



Our Community Responds to the Opioid Epidemic

Hospitals and Health Systems
Impacting the Opioid Crisis

DATE: July 22, 2016 PRESENTED BY: Tom Yackel, MD, MPH, CPE – Chief Clinical Integration Officer, OHSU Partners

The Opioid Epidemic is a community problem

- The liberal use of opioids to address acute and chronic pain over the past decade has fueled the current problem
- In Portland, OR more people die from prescription opioid overdose than heroin overdose


A community solution is required

- National guidelines are helpful, but don't, on their own, create local physician engagement
- Individual practices are too small to solve the problem “going it alone”
- Community organization around this problem is required



Community Health Needs Assessment drove our effort

- Our local community came together for the purpose of developing a city-wide CHNA
- Addressing the opioid epidemic, along with improving breast-feeding rates, were the 2 projects that all health systems agreed to work on



“When you look at the staggering statistics, in terms of lives lost, productivity impacted, costs to communities, but most importantly cost to families from this epidemic of opioid abuse, it has to be something that is right up there at the top of our radar screen.”

—President Barack Obama



Community Response to the Opioid Epidemic:
Oregon Hospitals & Health Systems
Impacting the Opioid Crisis

July 22, 2016



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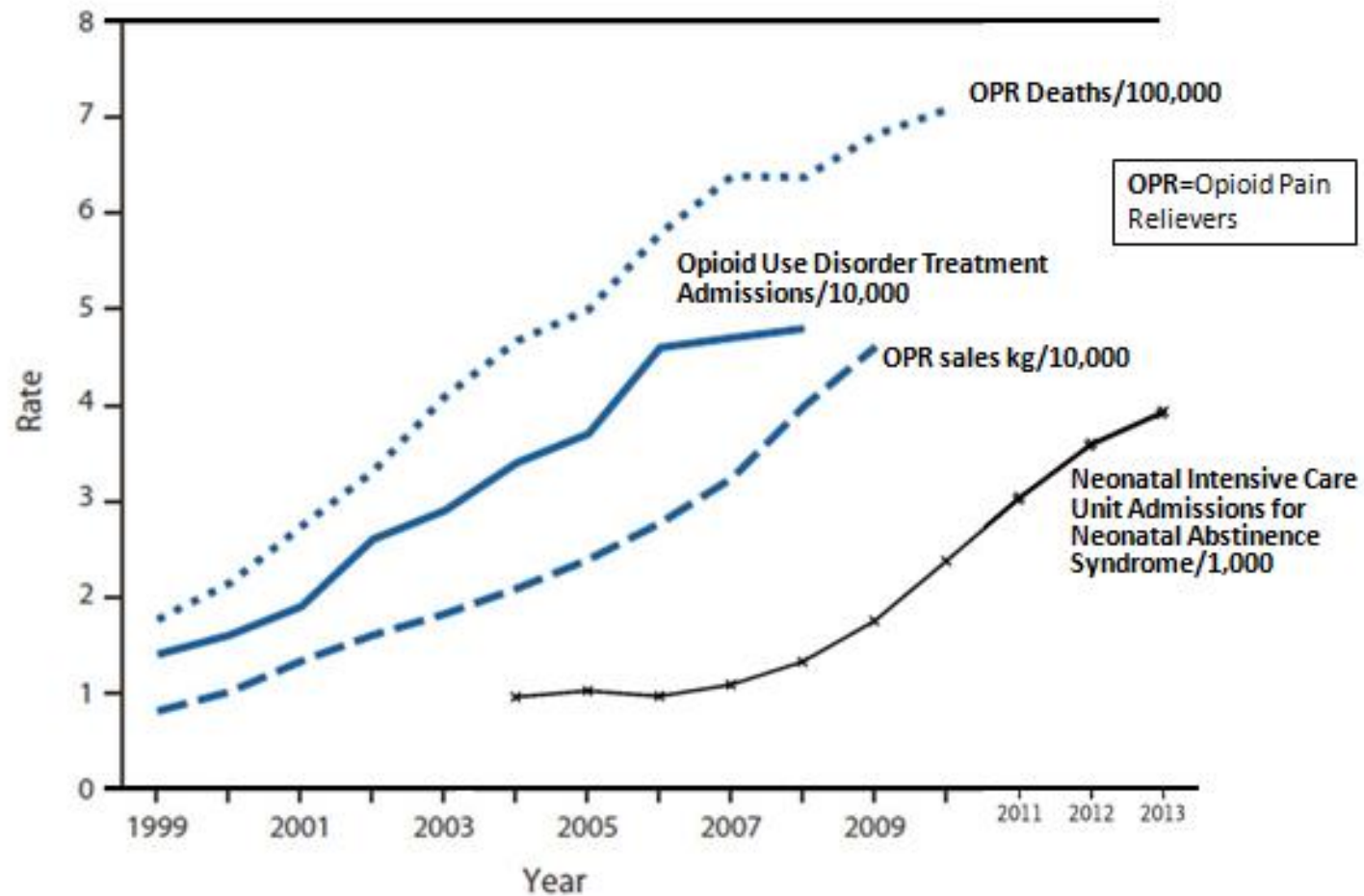
Division of Internal Medicine & Geriatrics

Oregon Health & Science University

Today's Objectives

- Describe a collaborative approach to developing a community standard for opioid prescribing
- Describe health system changes to improve opioid use disorder treatment
- Understand health system opportunities for opioid use disorder treatment

Worrisome Trends and Associations



Recent Opioid Overdose Trends

Opioid Overdose Trends, 2000-2013

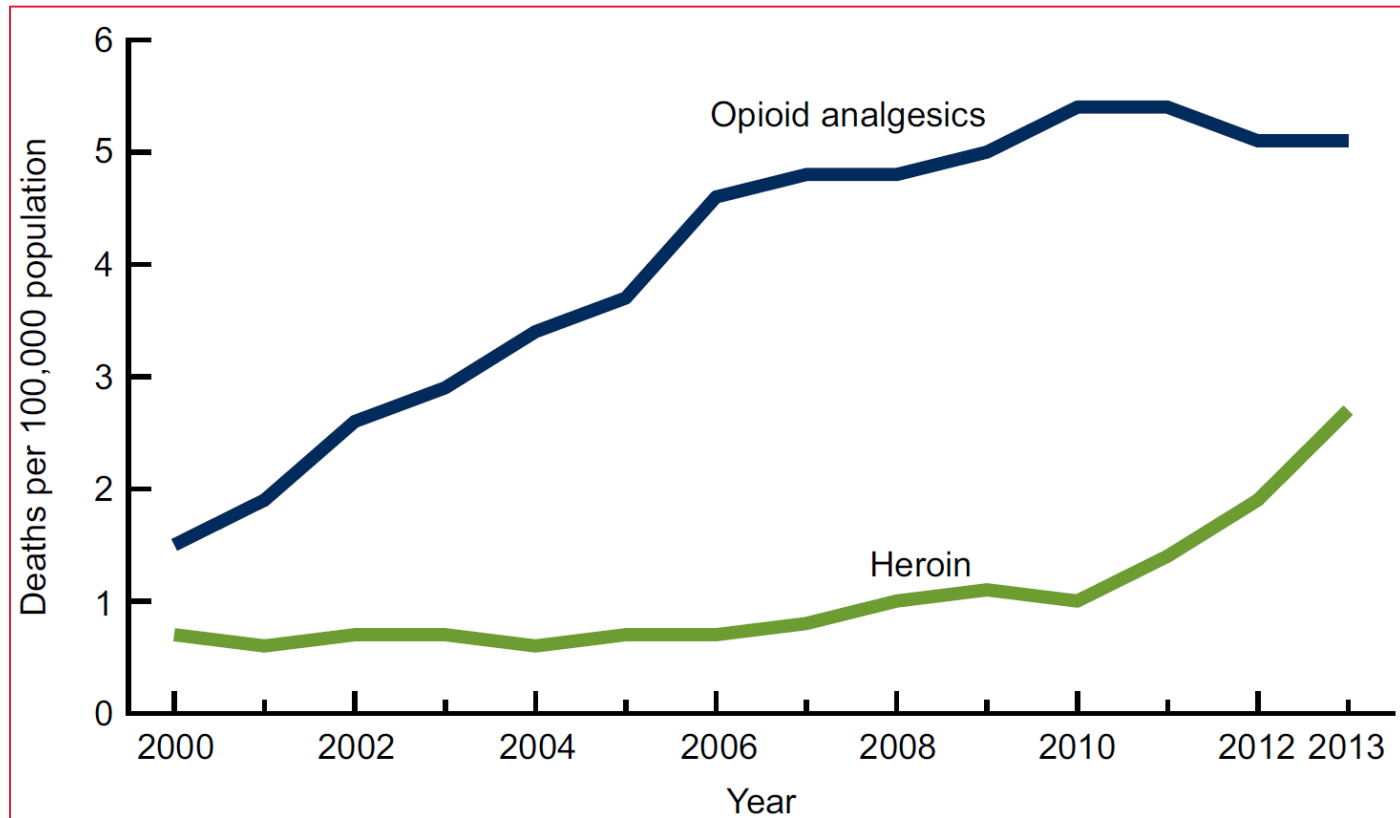


Figure 4. Primary heroin admission rates, by state or jurisdiction: 2002-2012
(per 100,000 population aged 12 and older)

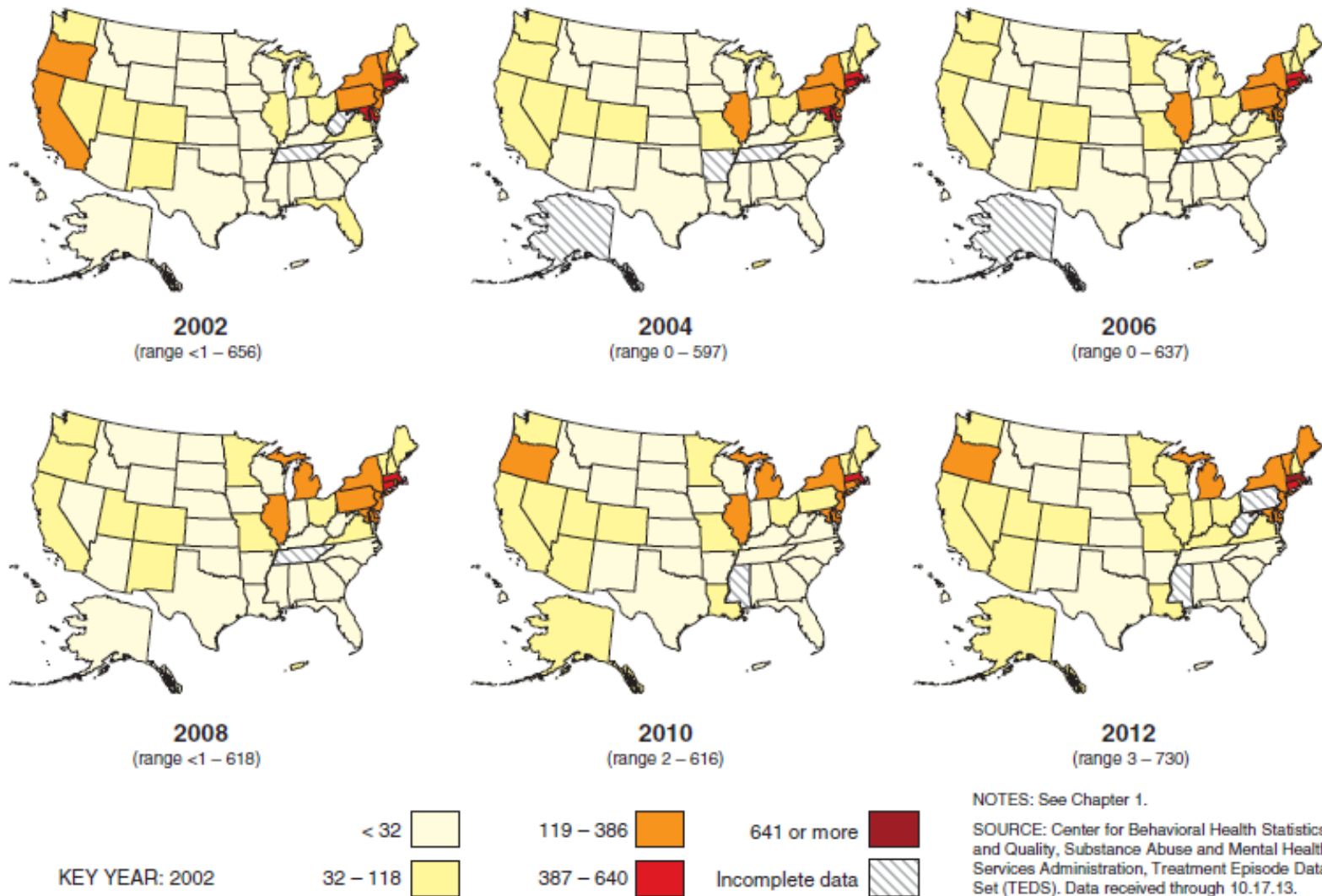
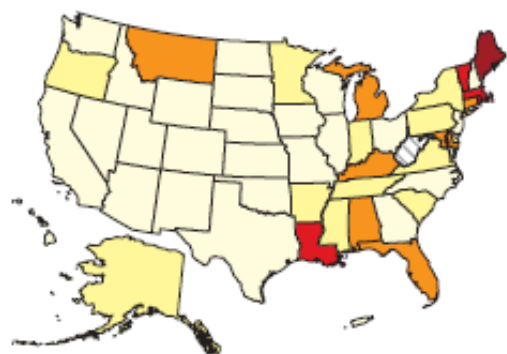
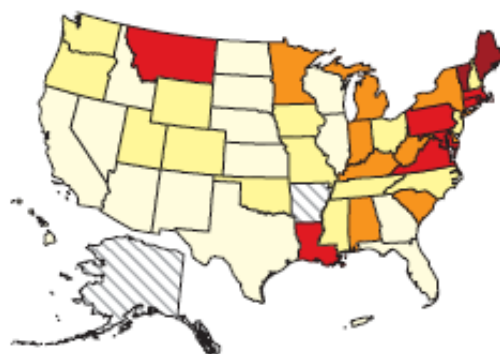


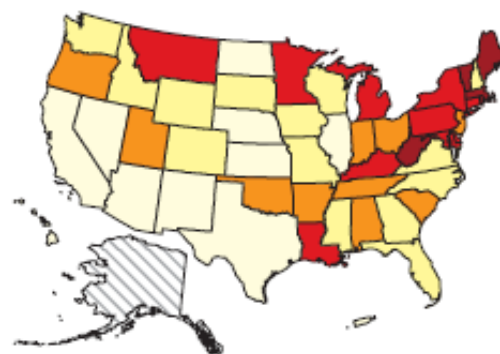
Figure 7. Primary non-heroin opiates/synthetics admission rates, by state or jurisdiction: 2002-2012
(per 100,000 population aged 12 and older)



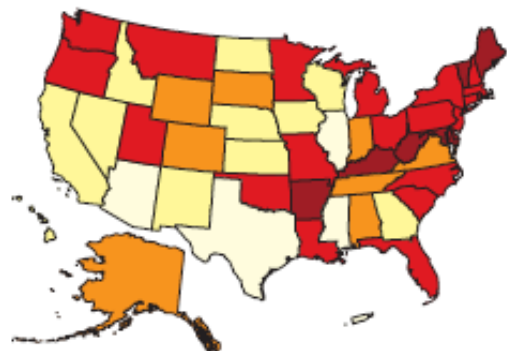
2002
(range 0 – 109)



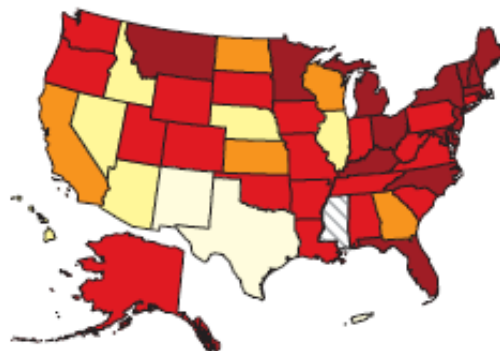
2004
(range <1 – 167)



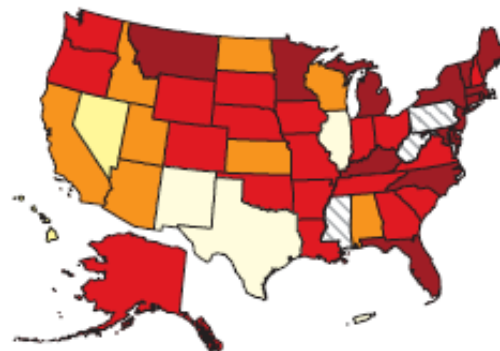
2006
(range <1 – 271)



2008
(range 1 – 395)

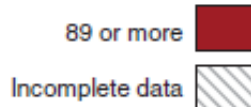
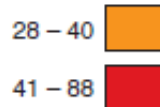
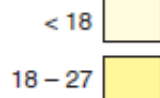


2010
(range 2 – 363)



2012
(range <1 – 443)

KEY YEAR: 2002

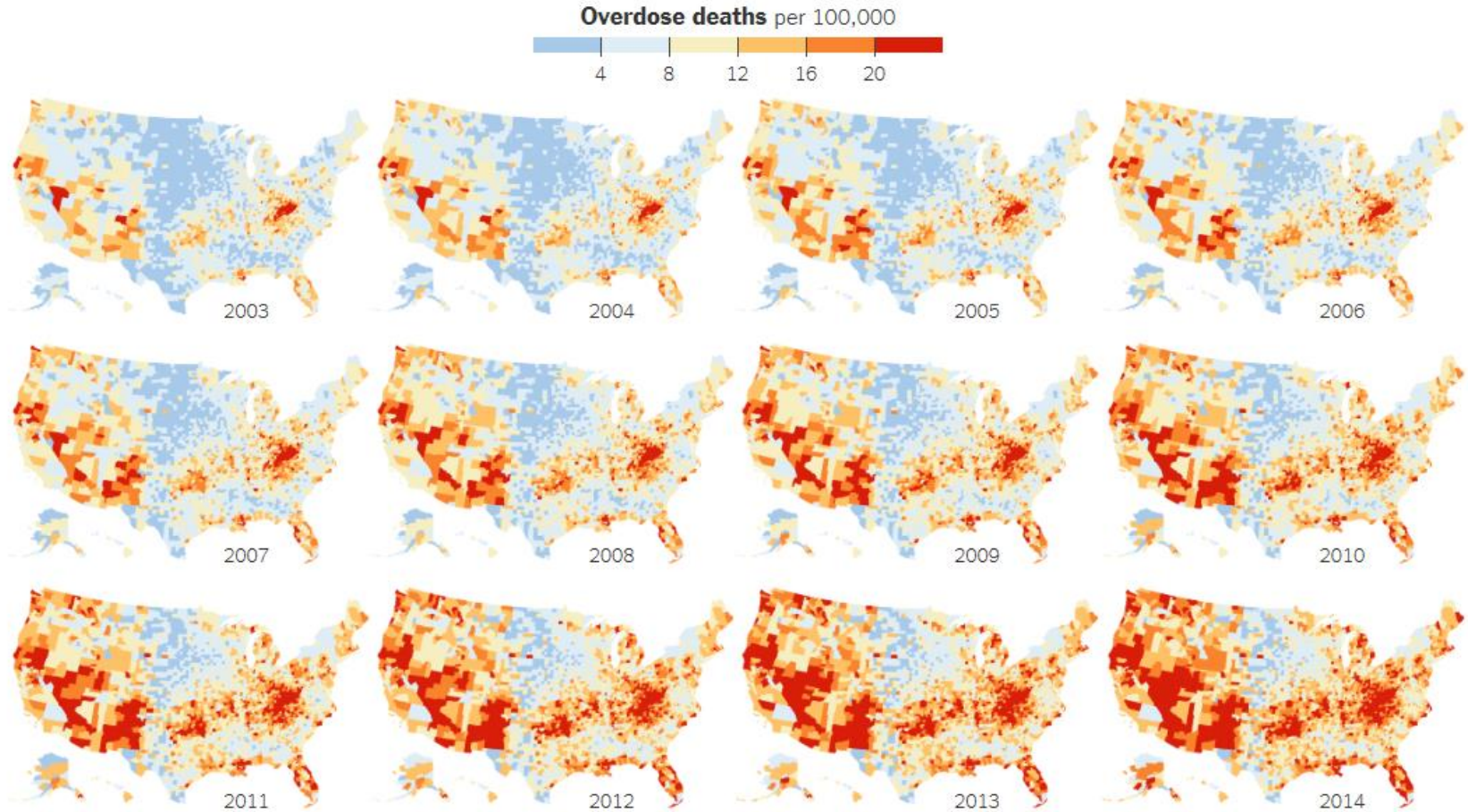


NOTES: See Chapter 1.

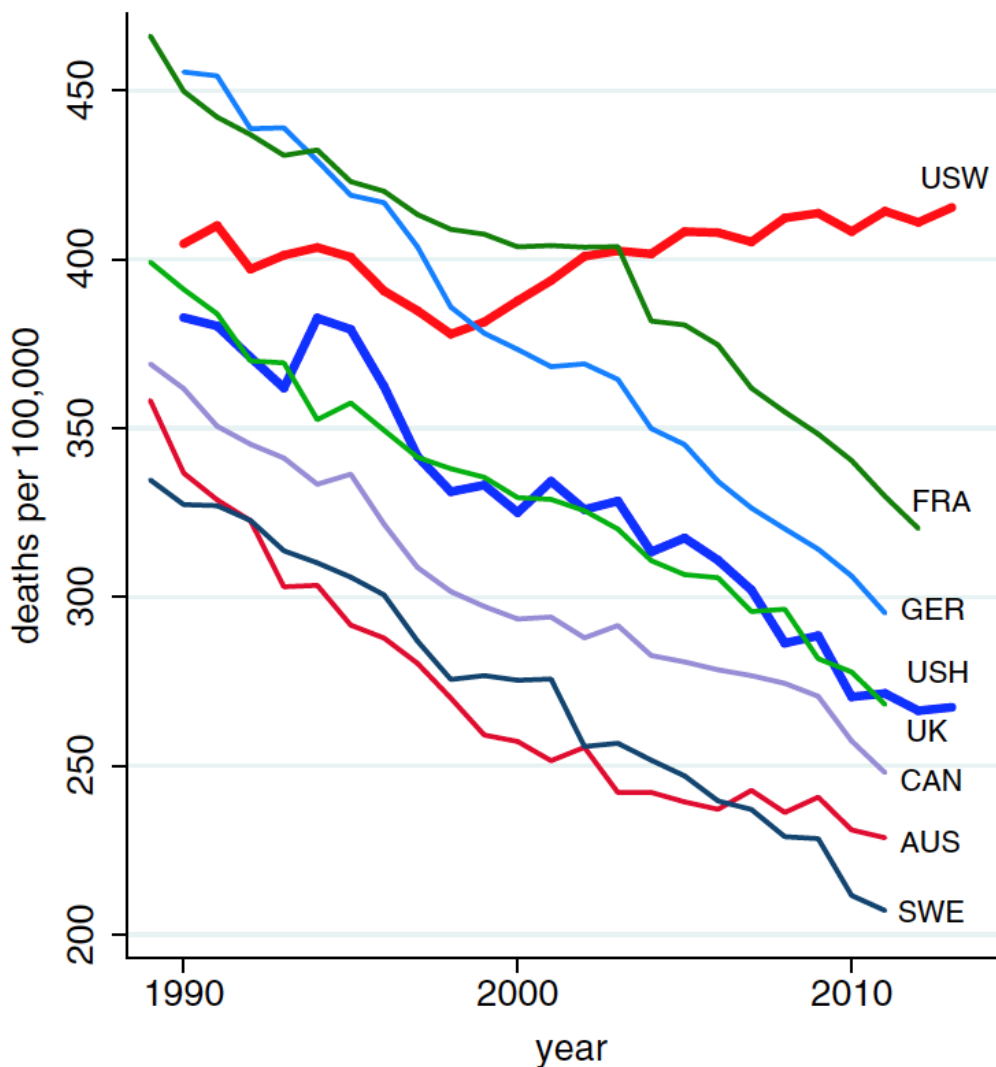
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.17.13.

How the Epidemic of Drug Overdose Deaths Ripples Across America

By HAEYOUN PARK and MATTHEW BLOCH JAN. 19, 2016

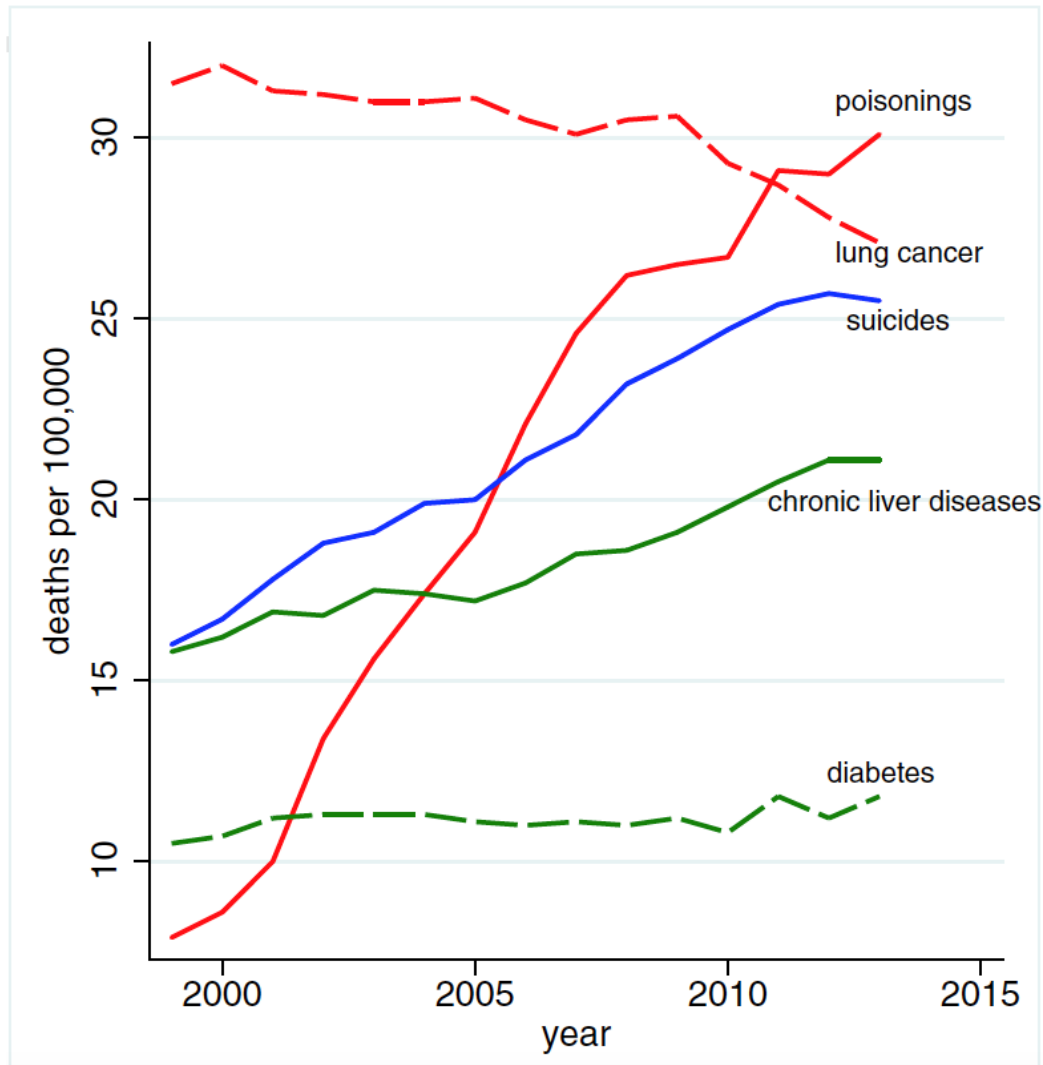


All-cause mortality, ages 45–54 for US White non-Hispanics (USW) , US Hispanics (USH)



France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Mortality by cause, white non-Hispanics ages 45–54



Source: Anne Case, Angus Deaton. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences*. November 2, 2015 (online ahead of print).

Controlling the opioid epidemic:

A Three-pronged Approach

- **Prevent** new cases of opioid addiction.
- **Reduce supply** from pill mills and the black-market.
- **Treat** people who are already addicted.

What is Healthy Columbia Willamette Collaborative (HCWC)?

Collaborative response to Affordable Care Act and Public Health Accreditation.

- Conduct comprehensive study of community health needs for 4-county region: Washington, Multnomah, Clackamas, Clark Co.
- Prioritize identified community health needs (2013):
Access, Veteran Suicide, [Opioid Misuse](#), Chronic Disease: Breastfeeding, Chronic Disease: Tobacco Use
- Develop regional strategies to address health need priorities.
- Identify indicators to monitor health outcomes.

Requirements

Federal Affordable Care Act Section 501(r)(3) requires tax exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at min. every 3 years.

Public Health Accreditation Board requires public health dept. to meet standards on core public health functions. Standards require a CHNA and community health improvement plan every 5 years.

2012 Oregon Coordinated Care Organization (CCO) Legislation each CCO must conduct CHNA every 3 years and establish a community advisory committee to oversee CHNA and community health improvement plan within its jurisdiction.

CCO Members

FamilyCare

Health Share Oregon

Public Health Members

Clackamas Co. Health Division

Multnomah Co. Health Department

Clark Co. Public Health

Washington Co. Public Health Division

Hospital Members

Adventist Medical Center

OHSU

Kaiser Sunnyside Hospital

PeaceHealth Southwest Medical Center

Kaiser Westside Hospital

Providence Milwaukie Hospital

Legacy Emanuel Medical Center

Providence Portland Medical Center

Legacy Good Samaritan Medical Center

Providence St. Vincent Medical Center

Legacy Meridian Park Medical Center

Providence Willamette Falls Medical Center

Legacy Mt. Hood Medical Center

Tuality Healthcare

Legacy Salmon Creek Medical Center



Opioid Misuse Prevention Strategies

- Adoption by HCWC member organizations of an opioid prescribing community standard for chronic, non-cancer related pain;
 - Implementation by HCWC member organizations of opioid-prescribing monitoring practices; and
 - Development and implementation of provider and patient education about chronic pain and prescription opioids.
-
- Goal #1: Implement community standard by 2016
 - Goal #2: Reduce the rate of opioid-related deaths in the HCWC region.

HCWC Community Standard

- Opioid Prescribing for Patients with Chronic Non-Cancer/Non-Terminal Pain
 - 10 Guiding Principles
 - Establishes an opioid dose limit/day

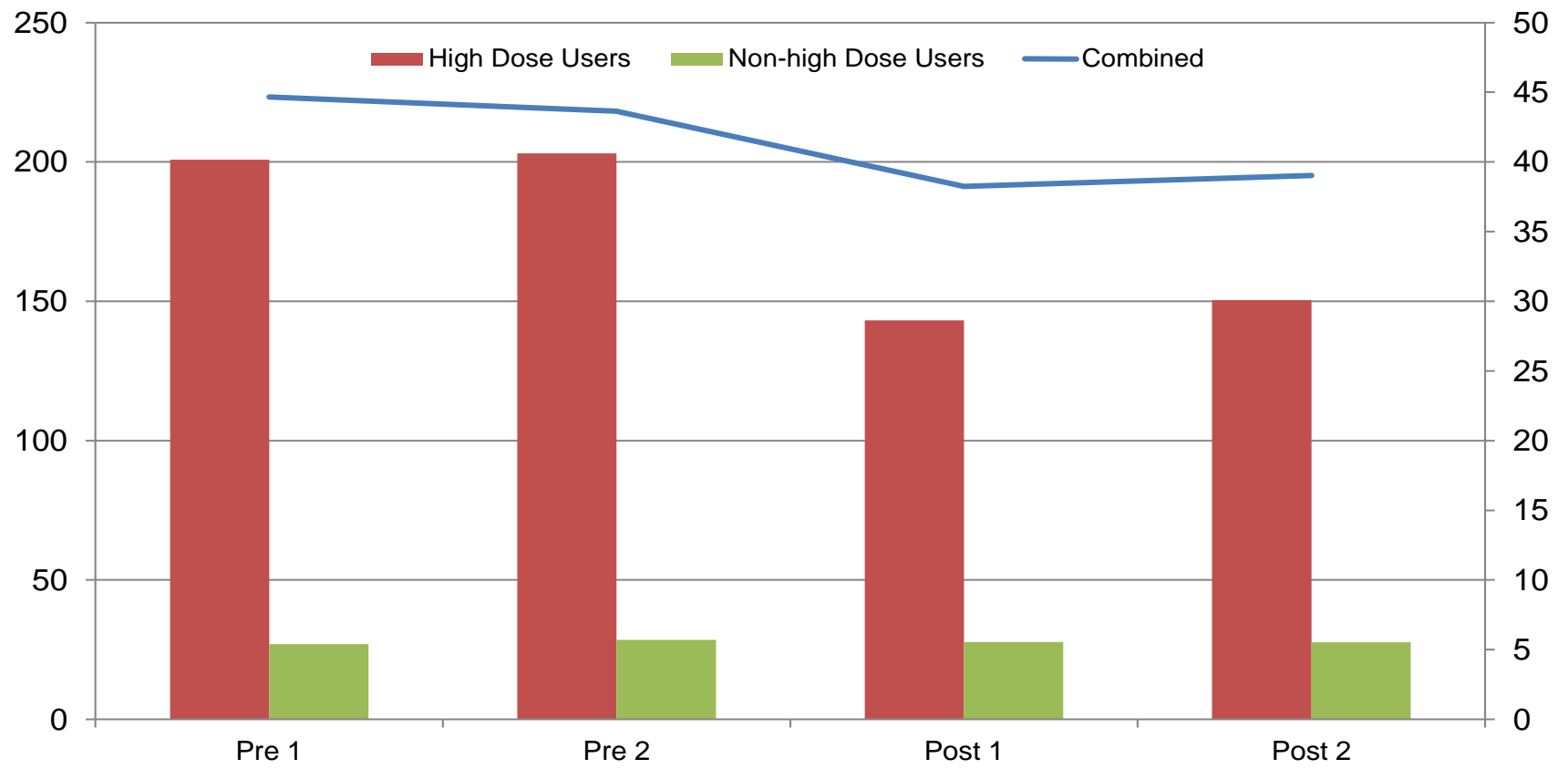
Community Standard for New Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain

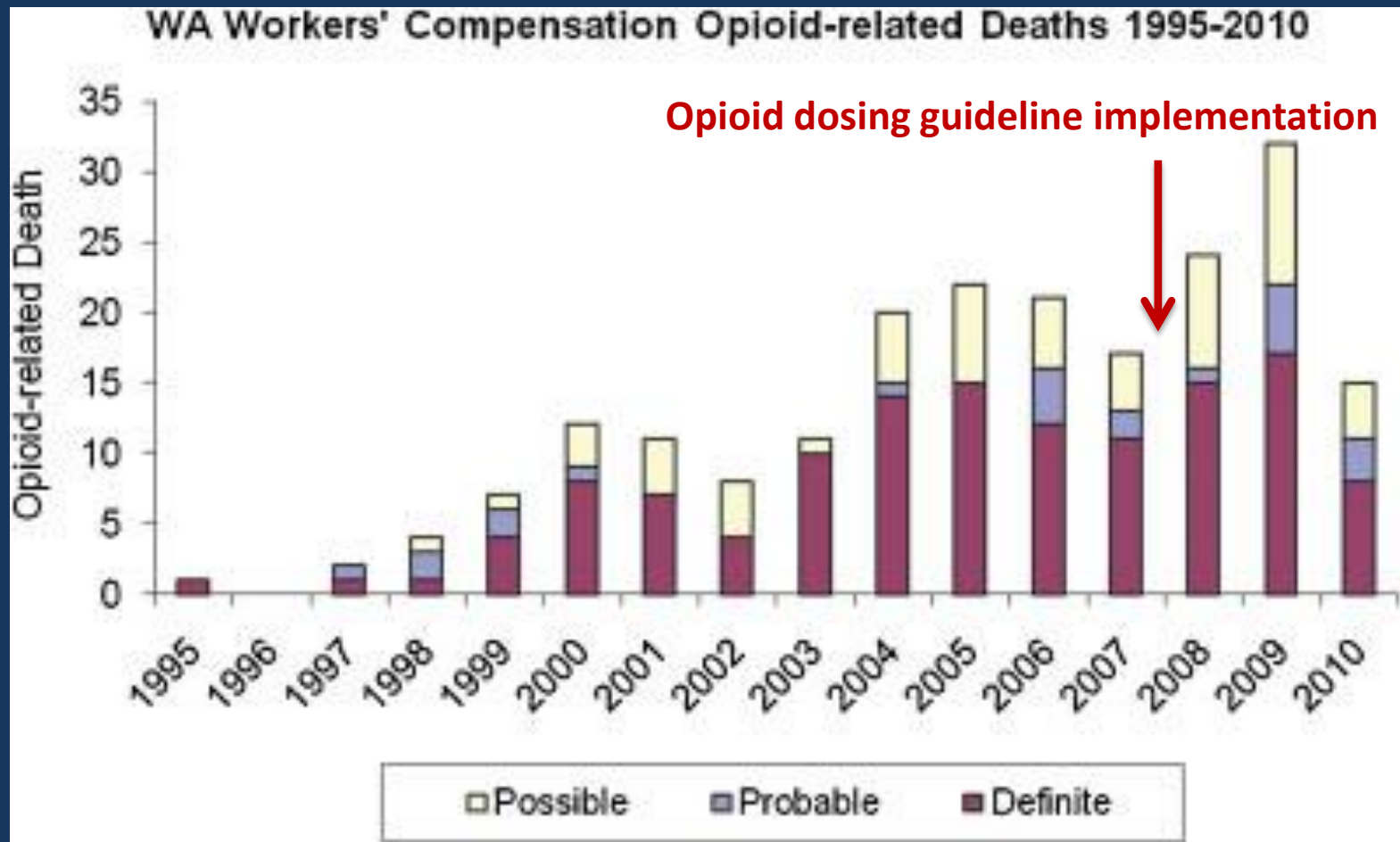
- **Guiding Principle (GP) 1: Perform a patient evaluation/history**
- **GP2: Document initial and periodic functional evaluation.**
- **GP3: Regularly monitor and document subjective pain measures.**
- **GP4: If considering prescribing an opioid, screen for opioid risk**
- **GP5: Establish an opioid prescribing daily dosing limit.**
 - Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)
- **GP6: Develop a comprehensive treatment plan with agreed upon treatment goals prior to beginning chronic pain treatment with daily opioids.**
- **GP7: Recommend behavioral health evaluation for patients with current or prior behavioral health conditions.**
- **GP8: Avoid use of high-risk medications or substances with opioids.**
- **GP9: Patients who develop an opioid use disorder during treatment should be referred to an addiction specialist/appropriate specialist and/or addiction treatment.**
- **GP10: Consider prescription for naloxone rescue kit in high risk individuals.**

Community Standard for On-going Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-terminal Pain

- **Guiding Principle (GP) 1: Perform a patient evaluation/history.**
- **GP2: Perform periodic functional evaluation.**
- **GP3: Regularly monitor and document subjective pain measures.**
- **GP4: Regularly monitor for opioid risk.**
- **GP5: Establish an opioid prescribing daily dosing limit.**
 - Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)
- **GP6: Maintain a comprehensive treatment plan with agreed upon treatment goals.**
- **GP7: Document behavioral health plan for patients with current or prior behavioral health conditions.**
- **GP8: Avoid use of high-risk medications or substances with opioids.**
- **GP9: Patients who develop an opioid use disorder during treatment should be referred to an addiction specialist/appropriate specialist and/or addiction treatment.**
- **GP10: Consider prescription for naloxone rescue kit in high risk individuals.**

Trend in median morphine equivalent daily dosing before and after high dose policy in OHSU Internal Medicine Clinic





Franklin, et al. Bending the Prescription Opioid Dosing and Mortality Curves: Impact of the WA State Opioid Dosing Guideline. *Am J of Industrial Medicine* 55: 325-331.

Implementation Strategies

- Identify and Support Key Leadership
- Adopt health system policy supporting the community standard
- Develop Epic EMR tools for monitoring and reporting
- Patient and Provider Education
- Referral resources

Potential Outcomes

- Decreased health care utilization
- Improved Staff Communication
- Decreased Non-productive Staff Time
- Improve Pain Treatment
 - ↑ patient functional status, ↓ opioid pills in circulation
- Decrease risk
 - ↓ opioid overdose morbidity and mortality, ↓ diversion, ↓ addiction
- Improve staff and provider job satisfaction
- May decrease patient satisfaction (temporarily)

***Aligned with Addictions Inpatient expansion**

Controlling the opioid epidemic:

A Three-pronged Approach

- **Prevent** new cases of opioid addiction.
- **Reduce supply** from pill mills and the black-market.
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OHSU Patient Needs Assessment

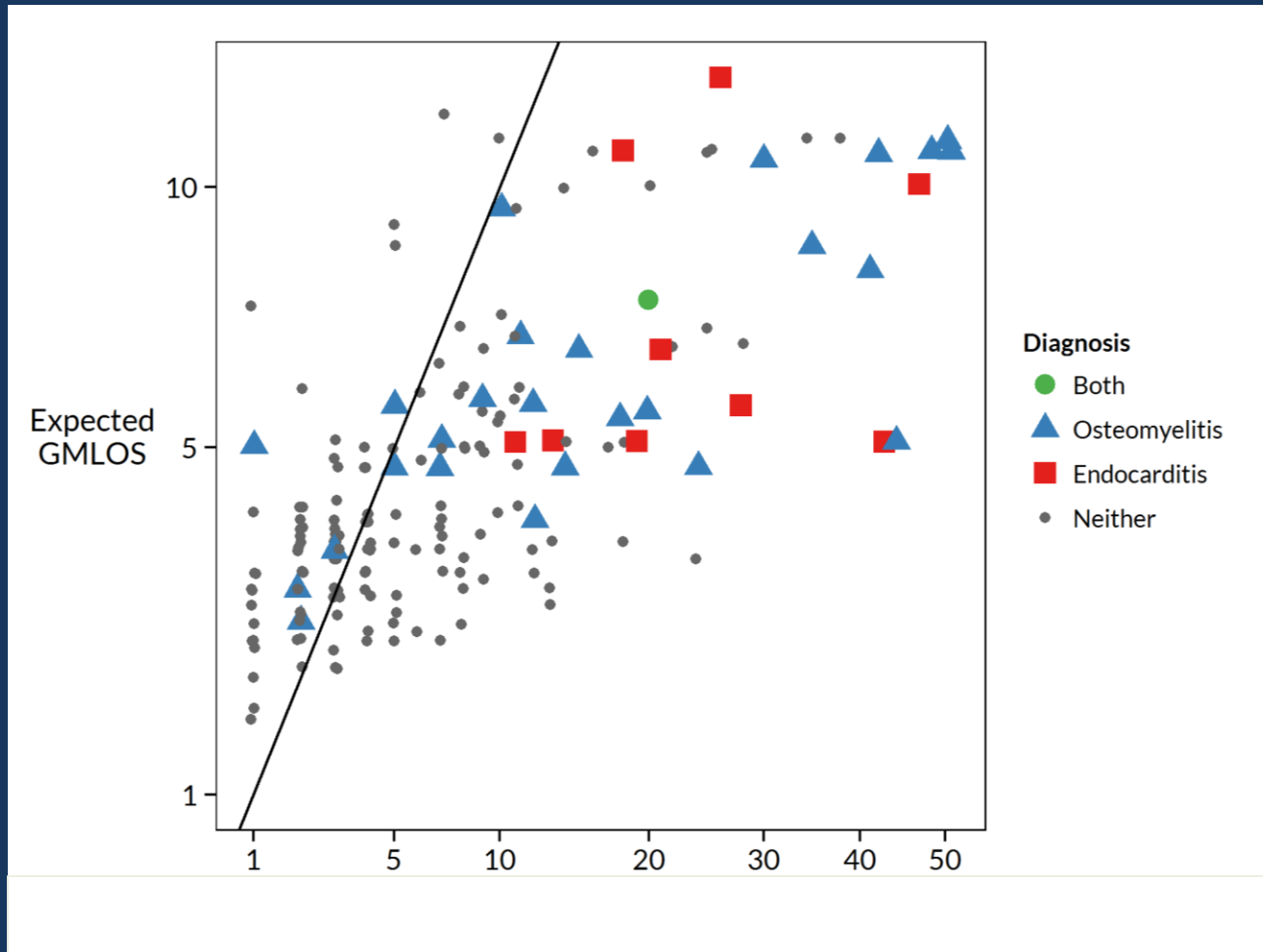
- Mixed-methods survey of 185 hospitalized adults (09/14-04/15)
- Hospitalization as reachable moment
 - 57% of high risk alcohol users; 68% of high risk drug users reported wanting to cut back or quit
 - Many wanted Medication Assisted Treatment (MAT) to start in hospital
- Gap-time to community SUD treatment
- Patients valued treatment choice, providers that understand substance use disorders (SUD)

Costly readmissions

Used interim data to meet demands of hospital budget cycle:

- Among 165 patients, 137 readmissions over mean observation period of 4.5 months
- Mean charge per readmission \$31,157
 - \$55,493 for endocarditis readmissions
 - \$68,774 for osteomyelitis readmissions

Prolonged Inpatient LOS



X-axis in units of 10 days

*unpublished data, Englander, 2015

Needs assessment: Engaging community stakeholders



- Convened leaders over 3 large group meetings, numerous small meetings
- Mapped patient and system needs to intervention components
- Developed business case

IMPACT:

Improving Addiction Care Team

Needs

- Hospitalization is a reachable moment
- Patients want MAT
- Engagement and trust key

- No usual pathways to outpatient addiction care, wait times long

- IV abx patients have long LOS
- Residential addiction setting not equipped for medically complex patients (IVs)

Intervention

Inpatient consult service:
MD/DO, NP/PA, SW, peer recovery mentors

'In-reach' from Central City and CODA to create rapid-access pathways

Bring IV antibiotics into residential addiction care setting with Coram and CODA

Preliminary Results

Results to date (July 1, 2015 - June 15, 2016)	Total to date n (%)
# of patients referred for IMPACT services (Internal, Family Medicine & Long term IV antibiotics)	237
# of patients IMPACT worked with in the hospital	218 (92%)
# of patients with IMPACT engagement	193 (89%)
# of patients receiving medication assisted treatment in hospital	124 (63%)
# of patients referred to community addiction treatment	131 (68%)

Summary

- Community standards for opioid prescribing are one way to address the opioid epidemic
- Awareness and access to treatment for opioid use disorder are essential to prevent serious harms from the opioid epidemic
- Health system support of these changes is essential

Thank you!



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