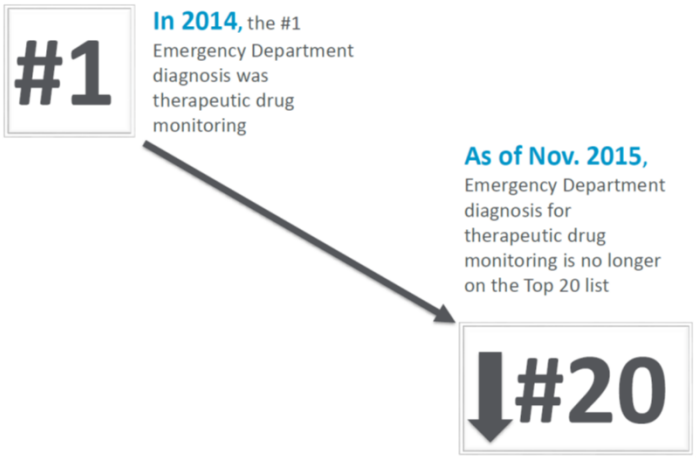
Opioid Abuse
A real solution.

Outcomes



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Opioid Abuse
A real solution.

Outcomes

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

These patient tapers account for **642,528 fewer pills/units** prescribed in a year.

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Opioid Abuse
A real solution

Outcomes

- 329 Total Tapered Patients (narcotics, stimulants or Benzo.)
  - Average decrease= 53,544 units/month no longer prescribed
  - Approx. $7/pill = $4.5 million per year
- Patient Needs/Support Referrals
  - 2016: 146
  - 2017: 334

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Opioid Abuse
A real solution

Outcomes

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

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Opioid Abuse
A real solution.

Changing Physician Culture: Slow and Ongoing

- Unexpected urine testing
- Overdoses and overdose deaths
- Police information
- CDC guideline information
- Pending state guidelines
- State Board interest in this issue

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Opioid Abuse
A real solution.

CDC guidelines

"Clinicians should continue opioid therapy ONLY IF there is clinically meaningful improvement in pain and FUNCTION…"

70

Opioid Abuse
A real solution.

CDC guidelines

"…increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function…"

71

Opioid Abuse
A real solution.

CDC guidelines

*"…and should avoid increasing dosage to ≥ 90 MME/day, or carefully justify a decision to titrate dosage to ≥ 90 MME/day."**

* This must be documented

72

Opioid Abuse
A real solution.

CDC guidelines

"Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible."

73

Opioid Abuse
A real solution.

Why should we care?

Because the Minnesota State Medical Board cares!

Minnesota Board of Medical Practice

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Opioid Abuse
A real solution.

MN Board of Medical Practice Policy

For use of controlled substances for the treatment of pain:

- Evaluate patient history and physical
- Document treatment plan
- Check the PDMP
- Informed consent and medication agreement

Minnesota Board of Medical Practice

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Opioid Abuse
A real solution.

MN Board of Medical Practice Policy

For use of controlled substances for the treatment of pain (continued):

- 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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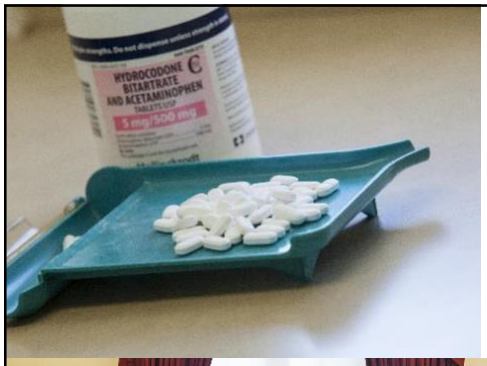

Opioid Abuse

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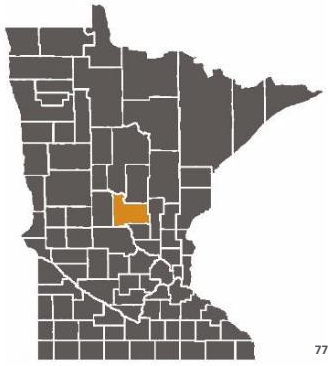

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Suboxone

What Is It?

- Buprenorphine/naloxone
- Agonist/antagonist
- Pills or films form

Versus Methadone

- Agonist only
- Ability to get high

Diversion Differences

Our Buprenorphine Program

Success Thus Far:

- Total considered for program= 100
- Total enrolled= 65
- Currently Active= 41
- Inactive= 24

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Buprenorphine Program
Defining success

- Time
- Employment
- Repaired relationships

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County Jail Buprenorphine Program

The issue: interrupted buprenorphine treatment

The solution: collaboration

- Assembling a team
- Developing protocols to continue buprenorphine
- Considering new starts

81

Emergency Room Initiative

Goal: Point of care intervention

- Interact with overdose patients or patients in withdrawal
- Flyer with control substance care team number
- Referral process for buprenorphine treatment

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Our Story: Minnesota Hospital Association Innovation in Patient Care

83

Our Story: American Hospital Association NOVA Award

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Opioid Abuse
A real solution.

Awards do not save lives, but…
they draw attention to the issue.

85

Opioid Abuse
A real solution.

- Community presentations
- Legislation to clone the program
- ECHO program

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Legislative Program

Through Cloning Our Program:

- Roughly 7 communities will receive legislative funding to hire staff to mirror our program.

Example of a Community Seeing Success Using Model

- Following our guidelines and model a community with one nurse (without any funding).
- 111,552 pills were decreased in one year.

Project ECHO

Project ECHO®

Moving Knowledge Instead of Patients and Providers

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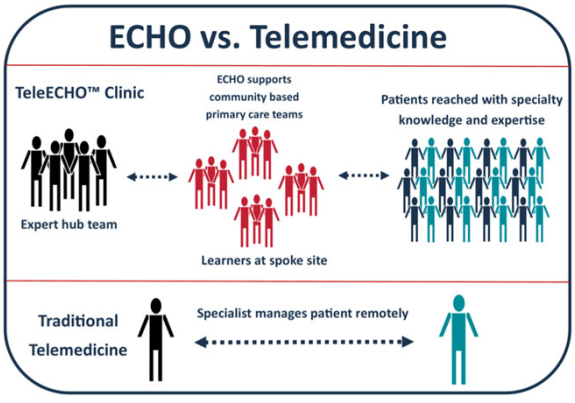

ECHO model is not 'traditional telemedicine'.
Treating Physician retains responsibility for managing patient.

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Goals of our ECHO

- Aid providers in the appropriate management of narcotic prescribing.
- Give providers the ability to identity patients that are not appropriate for opioids, through things such as chart reviews.

Goals of our ECHO

- Be able to identify comorbidities that put patients at higher risk of death.
- Collect data for the state that will demonstrate that we can improve prescribing practices and decrease the number of pills being prescribed.

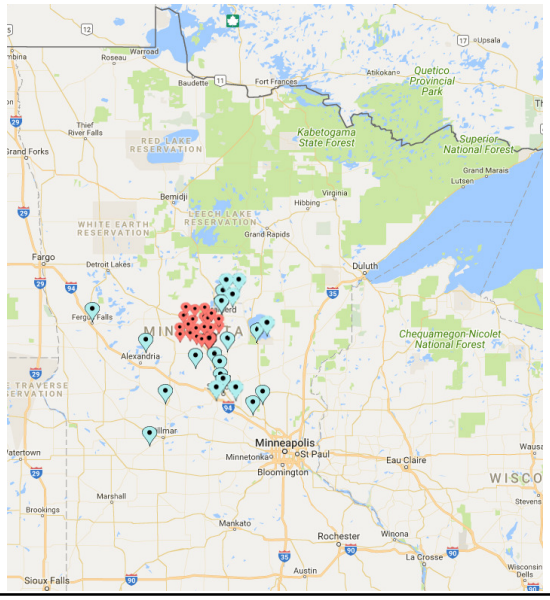
Goals of our ECHO

- Increase the number of buprenorphine providers in rural Minnesota.
- Educate physicians on the CDC and state guidelines.

Our Active Patients on Suboxone

Little Falls, MN- *20 patients*

Belgrade, MN
Big Lake, MN
Brainerd, MN- *5 patients*
Carlos, MN
Fergus Falls, MN
Merrifield, MN
Onamia, MN- *2 patients*
Pierz, MN
Raymond, MN
Rice, MN
Royalton, MN
St. Cloud, MN- *3 patients*
Sartell, MN
Upsala, MN
Zimmerman, MN

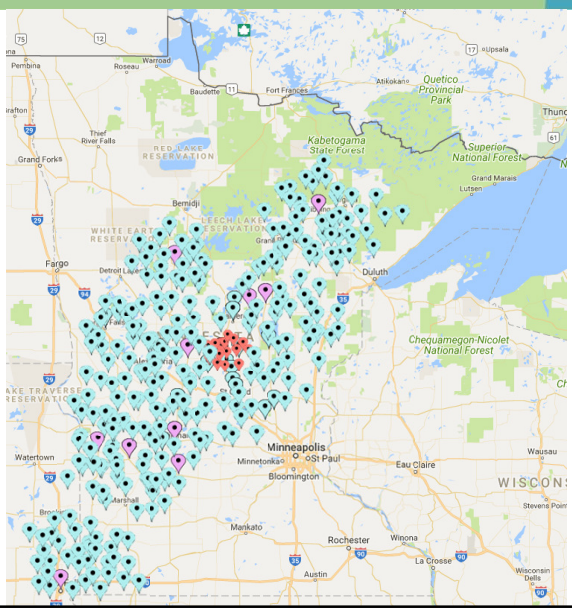


Potential Impact of the ECHO Program

Little Falls Suboxone Patients

ECHO Communities

Roughly 35 Patients per ECHO SPOKE



Project ECHO Benefits to Rural Clinicians

- Professional interaction with colleagues with similar interest
- A mix of work and learning
- Access to specialty consultation
- Possible opportunity for no cost CMEs

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Example of Project ECHO Clinic

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CHI St. Gabriel's Health

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THANK YOU!

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