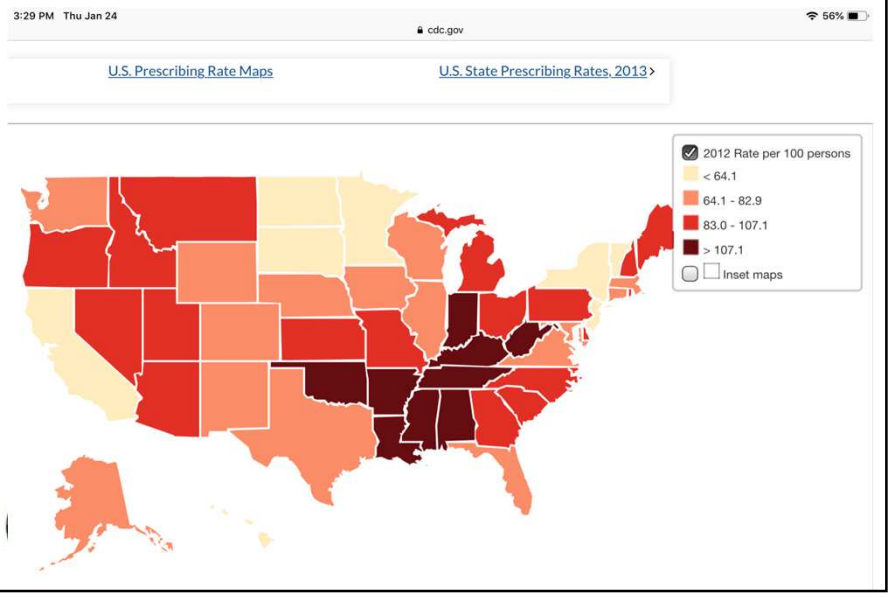
Office-Based Provider Support and Education

Michigan Center for Rural Health
Catholic Human Services
David S. McGreaham, MD

1

2012



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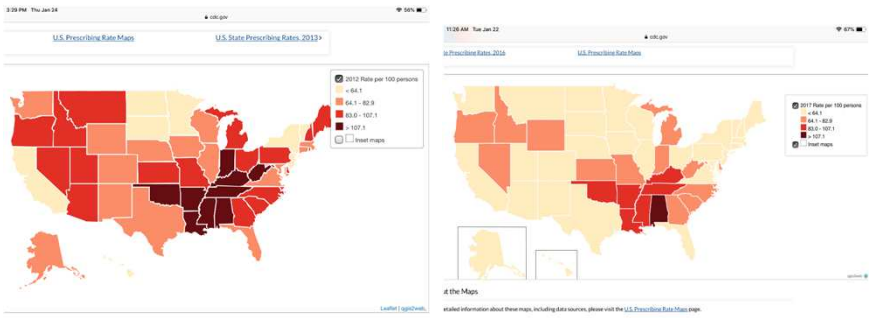
2012 **2017**



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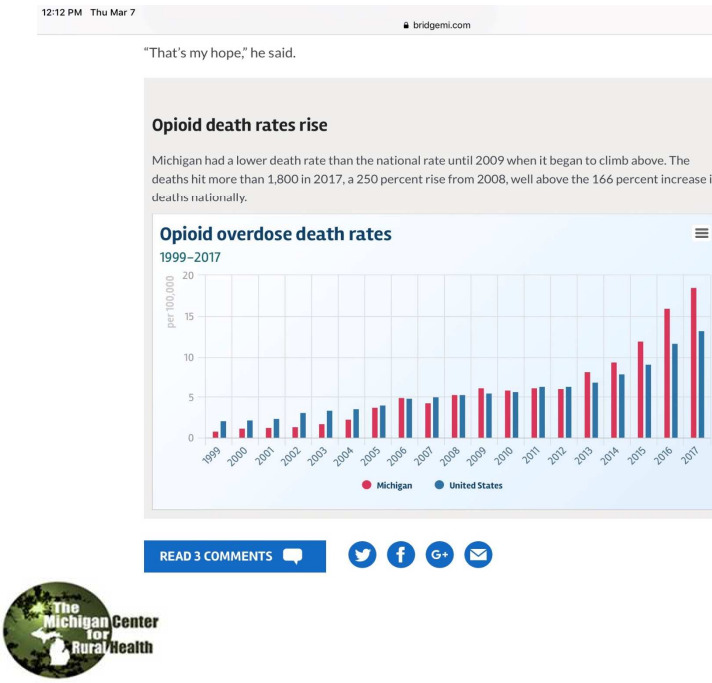
12:12 PM Thu Mar 7
bridgemi.com
100%
"That's my hope," he said.
Opioid death rates rise
Michigan had a lower death rate than the national rate until 2009 when it began to climb above. The deaths hit more than 1,800 in 2017, a 250 percent rise from 2008, well above the 166 percent increase in deaths nationally.
Opioid overdose death rates
1999–2017
per 100,000
20
15
10
5
0
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
Michigan
United States
READ 3 COMMENTS

4

Prescriptions/100 pop

	Grand Traverse	Kalkaska	Leelanau	Roscommon	US Average	Michigan
2007	146	130	N/A	121	76	86
2008	156	107	8	157	78	90
2009	146	113	17	169	80	92
2010	152	120	16	185	81	96
2011	155	120	15	185	81	99
2012	148	128	26	207	81	101
2013	141	137	27	209	79	99
2014	142	134	23	209	76	98
2015	128	122	22	183	71	91
2016	103	106	20	147	66	85
2017	96	92	19	127	59	74

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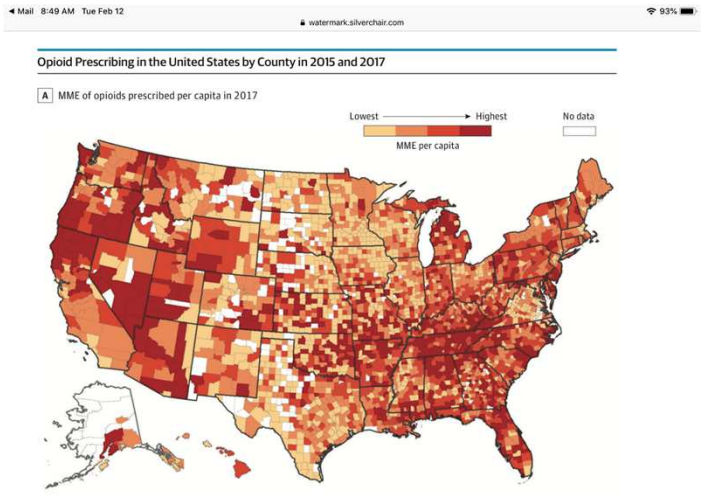

2017 Data

JAMA Internal Medicine Feb 2019 Research Letter

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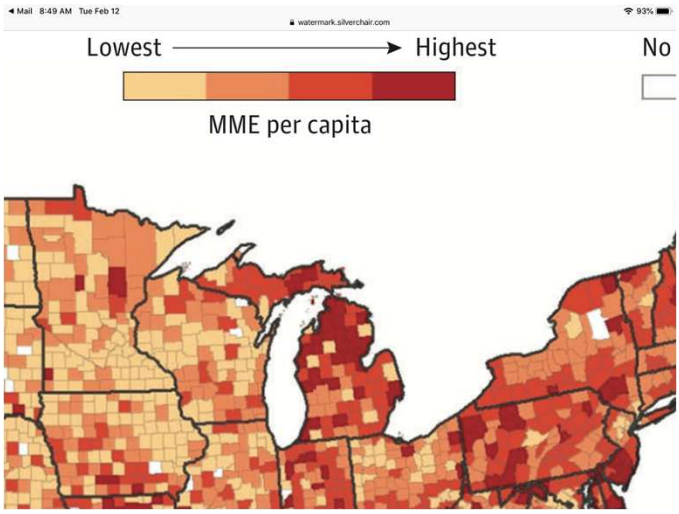

2017

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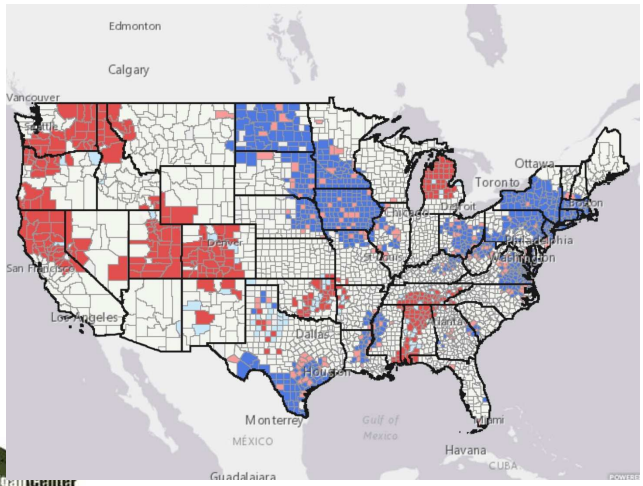
CMS Medicare Claims Data 2016



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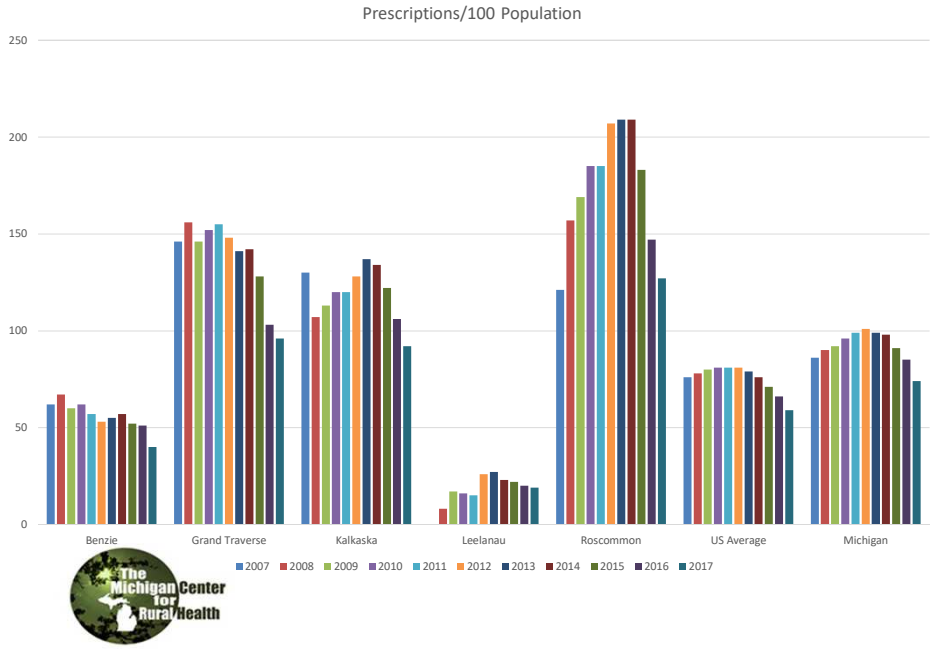

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Higher odds of opioid prescribing in nonmetropolitan counties might be due to :

- Prescription drug use and misuse at an earlier age
- Higher prevalence of chronic pain among persons living in rural areas
- Larger populations of older adults who have more conditions associated with chronic pain
- Opioid prescribing in rural areas is strongly influenced by providers' relationships with their patients and can be inconsistent with prescribing guidelines
- Access to MAT and alternative therapies are limited
- Others: Unemployment, multi-generational poverty, behavioral health shortages, ? ACE's

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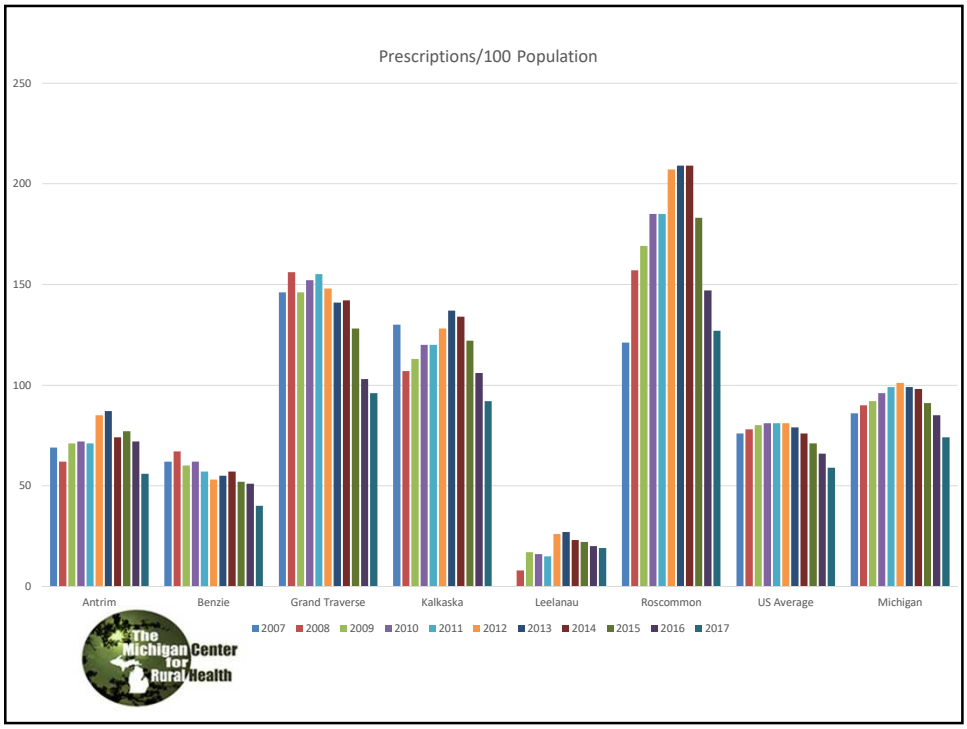

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MCRH, in joint partnership with MDHHS offered Office-Based Provider Support and Education to rural providers in 14 counties Jan-Sept 2019

This grant was funded through the CDC

Catholic Human Services, in partnership with the Northern Michigan Regional Entity, is offering AD October 2019-Sept 2020 in Leelanau, Kalkaska, and Grand Traverse counties

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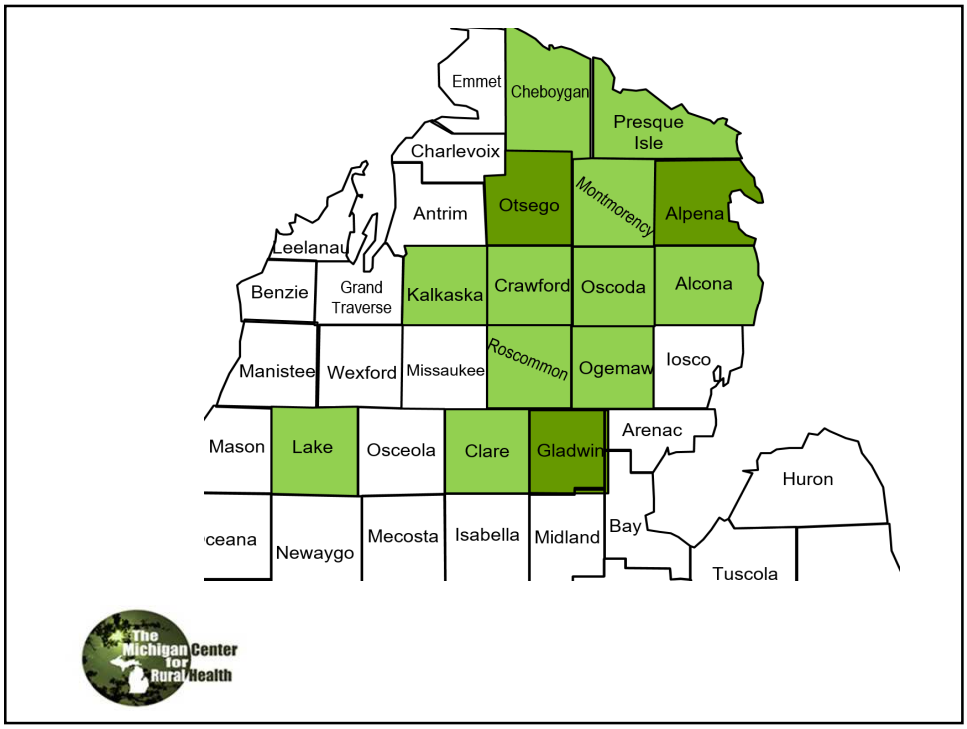
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Huron
Bay
Midland
Isabella
Mecosta
Newaygo
Tuscola
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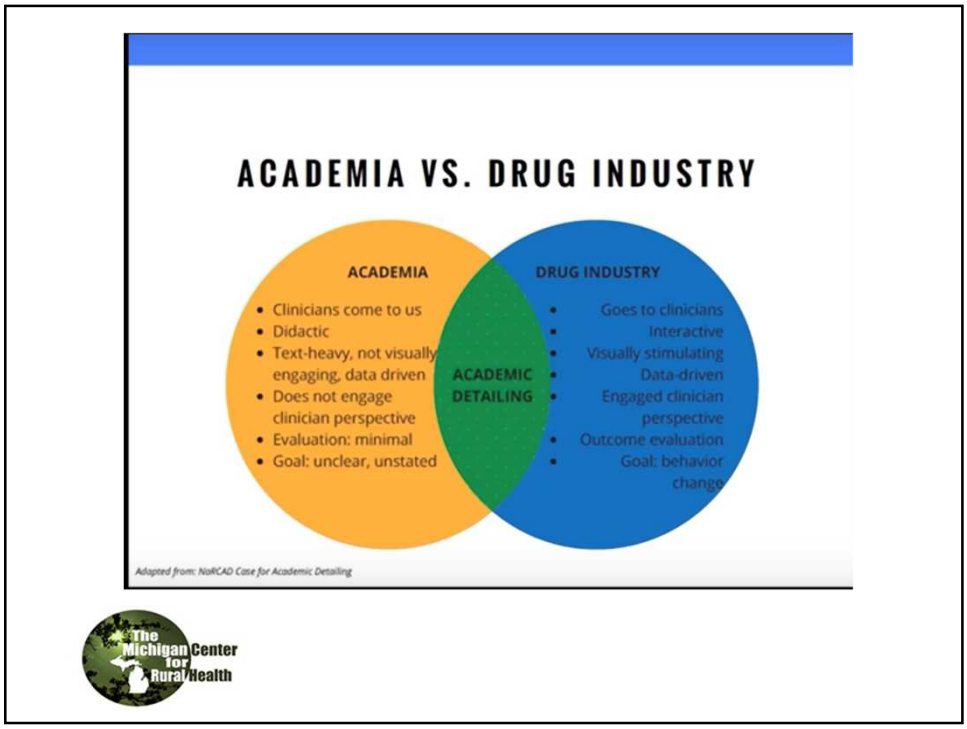
ACADEMIA VS. DRUG INDUSTRY
ACADEMIA
Clinicians come to us
Didactic
Text-heavy, not visually engaging, data driven
Does not engage clinician perspective
Evaluation: minimal
Goal: unclear, unstated
ACADEMIC DETAILING
DRUG INDUSTRY
Goes to clinicians
Interactive
Visually stimulating
Data-driven
Engaged clinician perspective
Outcome evaluation
Goal: behavior change
Adapted from: NoRCAD Case for Academic Detailing
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How do Clinicians benefit from educational visits?

- Busy clinicians need an accurate, ongoing source of current evidence based medicine.
- Clinicians have many competing demands for their time; trying on their own to assemble current evidence from a continuous influx of research is incredibly challenging.
- As a result, many clinicians may be unaware if better alternatives exist for prescribing, prevention, screening, and patient education.
- 1:1 or small groups: what are the advantages?

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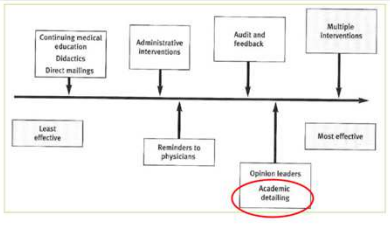
Introductions
AD is an effective approach



Dopp, et al; BMC Family Practice; 2013

MDHHS

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What resources would you like further education in:
___ Evidence-based criteria for opioid use in chronic pain
___ Patient conversations surrounding discontinuation of opioids
___ Teaching patients and their family proper use of naloxone
___ Information for non-prescribing members of my healthcare team
___ Provide guidance for instructing my patients how to properly dispose of opioid medicines
___ Understanding data in MAPS, including risk scores
___ Complying with new Michigan opioid laws
___ Patient education resources specific for chronic pain patients
___ Tools for identifying patients at risk for opioid abuse and dependency
___ Methods to quantify the number of patients in your clinic on narcotics and calculating their Daily Morphine Equivalent Dose
___ Criteria for categorizing your patients into low, medium and high risk groups
___ Shifting away from pain scores toward daily function as a measure for treatment continuation
___ Cognitive Behavioral Therapy (CBT) as a method of pain management
___ Available alternatives to opioids when addressing chronic pain
___ Guidance for how best to provide pain management for patients with pre-existing substance use disorder
___ Behavioral Health Integration
___ Other (please describe)
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ENGAGING WITH THE PROVIDER
Let the provider determine topics for discussion
Be ready to tailor the conversation
Engage in a two-way conversation
There will be a few points you want to emphasize regardless of provider interest work it into conversation or make sure to leave time at the end to quickly review
How much time do you have?
Determine this as soon as you sit down or before you arrive
Do you currently have patients on long-term opioids?
What topics are you most interested in covering today related to managing your patients' pain and opioid prescribing?
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Visits

- Kalkaska County:
  - Kalkaska FPx2 Mancelona x2 South Boardman X2
- Grayling Medical Staff Grayling Provider Network
  - Roscommon X 2
  - Prudenville x2 and private practice NP
- Gaylord
  - Elmira Indian River Lewiston Gaylord staff
- Manistee NP
- St Helen

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Insights

- It takes a lot of work to get into a provider office and not everyone wants to see me
  - It helps to be a physician
  - Leadership support is helpful
- Lunch meetings work best
- Providers are generally doing what they're supposed to be doing and want to be affirmed
- Most are very engaged (most) and want to talk, and would like more forums to discuss cases

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Themes

- The Conversations with Patients: Chronic pain: nearly all providers are attempting to taper doses, others are reluctant as they've tried multiple modalities and older patients have few good options. How do providers have the conversation?
  - **What's a safe dose/target?**
  - **DEA is watching us**
  - **High doses no better than low, goal is not the elimination of pain but keeping the edge off of it, and monitoring your function, so leverage functional status.**
  - Providers seem to enjoy discussing this topic…
- Benzos and Marijuana
- Provider relationship with their patients is the key, as is their judgement-they have to choose their battles. **Some providers have inherited many chronic pain patients.**
- Behavioral Health: Geographic barriers, insurance barriers, quality variable
  - Desire for on-site behavioral health or telemedicine, as you lose the patient once they're out of the office
- Resources: Desire for Functional Status forms (and Billing Code BH Assessment 96217) and CDC patient education handout Narcan/naloxone samples from ATS and NMRE

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PEG Pain Screening Tool

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

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PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4 PEOPLE*** receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

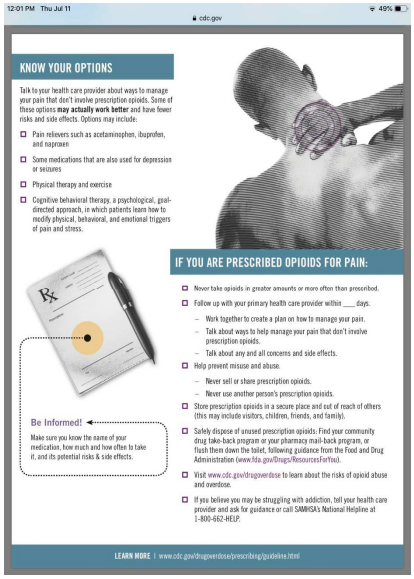
- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

American Hospital Association



KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ___ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids. Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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Next Steps: Grand Traverse, Leelanau, Kalkaska

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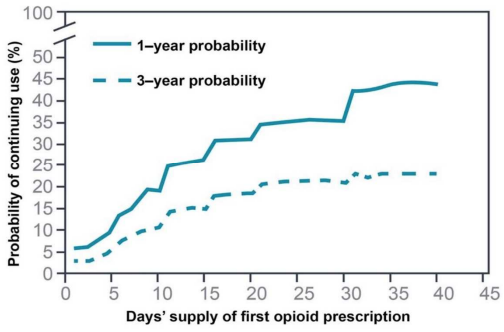
Opiate Days Prescribed vs Dependence

Figure 1. One- and Three-Year Probabilities of Continued Opioid Use among Opioid-Naïve Patients, by Number of Days' Supply of the First Opioid Prescription, United States, 2006–2015



Source: Adapted from Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use — United States, 2006–2015. *MMWR Morbidity and Mortality Weekly Report*. March 17, 2017;66:265-269.

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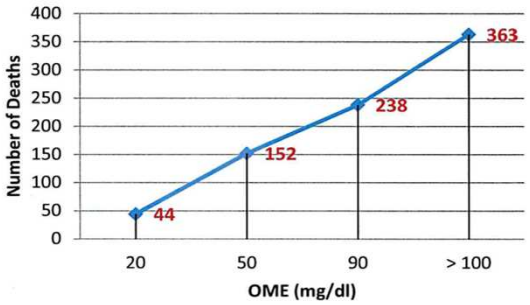
Opioid Dose vs Risk of Death



JAMA. 2011;305(13):1315-1321

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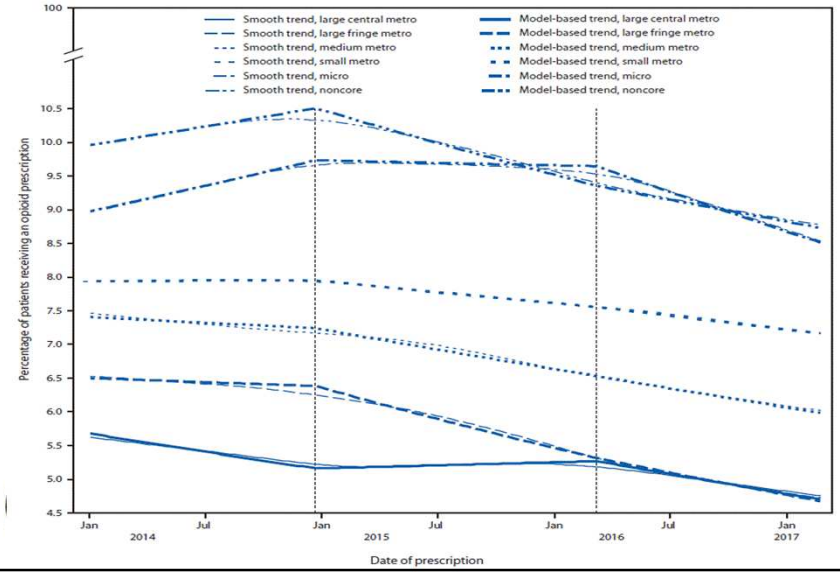
Why More Opiates in Rural Populations? MMWR Jan 18, 2019



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Prescriptions/100 pop

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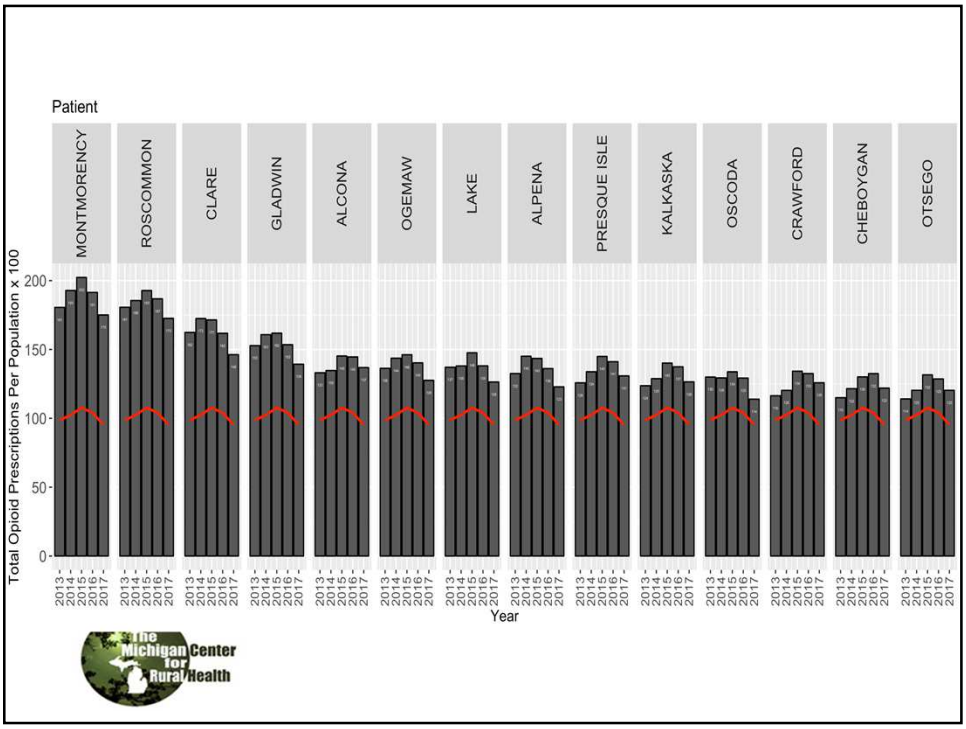

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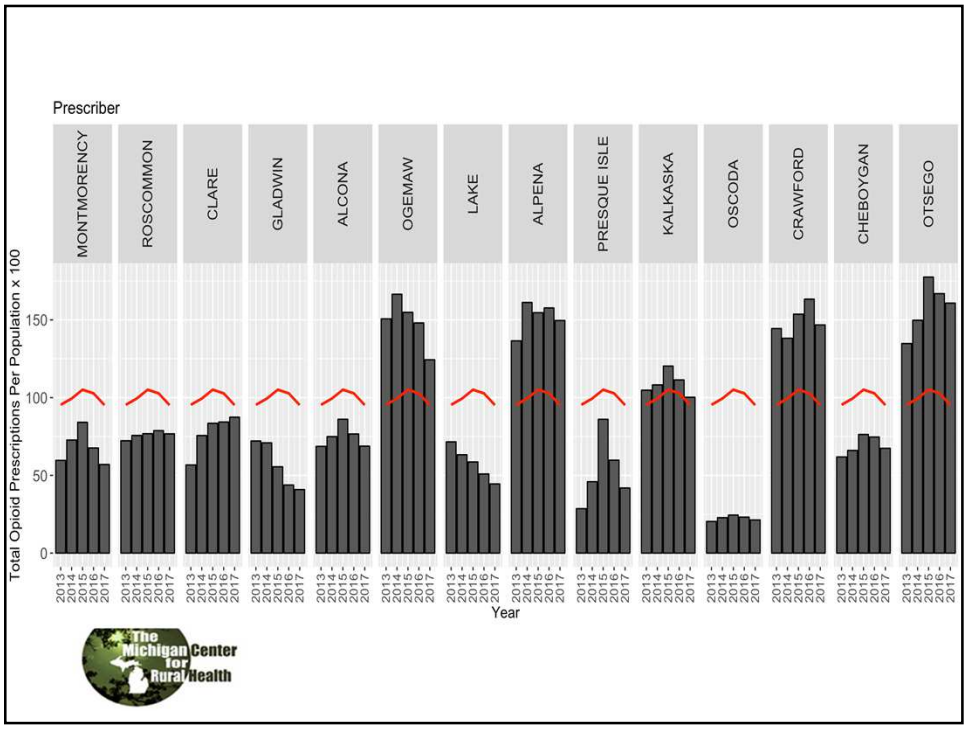
Prescriber
MONTMORENCY
ROSCOMMON
CLARE
GLADWIN
ALCONA
OGEMAW
LAKE
ALPENA
PRESQUE ISLE
KALKASKA
OSCODA
CRAWFORD
CHEBOYGAN
OTSEGO
Total Opioid Prescriptions Per Population x 100
0
50
100
150
2013
2014
2015
2016
2017
Year
The Michigan Center for Rural Health

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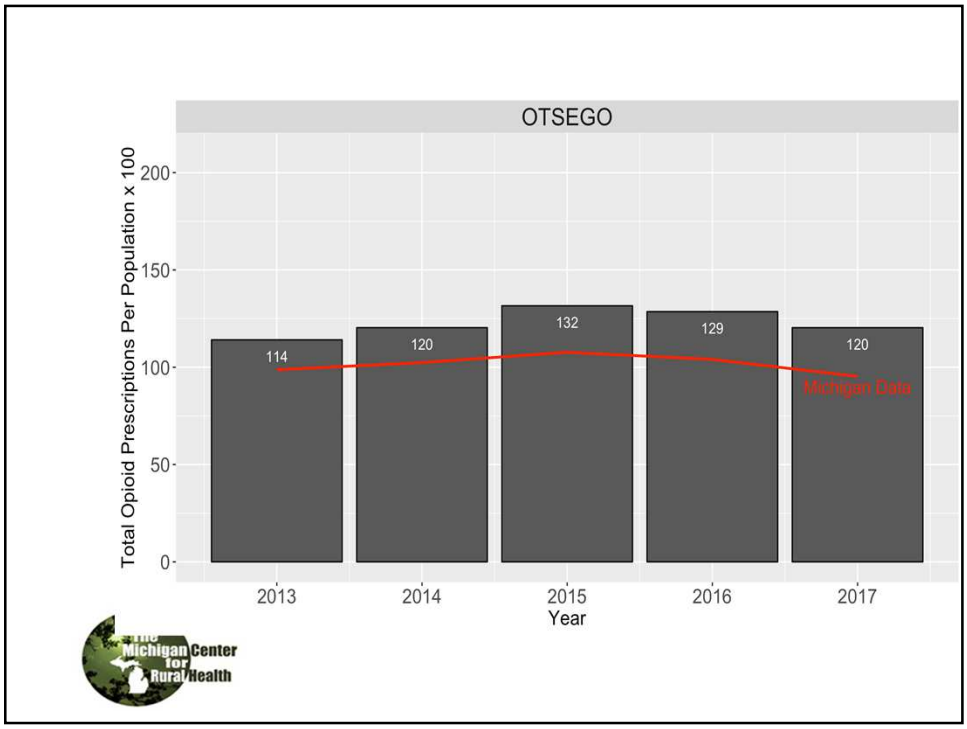
OTSEGO
Total Opioid Prescriptions Per Population x 100
0
50
100
150
200
114
120
132
129
120
Michigan Data
2013
2014
2015
2016
2017
Year
The Michigan Center for Rural Health

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SUMMARY FINDINGS: PROVIDER FOCUS GROUPS/ SURVEY/ INTERVIEWS

Provider input was obtained from focus groups, an online provider survey and a broader needs assessment survey. 21 providers participated by survey; 10 participated in focus groups and 33 as part of the online needs assessment survey. Providers represent a mix of primary care, pain management, behavioral health and substance abuse specialists.

Does your practice have measures in place to prevent opioid addiction in your patients?

Most providers indicated that they have measures in place to prevent opioid use disorder in their patients. Typically, they are using opioid contracts, risk assessment and screening, and drug testing. A few indicated that they are no longer prescribing opiates or they are limiting prescriptions. Only one provider indicated that they are not doing anything to prevent opioid use disorder.

One provider pointed out that pharmacists need to participate in prevention efforts by educating patients on both using the drug and disposing of the drug.

When you suspect a patient has an opioid use disorder, what are the greatest barriers to appropriately diagnosing and treating them?

Access to treatment programs that are close, affordable and with available appointment times.

Patient denial or unwillingness to seek treatment.

Access to alternative treatments for pain management

Lack of behavioral health services; some providers indicate that they don't even suggest the patient has a psychiatric issue as there's nowhere to send them.

Lack of support from insurance companies in the form of limiting opioid prescription coverage and not covering other services such as physical therapy

Access to a team-based, integrated approach

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What are the greatest barriers you see in offering patients recovery and treatment services?

Distance Cost No suboxone clinics

Lack of insurance coverage for physical therapy or behavioral health services

Stigma Patient's willingness/ compliance

How comfortable are you with prescribing naloxone and buprenorphine?

While many providers would be comfortable prescribing naloxone and buprenorphine, many indicated that they are not comfortable for a variety of reasons:

- Not certified
- Not educated
- Time constraint in practice
- Fear it will change the patient composition of their primary care practice
- Lack of a comprehensive team approach

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Here is a summary of needs identified by providers.

Access to MAT

MSWs or psychologists in community that specialize in addiction and participate in an integrated approach.

Team-based, integrated, multidisciplinary approach

Physician support through access to colleagues who can answer questions or consult on a case

Access to inpatient options for addiction and behavioral medicine that aren't so far away

Primary care practices that will take patients back after they've undergone treatment

Emergency rooms that send patients right over to chronic pain clinic; making the ER a place that chronic pain patients can't go.

A really good inventory of services and resources that are available; well-trained nursing assistants who can investigate and identify resources.

Streamlined paperwork and electronic medical records that can speak to one another in an integrated fashion; free up providers

Funding for ECHO or some other case conference system to support providers.

Peer coaches

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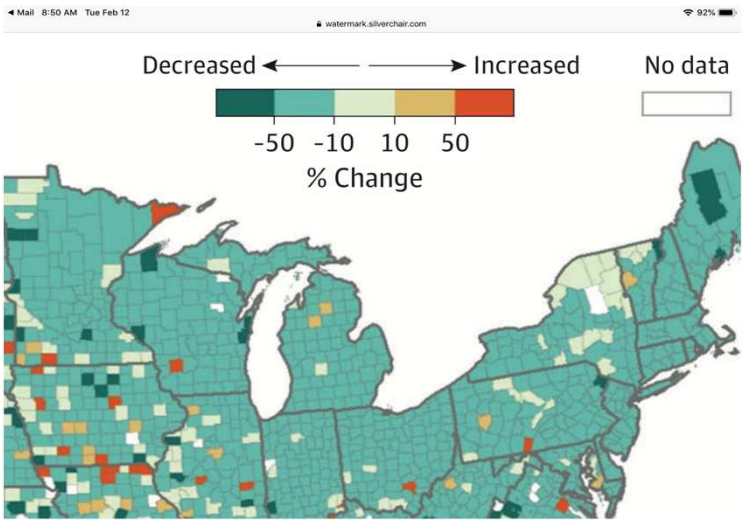

2017

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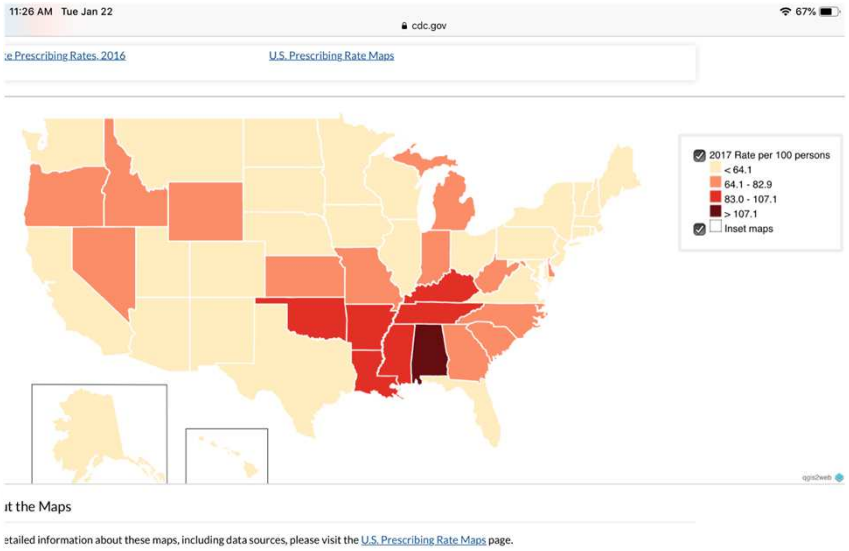
2017



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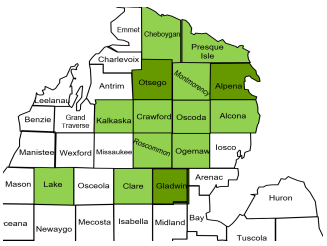
The Michigan Center for Rural Health (MCRH) was awarded a $200,000 Rural Communities Opioid Response Program (RCORP) planning grant by the Health Resources & Services Administration (HRSA) to focus on opioid use disorder in the 14 northern MI counties. Over the next year, MCRH will help facilitate the work of the newly formed Northern Michigan Opioid Response Consortium (NMORC).

The NMORC was assembled to:

- coordinate efforts,
- identify areas of best practice for replication and expansion,
- pinpoint gaps in care and develop solutions around these gaps,
- leverage state resources to address system and policy issues,
- reduce the duplication of efforts.



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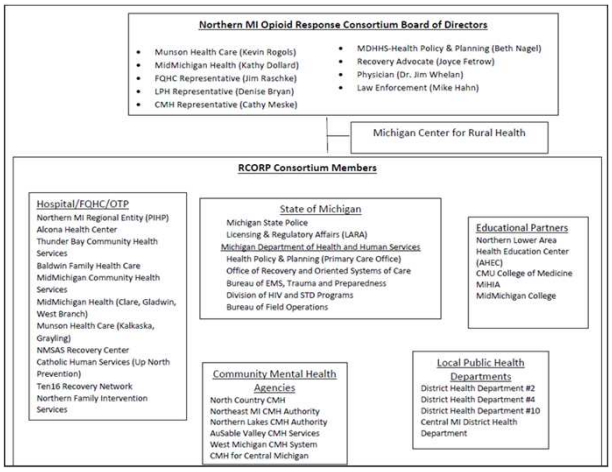
NMORC Consortium Partners Include:



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NMORC

- Collect data for each county
  - eg, rate of OUD, prescription #'s, OD
- Survey members and providers regarding barriers to prevention, treatment, recovery
- Inventory of current OUD programs
- Workforce analysis and gaps
- Make recommendations on how to proceed

40

Please indicate your opinion of the level of importance for each initiative	Combined very important/ important
Design a comprehensive, regional treatment model	157
Develop a strategy to increase the number & location of treatment	154
Educate and prepare primary care and other medical providers	154
Secure funding to expand programs and services in our region.	151
Educate the general public about treatment options.	148
Develop an easy and seamless referral process	148
Provide screening tools and approaches to diagnose substance abuse.	138
Educate the general public about preventing opioid use disorders.	136
Develop transition housing/ sober living options for patients	135
Educate law enforcement.	132
Educate the general public about identifying opioid use disorders.	129
Serve as advocates to influence legislation and statewide changes	127
Reduce the stigma attached to opioid addiction.	115
Work with employers in how to address SUD disorders in workforce.	110

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Summary of Recommendations
Northern Michigan Opioid Response Consortium (NMORC)

Prevention
- Increased number of treatment centers
- Sober support
- Education of the public on the dangers of opioids
- Proper mental health diagnosis

Treatment
- Access to MAT programs
- Access to behavioral health
- Coordinated continuum of care
- Multiple recovery pathways implemented during treatment
- More treatment options
- Physician education
- Insurance

Recovery
- Housing (sober living, transitional housing, recovery housing)
- Transportation
- Employment assistance
- Recovery Community Organizations
- Insurance coverage – specifically when transitioning to a commercial plan.
- Stigma – stigma from a variety of perspectives, but including stigma surrounding the various paths to recovery (i.e. MAT vs. abstinence-based recovery).

Workforce
- More behavioral health providers.
- Billing barriers – i.e. CAADC certification for Medicaid billing.
- Hiring more recovery coaches.
- Telehealth, and tele-behavioral health.
- Models that use creative ways to share provider staffing.
- Employer education for those that are attempting to hire those in treatment or active use.
- Drug screening does not differentiate between those on MAT, and those not in treatment.

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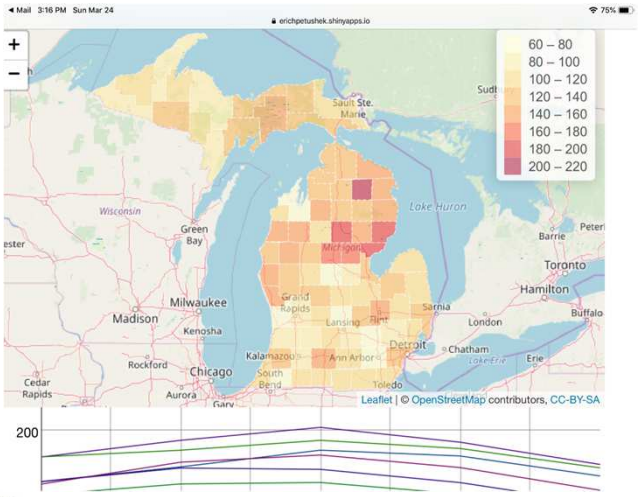
2015 per 100 Patients



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Summary of Recommendations Northern Michigan Opioid Response Consortium (NMORC)

Prevention

- Increased number of treatment centers
- Sober support
- Education of the public on the dangers of opioids
- Proper mental health diagnosis

Treatment

- Access to MAT programs
- Access to behavioral health
- Coordinated continuum of care
- Multiple recovery pathways implemented during treatment
- More treatment options
- Physician education
- Insurance

Recovery

- Housing (sober living, transitional housing, recovery housing)
- Transportation
- Employment assistance
- Recovery Community Organizations
- Insurance coverage – specifically when transitioning to a commercial plan.
- Stigma – stigma from a variety of perspectives, but including stigma surrounding the various paths to recovery (i.e. MAT vs. abstinence-based recovery).

Workforce

- More behavioral health providers.
- Billing barriers – i.e. CAADC certification for Medicaid billing.
- Hiring more recovery coaches.
- Telehealth, and tele-behavioral health.
- Models that use creative ways to share provider staffing.
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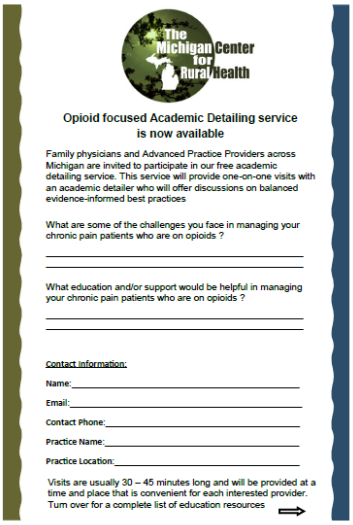
How do I receive AD services?



The Michigan Center for Rural Health

Opioid focused Academic Detailing service is now available

Family physicians and Advanced Practice Providers across Michigan are invited to participate in our free academic detailing service. This service will provide one-on-one visits with an academic detailer who will offer discussions on balanced evidence-informed best practices

What are some of the challenges you face in managing your chronic pain patients who are on opioids ?

_____
_____

What education and/or support would be helpful in managing your chronic pain patients who are on opioids ?

_____
_____

Contact Information:

Name:_____

Email:_____

Contact Phone:_____

Practice Name:_____

Practice Location:_____

Visits are usually 30 – 45 minutes long and will be provided at a time and place that is convenient for each interested provider. Turn over for a complete list of education resources ⇒

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HHS Narcan Guidelines Dec 2018

- Patients prescribed opioids who:
  - Are receiving opioids at a dosage of 50 morphine milligram equivalents (MME) per day or greater
  - Have respiratory conditions such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea (regardless of opioid dose);
  - Have been prescribed benzodiazepines (regardless of opioid dose).
  - Have a non-opioid substance use disorder, report excessive alcohol use, or have a mental health disorder (regardless of opioid dose).
- Patients at high risk for experiencing or responding to an opioid overdose, including individuals:
  - Using heroin, illicit synthetic opioids or misusing prescription opioids.
  - Using other illicit drugs such as stimulants, including methamphetamine and cocaine, which could potentially be contaminated with illicit synthetic opioids like fentanyl.
  - Receiving treatment for opioid use disorder, including medication-assisted treatment with methadone, buprenorphine, or naltrexone.
  - With a history of opioid misuse that were recently released from incarceration or other controlled settings where tolerance to opioids has been lost.

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Types/Cost of Naloxone:

- Evzio self-inject ($3,781 and requires insurance pre-approval) Rarely used.
- Nasal injector ($150)
- Pre-filled vials ($40 and need to have a 21-gauge needle given as well) $396 for 10
- 2cc vials ($19 cost and need needles and syringes) $190 for 10 vials

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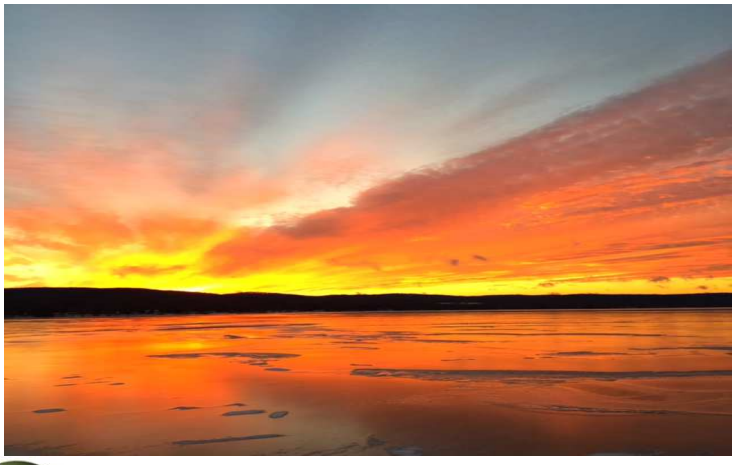
Your Feedback?



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