MENTAL HEALTH AND SUBSTANCE USE DISORDER: OPIOID EPIDEMIC

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2018 Open Season Seminar

Addressing the Opioid Epidemic

October 27, 2018

Opioid Addiction Is Headline News

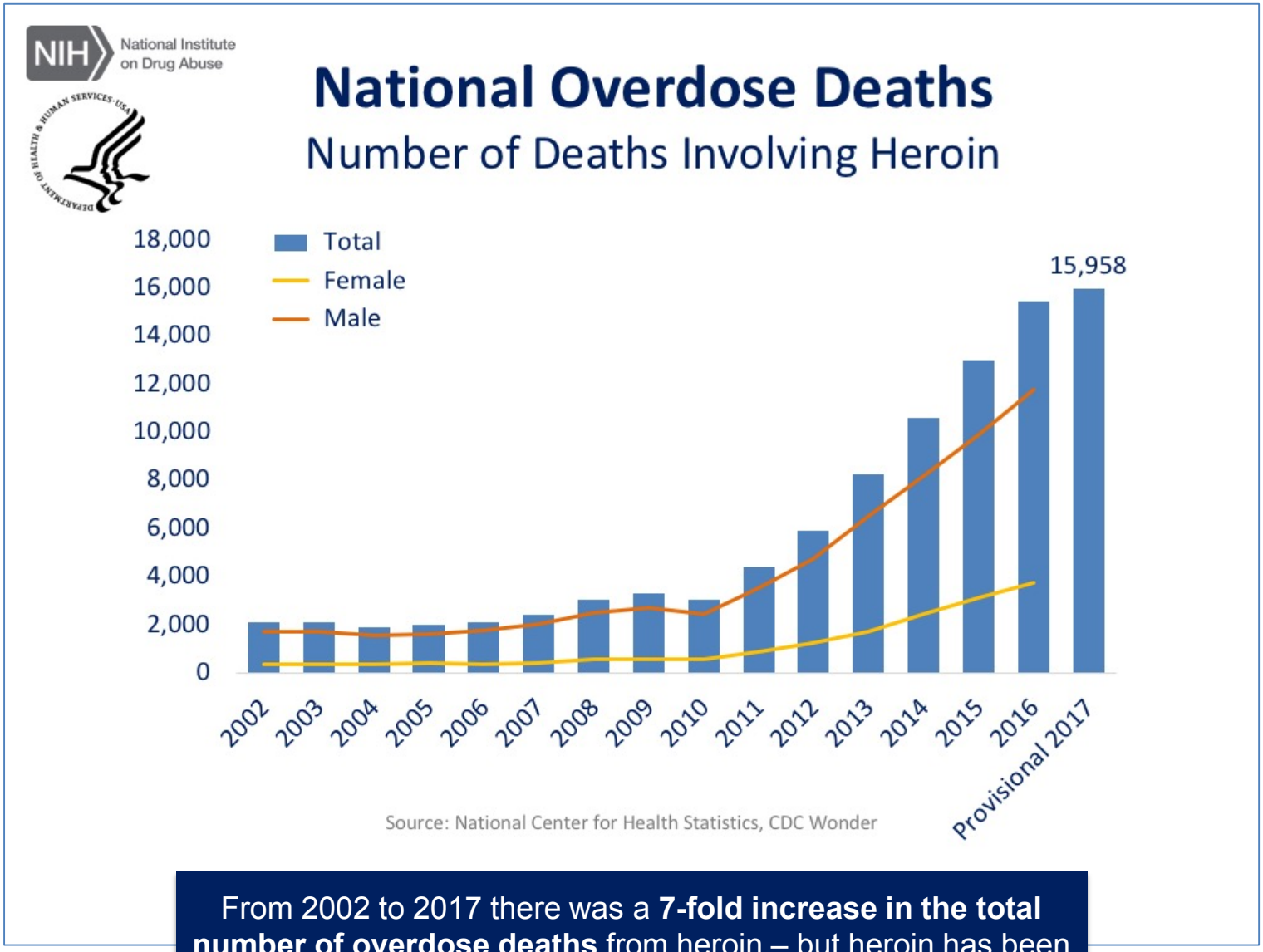


Deaths from opioids outnumber deaths from motor vehicle accidents per annum

Why?

- There has been massive overprescribing of opioid painkillers
- Heroin abuse is growing
- Treatment is fragmented and hard to access

Heroin Use is part of the Opioid Epidemic



From 2002 to 2017 there was a **7-fold increase in the total number of overdose deaths** from heroin – but heroin has been around since the 19th century

Source: National Center for Health Statistics, CDC Wonder, NIDA

The History of Heroin

- Heroin was first synthesized by a British chemist in 1874, and was introduced as a commercial product by Bayer in 1898
  - Imported to the US shortly after it was introduced
- Branded as “safe and non-addictive” alternative to morphine
  - Marketed as a “cure-all” for conditions ranging from tuberculosis to cancer, withdrawal, and even old age
- Over-the-counter drug kits quickly became available including morphine, heroin and cocaine
- By 1925 there were 200,000 heroin addicts in the US
- Symptom relief replaced by treatment of conditions, medical education and public awareness decreased usage in mid 1920s
- During the Vietnam War, over 15% of US soldiers developed an addiction to heroin
- Prevalent problem in inner cities in 1960s -1990s
- In 1970 heroin was classified as a Schedule 1 drug

Source: Annual public health 2015. 36:559-74 narconon.org

Foundations of the current opioid crisis

Government Regulatory

- Joint commission mid 1990s established assessment of **pain as an evaluation standard**
  - Pain is undertreated due to lack of assessment, 5th vital sign
  - Created an expectation that all pain should be controlled and/or controllable, measured against subjective patient self-report
  - Published a guide – "no evidence that addiction is a significant issue"
- FDA **approved prescription pain medications**
  - "safe and non-addictive"[2]

Healthcare system

- Doctors reimbursed against **patient satisfaction with pain management**
- Patients and providers do not want to be **inconvenienced by having to refill prescriptions** – provide large prescriptions upfront
- **"Pill mills"** start to pop up to capitalize on the economic opportunity of addiction treatment[3]
- **Undiagnosed mental health disorders** can contribute to addiction

1 National Pharmaceutical Council. 2 Am J Public Health. 2009 February. 3 drugrehab.com

Foundations of the current opioid crisis

Provider Pharma

- Mid 1990s Medical literature supported opiates safe long-term,
- Pain an underdiagnosed undertreated condition
- Risk of addiction and overdose low
- OxyContin released 1995 by Purdue pharma
  - 1996 - 2002 20,000 pain related educational programs in US
    - Focus long term use of opiates for non-cancer pain, confronted “opiophobia”
  - In 1996, new opiate is approved and marketed as “safe and non-addictive”[2]

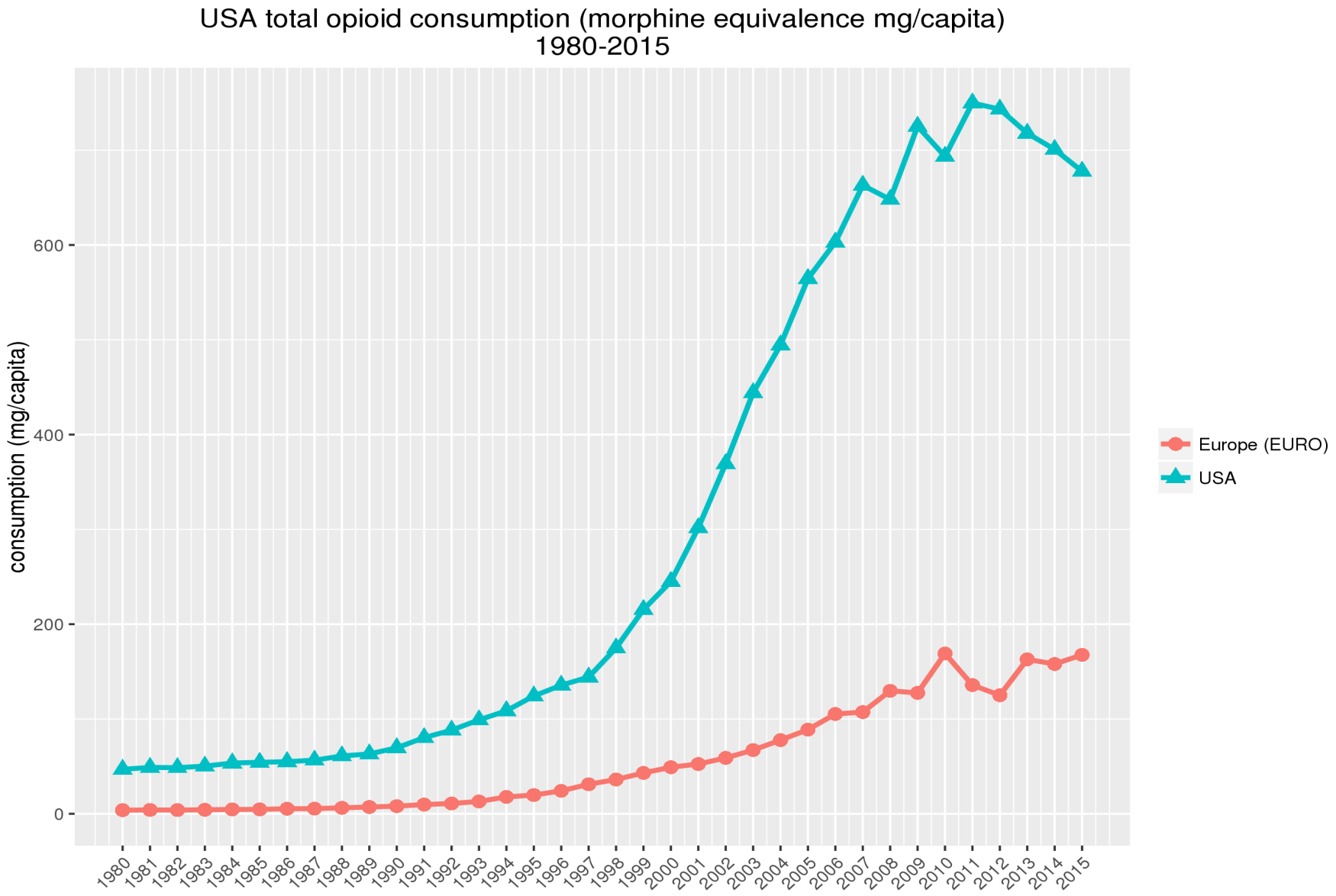


Societal

- 1970s widespread use of marijuana, LSD and other drugs spread “culture” of drug use and experimentation
- 1980s recreational use of cocaine spread through young and affluent society, lead to crack epidemic in inner cities
- 1990s synthetic designer drugs, methamphetamine cigarettes
- Late 1990’s heroin chic
- 2000s inexpensive high potency heroin
- 2000s national antidrug sentiment loosened, heroin spread among celebrities, supermodels and teenagers.

1 AnnuRev.Public Health 2015 36:559-74. 2 Am J Public Health. 2009 February. 3 drugrehab.com

US opioid consumption: 1980 to 2015



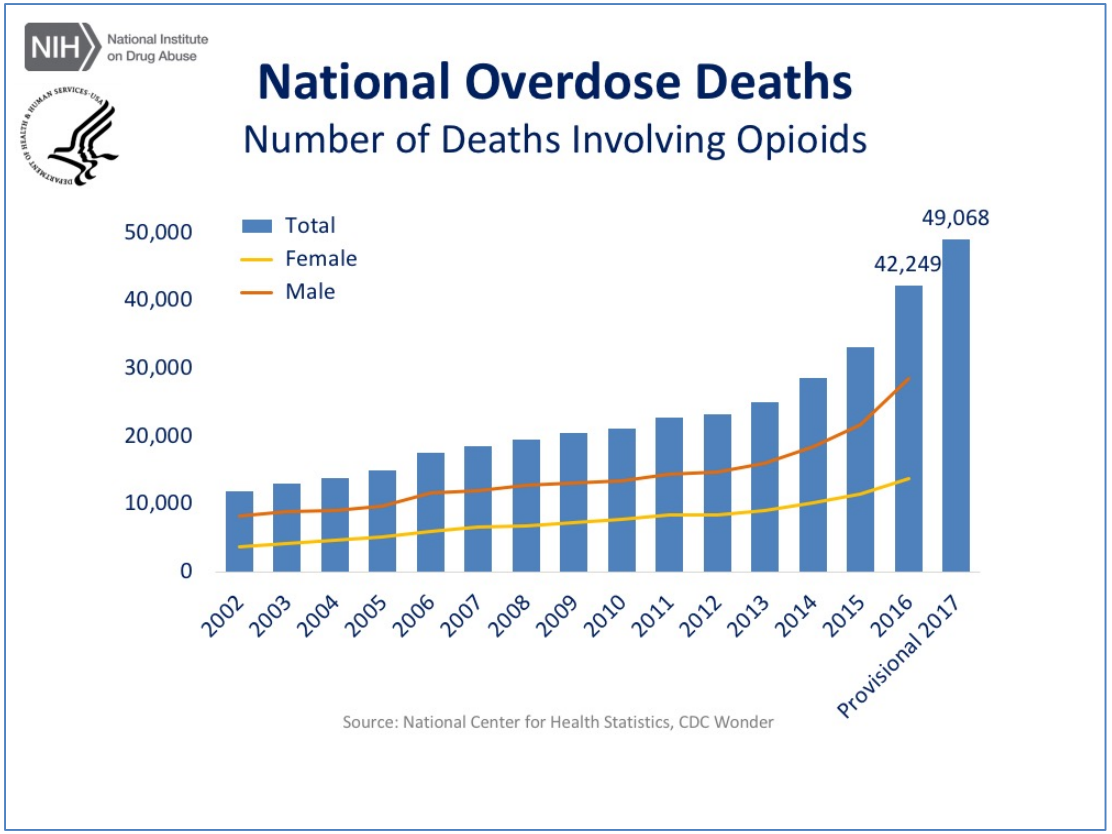
Sources: International Narcotics Control Board; World Health Organization population data

By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2017

The number of opioid-related deaths has grown nearly 400% since 2002

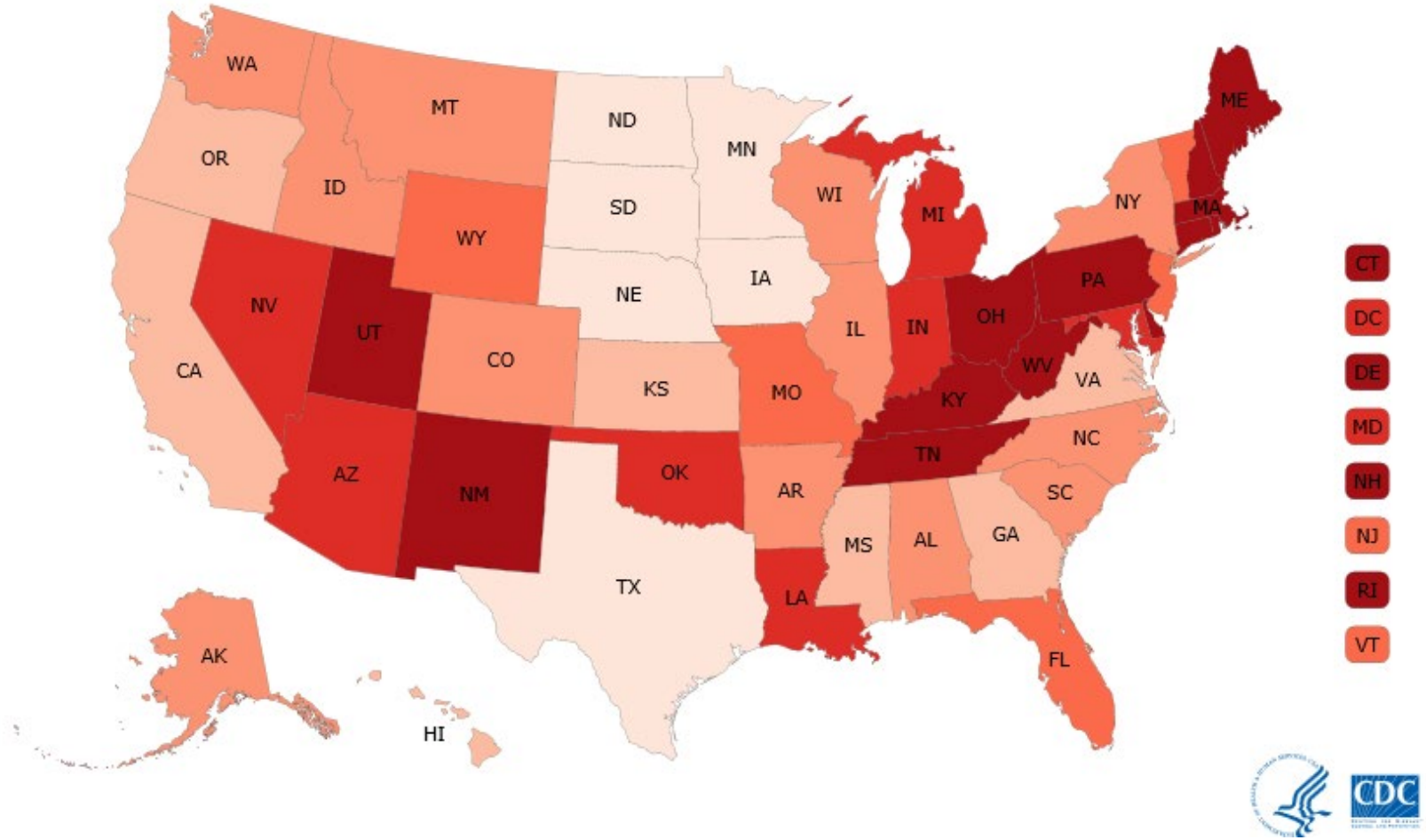
Facts and Figures

- Drug overdose is the **leading cause of accidental death** in the United States
- There are 2.6 million Americans suffering from opioid use disorder – **91 Americans die every day** from an opioid overdose
- In 2012, **259 million prescriptions** were written for opioid painkillers
- The rise of synthetic opioids (e.g. fentanyl, tramadol) is making **illicit opioid use** even more dangerous



Source: American Society of Addiction Medicine, *Opioid Addiction;* CDC Opioid Overdose

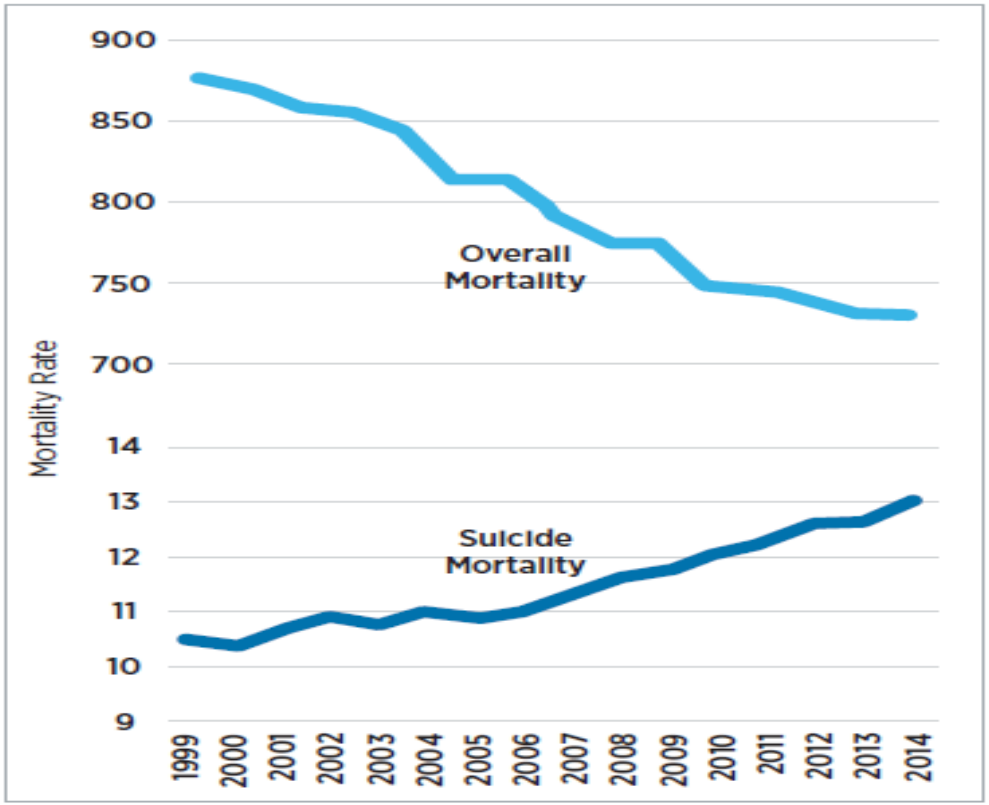
Increased mortality/state increase 2013-2015



the five states with the highest rates of death due to drug overdose were West Virginia (41.5 per 100,000), New Hampshire (34.3 per 100,000), Kentucky (29.9 per 100,000), Ohio (29.9 per 100,000), and Rhode Island (28.2 per 100,000).

Why Specialty Behavioral Health Matters

- Alcohol, Drugs, Suicide 2016 highest death rate ever recorded
  Causal for first successive two year overall life expectancy drop in US since 1993



Data Source: Centers for Disease Control

DEATH RATE BY
alcohol
PAST 10 YEARS

4% per year

40% over 10 years

Controlling the opioid epidemic involves an approach that addresses all aspects of the addiction continuum



Prevent addiction from starting	*Treat addiction effectively*	*Prevent recidivism*
• **Encourage safe prescribing** or non-opioid pain management alternatives • **Identify** people who are at risk, and **intervene early**	• Mandate **evidence-based clinical practice** • **Improve access to care** in a variety of care settings and use innovative reimbursement	• Improve community tenure and care longevity by **increasing member participation**



Understand condition and reduce stigma

A chronic illness should be treated through a chronic disease model

OPIOID ENVIRONMENT

- **There is massive overprescribing of opioid painkillers**
- Healthcare is organized to provide **episodic treatment while the underlying condition is chronic in nature** (i.e., relapsing and remitting)
- **Inpatient detoxification has 80% relapse rate** at 6 months and higher mortality rate
- **Medication Assisted Therapies (MAT) are scientifically proven**, but not universally adopted
- **Stigma** stemming from mischaracterization of the disease as a character flaw **is limiting the discussion of effective treatment approaches**
- **Discontinuous service systems** consisting of diverse providers and different payors (e.g., insurance/managed care entities, state and county governments) **impede access to care and may cause delays**
- PCPs are not trained in providing care for people with substance use disorders or navigating medically appropriate services

GOALS/OUTCOMES



Educate clinicians on effectiveness of medication assistance treatments including methadone and suboxone

Ensure follow-up in community settings once an individual is discharged from inpatient detoxification to reduce recurrent admissions



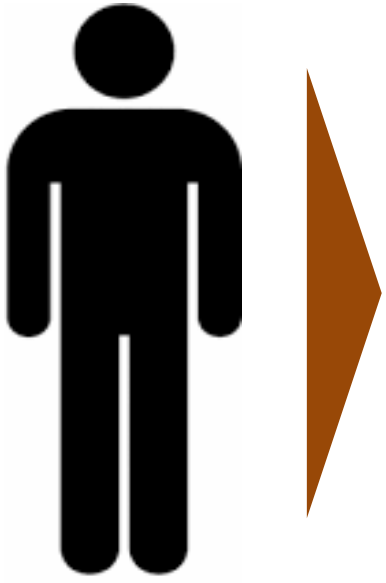


Stamp out Stigma - Effect a public epiphany about true nature of opiate addiction as a chronic brain disease

Develop more alternatives to inpatient levels of care for detoxification



Addiction is a chronic illness that should be treated through a chronic disease model





Health Systems

- Patients begin treatment in least restrictive setting
- Staff engages in constant evaluation and care improvement



Community-based treatment and resources

- Providers encourage patients to participate in effective community programs
- Partnerships are established with community resources across all levels of care to support and develop interventions



Self-Management Support

- Providers collaboratively set and document self management goals focused on goal setting, problem solving and personal barriers
- Providers monitor and follow up about specific self management goals



Delivery System Design

- Clearly defined provider roles and responsibilities distributed equitably including regularly planned interactions and follow up care



Decision Support

- Integrated specialist expertise and patient participation in education
- Utilization of proven education methods, materials and culturally appropriate practices



Clinical Information Systems

- Timely reminders for providers and patients
- Share information with patients and providers to coordinate care

MAT as *part* of the treatment program

- Medication-assisted treatment (MAT) is an evidence-based treatment for opioid addiction; however, it is not a stand-alone treatment choice
- MAT is very effective as part of a holistic, evidence-based treatment program that includes behavioral, cognitive and other recovery-oriented interventions, treatment agreements, urine toxicology screens and utilization of Prescription Drug Monitoring Programs (PDMPs)



Source: *American Journal of Psychiatry*

Overview of medications for opioid use disorder

- Patient Centered Care
  - Risks and benefits members should be informed
    - No treatment, treatment without medications, use of FDA approved medications.

SAMHSA expert panel consensus:

- "supports maintaining patients on medications for years, decades and even a lifetime if patients are benefitting
- Does not recommend medically supervised short term withdrawal alone due to high relapse rates

Overview of medications for opioid use disorder

- **Naltrexone XR (Vivitrol)**
  - IM every 4 weeks
- **Methadone**
  - Daily oral dose
- **Buprenorphine(Suboxone, Bunavil, Zubsolv)**
  - daily dosing
- **Probuphine**
  - Implant surgical every six months
- **Sublocade**
  - Monthly injection

Principles of Care

	1	Universal screening for SUDs across medical care settings
	2	Rapid access to appropriate SUD care
	3	Personalized diagnosis, assessment, and treatment
	4	Continuing long-term outpatient care
	5	Concurrent, coordinated care for physical and mental health
	6	Access to fully trained behavioral health professionals
	7	Access to FDA-approved medications
	8	Access to non-medical recovery support services

What Behavioral Treatments does APWU cover?

- Evaluation and referral to in-network resources
- Detoxification, inpatient and outpatient *
- Medication Management
- Inpatient Rehabilitation *
- Residential Treatment * [covered beginning January 2019]
- Partial, or Day Hospital *
- Intensive Outpatient *
- Outpatient visits

* *Requires review of medical necessity and authorization of services by Beacon*

National Association of Addiction Treatment Providers



NAATP_Newsletter_V3 Issue 1 Spring 2018_Online_0

Questions to ask a treatment center

- Are you accredited by a Nationally-recognized organization? If so, which one?
- Do you have a medical director on staff certified in addiction treatment?
- What are your clinician qualifications?
- Are group and individual counseling provided by Master's level staff?
- What evidence based practices are used?
- Is family counseling provided? By whom, and how often?
- When, in treatment, does discharge planning begin?
- What support services are provided after discharge?

News reports show instances of out-of-network providers taking advantage of patients with SUD

Members are at risk of becoming targets when they are disconnected from their support network

"With no job, little money and no place to live**, newly clean addicts – especially those with insurance - have become targets of unscrupulous business owners** or used as pawns in a variety of local scams."

Source article: "County's $1 billion gold rush: Addiction treatment draws FBI"

"Although sober homes were purportedly drug-free residences, **some of the defendants permitted the residents to continue using drugs…**"
"[Defendant] also **coerced female patients and residents into prostitution**…they would not have to pay rent or participate in treatment or testing so long as they would allow him to continue to **bill their insurance companies for substance abuse treatment and testing that patients did not receive.**"

Source article: "Two Defendants Plead Guilty in Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers""

Inadequate oversight of treatment facilities can expose vulnerable members to significant risk and illegal behavior

Inappropriate care can have dire and sometimes fatal effects on members

"..**two young adults from Danbury and Ridgefield died of heroin overdoses in sober homes** earlier this year."

Source article: "After overdose deaths, Chris Murphy wants federal review of sober homes"

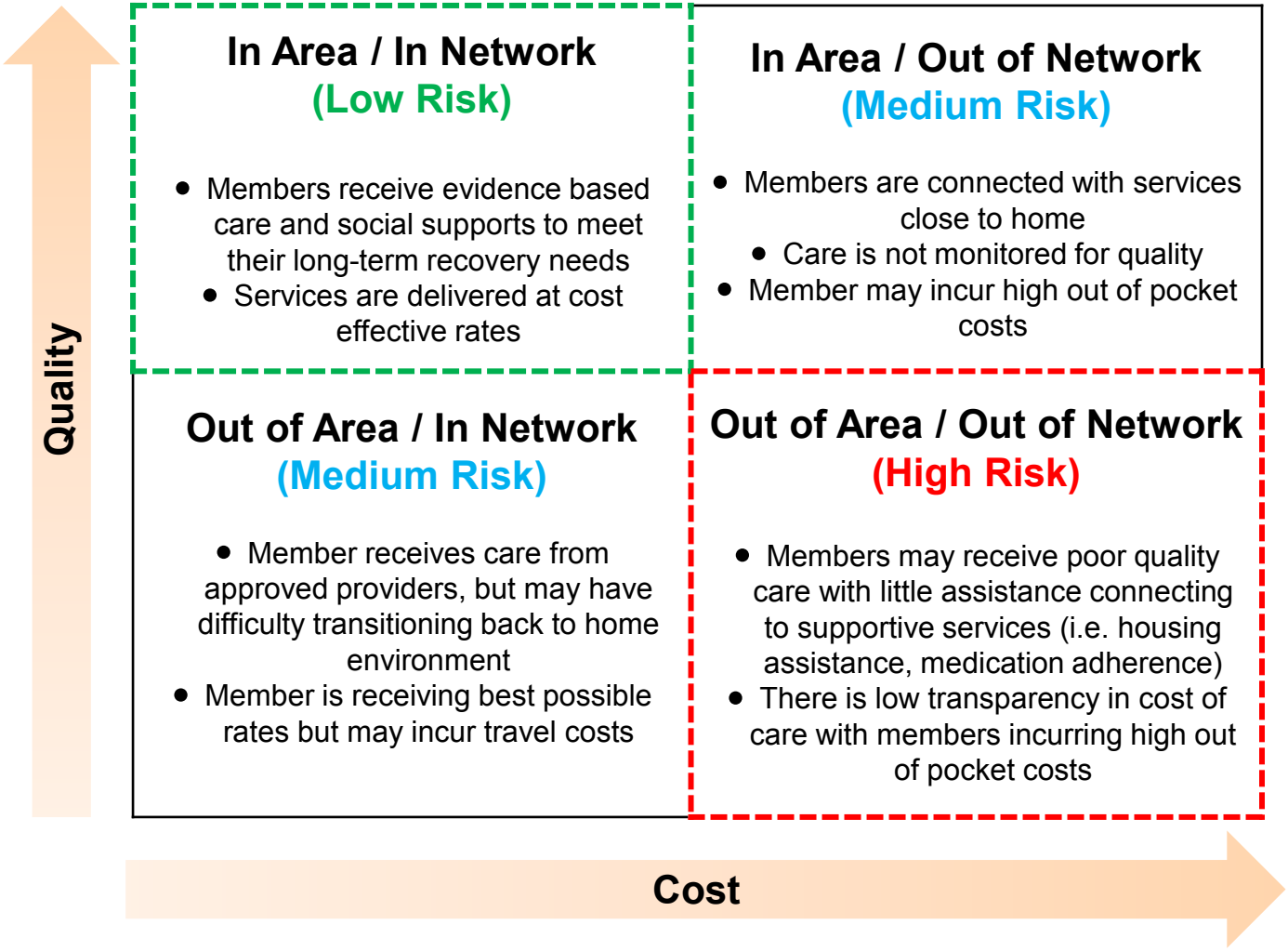
"Like thousands of families, when an out-of-state couple last year sent their 23-year-old son to Palm Beach County for addiction treatment, they understood his recovery could be lengthy and pricey. What they didn't anticipate was **the bill that arrived weeks after he finished treatment: a six-figure tab not for counseling or medical care, but for the humblest of drug screens – peeing in a cup**."

Source article: "Addiction treatment bonanza: How urine tests rake in millions"

Bills can be shockingly high for medically unnecessary care, with the cost borne by members through out of pocket payments and higher premiums

Out-of-Network / Out-of-Area services can lead to lower quality and higher cost care

Members face greater levels of risk as utilization of OON OOA services increase



Clinical guidelines indicate the importance of local, community-based care

OOA care is not best practice, especially for key levels of care

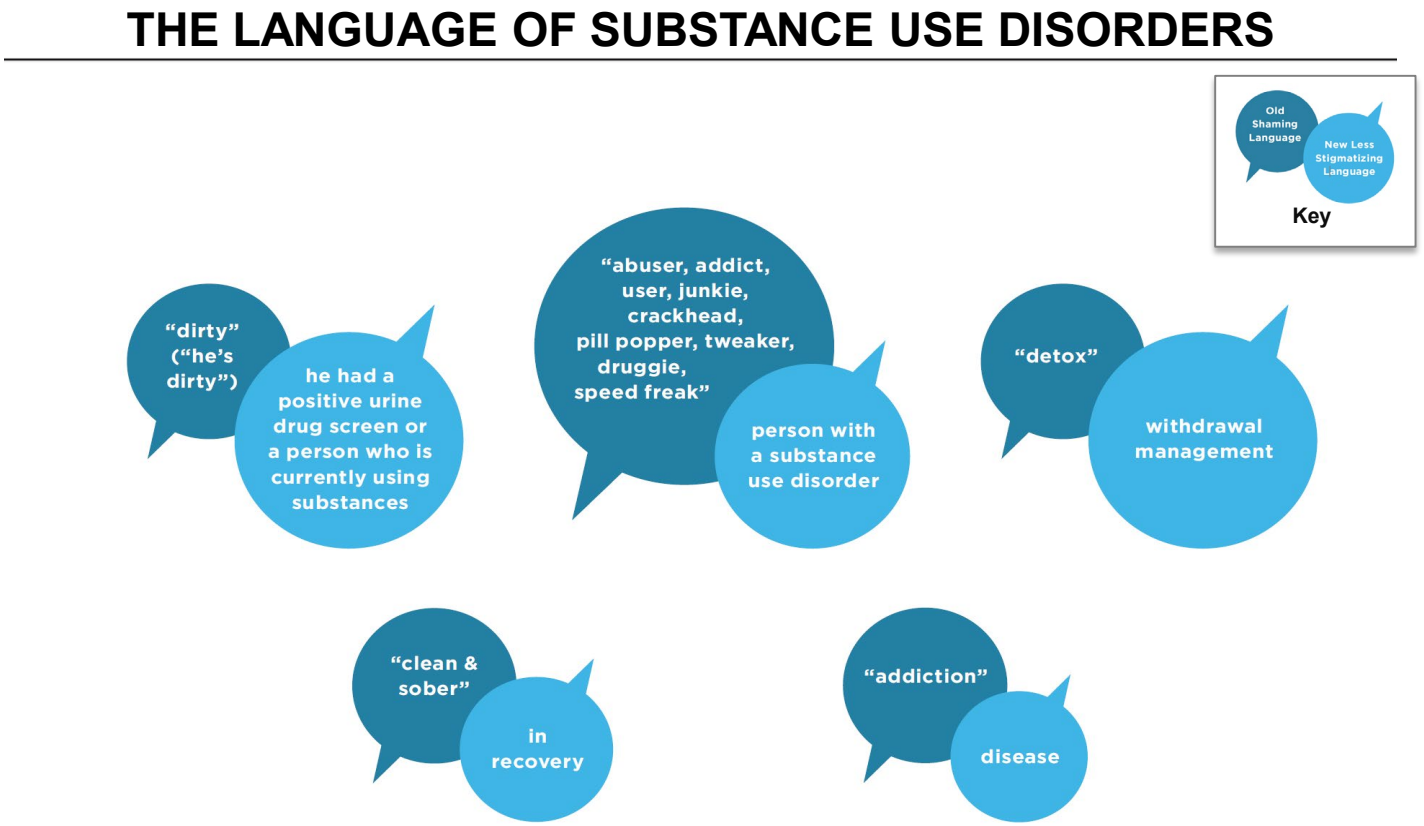
This is a medical necessity issue

- IOP and PHP levels of care are designed to **acquire skills for application in real world environments**
- **Treatment should be focused on applying skills** with family, supports, work or education
- **OOA PHP/IOP decreases the chances that a member can obtain and apply learnings** in their natural environment
  - In the end, members are left without the recovery skills they need when returning to family, work & stressors

OOA PHP or IOP treatment is acceptable in certain circumstances

- Home environment is not safe for supportive recovery
- Transportation to treatment is not available

The way we speak about OUD impacts the stigma associated with the disease



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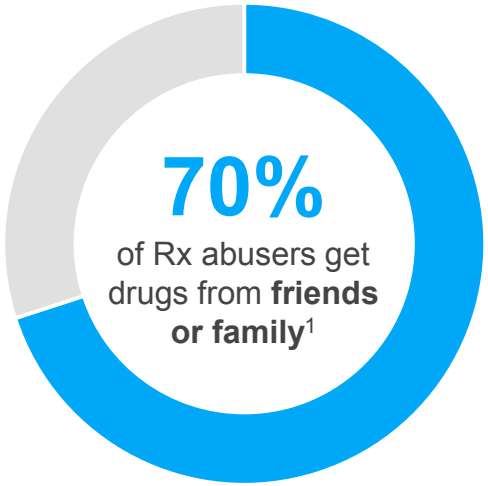
Prevent Misuse and Addiction by Ensuring Appropriate Opioid Treatment From the Start





The risk of chronic opioid use increases with each additional day of opioid supplied starting with the third day[2]

Prevention and education

- Applying insights from sophisticated data-sets
- Analyzing trends and usage
- Prescriber education

Minimizing early exposure

- Supply limits
- Provider engagement

Reducing inappropriate supply

- Ensure proper dispensing and appropriate use
- Prior authorization to ensure appropriate use
- Supply limits (individual and cumulative limits)

1. SAMHSA. 2014 National Survey on Drug Use and Health; https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-47b 2. MMWR / March 17, 2017 / Vol. 66 / No. 10
*Reinberg, Steven; HealthDay News; March 16, 2017

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APWU Health Plan: Next Generation Opioid Model

Sept 2018

Opioid Reversal Agents

$0 cost for Opioid Reversal agents

2016-2018

New strategies to reflect CDC guidelines

Minimize the potential for prescription drug abuse/misuse

2017-2018

Preferred drug options

Exclusions and preferred drug options added

2016-2017

Ensuring appropriate use

Implemented strategies to:

- Drive non-opioid options
- Limits on doses/day
- Monitor chronic diagnosis & use
- Prior Authorization on long acting agents

2013

High Narcotic Utilization Program

High Narcotic Program Implemented

Pharmacy Lock-In program implemented

Medication Assisted Treatment (MAT)

Medication used to treat opioid disorders

• **Zubsolv**	**Tier 1**
• **Naltrexone**	**Tier 1**
• **Buprenorphine**	**Tier 1**

Opioid Reversal Agents

NEW 9/1/18

Medication used to treat opioid overdose

• **Naloxone** (Previously Tier 1)	**$0**
• **Narcan** (Previously Tier 2)	**$0**

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Prevent Misuse and Addiction by Minimizing Early Exposure
Program Enhancements

Alignment with CDC guidelines

Opioids Are Not 1st-line Therapy For Chronic Pain
Non-opioid and non-pharmacologic treatment preferred

Short Duration for Acute Pain
3 days of therapy, > 7 days rarely needed
Prior authorization on **opioid-based cough preparations in pediatrics**

Lowest Effective Dose at Start
Max of 49 MED (morphine equivalent dose) per day and
7-day supply on all **new short-acting opioid scripts**

Minimize Dose Escalation
Prior authorization and 90 MED limits on long-acting opioids
Cumulative Opioid Limits (morphine equivalent dose based)

Avoid Opioids in Combo w/ Benzodiazepines
Avoid these drugs in combination due to increased overdose risk

NEW 7/1/18

Narrowed refill window on all opioids to limit early refills and stockpiling

Limited fills to **30 day supplies for OptumRx Home Delivery**

*M&R – pending CMS guidance or NA

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Opioid Safety Initiatives

Increasing Member Awareness

66% of people 12 and older who use opioids obtained them from a friend or family member[1]



NEW **Opioid Warning Labels**

- **New bottle caps and labels with opioid warnings** included with Schedule 2 opioids dispensed through home delivery
- Examples include Xtampza ER, morphine, fentanyl, hydrocodone/APAP and Oxycodone/APAP.
- A new Rx is required each time these medications are dispensed

Promoting Proper Disposal

Risk of opioid addiction increases with each additional day of opioids, **starting with the third day**[2]



NEW **Drug Disposal Kits**

- OptumRx members can call the number on their ID card to **receive a drug disposal kit at no charge**
- **Deterra kits** are for medications that are approved to be thrown away at home
- **Takeaway kits** are for medications that should not be thrown away at home and can be mailed to a DEA collector for proper disposal

1. Lipari, R.N. and Hughes, A. How people obtain the prescription pain relievers they misuse. The CBHSQ Report: January 12, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD; 2. MMWR / March 17, 2017 / Vol. 66 / No. 10; Reinberg, Steven. HealthDay News. March 16, 2017.

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Provider Initiatives

Physician Initiatives

Provider Education
Prior Authorization guidelines, CDC guidelines, Provider outlier review, Peer discussions, Provider Portal resources

High Narcotic Utilization Program & Retrospective Review
Provider education on patients that are high/frequent utilizers

Peer Comparison Reporting
Comparison data on prescribing patterns

PreCheck MyScript®
Real time provider feedback at the point of e-prescribing

Pharmacy Initiatives

Fraud, Waste and Abuse Training
Annual training as a participant in OptumRx Pharmacy Network

Claims Monitoring
Pharmacy outlier identification, evaluation and audit

Peer Comparison Reporting

- ✓ Prescribing Rate of high dose opioids
- ✓ Prescribing Rate of Opioids for an extended duration
- ✓ Prescribing Rate of Opioids in combination with benzodiazapines

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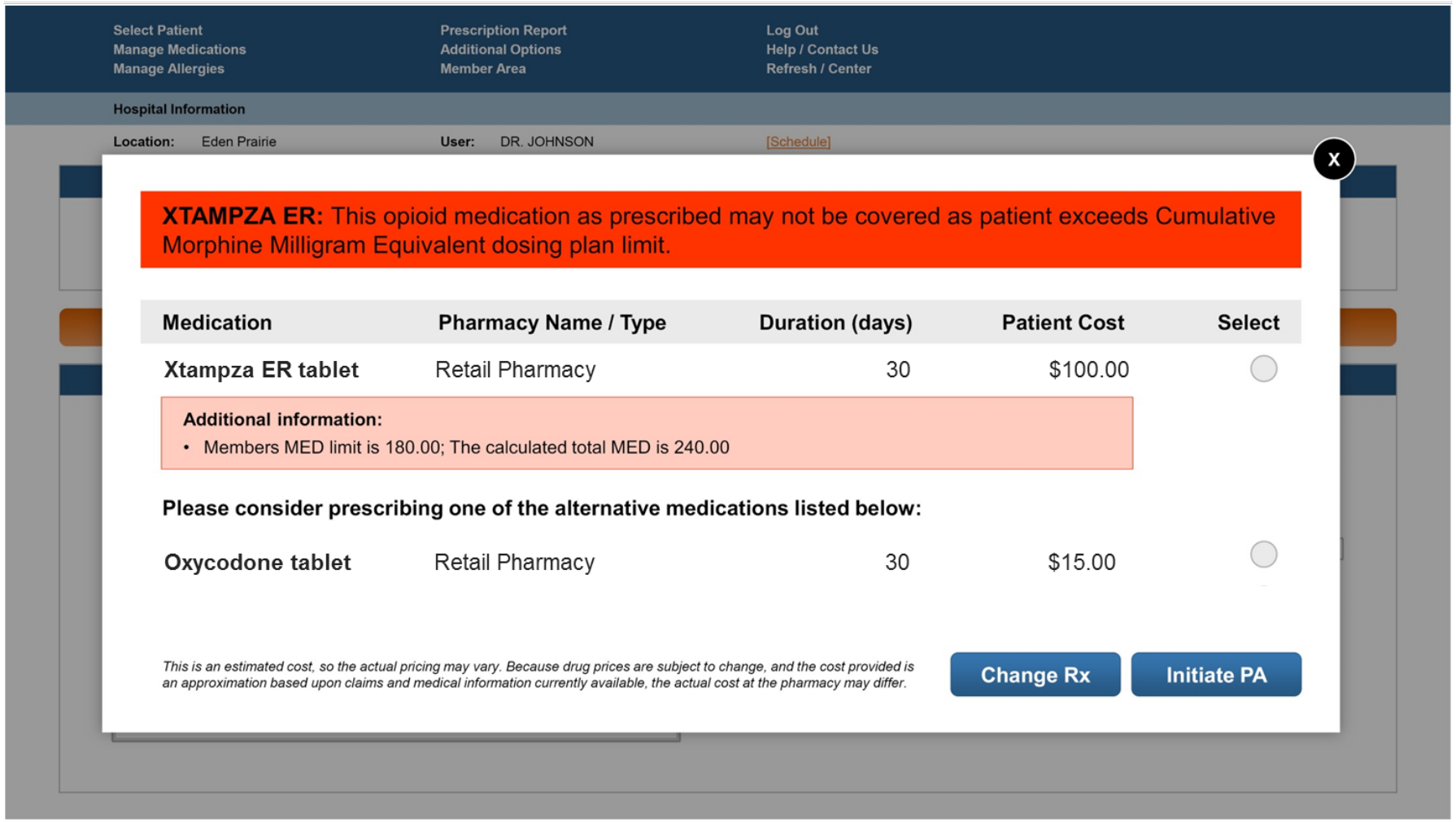
PreCheck MyScript

Real time provider feedback at the point of prescribing



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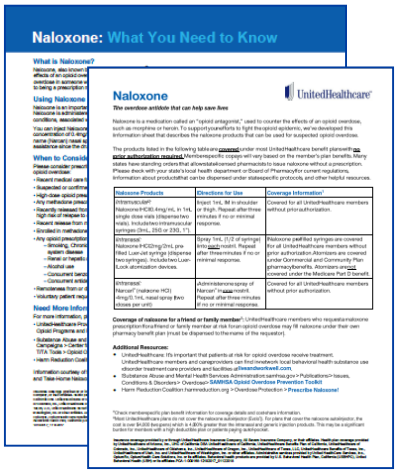
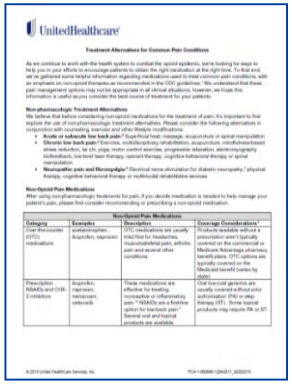
Prevent Misuse and Addiction
Resources Available on Provider Portal



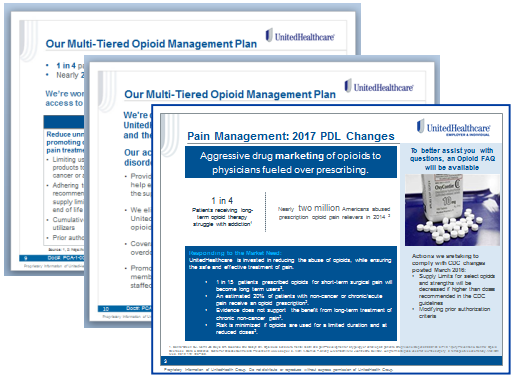
Naloxone (coverage, when to prescribe)



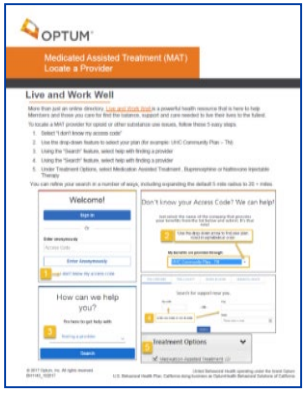
Opioid Resources Flyer



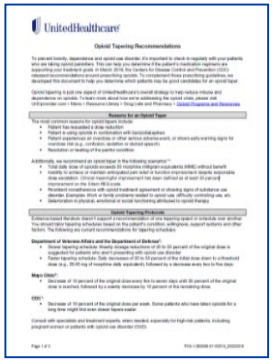
Non-opioid Alternative Treatment for Pain (includes general notes on coverage)



Opioid management strategy slides



MAT Provider Search



Opioid Tapering Guide

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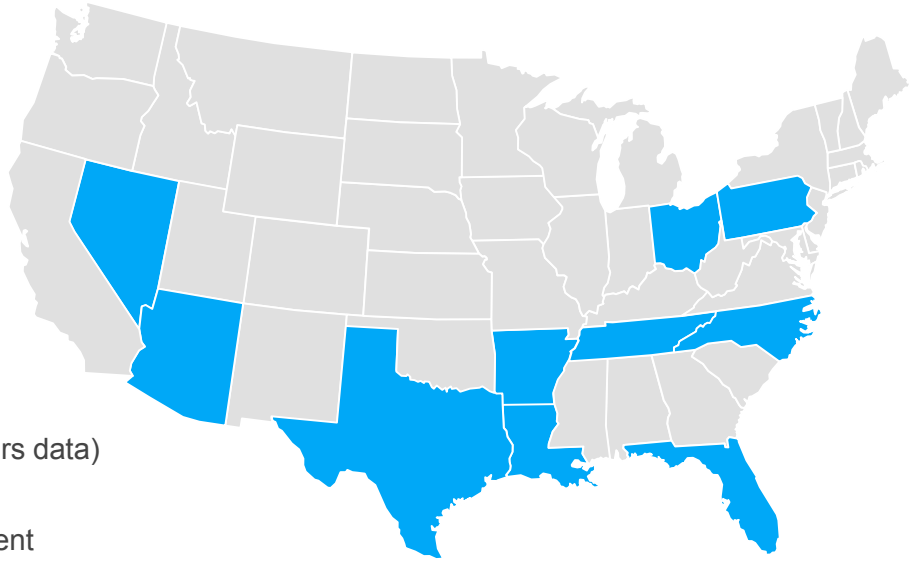
The UnitedHealthcare Opioid Community Partnership

- Little Rock, AR
- Phoenix, AZ
- Palm Beach, FL
- New Orleans, LA
- Winston-Salem, NC
- Las Vegas, NV
- Dayton, OH
- York, Hanover, Lewisberry, Gettysburg, Columbia, PA
- Nashville, TN
- Dallas, TX



Five interventions were selected to:

- Address specific needs of the 10 selected sites, based on several internal data sources (e.g., Optum Labs, ACO data, pharmacy-outliers data)
- Impact KPIs within a short timeframe
- Leverage processes and materials that exist or are under development

Physician Practice Modification

Prescription Over-utilizers



Physician Interventions

Neonatal Abstinence Syndrome Reduction

Naloxone Promotion

Medication Assisted Treatment (MAT)

UnitedHealthcare®

CDC Compliance Video Link



Putting the Brakes on the Opioid Epidemic





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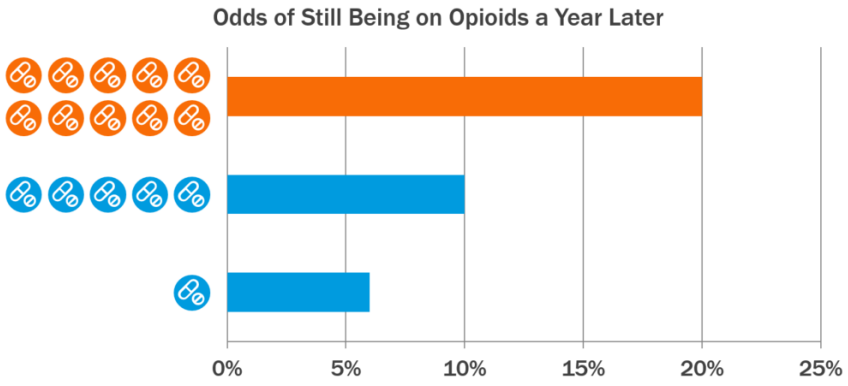
What you're up against: More overdoses caused by prescription drugs than illegal drugs

- Every day, 1,000+ people are treated in emergency departments for misusing prescription opioids
- 46+ people died every day from prescription pain killer overdoses in 2016[1]
- 6 in 10 overdose deaths involve an opioid

With a 10-day supply of opioids,
1 in 5 become long-term users.

Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report (MMWR)*



- Opioid abuse costs U.S. employers $18 billion
- Employers are paying for 1/3 of abused opioid prescriptions
- Employee opioid abuse to account for 64%+ of medically related absenteeism

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4287687/ | 1) http://www.cdc.gov/ | The Opioid Crisis Report http://www.castlighthealth.com/typ/the-opioid-crisis/

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Putting the brakes on opioids requires management across the care continuum

Minimizing early exposure

Preventing progression to overuse and abuse



PHYSICIANS **PHARMACIES** **HOME**

TO MANAGE THE OPIOID EPIDEMIC, ALL TYPES OF USERS MUST BE ADDRESSED

- New and Acute Use
- Short-term or Intermittent Use
- Chronic Use
- Overuse and Abuse

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The Pharmacy Benefit Solution



PHARMACY

Initial fill 7 days' supply

Prior Authorization and Quantity limits

Point of Sale (retail) Safety messages

Fraud Waste and Abuse oversight



HOME

Patient Educational letter

Pharmacist Outreach



PHYSICIAN

Physician Care Alerts

Prescriber Education

*New in 2018

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Reduce the risk of abuse

- **Keep drugs out of reach and don't make it easy for others to access.** Store your medications in a locked area out of children's reach. Avoid storing addictive drugs in an unlocked medicine cabinet. Ask your pharmacist if they can provide medication bottles with child-resistant caps.
- **Don't save for "next time":** Once your condition has been treated and your prescription regimen is complete, properly dispose of the drugs. Never keep extra medication for potential use in the future.
- **Don't share your medication:** The specific drug and dosage was selected specifically for the person it was prescribed for and could lead to dangerous drug interactions and serious side effects if used by someone else.

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Medication Disposal



From the US Food and Drug Administration

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THANK YOU!

You will receive an email following our Seminar with a link to fill out your class evaluations online.

Please note any questions for the Roundtable discussion on the card provided and place in the drop box at the Registration Desk.

The Roundtable discussion will be during Closing Session:

Sunday, October 28, 2018



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