A Rural Primary Care Clinic’s Successful Response to the Opioid Epidemic

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A Rural Response
A 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
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.

72,000 Americans died in 2017
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Opioid Use
An American Epidemic

4.6% of the world’s population

Consuming 80% of the global opioid supply

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
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Roadmap to Disaster
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
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.
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.
“People, the facts are inescapable. Any ideas how we can ignore them?”
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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Roadmap to Disaster

The JCAHO issued new standards telling hospitals to regularly ask patients about pain and to make treating it a priority.
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
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National Overdose Deaths
Number of Deaths Involving All Drugs

Source: National Center for Health Statistics, CDC Wonder
What we knew prior to the CDC guidelines:

- 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.
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
What caught our attention in our community?

- Emergency room visits
What caught our attention in our community?

- Police concerns
What caught our attention in our community?

- Overdoses deaths in the community
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Community issues require community collaboration.

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

- Community education
- Drug take-back events
- Community forums
- Coffee with a Cop
- Information sharing
- School Programs
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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- Task forces
- Narcan
- Drug Treatment
- Medication Assisted Treatment
These are NOT solutions to the opioid epidemic and addiction, rather these are reactions to the problem.
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.
Our initial focus:
Decreasing the narcotics leaving clinics and hospitals.
Catholic Health Initiatives

Our new goal: Put drug treatment centers and the manufacturers of Methadone, Suboxone, and Narcan out of business.

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

• One physician
  • Patient selection, implementation, guidelines (120 MME)
  • Process flow, workflow
• RN Care Coordinator
  • Meetings with patients for goals and care plans
  • Care plan and protocol writing
  • Initial physician discussions
• Administrator
  • Oversee the process
• Weekly meetings
March 2016: CDC 90 MME
### A Rural Response
### A Real Solution

<table>
<thead>
<tr>
<th>OPIOID (doses in mg/day except where noted)</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>41-60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>≥ 61-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
</tbody>
</table>

Methadone— **not a linear relationship, exponential as dose increases**

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Top 3 Things Physicians Love to Hear:
1. More documentation
2. More time required (care plans)
3. Told how to manage their patients
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Team Advancement:
- Social Worker
- Patient Centered Med. Home Physician

Heather 2.0 vs. Kurt 1.0
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Getting Started
• Data gathering
• Making the “list”
• Working the “list”
Criteria for the List

- Narcotics
- > 3 months consecutive prescriptions
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Benzodiazepines
Comorbidities
Initial Evaluation

• Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker
• Care plan signed
• UDAS
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Witnessed
UDAS
Information Gathering

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

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

• All doctors are registered with PMP
• Clinic nurse delegate for physician
• Controlled Substance Care Team nurse delegate
Chart Reviews

• After care plan is signed by patient, the CSCT nurse reviews and prints PMP for team to review
  • Make sure medications filled match their medication list
  • Used to check for doctor shopping - although more rare
  • Fill dates - early fills, etc.
Clinic Nurse

- Prints out ahead of visits for patients on a controlled substance
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Suboxone Patients

- PMP is used to check for benzodiazepines and others
Process Flow Adaptation

- Highlight pertinent issues from nurse and social worker onto “user friendly” form for easy review
- Efficiency!
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: __________________________________________________________________

Form scanned in to EMR: Y/N

Signed: __________________________________________________________________

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MD Recommendations
CSCT Review Form
Evaluated at weekly meetings by physicians.

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

- Formulated based on review
- Discussed with primary provider
Components of Recommendations

- Dose reductions
- Further work-up or updated work-up
- Discontinuation of other medication due to risk (benzodiazepines)
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”
Priority Patients

- These patients make the biggest impact on physician culture change
- Best opportunity for MD-MD discussion
- CDC guidelines didn’t change prescribing habits until something unforeseen happened
- Program evolution
- Overdoses, pill mill, diversion, “good” patients, urine results
Changing Physician Culture: Slow and Ongoing

- Unexpected urine testing
- Overdoses and overdose deaths
- Police information
- CDC guidelines information
- Minnesota State Prescribing Guidelines, 2018
- State Board interest in this issue
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.
Outcomes

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

These patient tapers account for 664,220 fewer pills/units prescribed in a year.
Outcomes

626 total taper patients (narcotics, stimulants, or benzodiazepines)

- Average decrease = 55,352 units/month no longer prescribed

Patient Needs/Support Referrals

- 2016: 146
- 2017: 336
Schedule 2 units filled each month at local pharmacy
SCHEDULE 2 UNITS FILLED EACH MONTH AT LOCAL PHARMACY (OVERALL TREND)
SCHEDULE 4 UNITS FILLED EACH MONTH AT LOCAL PHARMACY (OVERALL TRENDS)
Outcomes

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
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Medication Assisted Treatment
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Medication-Assisted Treatment

Why start an MAT program in a rural clinic?
• Patients presenting with opioid use disorder are unable to taper from narcotics
• Large population of patients using heroin
• Overdose deaths
• Barriers to treatment
  • Distance
  • Accessibility
• Standard of care
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Patients like to be treated in their local clinic
Physician barriers to providing MAT rurally
• Lack of mentors
• Prior authorizations
• Untrained staff
• Stigma and lack of understanding
• Availability of medication in pharmacies
• Education (Atlanta 2016)
• Decrease deaths
• Relapse rate
• Decrease crime
Physiology of Opioid Use Disorder
## A Rural Response
### Medication-Assisted Treatment

**Our Process:**
- Waivered
- Visited a buprenorphine clinic
- Protocols
- Developed intake form
- Patient packet

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### Substance Use Assessment

Instruction: Fill out the section for each of the drugs that you have used, even if that substance was never prescribed to you. If you don’t remember specifics, give your best estimate.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Frequency of use</th>
<th>Was this substance ever a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(yes/no)</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioids (heroin, oxys, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Patient #1**
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Medication-Assisted Treatment

Our Workflow

Patient calls clinic and talks with nurse care coordinator
- Drug history
- “Story”

Doctors review

Patient scheduled
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Not appropriate for our program

- Drug of choice
- High risk
- Distance
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Appropriate

- Forms filled out: consents, contract/care plan, releases
- UDAS
- Overview
- Social Worker: insurance, talk about Rx
- Medication called in: PA
- Schedule for induction
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Ultimate Goal:
• Seeing the patient when they are ready
• Treating the condition like it is an emergency
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Follow ups

- Frequent
- UDAS
- Social worker
- Work toward Rx
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Problems
- Unexpected UDAS
- Don’t follow-up
- Police
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Our Buprenorphine Program Success Thus Far

• Currently Active: 74
• Inactive: 40
Buprenorphine Program: Defining Success

- Time
- Sobriety
- Past point of brain healing
- Employment
- Repaired relationships
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County Jail Program
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County Jail Program

What happened?

Learned
• Lose medical assistance
• County responsible for medication cost
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Convened a county panel

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

- Stable on buprenorphine
- < 30 day jail time
- Go in with one month of meds
- 2 patients

Obstacles

- Department of Corrections
- Cost → county
- Controlled substance in jail
Initiating MAT

• In withdrawal
• Want help
• Recidivism problem: $120/day vs $8.10/day

Barriers

• Significant cost to county
• Waivered doctor/training
• Staff education
• Strict protocols
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County Jail Program

Average Days Spent In Jail from January 2015 Until Patient Started Buprenorphine vs. After Buprenorphine
36 patients surveyed

Current Life Activity
• Full time employment
• Retired
• Stay at home mom
• Unemployed for treatment
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Emergency Room
Goal: Point of care intervention

- Interact with overdose patients or patients in withdrawal
- Flyer with controlled substance care team phone number
- Referral process for buprenorphine treatment
- High risk of death if discharged
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
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Duplicating our Program
A Rural Response
Duplicating our Program

Same program, bigger community
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Duplicating our Program

Through duplicating our program:

- Eight communities have received legislative funding to hire staff to mirror our program.
- Legislation grant money based on our success
- Funding other communities
- Data: pills, tapers, care plans

ONE MILLION PILLS
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Project ECHO
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Our communication throughout our state and further.

Moving Knowledge Instead of Patients and Providers

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ECHO model is not “traditional telemedicine.” Treating physician retains responsibility for managing patient.
Goals of our ECHO:

• Aid providers in the appropriate management of narcotic prescribing.
• Give providers the ability to identify patients that are not appropriate for opioids, through things such as chart reviews.
• Be able to identify comorbidities that put patients at higher risk of death.
Goals of our ECHO:

• Collect data for the state that will demonstrate improvement in prescribing practices and decreases in the number of pills being prescribed.
• Educate physicians on the CDC and new state guidelines.
• Increase the number of buprenorphine providers in rural Minnesota.
• Decrease OD deaths
ECHO Clinic Format

- Attendance
- Didactic
- Case discussion/reviews
- Specialist partners
  - Addiction specialist
  - Pain doctor
  - Toxicologist
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Project ECHO

Topics Covered:

• Data Collection
• CDC Guidelines
• Task Force Components
• Care Plans
• Urine Drug Screens
• Thinking About Doing Buprenorphine in Primary Care Clinic
• Changing Physician Culture
• Care Team Functions
• Comorbidities Associated with Opioid Overdose

• ACE Scores
• Overview of Kratom
• Documentation for Patients on Narcotics and Suboxone
• Opioid Use Disorder in Pregnancy
• Marijuana Overview
• PDMP Overview
• The Treatment Experience
Presenters:

- Family physicians
- Maternal Fetal Medicine Specialist
- Prescription Drug Monitoring Program Administrator
- Director of Minnesota DHS
- Addiction Medicine physician
- President of a women’s treatment center in Minnesota
- LADC from Hennepin Healthcare
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Little Falls Hub

ECHO Spoke Locations
A Rural Response
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Little Falls Hub

ECHO Participants
“Multiplication of Force”

Little Falls buprenorphine patients

ECHO Spokes

Roughly 10 patients per ECHO SPOKE
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New ECHO Program

• Partnering with the University of Minnesota Rural Physician Associate Program (PMP)
  • Nine-month, community-based educational experience
  • For third-year medical students who live and train in rural communities
  • Experience hands-on learning as they care for patients of all ages
  • Supervised by a physician preceptor who is a practicing, board-certified family physicians
Recipe for Success

- RPAP students are generally:
  - Motivated
  - Eager to learn
  - Caring about rural health

- Goal
  - Generate interest in these students to consider addiction fellowship
  - Inspire students and physician preceptor to become buprenorphine waivered
What We’ve Done in Three Years

626 patient tapers
Cut out 664,220 pills a year so far
74 active buprenorphine patients
Gold card for prior authorization
First ECHO in the state of Minnesota
First provider of buprenorphine in a county jail
Changed ER process for overdose
8 communities a part of legislative grant
OUR NEW COMMUNITY
FOCUSED ON REDUCING PILLS
AND ENCOURAGING
MAT IN PRIMARY CARE
Justice will not be served until those who are unaffected are as outraged as those who are.

Benjamin Franklin
THANK YOU!
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Kurt Devine, MD:

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