A Vision for Substance Use Disorder Treatment in Delaware

What is Possible?

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JOHNS HOPKINS

BLOOMBERG SCHOOL

of PUBLIC HEALTH

An Alternative Title:

What would a comprehensive, well-coordinated, integrated, high-quality, person-centered opioid use disorder care delivery and financing system look like?

Overview

1. Opioid epidemic as a public health crisis
2. Major barriers to combating the epidemic
3. Evidence-based responses are needed
   - Prevention response
   - Rescue response
   - Treatment response
   - Recovery response
4. How might system change to meet the need?
   - Building capacity: care Integration, coordination, hub & spokes
   - Person-centered data to drive system-level improvements
   - Performance metrics and incentives to drive improved quality
   - Innovative financing (e.g., Medicaid waiver authority, health homes)

Framing the Opioid Epidemic as a Public Health Crisis

The Opioid Epidemic Is Hard to Miss

State officials say Delaware opioid epidemic needs more resources, funding

By SARAH MUELLER • SEP 6, 2017

SARAH MUELLER / DELAWARE PUBLIC MEDIA

Attorney General Matt D

Hooked: Delmarva's Drug Crisis

Posted: 10/23/2017 09:08:00 -04:00
Updated: Oct 23, 2017 11:55 AM EDT

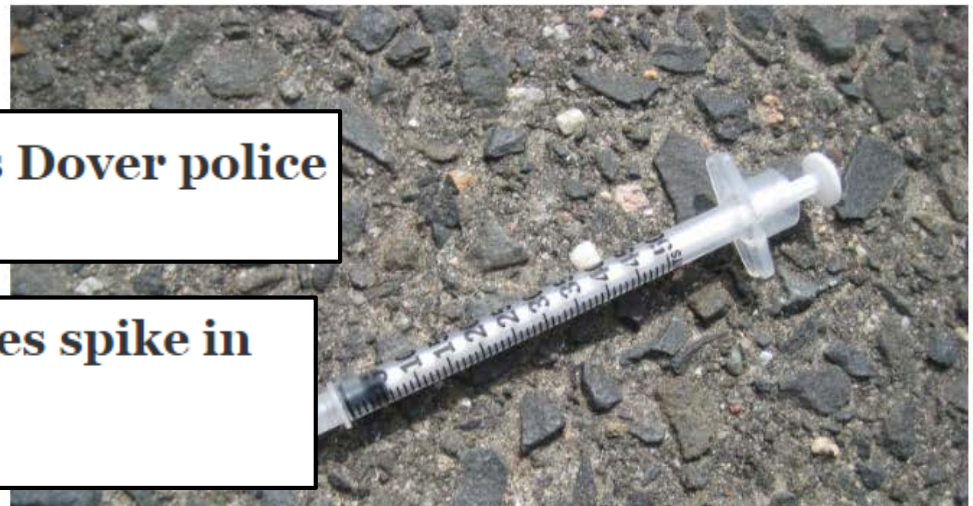
Six overdose deaths in Delaware during past five days underscore opioid epidemic

Rob Petree / WXDE Aug 9, 2017 - 10:43 am (4)

Dover's 'ANGEL' initiative steers opioid users into treatment instead of jail

By JAMES MORRISON • MAR 10, 2017

PROGRAM
The Green



Seizure of more heroin troubles Dover police

Jun 16th, 2015 · by Craig Anderson · Comments: 0

Deaths due to Fentanyl overdoses spike in Delaware

Jun 22nd, 2016 · by Delaware State News · Comments: 0

Drug Deaths in America Are Rising Faster Than Ever

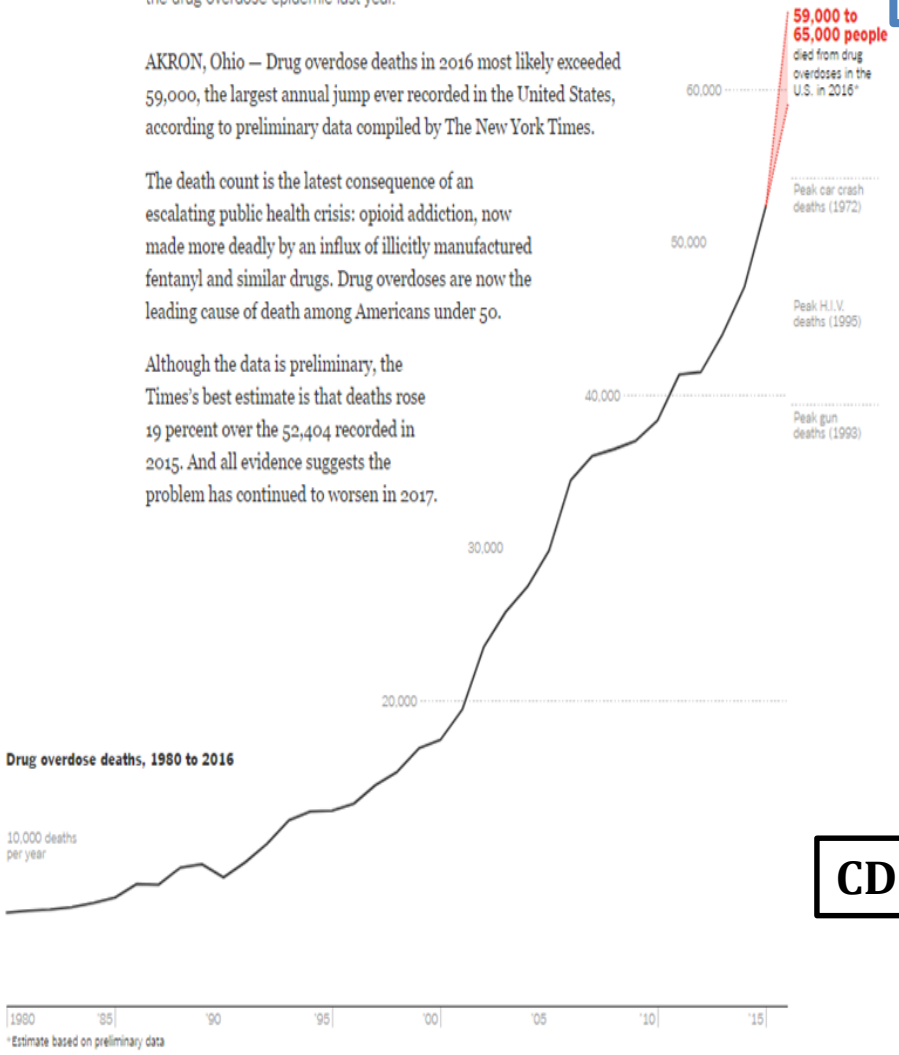
By JOSH KATZ JUNE 5, 2017

New data compiled from hundreds of health agencies reveals the extent of the drug overdose epidemic last year.

AKRON, Ohio — Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States, according to preliminary data compiled by The New York Times.

The death count is the latest consequence of an escalating public health crisis: opioid addiction, now made more deadly by an influx of illicitly manufactured fentanyl and similar drugs. Drug overdoses are now the leading cause of death among Americans under 50.

Although the data is preliminary, the Times's best estimate is that deaths rose 19 percent over the 52,404 recorded in 2015. And all evidence suggests the problem has continued to worsen in 2017.



PUBLIC HEALTH

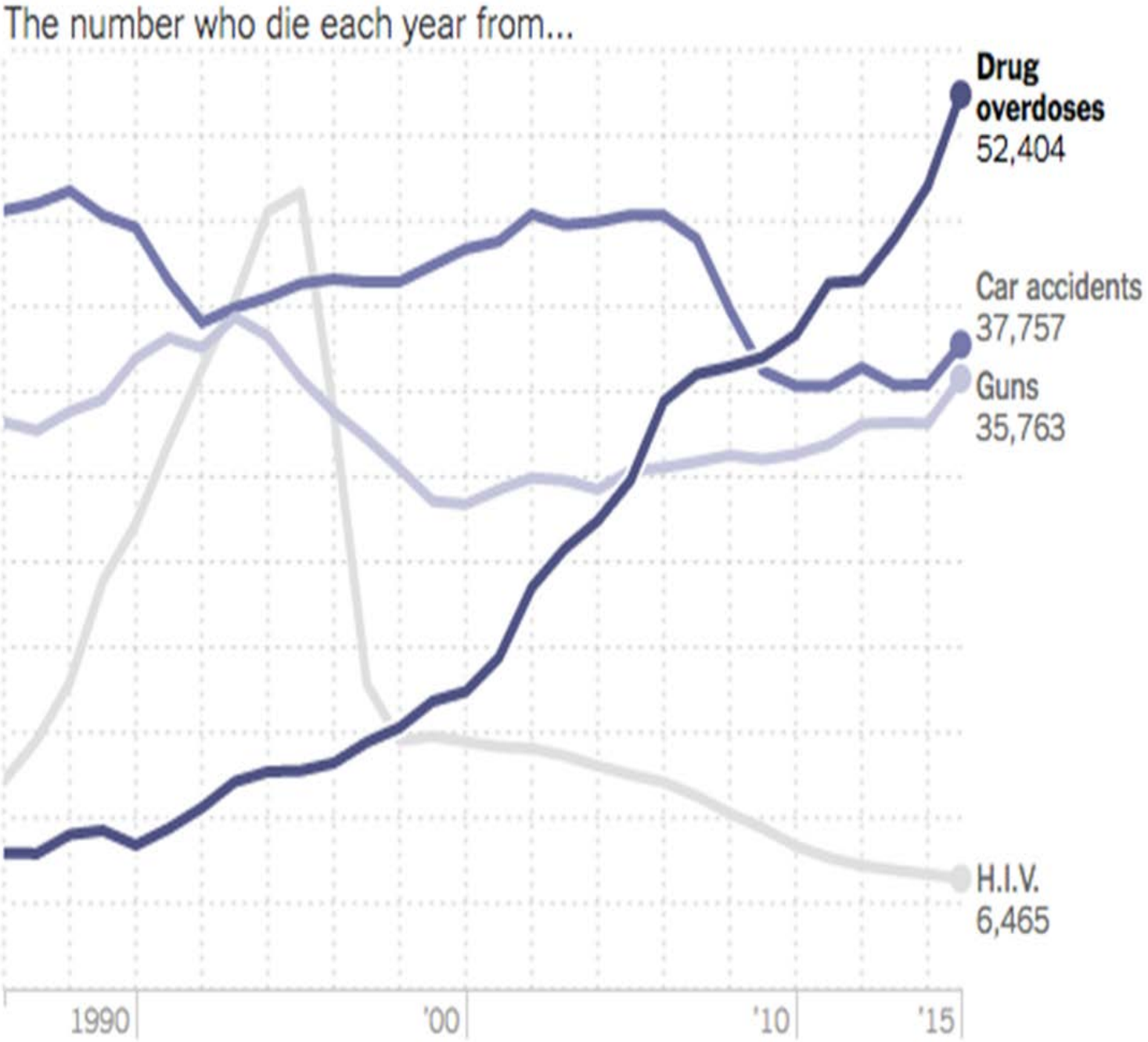
Life Expectancy In U.S. Drops For First Time In Decades, Report Finds

December 8, 2016 · 12:02 AM ET

Heard on Morning Edition

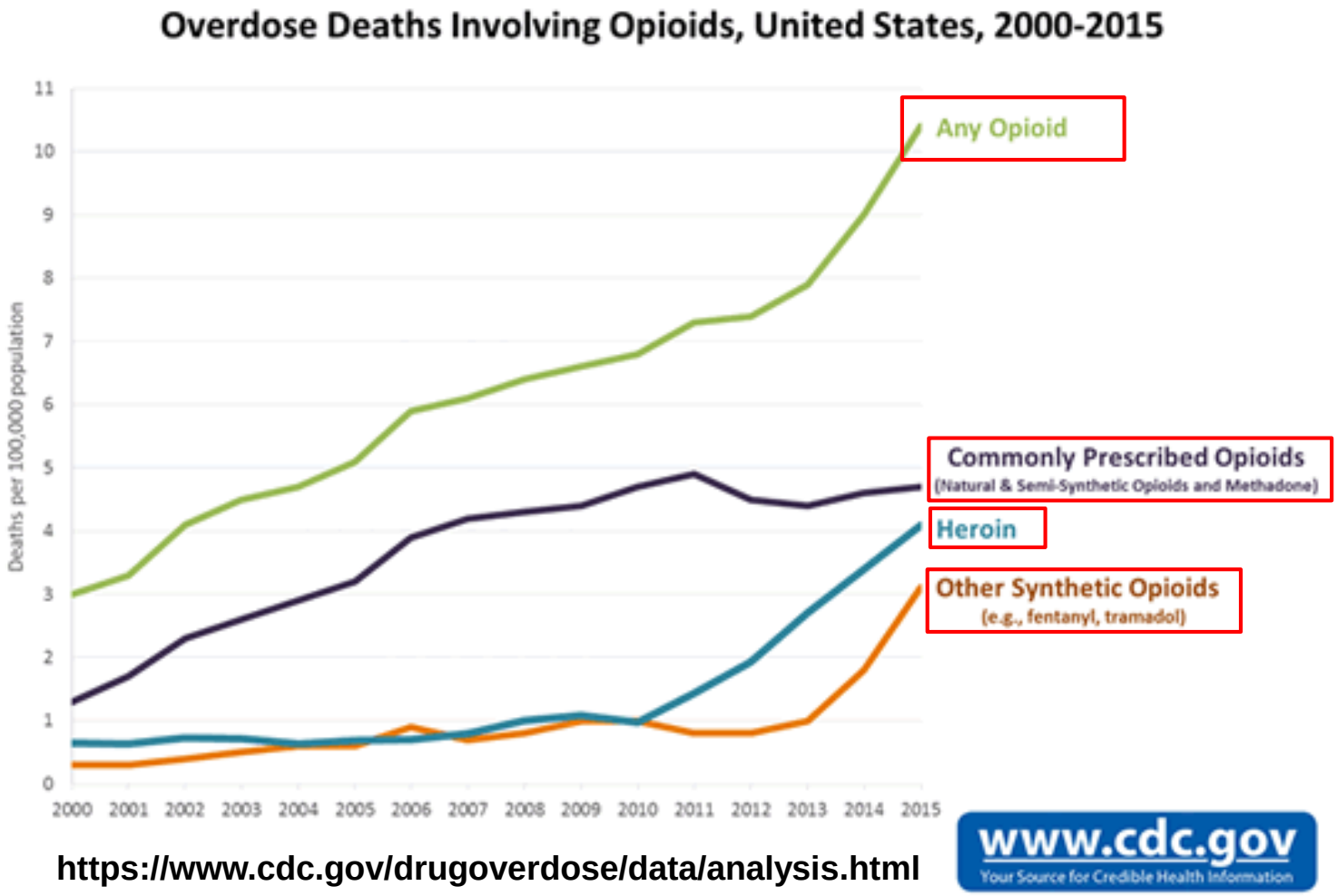
The New York Times

CDC's provisional count for 2016: 64,070



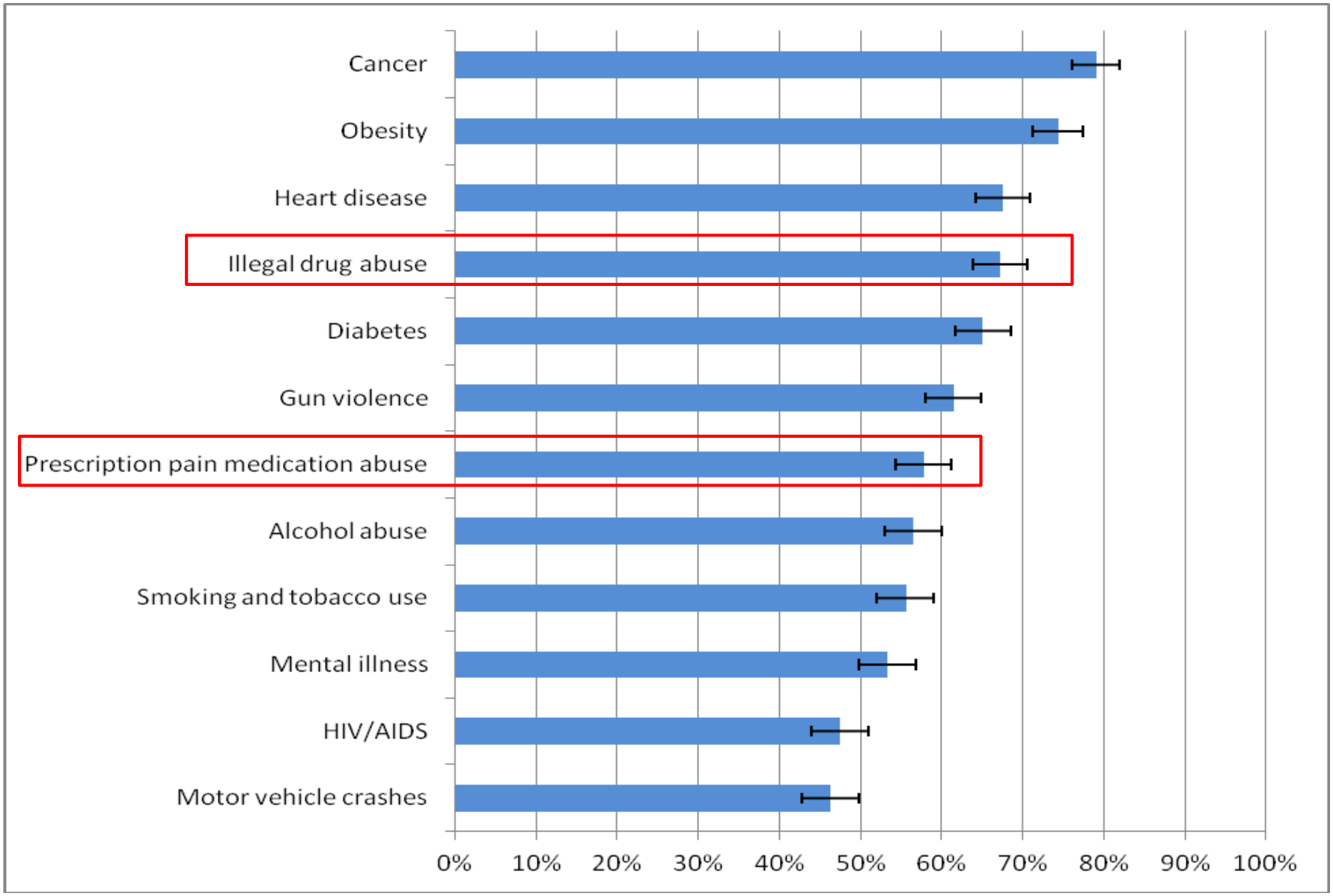
The New York Times

Prescription Drug Deaths have Leveled Off, but Heroin and Fentanyl Surging



https://www.cdc.gov/drugoverdose/data/analysis.html

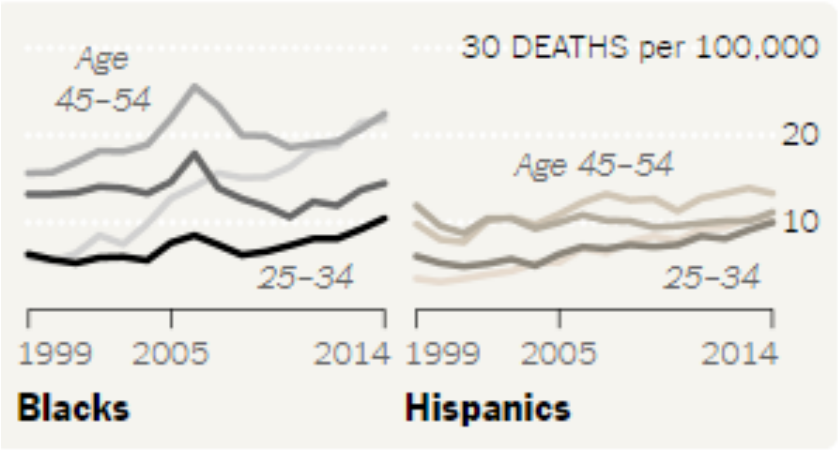
How the Public Ranks the Seriousness of Health Issues

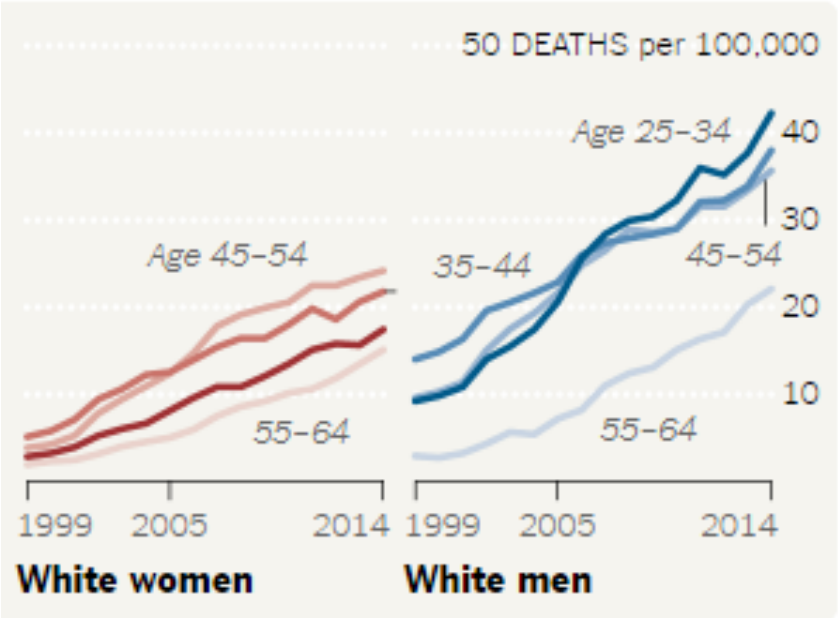


Barry et al. *Addiction*, 2016

Recent Rise in Overdose Fastest among Whites, but Longstanding Urban Minority Epidemic

Deaths from drug overdose and other accidental poisonings





https://www.nytimes.com/2016/01/17/science/drug-overdoses-propel-rise-in-mortality-rates-of-young-whites.html?_r=0

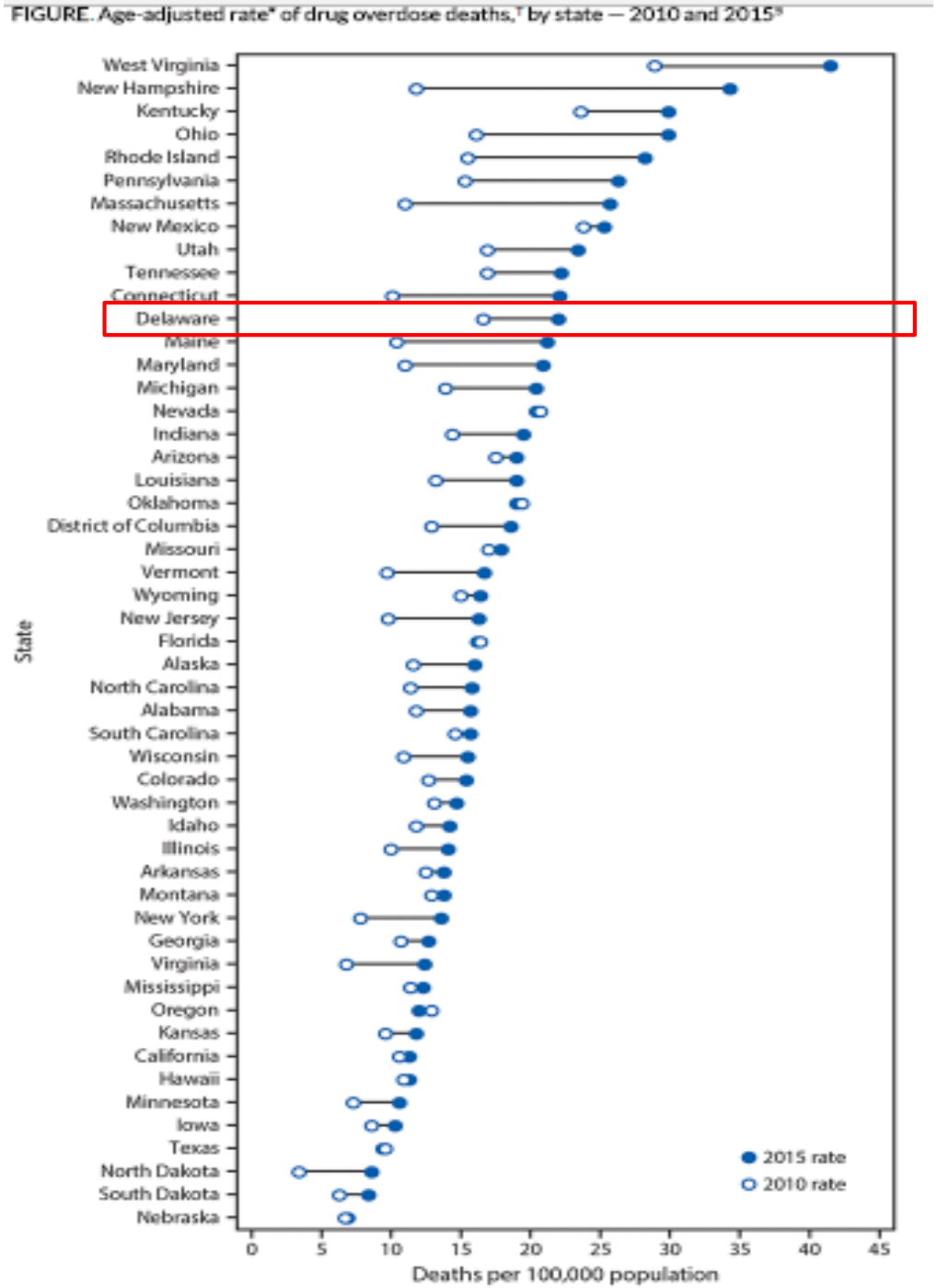
Epidemic has Different Dimensions in Rural Areas

- Increased sales of opioid analgesics in rural areas lead to greater availability for nonmedical use through diversion
- Out-migration of upwardly mobile young adults from rural areas increases economic deprivation, creates an aggregation of young adults at high risk for drug use
- Tight kinship and social networks allow faster diffusion of nonmedical prescription opioids among those at risk
- Increasing economic deprivation, unemployment create a stressful environment that places individuals at risk

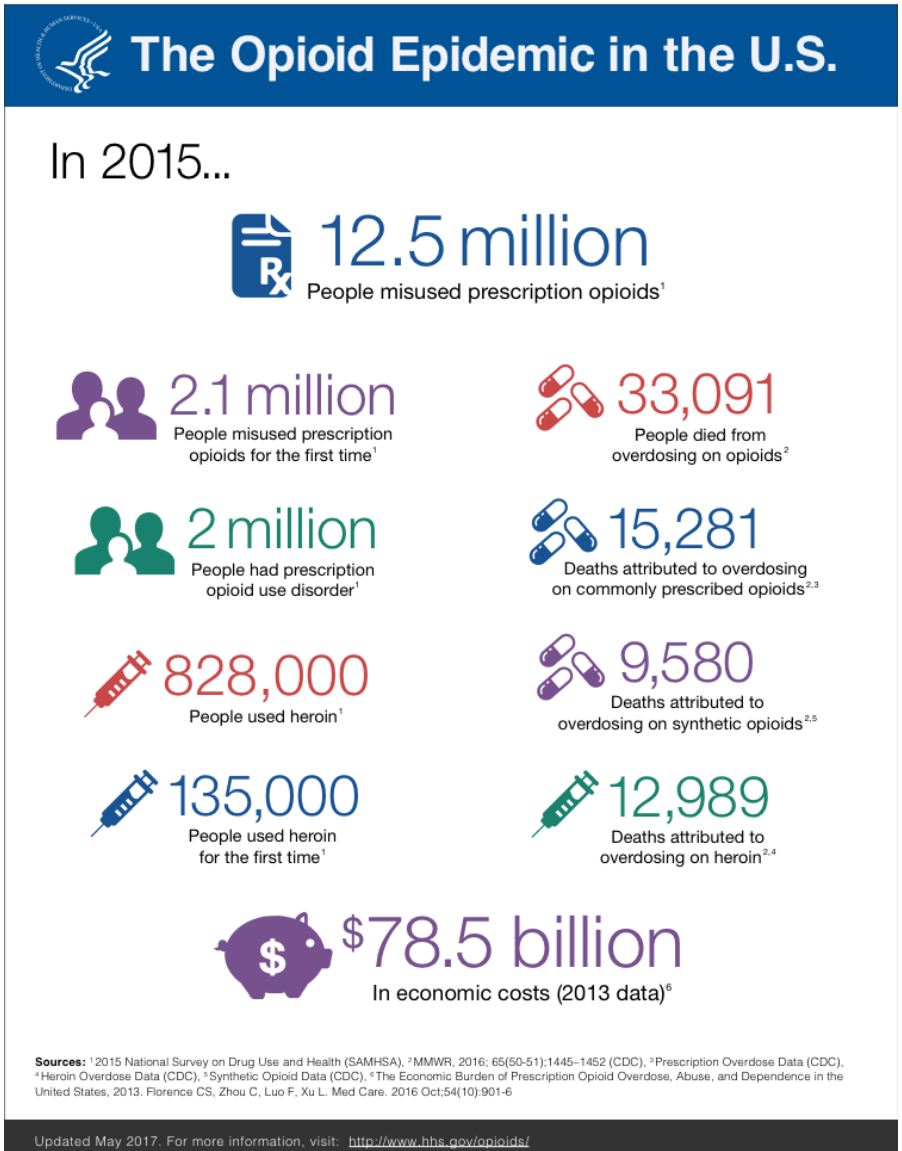
Keyes, Katherine M., et al. "Understanding the rural–urban differences in nonmedical prescription opioid use and abuse in the United States." *American journal of public health* 104.2 (2014): e52-e59.

Regional variation in age-adjusted drug overdose deaths

https://www.cdc.gov/drugoverdose/data/analysis.html



Toll of Epidemic Goes Far Beyond Fatal Overdoses



BEYOND THE NUMBERS

Source: 52 Weeks, 52 Faces: Obituaries Narrate Lives Lost to the Opioid Epidemic, STAT

BEYOND THE NUMBERS

Tanita Landry (July 14)

31 years old
Singer and songwriter
Salem, New Hampshire

She was a talented singer, songwriter and artist and she was an excellent athlete. Tanita enjoyed playing the guitar and loved animals … read more

(Source: Legacy.com/Union Leader)

Johnnie Rae Criss (July 20)

52 years old
Grandmother
Mansfield, Ohio

Johnnie will not be defined by her addiction, but rather by the many years of loving life and living it to the fullest. … She was joined in death just two days later by her husband, Robert L. Criss, also of an overdose … read more

(Source: Legacy.com/Akron Beacon Journal)

Alex Thomas Zimmer (July 23)

27 years old
One of nine children
Tolland, Connecticut

Alex had been working very hard for the past 2 1/2 years to get his life on track and overcome this terrible addiction. The family requests that everyone spread the word of this horrific epidemic taking our children. Please talk to your children repeatedly about the danger of drug addiction … read more

(Source: Legacy.com/Journal Inquirer)

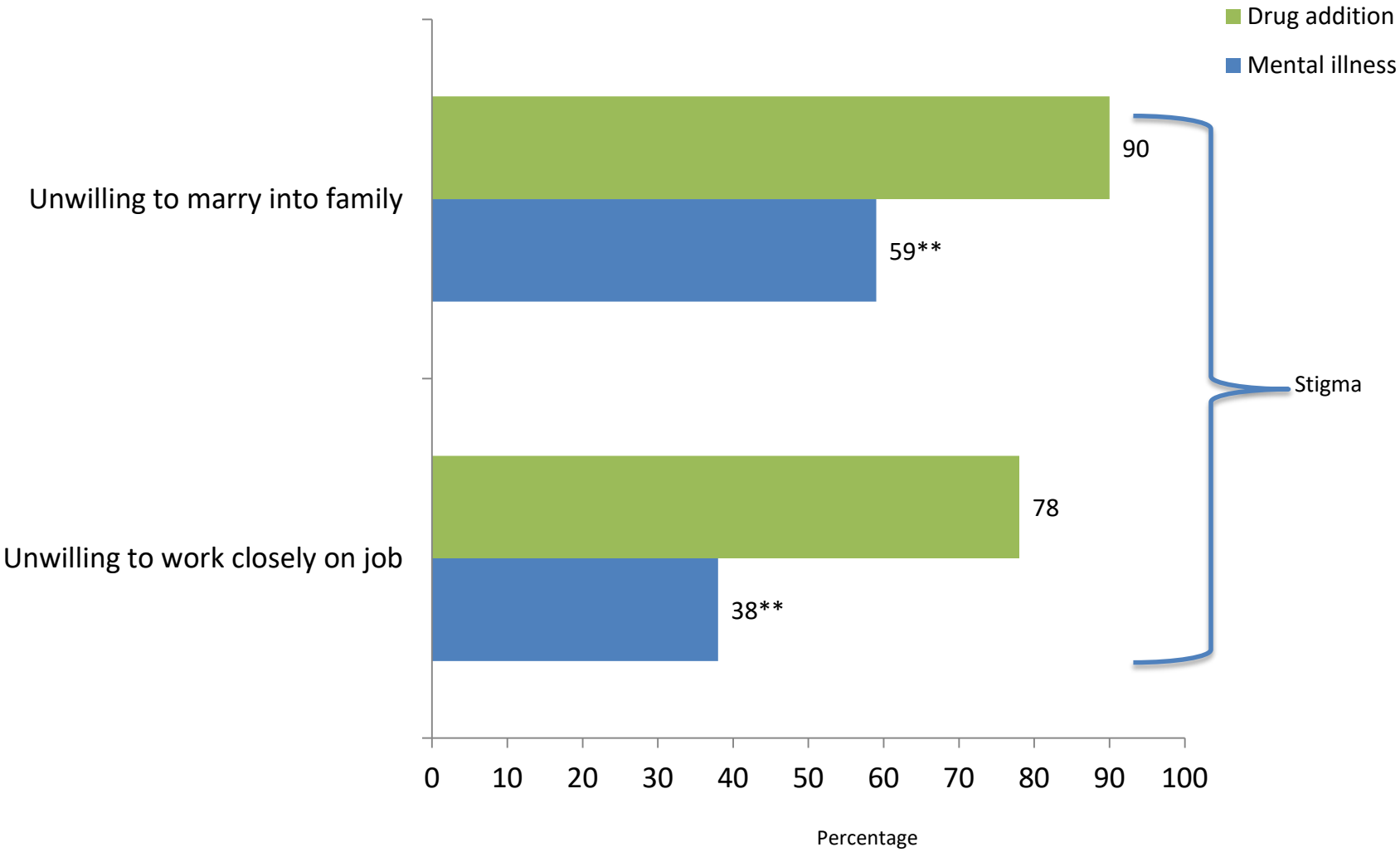
Source: 52 Weeks, 52 Faces: Obituaries Narrate Lives Lost to the Opioid Epidemic, STAT, 12/20/2016

Major Barriers to Combating the Opioid Epidemic

Major Barriers to Combat Epidemic

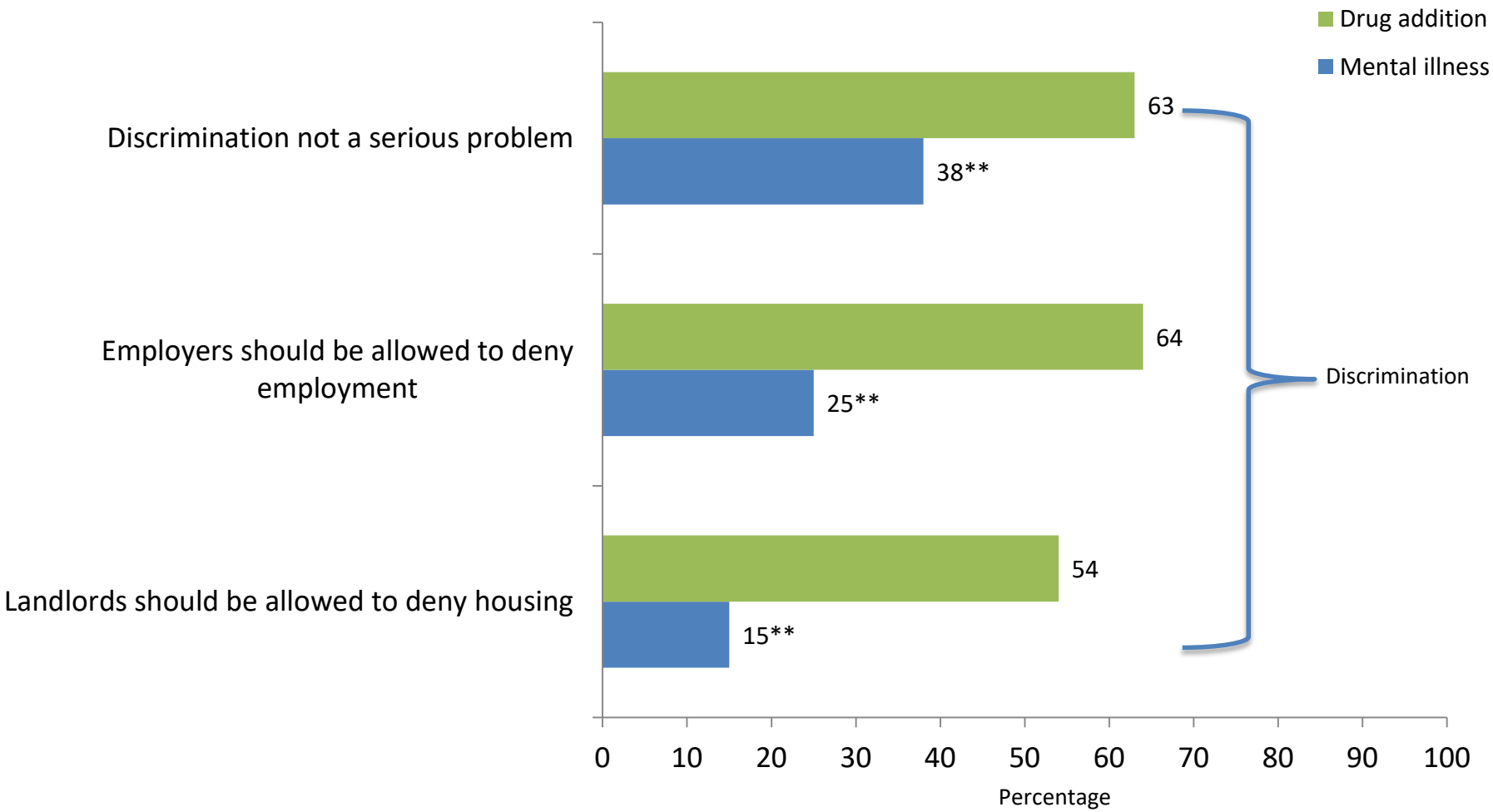
1. High rates of stigma
2. Lack of understanding that opioid addiction is a chronic, relapsing illness, but responsive to evidence-based pharmacological treatment
3. Poor availability of evidence-based pharmacological treatments for opioid addiction in communities
4. The epidemic is evolving

Social Distance Attitudes



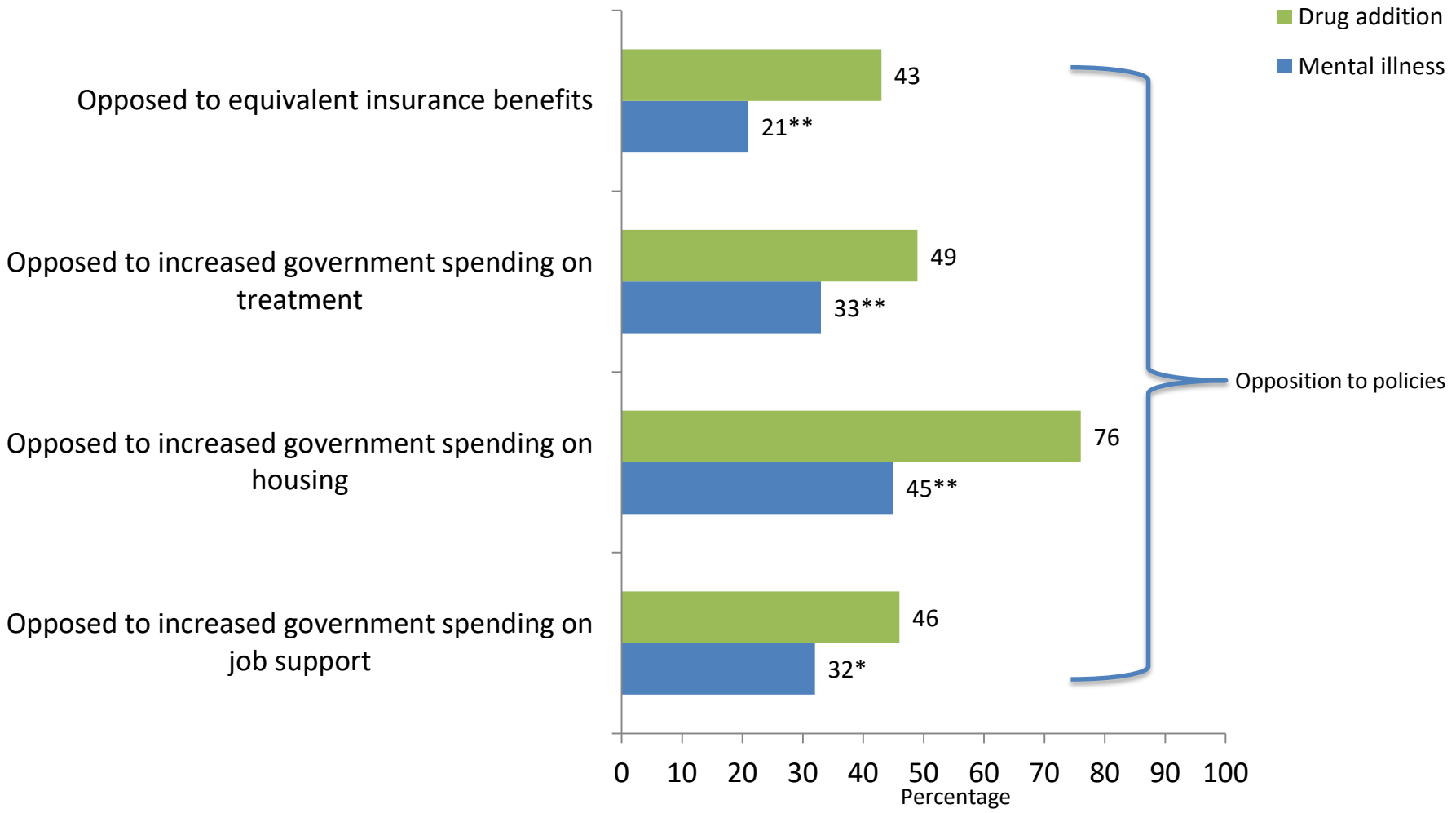
Responses on 7-point Likert scales were collapsed to dichotomous measures. Pearson chi square tests assessed whether attitudes differed by the drug addiction or mental illness version of each survey item. *p,.01, **p,.001

Acceptability of Discrimination



Responses on 7-point Likert scales were collapsed to dichotomous measures. Pearson chi square tests assessed whether attitudes differed by the drug addiction or mental illness version of each survey item. *p,.01, **p,.001

Opposition to Public Policies



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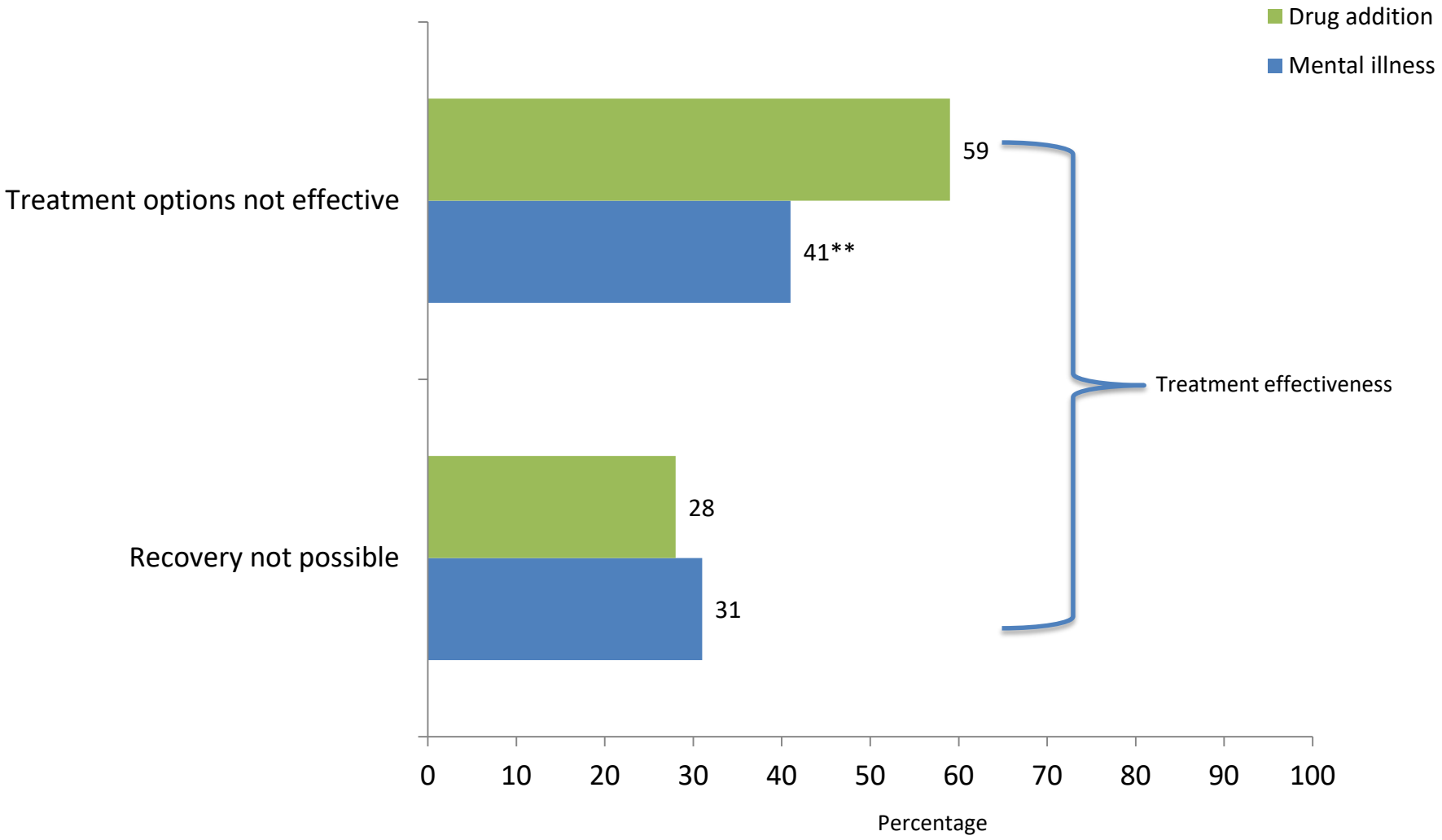
Treatment Effectiveness Attitudes



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Poor Availability of Evidence-based Treatment

- Nationally, ~70% of people with OUD do not receive any formal treatment, many in treatment never receive effective medications
- Treatment is often received under legal mandate (court-ordered)
- The strongest evidence supports pharmacotherapy for opioid use disorder, especially buprenorphine & methadone
- But, access to pharmacotherapies entirely insufficient to meet current need
- Nationally, only ~30 of 5000+ jails and prisons offer methadone or buprenorphine

Major Barriers to Combat Epidemic

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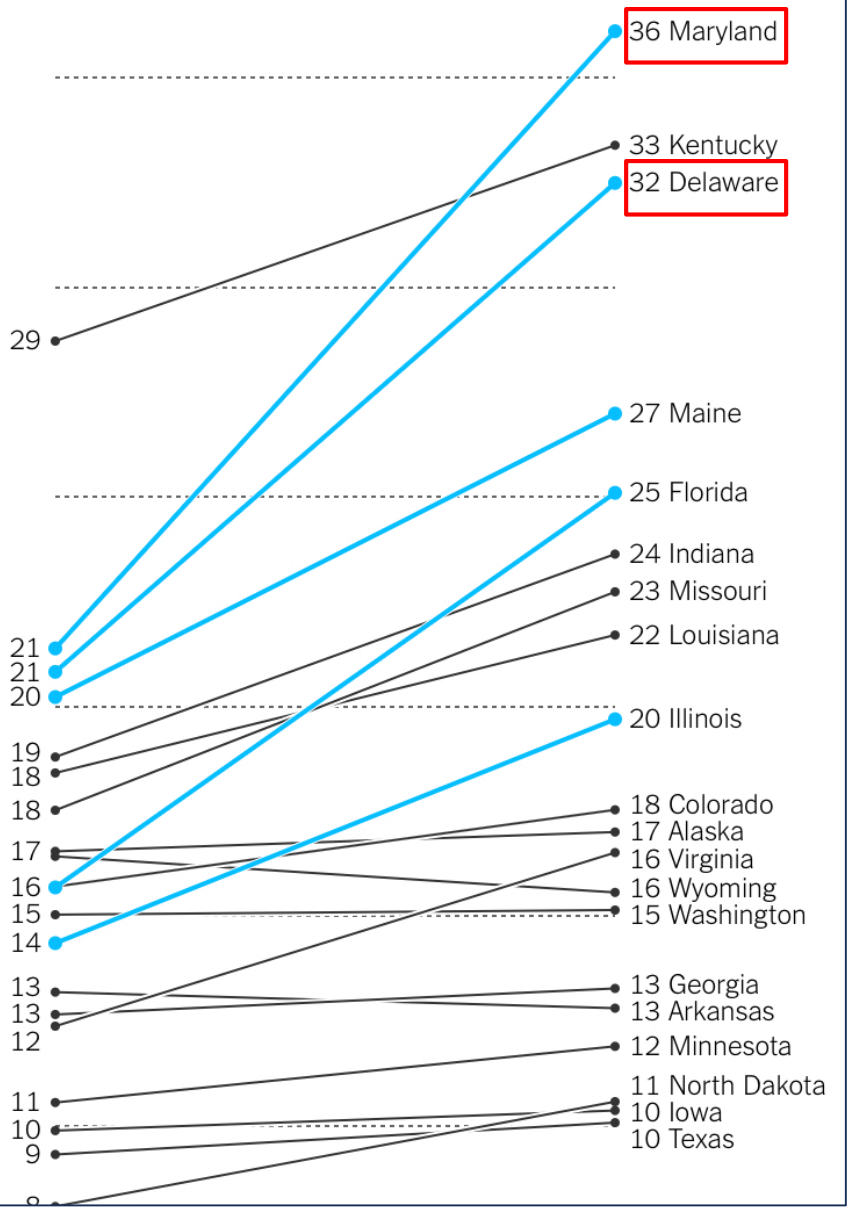
4. The epidemic is evolving - fentanyl

Emerging Public Health Crisis of Fentanyl

- An emergence of a public health crisis related to illicit fentanyl (mixed with heroin, counterfeit oxycodone)
- Fentanyl: opioid agonist to treat severe pain (e.g., advanced cancer pain), potency 50-100x morphine
- Share of overdose deaths involving fentanyl increased sharply over past few
- Although some pharmaceutical fentanyl is diverted, illicitly manufactured synthetic

Drug overdose deaths per 100,000 residents in 2015 and 2016

Of the 21 states that reported the highest quality data for 2016, the steepest rises were in Delaware, Florida and Maryland.



The New York Times

TheUpshot

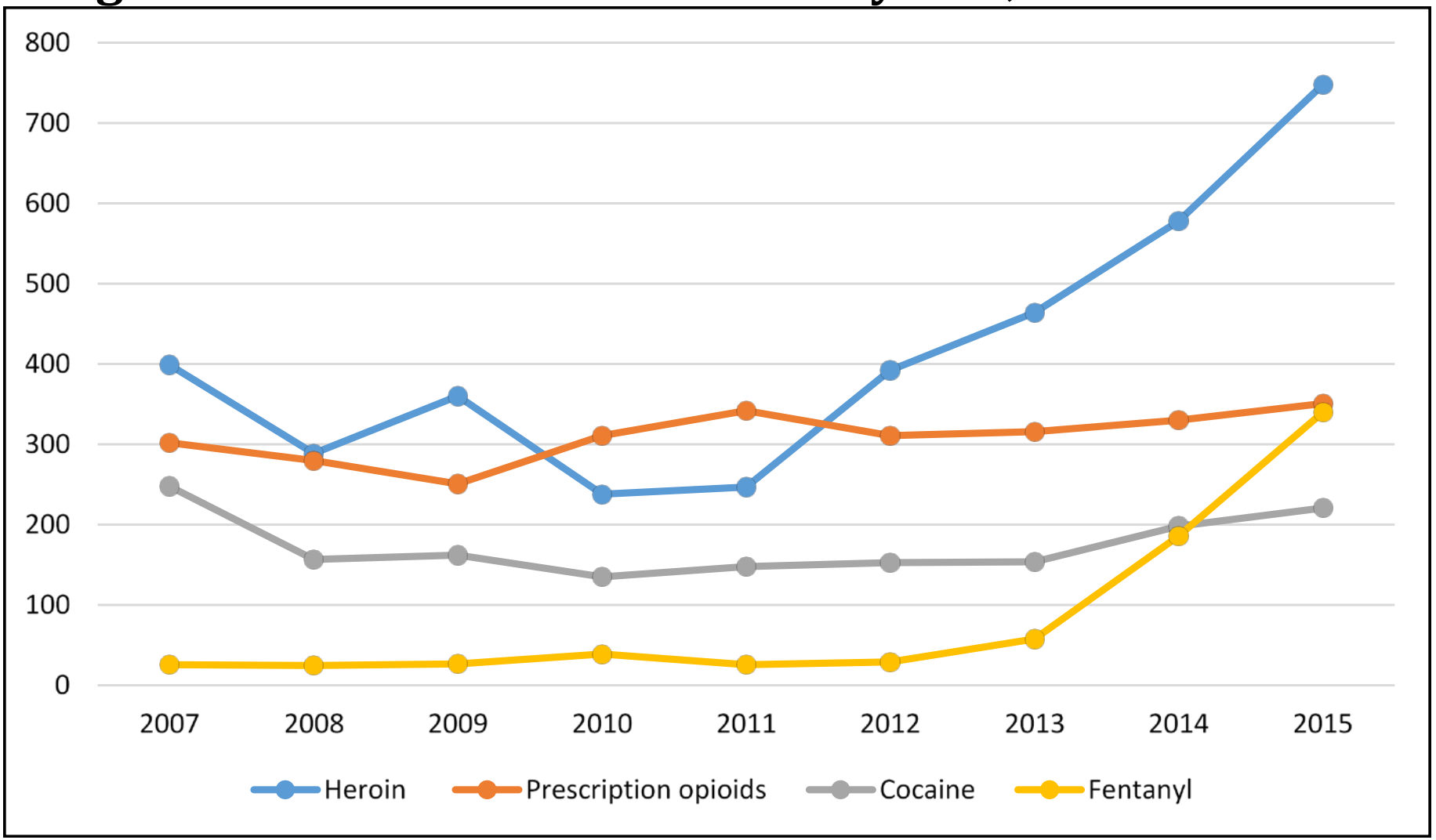
SHARE

The First Count of Fentanyl Deaths in 2016: Up 540% in Three Years

By **JOSH KATZ** SEPT. 2, 2017

The first governmental account of nationwide drug deaths in 2016 shows overdose deaths growing even faster than previously thought.

Drug-Related Deaths in State of Maryland, 2007-2015



Source: Annual Overdose Death Reports, Vital Statistics Administration, Maryland Department of Health and Mental Hygiene

Note: Deaths may involve more than one substance.

Features of Fentanyl: Devastating Public Health Consequences

1. Highly potent - Small amount can cause respiratory depression, rapid death
2. Low production costs of fentanyl → incentive to mix fentanyl with heroin or other illicit narcotics
3. Many individuals not aware that they are consuming fentanyl, drug suppliers may not be aware that drug contains fentanyl
4. Rapid lethality of fentanyl means traditional overdose rescue (Narcan) not adequate → quicker administration, multiple doses

Evidence-based Responses to the Epidemic are Needed

Evidence-based Responses to the Opioid Epidemic

1. Prevention Response: Safer prescribing, dispensing, monitoring and disposal of opioids
2. Rescue Response: Improve availability of lifesaving naloxone, updated overdose prevention strategies
3. Treatment Response: Improve availability of evidence-based pharmacotherapies for opioid use disorder (focus on buprenorphine, methadone)
4. Recovery Response: Better access to peer recovery coaches, other supports to help maintain people in long-term, evidence-based treatment

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Prevention Response: Safer Prescribing, Dispensing, Monitoring and Disposal of Opioids

- Key challenge: many patients have real chronic pain and need help managing pain, but opioid medications are easily misused/diverted
- Good evidence that initial prescriptions given to a person in pain can affect their subsequent opioid trajectory
  - Recent CDC guidelines: "start low, go slow"
  - Need for non-opioid alternatives
- Prescription drug monitoring programs: state registries of controlled substances prescribed to patients
  - Hope is that querying portal reduces high-risk prescribing and improves care for patients
  - Reality is more complicated!

(Kennedy-Hendricks, *JAMA Internal Medicine*, 2016)

Safe Storage and Disposal

- National survey of adults who used prescription opioids within the last 12 months
- 1 in 5 had shared an opioid medication with another person
- 20% kept their medication locked/latched location; only 9% kept medication locked
- Of those who had stopped using, 6 in 10 had leftover medications in their home
- Only 7% had taking advantage of ‘take back’ disposal programs

Bottom Line: Suboptimal sharing, storage and disposal practices

Evidence-based Responses to the Opioid Epidemic

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Overdose Prevention Strategies

- Core principle: it's possible to reduce the negative consequences of substance use, even if people are not ready to stop using/seek treatment

- A variety of tools that have strong empirical support:
  - Syringe/needle exchange
  - Broader distribution of naloxone (e.g., first responders, friends & family members)
  - Overdose prevention facilities (e.g., SCS)
  - Spot-testing for fentanyl

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Medication-Assisted Treatment for Opioid Use Disorder

- Pharmacologic treatment for OUD include
  - opioid agonists - methadone or buprenorphine
  - opioid antagonists - naltrexone

- Used in conjunction with behavioral therapies

Why are Opioid Agonist Medications Key to a Comprehensive Approach to the Opioid Epidemic?

- Key challenge for opioid addicted individuals is managing physical changes accompanying disorder (craving, withdrawal)
- When appropriately dosed, buprenorphine and methadone work by occupying opioid receptors in the brain, thereby reducing craving, without creating euphoric effects
- Numerous well-designed randomized controlled trials (RCTs) have evaluated buprenorphine and methadone
- Both medications significantly increase abstinence, treatment retention compared to non-medication treatments
- Some evidence of reduced criminal recidivism and mortality risk
- Medication is more effective when used for maintenance than for short-term detoxification
- Methadone has a lower cost per patient and is particularly cost-effective, but some patients may prefer buprenorphine

What about other treatments?

- Long-acting naltrexone is a non-opioid medication (antagonist) that blocks opioids, preventing opioid misuse when an individual is maintained on the medication
- It is most frequently used in settings where diversion is a concern or there are other barriers to access to opioid agonists (e.g., detention settings)
- Naltrexone is costlier than methadone and buprenorphine and has less evidence supporting its efficacy
- A variety of non-medication therapeutic approaches may be effective, such as group counseling and psychosocial support
- American Society of Addiction Medicine recommend stepped approach to treatment setting, with residential treatment typically recommended as acute, short term intervention
- A lack of evidence supporting long-term, medication free residential treatment programs

Citations:

Mattick, Richard P., Courtney Breen, Jo Kimber, and Marina Davoli. "Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence." *The Cochrane Library* (2009).

Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R.J., Fry-Smith, A., Day, E., Lintzeris, N., Roberts, T. and Burls, A., 2007. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation.

Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R.J., Fry-Smith, A., Day, E., Lintzeris, N., Roberts, T. and Burls, A., 2007. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation.

Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care–based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial. *JAMA internal medicine*, *174*(12), 1947-1954.

Murphy, Sean, Daniel Polsky, Zachary Meisel, and Julia Mitchell. "Show Me the Money: Economic Evaluations of Opioid Use Disorder Interventions." (2016).\

Minozzi, Silvia, Laura Amato, Simona Vecchi, Marina Davoli, Ursula Kirchmayer, and Annette Verster. "Oral naltrexone maintenance treatment for opioid dependence." *The Cochrane Library* (2011).

Tanum L, Solli KK, Latif Z, Benth JŠ, Opheim A, Sharma-Haase K, Krajci P, Kunøe N. The Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid DependenceA Randomized Clinical Noninferiority Trial. *JAMA Psychiatry.* Published online October 18, 2017. doi:10.1001/jamapsychiatry.2017.3206

Schuckit, M. A. (2016). Treatment of opioid-use disorders. *New England Journal of Medicine*, *375*(4), 357-368.

Connery, H. S. (2015). Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. *Harvard review of psychiatry*, *23*(2), 63-75.

MAT Stigma

- Despite evidence base – deep distrust of MAT
- Framed as “substituting one substance for another”
- Comes up when weighing prioritization of residential treatment versus outpatient treatment options
- Comes up when discussing Vivitrol versus methadone or buprenorphine in criminal justice settings
- Important to assure that providers are using MAT properly, including with counseling and other supports, not with benzos, etc.
- However, important not over-regulate MAT to the point where it becomes a barrier to access

Evidence-based Responses to the Opioid Epidemic

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How Might Systems Change to Meet the Need?

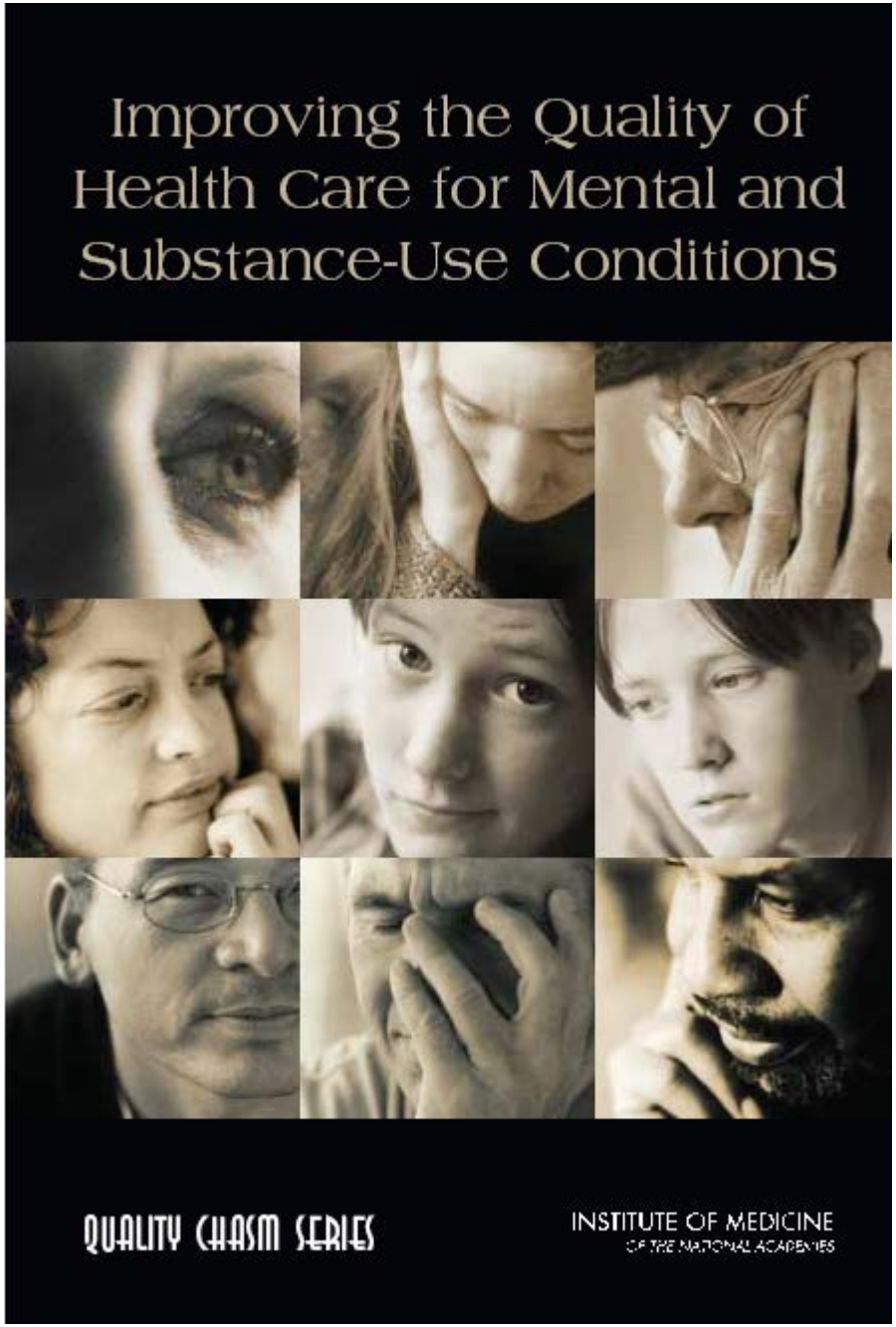
Key Principles to Expanding Evidence-Based Treatment

1. Build capacity – e.g., “hub and spokes” models, telemedicine, centers of excellence
2. Improve financing and health insurance coverage
3. Open new facilities and get more physicians to prescribe buprenorphine to more patients
4. Provide access to care where people are including emergency departments, jails
5. Multiple doors to treatment entry - create more pathways (through primary care, FQHCs, EDs)
6. Address stigma of pharmacotherapy treatment

Data Analytics to Inform Response to Opioid Crisis

- Strong data management to inform action critical at time of crisis
- Improving data collection and data linkage capacity
- Data to measure need and outcomes in real time
- Outcomes include overdose rates…but, also treatment initiation, utilization and continuity, follow post-treatment
- Shift from an admissions-centric to a client-centric surveillance approach

Person-centered data important to know at what point individuals are falling out of treatment



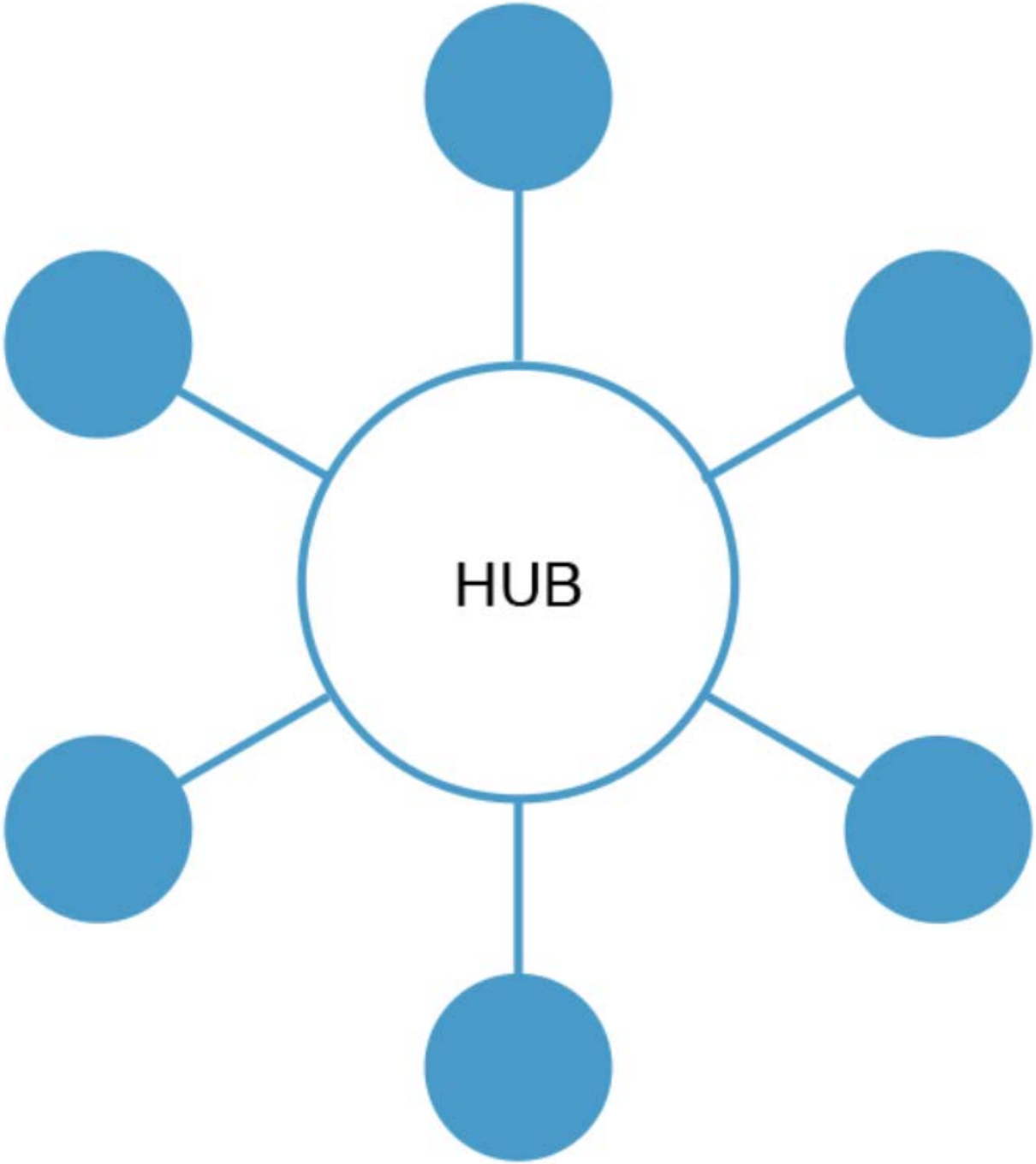
Crossing the Quality Chasm:

What Does High Quality Substance Use Disorder Treatment System Look Like?

- Client-centered quality orientation
- Well-validated performance metrics that can be used for payment (treatment engagement, retention)
- Close monitoring of co-prescribing (e.g., benzos)
- Treatment facility monitoring, while preserving treatment access

What Coordinated Treatment Options Should Delaware Look At?

- CoOP Model in Maryland
- Hub and spokes in Vermont
- Rhode Island Centers of Excellence model


HUB

CoOP Model in Maryland: OTP-Centric Hub and Spokes

- No central govt action required – can be OTP initiated
- OTP at the center of SUD treatment
- Spokes – office based (usually PCP); for stable patients, co-managed by OTP and PCP with spoke prescribing during periods of stability
- All other treatment services occur through OTP; can be dialed down when a patient is stable (e.g., one counseling session per month)
- When a person no longer stable → counseling at OTP dials up; prescribing duration at spokes decreased; patient may eventually require returning to dispensing at OTP until adequately stabilized
- OTP steers decisions and adjustments
- OTP support spokes in gaining comfort with prescribing; might even lead to induction by spokes and full mgmt of most stable patients

http://www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper-.pdf

Vermont Hub and Spoke System

- Multiple hubs, multiple spokes – state government implemented
- A system wide response with input from many stakeholders
- VT system involves Medicaid health homes
- Additional resources to spoke PCP offices to provide behavioral health services (counseling, case management)
- Less flexible than single site CoOP model, but more ability to collect data, pay for additional services with state funding, etc.
- Drive business to spokes deemed “high quality”

Rhode Island's Strategic Plan on Addiction and Overdose

Four Strategies to Alter the Course of an Epidemic

Treatment Strategy The core of this initiative recommends the development of a system of medication-assisted treatment at every location where opioid users are found, primarily:

- the medical system (Emergency Departments, hospitals, clinics, etc.)
- the criminal justice system
- drug treatment programs, and
- in the community

To help our systems of care to better identify patients in need and provide medication-assisted treatment, this initiative recommends:

A) Building capacity for medication-assisted treatment delivery, by:

1. Developing "Centers of Excellence for the Treatment of Opioid Problems" that can provide comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as support to providers in the community. It is envisioned that such Centers would refer stabilized patients to other providers and receive back patients if they destabilize and require more intensive services.

Special Populations

- Certain populations particularly at risk of overdose, benefit from targeted efforts to get treatment access

These are:

- Criminal justice involved population both inside and outside jail/prison
- Persons that have had a non-fatal overdose (with interactions with first responders)
- Persons that end up in ED/hospital (whether for opioid-related issue or not)
- Mothers and families who come into contact with hospitals/department of family services

Achieving System Transformation Using Medicaid

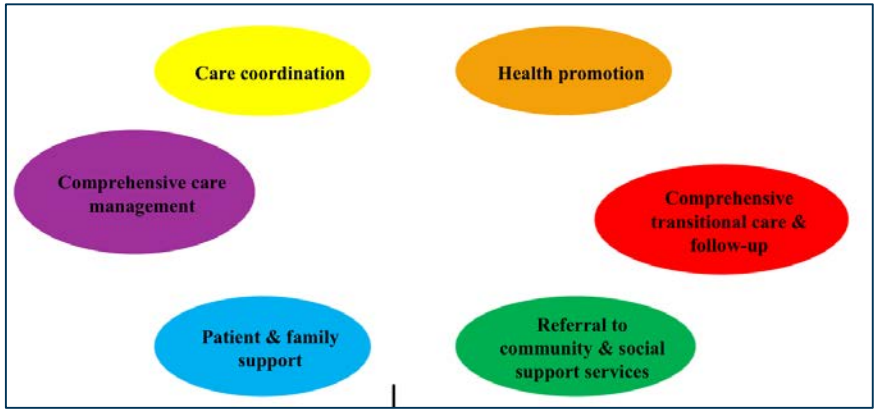
- Medicaid payment rates can be used to create quality incentives for treatment (e.g., re-bundling payment to create incentives for counseling with methadone services)
- Medicaid can also be used for delivery system reform through the use of 1115 waivers (e.g., the California Drug Medi-Cal waiver which puts in place new utilization management controls to steer populations toward evidence-based treatments)
- Medicaid waivers can also be used to offer new services, including those that may not be standardly included in a Medicaid benefit package (e.g., paying for peer recovery coach services)
- Medicaid waivers can also be explored as a tool to engage Medicaid eligible populations with SUD who have complex needs (e.g., referrals to social services or interface with criminal justice)

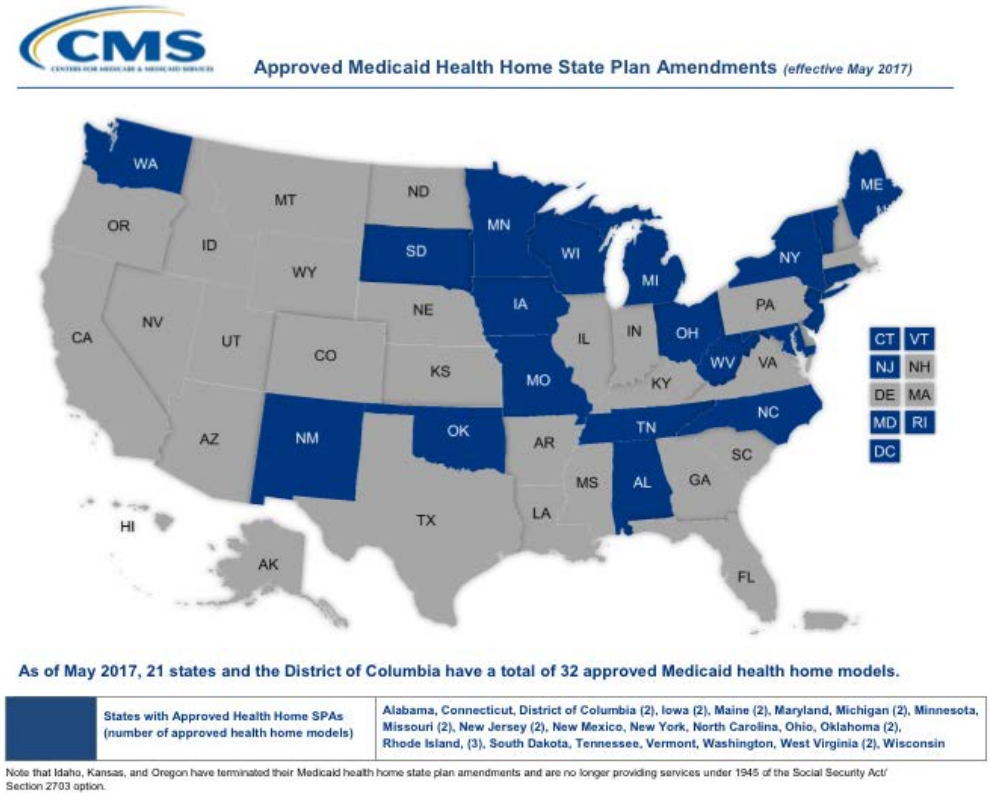
Recovery coaches at ERs try to help opioid addicts avoid another overdose

By Christine Vestal
July 22, 2017 at 11:00 AM

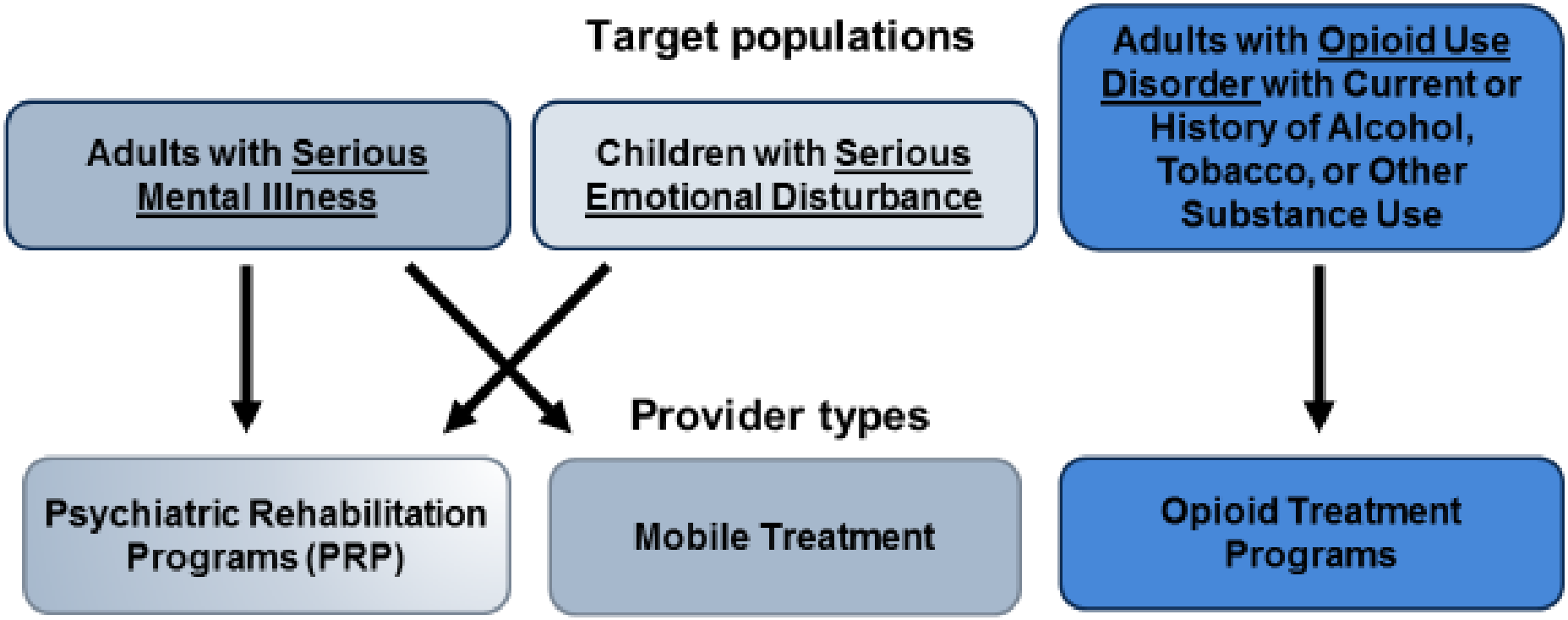
Medicaid Health Homes: ACA Demonstration

- Health home for high cost/high need population
- Two-year enhanced Medicaid match
- Billing for non-traditional services:





Maryland's Medicaid Health Home



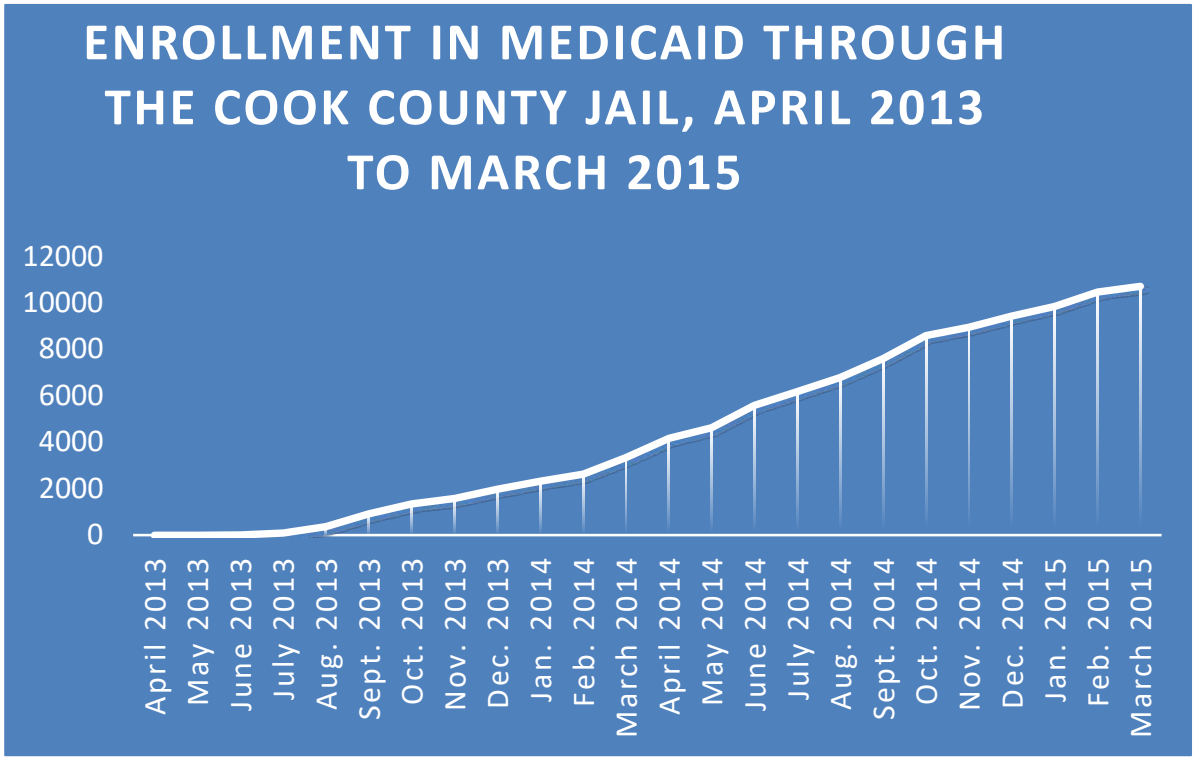
Criminal Justice System

- Divert people with SUD from criminal justice system to treatment where possible
- If diversion not possible, provide detox and medication in criminal justice settings

MAT in Corrections Settings

- Research suggests medications have positive impacts on individuals with OUD who are incarcerated
- Improved treatment participation post-release, reduced risk of relapse, and reduced opioid use
  - Randomized trial of methadone maintenance and counseling initiated pre-release for persons incarcerated in a Baltimore - fewer days criminal activity and heroin use vs. counseling only
  - Randomized trial of initiation of methadone maintenance pre-release more effective at reducing drug use, increasing engagement in treatment post-release than referral to treatment for methadone at release
- Most US correctional facilities offering SUD treatment primarily provide non-pharmacologic treatments (peer support, therapeutic communities, and counseling alone)

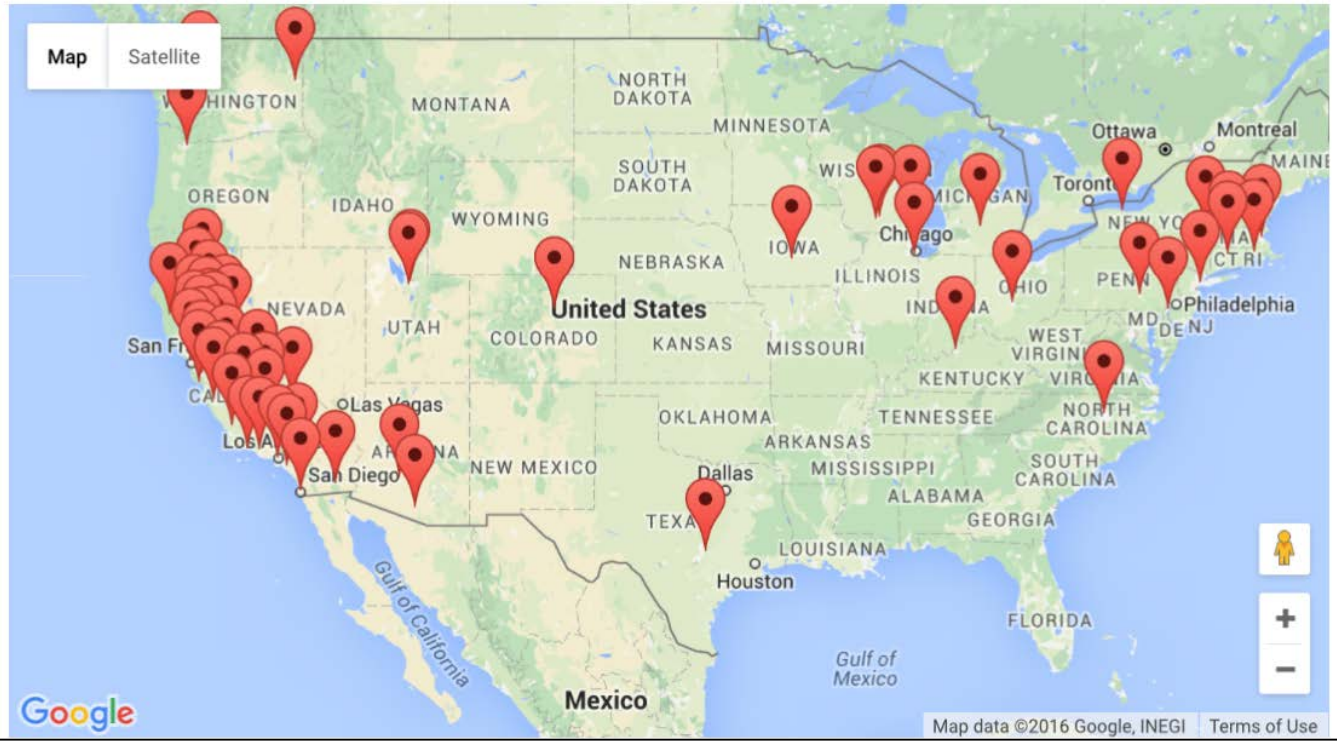

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
CONNECT CARD
600 890
SHAWN SELLS
02 24 2014


ENROLLMENT IN MEDICAID THROUGH THE COOK COUNTY JAIL, APRIL 2013 TO MARCH 2015
12000
10000
8000
6000
4000
2000
0
April 2013
May 2013
June 2013
July 2013
Aug. 2013
Sept. 2013
Oct. 2013
Nov. 2013
Dec. 2013
Jan. 2014
Feb. 2014
March 2014
April 2014
May 2014
June 2014
July 2014
Aug. 2014
Sept. 2014
Oct. 2014
Nov. 2014
Dec. 2014
Jan. 2015
Feb. 2015
March 2015

AFFORDABLE CARE ACT ENROLLMENT

By Sachini N. Bandara, Haiden A. Huskamp, Lauren E. Riedel, Emma E. McGinty, Daniel Webster, Robert E. Toone, and Colleen L. Barry

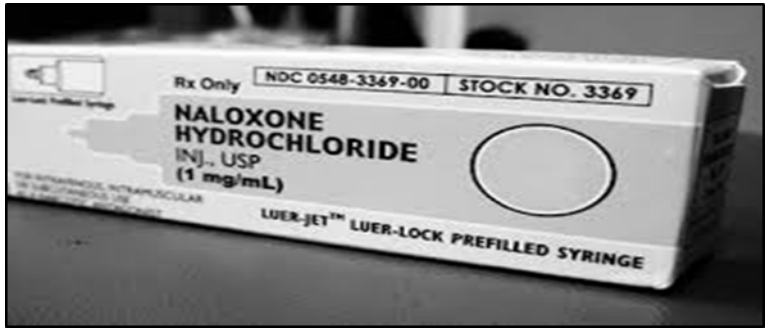
Leveraging The Affordable Care Act To Enroll Justice-Involved Populations In Medicaid: State And Local Efforts

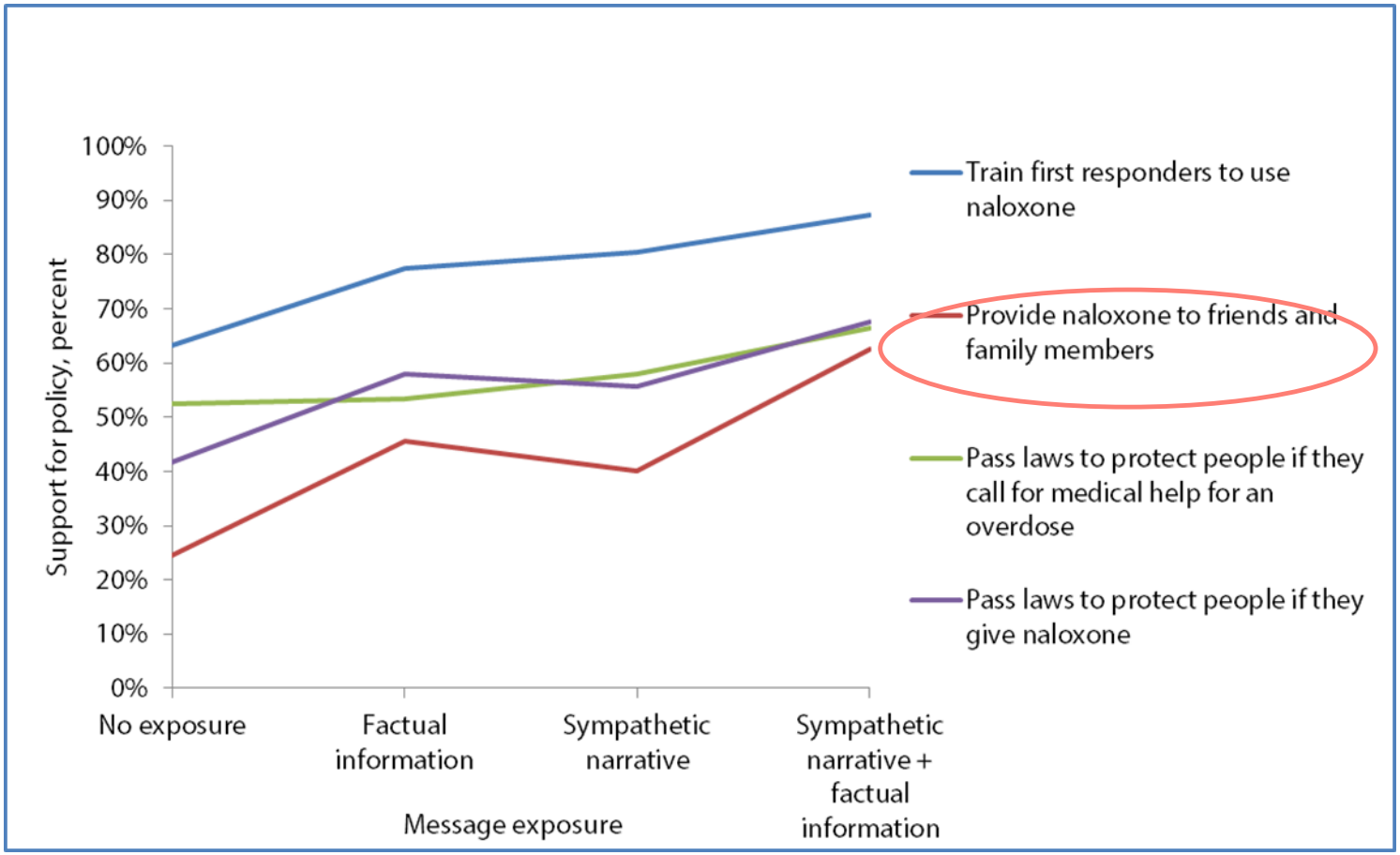


Language Matters

Terms to Avoid	Why	Preferred Terminology
Addict, Abuser, Junkie, User	These terms are demeaning because they label a person soley by his/her illness or behavior and imply a permanency to the condition	Person with a substance use disorder
Clean or Dirty	These words associate symptoms (i.e. positive drug tests) with judgement statements about cleanliness.	Negative, positive, abstinent, substance-free, actively using
Habit or Drug Habit	These terms deny the medical nature of the condition and imply that resolution of the problem is simply a matter of willpower in being able to stop the habitual behavior	Substance use disorder, regular substance use
Opioid Replacement or Methadone Maintenance	These words imply that treatment medications are equal to street drugs and suggests a lateral move from illegal to legal addiction	Medication-assisted treatment, medication-assisted recovery

Humanizing the Epidemic Matters





Bachhuber et al, PLOS One, 2016


Sobah Life