Addressing A Crisis: A Health System’s Response to the Opioid Crisis
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CME Disclosure

• We do not have any financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.
Agenda

- Overview of MaineHealth
- Nature of the Problem
- System Response
  - The Work
  - Strategies
  - Organizational Model
- Challenges and Benefits
Maine’s largest non-profit integrated healthcare system with 8 member and 3 affiliate acute care general hospitals and a 100-bed psychiatric hospital

Maine Behavioral Healthcare, the state’s largest behavioral health provider, is an integrated member of the system, providing a comprehensive array of inpatient, crisis and outpatient behavioral health services throughout the footprint

An ACO with over 1,500 independent and employed physicians and over 400 primary care physicians

Social workers embedded in each primary care Patient Centered Medical Home promote integrated model

A behavioral health service line assures alignment of services and best practice dissemination across members and affiliates

MaineHealth’s Vision: Working Together so Our Communities are the Healthiest in America
The Opioid Epidemic by the Numbers

- US Overdose Deaths
  - Drug overdoses killed 630,000 people between 1999-2016
    » That is half the population of Maine or New Hampshire— and greater than the entire population of Vermont
    » Opioids were involved in 5 time more deaths in 2016 than 1999
    » It’s the leading cause of death under age 50
    » Opioids (prescription, heroin, fentanyl) comprise 2/3 of the total overdose deaths

“A group of middle-aged whites in the US is dying at a startling rate”  NY Times, Josh Katz, September 3, 2017

“We know of no other medication routinely used for nonfatal conditions that kills patients so frequently.”  NEJM: 374; 16 4-21-16
Number of Overdose Deaths in 2017:
- ME – 418
- NH – 483
- VT - 104
The Opioid Epidemic By the Numbers

Drug-Affected Babies

**FIGURE.** Neonatal abstinence syndrome (NAS) incidence rates* — 25 states, 2012–2013

**Source:** State Inpatient Databases, Healthcare Cost and Utilization Project.

* NAS cases per 1,000 hospital births.

Pregnant women who use drugs potentially harm their unborn children. The number of drug-affected babies has surged in the past decade, as opioid addiction has worsened.

**Drug-affected babies born in Maine**

2006: 201 cases (1.4% of all babies in Maine)
2007: 274 cases (2.5%)
2008: 343 cases (3.4%)
2009: 451 cases (4.5%)
2010: 572 cases (6.1%)
2011: 668 cases (7.1%)
2012: 772 cases (8.3%)
2013: 927 cases (8.7%)
2014: 1,013 cases (8.7%)
2015: 1,024 cases (8.7%)
2016: 952 cases (8.2%)

**Source:** Maine Department of Health and Human Services

STAFF GRAPHIC | MICHAEL FISHER
Downstream Financial Cost of Untreated Addiction

• Medical Costs
  - $500,000 per inpatient stay for related medical conditions
    » 8-12 patients on any given day at MMC for related medical conditions
  - Emergency Department Utilization
  - A Washington State study reported a 50% decrease in medical costs for individuals who received substance use treatment

• Corrections and Societal Costs
  - Have yet to quantify impact on future generations
How Did We Get Here?

- 3400 BC – Opium poppies were cultivated in lower Mesopotamia. The poppy was known as the “joy plant”
- 1827 – E. Merck & Co. of Germany begins commercial manufacturing of morphine (active opium ingredient)
- 1898 – Heroin is created and introduced commercially. It is marketed as a cure to morphine addiction.
- 1903 – 1905 Heroin addiction rises significantly. US Congress bans opium but it has gained a foothold as a black market drug.
- 1916 – First synthesis of oxycodone with goal it would retain analgesic effects of morphine with less dependence
- 1996 – Purdue Pharma begins marketing of OxyContin in “Partners Against Pain” campaign claiming addiction risk is small. By 2001 it is best-selling narcotic in U.S.
- 1999 -- Promotion of pain as “5th Vital Sign” by VA intended as quality measure for pain management; became Joint Commission standard in 2001
- “Rate pain management” continues as key question on patient experience surveys
- 1999 to 2010 – Opioid related deaths increased by a factor of 4

This is the first public health crisis that was created, in part, by the health care system
Some characteristics of counties with higher opioid prescribing:

- Small cities or large towns
- Higher percent of white residents
- More dentists and primary care physicians
- More people who are uninsured or unemployed
- More people who have diabetes, arthritis, or disability

The amount of opioids prescribed per person in the US increased by 350% between 1999-2015.
Law Makers Respond

• Federal: Comprehensive Addiction and Recovery Act (CARA)
  - Minimal funding for Maine included to support its implementation

• State:
  - Public Law Chapter 488
  - Task Force to Address the Opioid Crisis in the State
  - $6.7 Million to Treat Uninsured Patients
  - Opioid Health Homes Initiative
Maine: Prescribing Law Enacted

– Implements Strict Prescribing Limits
  • 7 days acute pain and 30 days chronic pain
  • Cap of 100 MMEs

– Mandates Electronic Prescribing

– Mandates Prescription Monitoring Program Checks
  • For opioids and benzodiazepines
  • Upon initial prescription and every 90 days thereafter
  • Certain exemptions

– Prescription Monitoring Program Improvements

– Licensed prescribers will be required to complete 3 hrs. of CMEs about opioids every 2 years

The first time in memory in which the medical community asked for legislative involvement in a clinical issue
As prescription opioid drug supply wanes, illicit opioid use increases.

The MaineHealth System Responds
Multi-Faceted Response Required

- Supply and Demand: Education
- Supply: Prescribing
- Demand: Treatment
- Demand: Community Support Services
- Supply: Law Enforcement

Community
Provider
Patient

MaineHealth
Opioid Use Workgroup Formed

• **Purpose:** To lead the development of a system-wide response to the urgent community need surrounding the opioid epidemic.

• **Scope:** To identify those facets of prevention and treatment for which health care providers can be influential and accountable.

• **Participants:**
  - Physician and administration leaders from each MaineHealth local service area and
  - Maine Behavioral Healthcare

• **Subgroups:**
  - Prescribing for Acute and Chronic Pain
  - Opioid Use Education
  - Treatment for Dependent and Addicted Patients
  - Treatment for Pregnant Women and Babies
Medical Community Responds
MaineHealth: An Integrated Approach

- **Goal:** Develop a system-wide response to the urgent community need surrounding the opioid epidemic.

- **Scope:** Identify those facets of prevention and treatment for which health care providers can be influential and accountable.
Progress: Focus on Unnecessary Opioid Prescribing

- # Patients with ≥100 MME* per day at MaineHealth Member-Owned Practices**
- MaineHealth Epic Electronic Medical Record (2015 – 2017) 3-year rolling averages

* MME=Morphine milligram equivalents
** Data from practices at Franklin Community Health Network, Memorial Hospital and Southern Maine Health Care are not included, because these practices were not using the EPIC electronic medical record during the whole time period presented (July 2015 – December 2017).
Progress: Education & Communications

- 110 providers trained to provide Medication Assisted Treatment
- Training about Opioid Use Disorder, prevention and treatment for clinical teams
- Conference attended by 130 clinicians focused on IMAT
- Patient education materials
MaineHealth Board’s Focus on Treatment

“By Sept. 30, 2017, and with support from Maine Behavioral Health, every MaineHealth local health system will actively provide Medication Assisted Treatment in one or more adult primary care practices for patients with opioid use disorder.”

“By Sept. 30, 2018, MaineHealth members will have served 900 patients with OUD through hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area.”

By Sept. 30, 2019, MaineHealth members will have served 700 new patients with OUD through hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area.
System Buy-In: Key Messages
A System-wide Approach

• **Our message:** This epidemic requires a comprehensive health system response
  - Community Health Needs Assessments
  - MaineHealth Board calling for plan of action
  - Partnership between primary care and behavioral health required
  - These are our patients
  - Health care practitioners asking for support

• **MaineHealth’s structure supports a scalable, evidence-based model**
  - **Maine Behavioral Healthcare provides continuum of services**
    » Limited substance use treatment experience
  - Behavioral Health Clinicians integrated into all primary care offices

• **Nascent in developing standardized care models**
Addiction is Like Other Diseases…

- It is preventable
- It is treatable
- It changes biology
- If untreated, it can last a lifetime

Decreased Brain Metabolism in *Drug Abuser*

Healthy Brain  Diseased Brain/ Cocaine Abuser

Decreased Heart Metabolism in *Heart Disease Patient*

Healthy Heart  Diseased Heart

*Research supported by NIDA addresses all of these components of addiction.*
Treatment Works

- **Addiction** can be treated
- **Partial recovery** with protracted abstinence
Affected Individuals Behave Similarly


Relapse rates for people treated for substance use disorders are compared with those for people treated for high blood pressure and asthma. Relapse is common and similar across these illnesses. Therefore, substance use disorders should be treated like any other chronic illness. Relapse serves as a sign for resumed, modified, or new treatment.
Chronic Disease Model Applies

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<th>Health Systems Role – Medical</th>
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<th>Community Role: Social Determinants</th>
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<td>Peer Support</td>
<td>Family &amp; Friends</td>
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“The opposite of addiction is connection”

Barriers:
• Stigma
• Lack of Insurance
• Lack of Providers
• Transportation
• Childcare
• Lack of Social Supports
• Safe housing needs
MaineHealth Hub and Spoke Model Overview

Scalable model that incorporates specialty treatment with primary care
MaineHealth’s Treatment Model:
Primary Care + Specialty Substance Use Services

**Intensive Hubs**
Community-based behavioral health centers:
- Medical Evaluation & Screening
- Induction of IMAT
- Intensive Outpatient Treatment
- Stabilization Treatment
- Specialty Treatment
- Consultative Support for Intermediate & Primary Care Practices.

**Intermediate Hubs**
Primary care offices & integrated behavioral health clinicians:
- Screening
- IMAT inductions & treatment
- Ongoing treatment for stabilization & maintenance phases

**Hubs:**
- Biddeford
- Springvale
- Portland
- Damariscotta
- Augusta
- Lewiston
- Brunswick
- Farmington
- Rockland

**Patient Centered Medical Homes Spokes:**
- Biddeford
- Springvale
- Portland
- Damariscotta
- Augusta
- Lewiston
- Brunswick
- Farmington
- Rockland

**Intermediate:**
North Conway
Norway
Belfast

**Intensive Hubs**
Community-based behavioral health centers:
- Medical Evaluation & Screening
- Induction of IMAT
- Intensive Outpatient Treatment
- Stabilization Treatment
- Specialty Treatment
- Consultative Support for Intermediate & Primary Care Practices.

**Goal:** Ensure that any patient within the MaineHealth service area has access to evidence-based treatment for Opioid Use Disorder.
Focused Goal: Population Health

By September 30, 2018, MaineHealth members will have served 900 patients seeking treatment for Opioid Use Disorder through hubs operated by Maine Behavioral Healthcare and primary care Patient Centered Medical Homes located in each local health service area.

As Of July 31st 2018

Total Patients Served

- Patients Served
- New Patients

Patients By System

- Current Month Payer Mix

Payer mix for appointment with prescriber

- Medicare: 14%
- Medicaid: 42%
- Commercial: 23%
- Uninsured: *

Random Checks

Recommended at least 2 per patient per annum.

* Some locations do not take uninsured patients. Only some practices/locations recommended at least 2 per patient per annum.
Challenges Remain – and Policy Makers Can Help!

- Funding
  - 81% of patients are uninsured or enrolled with government payors
  - Cost per unit of service exceeds revenue = unsustainable
  - Key elements of recovery model not covered by payors
    » Peer/recovery coaches
    » Recovery housing
    » Transportation for uninsured
    » Vocational Services

- Deconstructing Siloes and Regulatory Barriers
  - CMS and SAMHSA
    » Commercial insurer carve outs
    » Federal Privacy Law - 42 CFR Part 2
A Case to be Made: The Financial Return on Investment

Cost-Savings as a Result of Implementing a Recovery-oriented System

SAMHSA “Briefing on Substance Use Treatment and Recovery in the United States.”
Can You Tell Who Is In Recovery from Opioid Use Disorder?
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- https://mainehealth.org/healthcare-professionals/clinical-resources-guidelines-protocols/opioid-use-treatment-resources