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

Thursday, October 24, 2019
A Statewide Performance Improvement Project
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 Pharmacotherapeutic Alternatives**

Reducing Chronic Opioid Use – Provider Toolkit
Together
We’re Stronger

Opioid Abuse Epidemic: A Rural Health System Tackles a Crisis

Erin Foss, RN

Catholic Health Initiatives
Imagine better health.

[Image of the cover page of a document titled "Opioid Abuse Epidemic: A Rural Health System Tackles a Crisis" by Erin Foss, RN.]
A Rural Response

Together
We’re Stronger
Where are we?

Together
We're Stronger
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

Together
We’re Stronger
Community issues require community collaboration.

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

Together
We’re Stronger
A Rural Response

Prescription Drug Task Force functions:

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

Together
We’re Stronger
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.
A Rural Response

State Innovation Models Initiative (SIM) Grant Recognition

Together We’re Stronger
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.
A Rural Response

Key Partnerships

Together
We’re Stronger
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
A Rural Response

Heather Bell, MD

Together
We’re Stronger
A Rural Response

Kurt DeVine, MD

Together
We’re Stronger
The number of emergency room visits attributable to pharmaceuticals alone increased 97% between 2004 and 2008.

SOURCE: U.S. Drug Enforcement Administration
The number one cause of death for Americans <50 years old
More than 50 million Americans have admitted to abusing prescription drugs.

SOURCE: CBS Evening News
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
Opioid Use
An American Epidemic

4.6% of the world’s population
Consuming 80% of the global opioid supply

Recipe for:

DISASTER

Opioids

+ 

Benzodiazepines
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

*Together We’re Stronger*
A Rural Response

Opioid Lane
A Rural Response

Opioid Lane
Dr. Portenoy co-wrote a seminal paper arguing opioids could be used in people without cancer.
“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
Impact of Chemical Dependency on Child Protection Placements
92 Children
2018

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

The American Pain Society trademarked the slogan, “Pain: The Fifth Vital Sign.”
This same year (1996), Purdue Pharma released OxyContin, the most widely used narcotic pain killer today.
“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
The Veterans Health Administration made pain a “fifth vital sign.” The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) did the same.
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%.
Less than 1%?

**Study 1: Porter and Jick**

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


**Study 2: Perry and Heidrich**

Management of pain during debridement

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


Together
We’re Stronger
The problem: these studies reflect patients treated for acute pain, not daily chronic pain.
Multiple studies from 1991 to 1997 showed addiction rates from 3-43% in patients on chronic daily narcotics, research Purdue Pharma chose to ignore.

Together
We’re Stronger
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.
The JCAHO issued new standards telling hospitals to regularly ask patients about pain and to make treating it a priority.
A Rural Response

Rethinking the way we talk about pain
The Federation of Medical Boards called on state medical boards to make under-treatment of pain punishable.
“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
A Rural Response

National Overdose Deaths
Number of Deaths Involving All Drugs

Source: National Center for Health Statistics, CDC Wonder
A Rural Response

Opioid overdose deaths surpass car accidents as the leading cause of accidental death, a 4-time increase in deaths from 1999.
What caught our attention in our community?

• On call narcotic refills
• Emergency room visits
• Police concerns
• Overdose deaths
A Rural Response

Our initial focus:
Decreasing the narcotics leaving clinics and hospitals.

Together
We’re Stronger
Most patients addicted to heroin started on pills, and many times first exposure was legally prescribed.
A Rural Response

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
A Rural Response

Program Planning & Early Workflow Development

• One physician
• RN Care Coordinator
• Administrator

Together
We’re Stronger
Top 3 Things Physicians Love to Hear:

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

Team Advancement:
• Patient Centered Medical Home Physician
• Recovery Corp Peer Support Specialist
• Social Worker
• Program Coordinator
• Nurse Practitioner
• Outreach Coordinator

Together
We’re Stronger
Getting Started

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

- Past medication history
- Substance use history
- Drug-related convictions
- PDMP
- Family history
- Review of appropriate dosing
- Pharmacy review (if necessary)
- Facebook
- Mental health concerns
- Medication interaction
  - ER visits
  - Work history
- Diagnosis for medication
# MD Recommendations

**A Rural Response**

---

<table>
<thead>
<tr>
<th>CSCT REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. ___________</td>
</tr>
<tr>
<td>The CSCT has reviewed the following patient:</td>
</tr>
<tr>
<td>Patient Name: ___________</td>
</tr>
<tr>
<td>Diagnosis: ___________</td>
</tr>
<tr>
<td>Medication Agreement/Care plan signed: Y/N, Date: ___________</td>
</tr>
<tr>
<td>Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N,</td>
</tr>
<tr>
<td>Mental Health Provider/Therapist: ___________</td>
</tr>
<tr>
<td>Current Medications of Concern:</td>
</tr>
<tr>
<td>___________</td>
</tr>
<tr>
<td>___________</td>
</tr>
<tr>
<td>___________</td>
</tr>
<tr>
<td>Images Reviewed: Y/N ___________</td>
</tr>
<tr>
<td>Other Modalities attempted: ___________</td>
</tr>
<tr>
<td>UDA in past year: Y/N, Date of most recent UDA: ___________</td>
</tr>
<tr>
<td>UDA Findings:</td>
</tr>
<tr>
<td>: ___________</td>
</tr>
<tr>
<td>: ___________</td>
</tr>
<tr>
<td>Pill Counts: ___________</td>
</tr>
<tr>
<td>PMP Reviewed: Y/N, Findings: ___________</td>
</tr>
<tr>
<td>Social History: ___________</td>
</tr>
<tr>
<td>Social Needs identified: ___________</td>
</tr>
<tr>
<td>Recommendations: ___________</td>
</tr>
<tr>
<td>Form scanned in to EMR: Y/N</td>
</tr>
<tr>
<td>Signed: ___________</td>
</tr>
</tbody>
</table>
CSCT Review Form
Evaluated at weekly meetings by physicians.

Review Includes
- Previous work-ups
- Scans
- Previous treatments
Components of Recommendations

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

- Provider or nurse referral
- Drug refill issues (RN reviews)
- Police information
- Pharmacy concerns
- Slowly working the “list”
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
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
In 2014, the #1 Emergency Department diagnosis was therapeutic drug monitoring.

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

Together
We’re Stronger
A Rural Response

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
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)*
A Rural Response

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

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

Together
We’re Stronger
Rural Barriers to Treatment

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

A Rural Response

Employment

- Working: 60%
- Retired: 10%
- Other (treatment, disabled, not working): 30%
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

Pregnancy

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

Getting into “our program”...

Together
We’re Stronger
Our Workflow

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

- Drug history
- “Story”

Doctors review

Patient scheduled
Ultimate Goal:

- Seeing the patient when they are motivated to change
- Treating the condition like it is an emergency
Our Buprenorphine Program Success Thus Far

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

Together
We’re Stronger
A Rural Response

Convened a county panel

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

Together
We’re Stronger
A Rural Response

Typical Process

1. **Arrested**
2. **Withdraw in Jail**
3. **Released**
4. **Overdose and Die**
5. **Uses Drugs Again**

Together
We’re Stronger
A Rural Response

New Process

1. Arrested
2. Treat with Suboxone if appropriate
3. Released and referred to program
4. Continue Suboxone treatment
Average Days Spent In Jail Prior to Buprenorphine vs. After Buprenorphine-83 patients surveyed
A Rural Response
A Rural Response
Emergency Department
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
A Rural Response

Typical Process

1. Uses Drugs Again
2. Overdose and Die
3. Presents to Emergency Room
4. Treated with benzos/naloxone or nothing
5. Released
6. Uses Drugs Again
7. Overdose and Die
8. Presents to Emergency Room
9. Treated with benzos/naloxone or nothing
10. Released

Together
We’re Stronger
**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 (520) 630-5607
OR
Dr. Kurt Devine (520) 639-2507

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

- **DO NOT GIVE BENZOS**

>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

**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
A Rural Response
Duplicating our Program
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
What the Communities Need To Do

• Monitor prescribing
• Assemble county task force
• At least one buprenorphine waived physician
• CSCT
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
A Rural Response
Duplicating Program
Our communication throughout our state and further.

Moving Knowledge Instead of Patients and Providers

Copyright 2017 Project ECHO®
A Rural Response

**ECHO model is not “traditional telemedicine.”**
*Treating physician retains responsibility for managing patient.*

*Together We’re Stronger*
Goals of our ECHO:

• Increasing general knowledge of opioids and addiction
• Demonstrating how to implement our program in rural primary care
A Rural Response

ECHO Clinic Format

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

One free hour of CME/CEU weekly!

Together
We’re Stronger
Topics Covered

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

Together
We’re Stronger
A Rural Response

Little Falls Hub

ECHO Spoke Locations

Together
We’re Stronger

109
A Rural Response

Little Falls Hub

ECHO Participants

Together
We’re Stronger
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
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.

farmtownstrong.org
Quick Story

Minnesota Farm Bureau Foundation has partnered with RxMN 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.
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.
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
Ruth Meirick
Foundation Director

farmtownstrong.org
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
  - IDEAag -- 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
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

Minnesota Farm Bureau Foundation
Ruth Meirick
Foundation Director

farmtownstrong.org
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.

Minnesota Farm Bureau Foundation
Ruth Meirick
Foundation Director

farmtownstrong.org
Contact Information

Minnesota Farm Bureau Foundation
Ruth Meirick, Director
507 383 1400
Ruth.Meirick@fbmn.org