WEBINAR: Efforts to Address the Opioid Epidemic Across New England

March 14 @ 11:30 am - 12:30 pm

>> Good morning everyone. This is the new England QIN-QIO with Efforts to Address the Opiate Epidemic Across New England. Many Americans are addicted to opiates. Providers across the country are exploring their roles in this epidemic regarding prevention. The New England QIN-QIO, in collaboration with the Rural Health Roundtable, is pleased to highlight a couple of efforts in the treatment program. This session will provide information about the opiate epidemic. We will include information for clinicians and include models that are accessible in intervention and prevention.

>> Before we get started, I will review a few housekeeping items. The lines are all muted during our presentation. We will unmute the telephone line to take your questions at the end of the session. We want you to participate during the session by using the chat feature. Do not be shy, we want to learn about your efforts. We'd also love to hear your thoughts about what the speakers are saying. It is important to note that today's speakers do not have any conflicts to discuss.

>> Now we can test out the chat feature to see who is on the call. Please type in your name, your organization and your state. Upon completion of this session participants will be able to explore the impact that the opiate epidemic is having across New England and to describe a four pronged approach that providers can take to address the epidemic in their own community and to identify available tools and resources.

>> I would like to introduce Danna Gobel – a coordinator and co-facilitator of the opiate addiction treatment at Boston Medical Center. She has been managing educational and nonprofit organizations for 20 years. She works with clinicians and community health centers within the city.

>> We also have Daniel Bell, program coordinator from Maine. He is the MAT program coordinator at Sacopee Valley Health Center where he became a certified alcohol and drug counselor. He attended the University of New England. Danny has worked in many different capacities and in many different fields.

>> We also have Aleece Daleo, Population Health Program Coordinator. She has worked in a number of roles – social services, education coordinator, and she supports MAT. She is responsible for the day-to-day activity to improve quality of care. She is part of the committee that develops and implements information strategies to improve the health of patients, family and the community served.

>> We try to create a teachable environment. We want to be able to share what we have learned and what has worked. I encourage you to share your thoughts in the chat. People indicated they wanted to learn more about the opiate epidemic. They want to learn what others are doing with patients.
We also want to learn how to make this an open learning forum and how to work with this population with resources and education, access to treatment for this population and information about new policies in prescribing, and looking at outliers. So we will be able to cover some of these areas but your input will help us throughout the session. This slide will quantify the impact that the opiate epidemic is having on the population. There are recently over 1 million people who use opiates. The health care cost is $504 billion. Diabetes costs $245 billion. The statistics show that people die every day from opiate-related drug overdose. This is something where we have to take action. What is your role?

Please take a moment, and type in the chat what you are doing with your work. We all have a part in the solution, and so we use this forum to share. According to U.S. National Institute of Drug Abuse, 29% of patients are prescribed opiates for chronic pain. And many develop addiction and opioid disorder. You can see we are in the middle of a crisis, and the number of overdoses occurring, is not for any specific urban demographic. This slide looks at the increase, and according to the CDC surveillance program, they have 16 states reporting. The largest increase is happening in the metropolitan cities. One of the measures is looking at different rates for Medicare, and at high risk medication. This slide is specific to New England. Most of the New England states are higher than the rest of the United States. This is based on July 2016 through June of 2017 and that QIN-QIO also has New England specific data, on readmissions. If you are interested in diving deeper on this data, please contact your state’s QIN-QIO representative.

So where do we start? As I said it is going to take a coordinated team approach. Everyone on this call, and in the community needs to do their part. Across New England we find that this is best to use a four pronged approach. We need to understand the prescribing guidelines and determine when we need to prescribe an opiate that is appropriate and safe. We have to look at the risk and level of pain. We need to closely monitor patients and reduce opiate use over time and to expand access to medication, which is critical. And again we ask, what is your role? And more importantly, how can QIN-QIO support your efforts? Please use the chat function.

Using the CDC opiate guidelines is a great place to start. When opiates are used, the lowest possible dose should be prescribed. To reduce opiate use, monitor all patients closely. The 12 guidelines, here we have risks and benefits. Use the lowest effective dose. Evaluate benefits. Use strategies to mitigate risk. Use urine drug testing. To help providers, the National Quality Partners of Opiate Stewardship was released. This includes federal agencies, clinicians, healthcare organizations, pharmacists, paid management experts. This will identify fundamental guidelines for opiate stewardship. We need commitment from healthcare providers, and guidelines. Providers should engage patients, family and caregivers about the risk and benefits, looking at strategies, looking at accountability, and collaboration with community to have widespread opiate safety. And implementing a stewardship program. We will include a link in the chat if you would like to learn more. We have seen formulary management strategy programs, such as prior authorization and quantity limit. There are similar efforts, federal and local, to educate providers about opiate prescribing guidelines and additional strategies to promote awareness.

This action can start with you. So we invite you to join other providers, signing that medication management pledge – this will indicate your commitment to education and leveraging existing
guidelines to combat opiate misuse. We will include a link in the chat so you can explore the pledge. Make your commitment today.

>> This is a national effort to bring together providers, patients and lawmakers. There are tools and brochures available for awareness and additionally there is patient education on the disposal of prescriptions. We encourage our patients to start looking through their medicine cabinet and determine what medication is no longer being used and to prepare for the National Medication Take Back Program on April 28.

>> There are efforts to expand the distribution of Naltrexone. Medication assistance can help guide patients to manage their addiction with counseling and behavioral therapy. We will specifically explore how ECHO does this, and how it works. At this time, I will turn it over to Danna Gobel who will start the presentation.

>> Thank you for this opportunity to showcase the Boston Medical Center program, ECHO. We provide exceptional care without exception. We are a hospital in New England. We look at addiction and addiction treatment, and we want to replicate the care model. For time’s sake I will use the acronym OBAT for Office Based Addiction Treatment and OUD for Opioid Use Disorder.

>> I do not have to convince anyone on this call – there is a public health crisis. In our own backyard in Massachusetts, over the last 16 years, there has been a 450% increase in opiate related deaths. In Massachusetts, seven people per day are dying from opiate overdose. As you know, the FDA has approved three treatments. Buprenorphine and Methadon can only be dispersed at designated clinics. Buprenorphine treatment has been the superior treatment for OUD. However, one of the barriers in prescribing this, is that providers need special training and they need to provide a waiver in order to do so. As of today over 47,000 providers can provide Buprenorphine in the United States. There have been a number of barriers that have been identified by clinicians treating opioid addiction and this is related to insufficient administration and nursing support. Many doctors feel, even after appropriate training, the delivery of opioid agonist treatment in an office-based setting is difficult. To address this dilemma in 2003, Colleen LaBelle and a multidisciplinary team at Boston Medical Center developed a new model of care, and this is called the Collaborative Care Model of OBOT – subsequently dubbed the Massachusetts model. It addresses these top barriers and it uses addiction training by nurses.

>> The Collaborative Care Model addresses top barriers to providing comprehensive health care. The model uses addiction trained nurse care managers to take a lead role in patient care. In the ensuing 14 years this model has been nationally recognized and replicated. It is now in 43 other health centers in Massachusetts. And given all of this learning -- over the years, and integrating the treatment, the ECHO model, offers the opportunity to expand our reach. Especially those in rural sites who have little or no transport. This model was developed in the University of New Mexico and to address disparity in rural areas. And we also have an education model that we have a hub. As an ECHO hub we can best disseminate best practices. Like telemedicine where providers are treating one patient at a time, ECHO is able to train providers in order to go out and treat patients, to increase access to treatment, and to provide clinicians the knowledge and support they need. And this model has been used to help treat
conditions like hepatitis C and tuberculosis. And it is now an effective model to train those who treat patients with opiate disorders. We have adult learning and behavioral change models.

So ECHO clinic sessions are held twice a month. We have about 30 individuals – and this includes MDs, RNs, and social workers. They all sign in from their desktop or iPhone. Each session is composed of an expert and there is a discussion. The case presentation is the heart of the model. Nurse practitioners and PAs are able to get waivers to describe. And in our sessions, this is counted as part of their training. There is an additional 10% of primary care providers who began prescribing buprenorphine to 30 patients. And they had the capacity to treat additional patients. And this is what a session will look like. You have the panel on the left. We encourage persons to participate as a multidisciplinary team. And the multidisciplinary team should include addiction training personnel, nurses, social workers, obstetricians, general internist, and young adult care. And this is what the panel members see when they discuss patient cases. There really is a learning loop that is created from the specialist. And providers learning from other providers. And specialists being informed about the emerging best practices. And here are some of the strengths of the model. It does address those barriers that were identified by the providers. They can strengthen the team and provide cohesion. An increase in professional satisfaction. And we currently have two projects. We have a national project, and this is one of five of treatments on opiate disorder. And the second is Massachusetts state wide ECHO.

So the national ECHO is highly regulated and monitored. It is limited to HRSA funded providers. The Massachusetts-based panel is knowledgeable about community resources and they are able to give you optimal resources. They also have on-site training. And for the national ECHO, early results indicate that the case study session taught them something new and what they learned will change some aspect of care for their patients. An 85% stated that the discussion changed their plan of care. Over time, confidence in providing treatment and attitudes have changed in the providers that for the providers.

You can see some actual quotes from participants when active, asked about their sessions. In addition to this I think there are two stories that come to mind. We had a new proprietor from Tennessee who was working with a pregnant patient, and she had never treated a pregnant patient. Others on the panel walked her through treatment and this provider was able to give us a follow-up on her patient. She really thanked them for their recommendation and their coaching.

We have two local Massachusetts centers, and the nurses for each center really did not know each other. So it was wonderful to see them listening to each other and they made a connection and they agreed to actually share resources. There is a bidirectional learning, and this has been identified and used to help us with training. This helps us to develop curriculum for future sessions. This too will help the team remain responsive and relevant and help us to fine-tune our needs. We will continue to evaluate and really engage, encourage and empower best practices. Thank you for your time.

At this time I will like to introduce Danny.

Hello, how is it going? Our center is a federally qualified center. We are right on the border of New Hampshire. We are the only medical center for about 30 miles in any direction. We were established in 1976. We have family medical care – podiatry, dental and family planning just to name a few. We have
resources including financial and education resources. We do offer a discount on most services who are not insured or under insured. We were seeing a trend in opiate disorders in our area and unfortunately we had to refer them outside of our facility and that was very difficult. And addressing the stigma – back in October of 2016, we addressed the opiate crisis in our area. We had a panel of experts. And this included a D.O. who was providing treatment. We had alcohol and drug counselors. We had our own behavioral health specialist. We had two individuals who were in recovery. We also had a high school principal, and a member of the Sheriff’s department who actually had a personal connection, because he lost his daughter to a drug overdose. So he had a lot of effect on our panel. We do plan to hold a follow-up presentation this year. We are now discussing successes within our community.

>> I will talk about the actual intervention. Medication treatment, in the office setting. First you have the medication itself. It has to be administered by a member of our medical team and we also have psychosocial intervention. This is by our clinical mental health team. Typically, this is delivered in an outpatient setting. But we have the opportunity to do this in the office based setting.

>> I would like to talk about our team. We are an interdisciplinary team. We were in a very good position, because we had prescribers and mental health clinicians and a healthcare coordinator. As I mentioned, I am trained as a social worker and provide direct clinical services. We have clinicians. We also have psychosocial intervention. We have a D.O. who is our medical director. We have a psychiatrist. We also have a nurse practitioner. If we have patients who have acute mental health issues, we get them connected with a psychiatrist. We also have a population health coordinator. She tracks our data. And a lot of our funding is through HRSA. So this requires a lot of tracking.

>> We also in our program utilize ECHO. Prior to me, we actually started ECHO and implemented the program. This was vital in getting knowledge and resources for development. We have providers who had little experience working with this population and treatment. We had sessions on how to help patients. We are currently enrolled in a second project through ECHO. We allocate a certain amount of funding for ECHO. I want to talk about the program itself. We are in a rural area of the state. We are the only medical care center within 30 miles in any direction. If the patients are not established in the area, we require them to get together with a primary care provider to be in our program. And this ensures better health outcomes. It also helps promote preventative care. And the majority of our patients are self-referred to our program. We do not do a lot of advertising. But I would say 85% of the patients are self-referred. And our program uses a phase based treatment model and I will talk about that on this slide. So basically, when a patient is starting treatment, we have more frequent contact with them. And the research shows this produces a better outcome. We also include induction phase for the first 45 days of treatment. And this includes a weekly medical appointment. We look at psychosocial factors. The next phase is stabilization. This is a biweekly appointment. The next is maintenance phase. They have one hour individual or group session monthly. We also look at your toxicology results, engagement in treatment, and so-called psychosocial factors. And we do meet as a team with all of their providers. We have the ability to consult each other. And now we will talk about our program data with Aleece Daleo.
In 2017 there were 116 healthcare patients diagnosed with OUD. Out of those, 94 patients were enrolled in our program and receiving treatment. In the timeframe from first contact with the patient, we see if they are appropriate for our program. And it is usually the same day of the induction, no longer than one week wait.

Here are some of the challenges and lessons that we have learned from our program. One major one is strategies, to enhance counseling compliance. And knowing that the medication a lot of the time is the motivator for counseling adherence. We are looking at communicating between prescribers and mental health clinicians to make sure that our patients are engaged because research shows, medical intervention should be combined with psychosocial intervention. For myself as a coordinator, when I first came on board we had some challenges with people not adhering to their counseling. And it is very frustrating for the clinician. So we have done a lot of work on improving the system. And with that, the patient will have a medical appointment and a counseling appointment. Things do happen such as the patient canceling their appointment. So we do need to look at improving education. We really believe in access to treatment. So now we use our walk-in clinic. We want to be able to be there to engage the patient right away. The clinician will do a pre-assessment to make sure that it is appropriate to prescribe. And this is one challenge that we have done very well. One thing that we have seen, we try to integrate psychotherapy even more, because psychotherapy can be very good for people who have substance disorders. And to continue to educate our staff. Continuing to educate the community. And to bring to light that this is a medical illness and that people need treatment.

We did have two individuals come to the health center to do a staff training. These were young people who were in recovery. They educated our staff on how to use the language. Things like changing the word addict to person in recovery.

Thank you so much you guys did such a great job. At this time, we are going to open up the telephone line for a discussion.

If you would like to ask a question over the phone please press pound six to ask your question. Or you may type your question in the chat.

This is from Sharon. She works at a HRSA facility in Texas: Can our facility be included in the ECHO program?

What I can do, I will help connect you to the University of New Mexico. They have clinics specifically for pain. So if she emails me I will be happy to make the connection with the University of New Mexico and get her registered as one of those clinics.

My name is Elizabeth. I am a specialist here in the state of Maine. I am part of a project. We are weaning pain patients to reduce their opiate use by 40% per month. I just received a grant in which I can share my excess. We want to reach out to pharmacists primarily. If you want to proceed more in information, we do have literature on several maneuvers in which you can lessen the burden of being on pain medication. I will give you my contact information.
That is so great and thank you so much for your information.

Do we have a question over the telephone?

I have a question: When it comes to treatment options, what we are finding is that patients who are on Medicaid or Medicare cannot find treatment. Are you finding the same thing?

Danny? Do you want to start this discussion?

We have a discount program here. And many of our patients will utilize that program. It is for low income. We do base this on federal poverty guidelines. And that has been very beneficial for many of our patients.

Danna? Do you have anything you would like to add?

No, not at this time.

Do we have any other questions?

How is charging for your services handled?

I am not the best person to speak on this. But I know we can bill certain insurance companies here in New England.

I think we have time for one more question.

Is the goal is to remove the addiction or is the person in recovery for life?

I think there are different philosophies. As I mentioned before, I do not think there is another medical condition that has so much to debate. I think somebody's recovery is a personal definition to them. Are they content with maintaining high level functioning? And that is fine. It really is driven by the patient. Once they stabilize and things are getting better, that process is directed by the patient. And that can take some time. I do not think there is a universal answer to that question. But we look at the definition of recovery. This is for people who are also interested in tapering – as well as the provider.

Unfortunately we are at the end. I want to thank you all for your great presentation. I want to share there is a national disparity webinar, and to identify one process that you can take to manage patient pain. And how communities help individuals. And how community health workers can help patients with their pain management. If you are looking for continuing education credit your code is [ ]. And here is the contact information. So if you are looking for more data or more information, please contact the following individuals.
Thank you all again. I have a few final announcements before we end today’s call. As you can see from this slide, we are now on social media! Please connect with us on Facebook and/or Linked-In for the latest resources, webinars and other offerings from the New England QIN-QIO. When you close out of this webinar, the evaluation will automatically pop up on your computer. If you could please fill that out, we would greatly appreciate it. If you don’t have time to fill out the evaluation right now or you’re currently sharing a computer with someone else, you’ll receive an email tomorrow with the link to the evaluation, as well as the link to the event page on our website. The PowerPoint presentation was in your day of details email and is posted on the website – we will also add the link in chat. Within the next few business days, a transcript of this webinar will be added to the event webpage.

We know your time is valuable, so thanks everyone for attending. Have a great rest of your day!

>> [Event concluded]