

The State of Opioid Addiction in Vermont: Treatment and Research

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Objectives

Gain an understanding of:

- current U.S. and Vermont opioid prescribing and overdose statistics;
- research on local prescribing practices
- programs to educate providers and learners about safe and appropriate opiate prescribing; and
- current state of treatment availability to people with an opiate addiction

Scope of the opioid problem

Stephen Leffler, MD
Chief Medical Officer
UVM Medical Center

National Attention

New York Times

**How the Epidemic of Drug
Overdose
Deaths Ripples Across America**

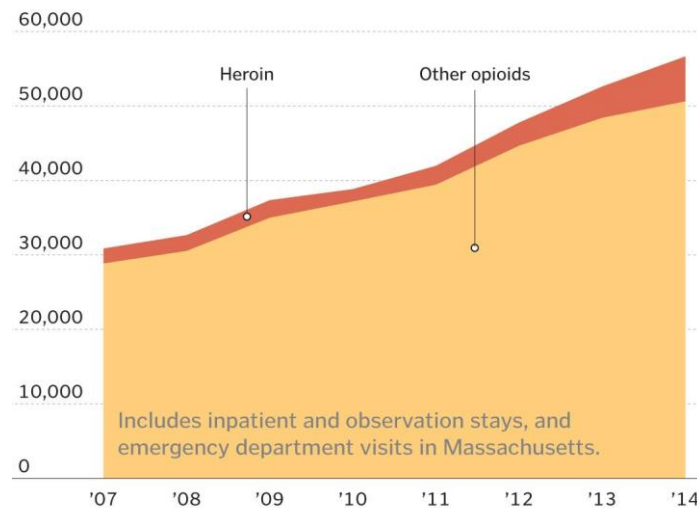
By HAEYOUN PARK and MATTHEW BLOCH JAN. 19, 2016

**“Deaths from overdoses are
reaching levels similar to the
H.I.V. epidemic at its peak”**

Mass. hospital visits for opioid abuse soar

By Felice J. Freyer Globe Staff March 28, 2016

OPIOID-RELATED HOSPITAL VISITS



SOURCE: Massachusetts Health Policy Commission

GLOBE STAFF

Associated Press

AP-NORC Poll: Most Americans See Drugs as a Big Problem

By Lisa Marie Pane and Emily Swanson, Associated Press

Mar 25, 2016, 11:18 AM ET

The poll found that most Americans — 62 percent — said that at least one type of substance use was a serious problem in their communities

Opioid Addiction Facts & Figures

259,000,000 Prescriptions were written for opioids in 2014, which is more than enough to give every American adult their own bottle of pills.

21,500,000 Americans 12 or older in 2014 had a substance use disorder. *(6.6% Americans, 323M U.S. Pop.)*

168,000 Adolescents 12-17yo are addicted to prescription pain relievers.

47,055 Died from drug overdose in 2014, resulting in it being **the leading cause of accidental death in U.S.**

28,000 Adolescents had used heroin in the past year. *(2014)*

SOURCE: American Society of Addiction Medicine:

<http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf>

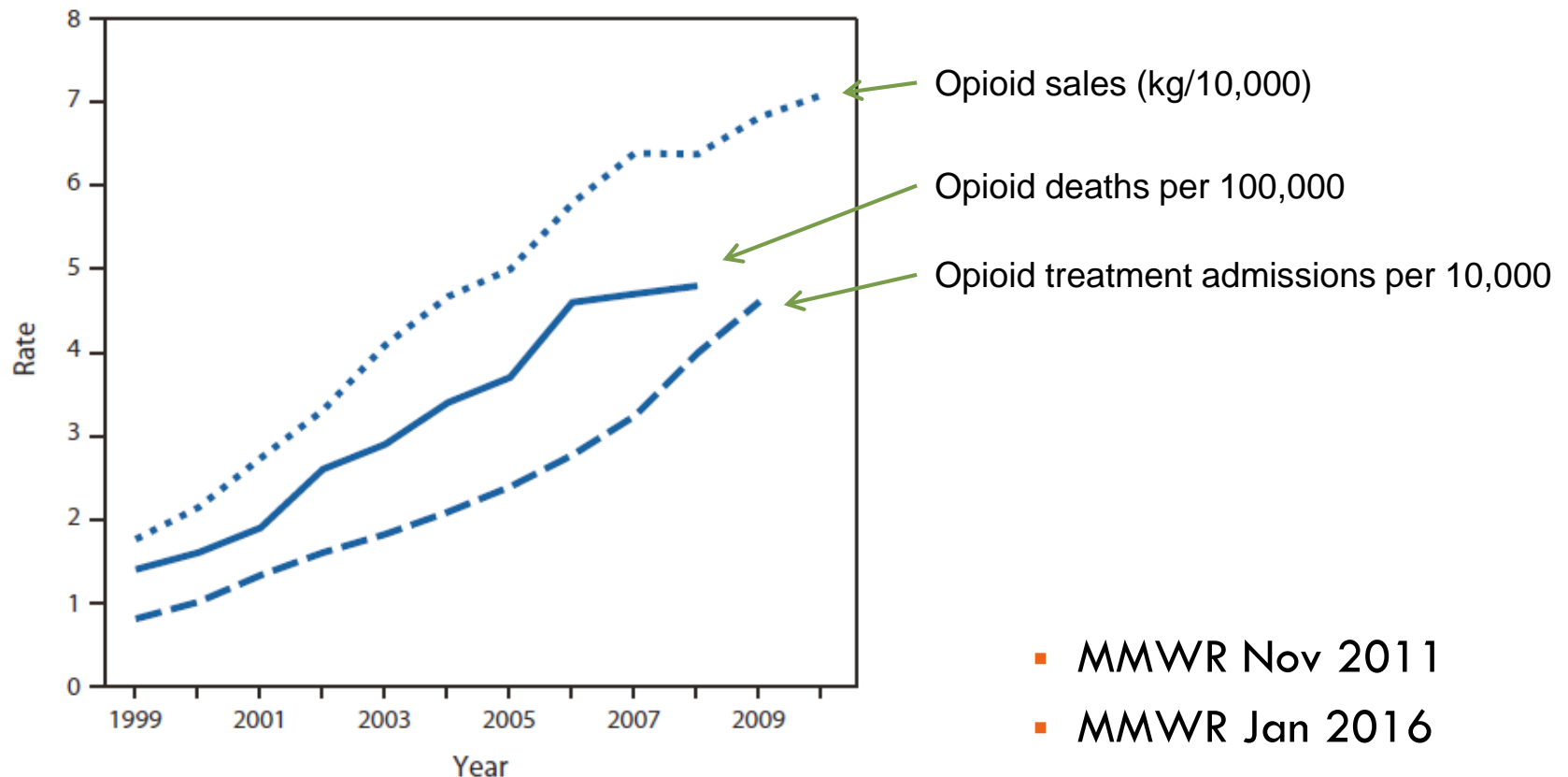


Top Generic Prescriptions in the US (2014)

1. Hydrocodone + acetaminophen [Vicodin] (n=122,806,850)
18. Oxycodone + acetaminophen [Percocet] (n=28,705,243)
46. Propoxyphene + acetaminophen [Darvon] (n=14,274,354)
51. Oxycodone (n=12,652,375)
114. Fentanyl patch (n=4,914,785)
121. Methadone (n=4,558,532)
170. Morphine (n=2,740,358)
192. Hydromorphone [Dilaudid] (n=2,272,481)

Opioid prescribing in the US

- Increase in opioid prescribing in past decade
- Overdose deaths tripled between 1999-2008

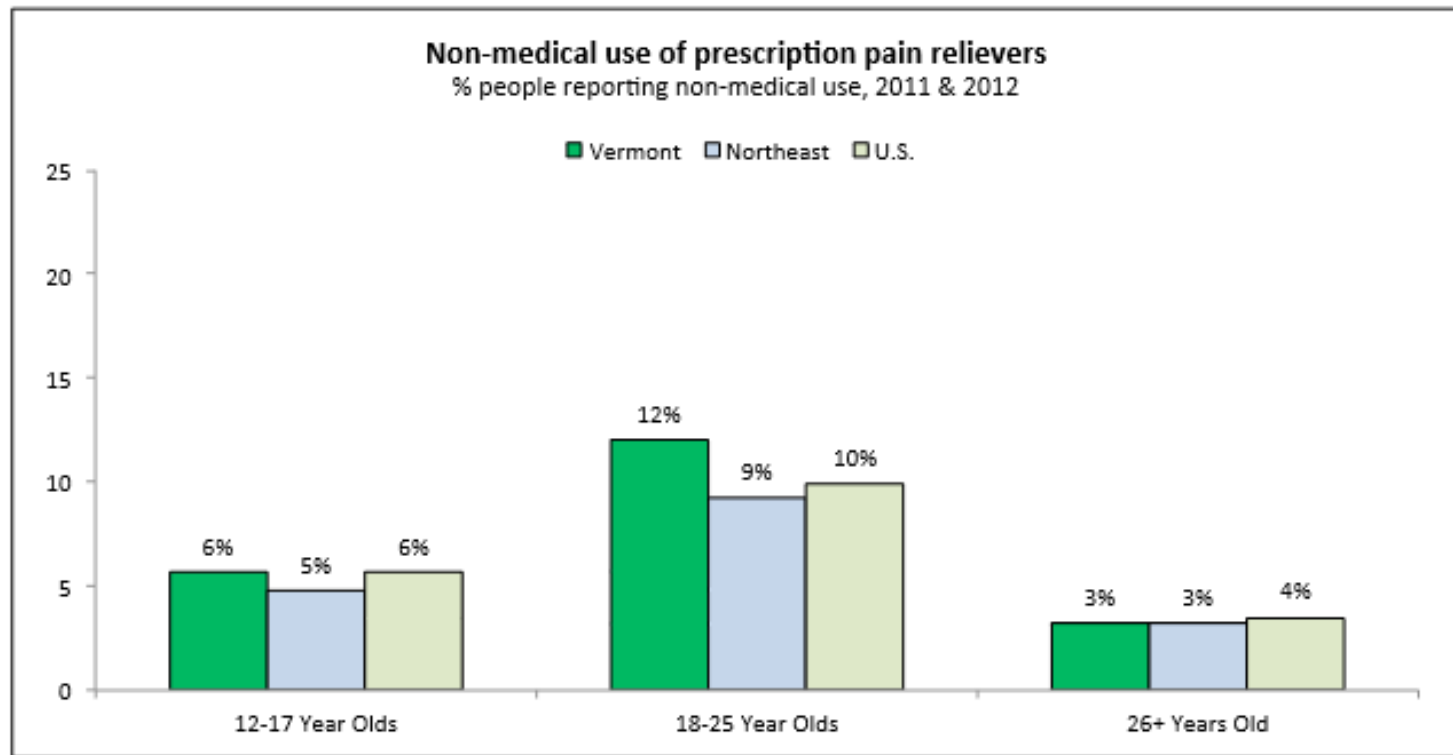


Opioid abuse in the US

- As many as 1/4 people who receive prescription opioids long term for non-cancer pain in primary care settings struggle with addiction
- 1/20 people in the US report using prescription opioids for nonmedical reasons
- Source of misused prescription opioids:
 - 71% of prescription opioids are obtained from a *family member or friend* (given, bought, or stolen)
 - Most of these opioids are from a single prescriber source and not from doctor shopping

» National Survey on Drug Use and Health, 2011

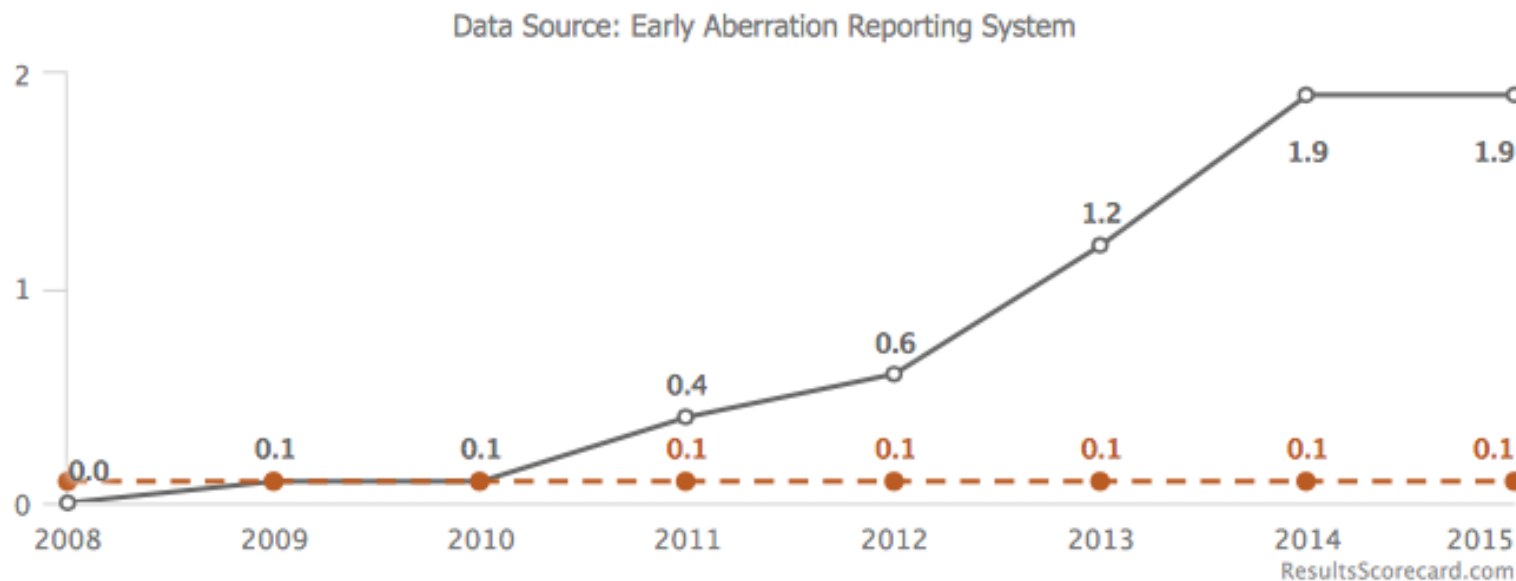
Opioid abuse in the US



Substance Abuse & Mental Health Services Administration/National Survey on Drug Use & Health (NSDUH) 2012

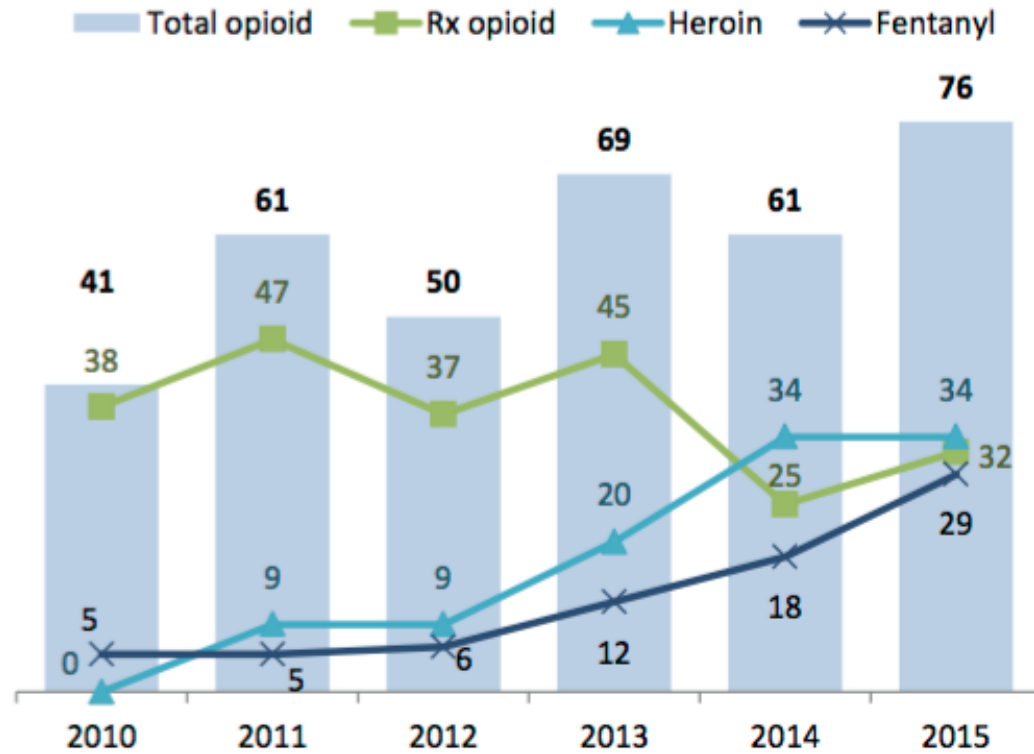
Vermont ED Overdose Visits

- I Opioids Rate of Emergency Department visits for heroin overdose syndrome per 10,000 Vermonters



Vermont Deaths

**Total number of accidental and undetermined
manner drug-related fatalities involving an opioid
(categories not mutually exclusive)**



Heroin users



Previous era heroin users:

- young, minority male living in urban centers
- Unemployed
- 80% started with heroin

New era heroin users:

- 25-34 y.o., white male/female living in a suburban/rural area
- employed
- 75% start with rx opioids

2x

Heroin use more than doubled in young adults ages 8-25 in the past decade

9 in 10

More than 9 in 10 people who used heroin also used at least one other drug

3x

the number of people dying from heroin overdoses since 2010

75%

start by using prescription opioids

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least **3** other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and **death** for users.

People who are addicted to...



ALCOHOL

are

2x



MARIJUANA

are

3x



COCAINE

are

15x



Rx OPIOID PAINKILLERS

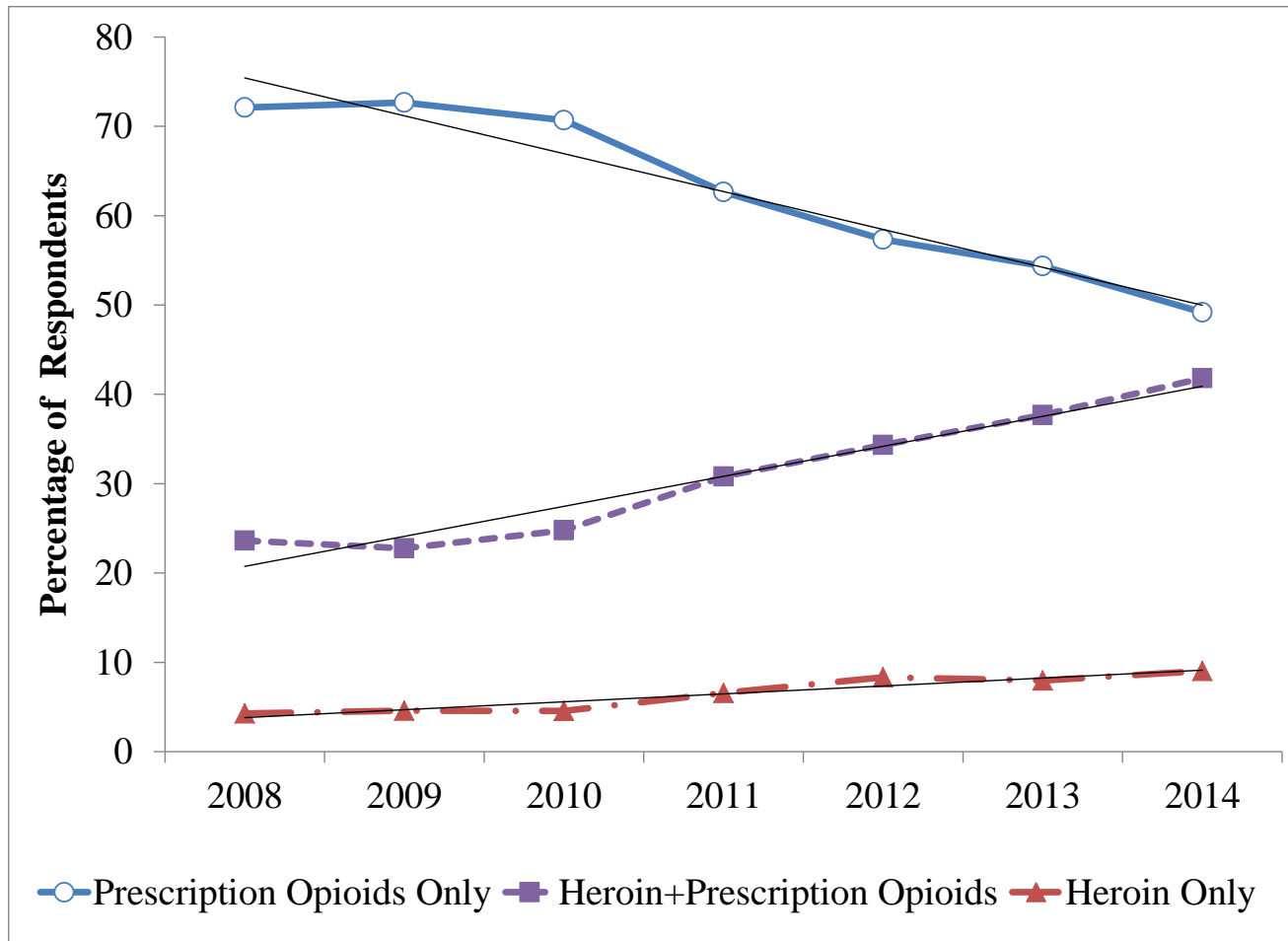
are

40x

...more likely to be addicted to heroin.

SOURCE: National Survey on Drug Use and Health (NSDUH), 2011-2013.

Transition to heroin across the U.S.

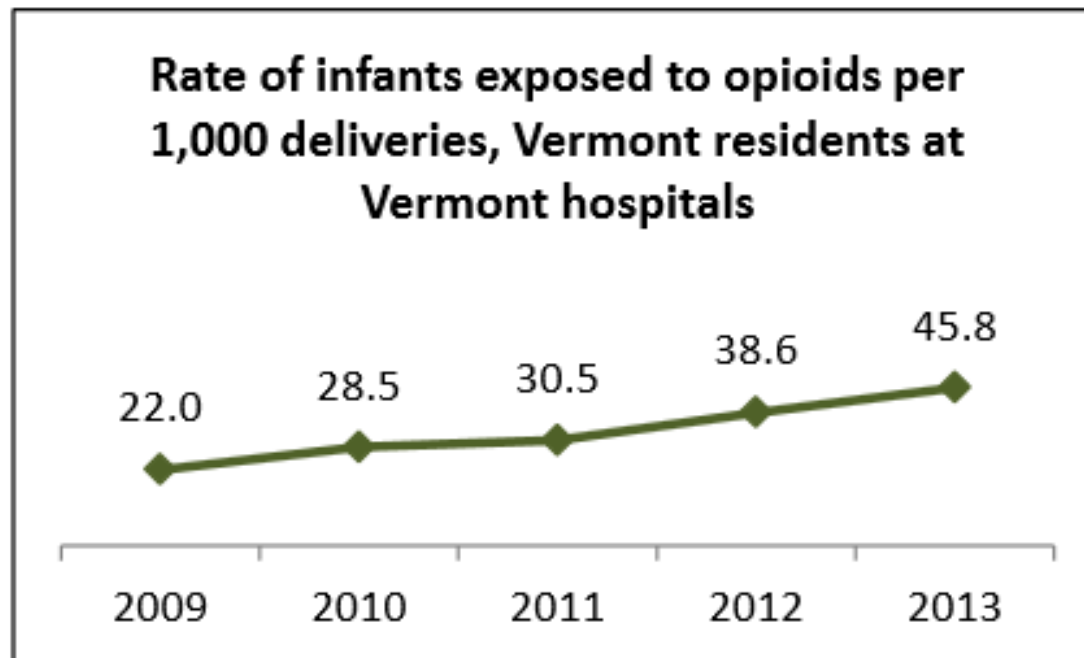


Other Health Concerns

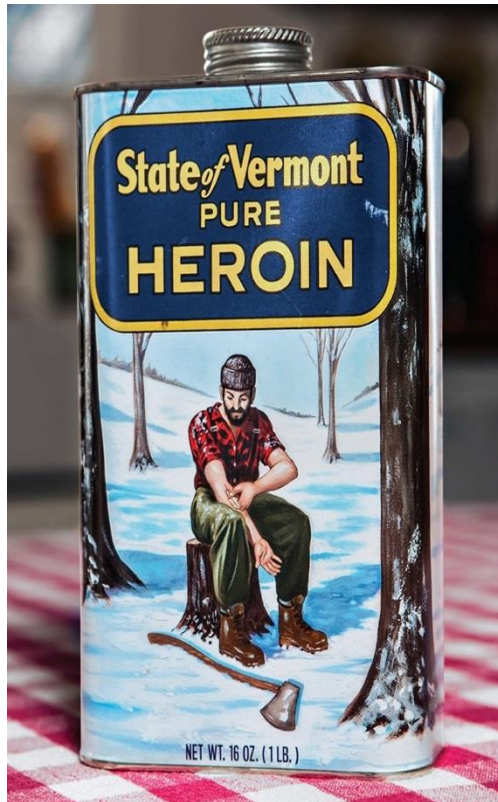


- Heart infections
- Blood stream infections
- Skin and muscle infections
- Bone infections
- Lung damage
- Traumas
- Babies born addicted to opioids
- Hepatitis and HIV
- Falls in elderly resulting in fractures
- Withdrawal symptoms
- Use of other alcohol or drugs

Vermont



Social Issues/ Societal costs



- Job Loss
- Family Disruption
- Criminal Activity
- Incarceration
- Effects on children
- Social Stigma
- Loss of housing
- Loss of custody of children
- Estimated \$72.5 billion annually in health care costs in the US

Best practice prescribing:

Finding solutions for the *Upstream* problem of opioid prescribing

Charles MacLean MD
Associate Dean for Primary Care
UVM Medical Center



CDC guidelines

*Recommendations for Prescribing
Opioids for Chronic Pain Outside of
Active Cancer, Palliative, and End-of-
Life Care*

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

CDC guidelines 2016 (condensed)

- Use alternatives to opioids whenever possible
- Explain the risks and benefits
 - Informed consent
- Focus on function
- Start low and go slow
- Track progress carefully
 - Surveillance for misuse
- Avoid benzodiazepines

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

- Q1:** What number from 0–10 best describes your **pain** in the past week?
0 = “no pain”; 10 = “worst you can imagine”
- Q2:** What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?
0 = “not at all”; 10 = “complete interference”
- Q3:** What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?
0 = “not at all”; 10 = “complete interference”

TO LEARN MORE

WWW.CDC.GOV/DRUGOVERDOSE/PRESCRIBING/GUIDELINE

March 2016



PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your **PAIN** in the past week?
(0 = “no pain”, 10 = “worst you can imagine”)

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your **ENJOYMENT OF LIFE**? (0 = “not at all”, 10 = “complete interference”)

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your **GENERAL ACTIVITY**? (0 = “not at all”, 10 = “complete interference”)

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.



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

THE
University of Vermont
HEALTH NETWORK

Are opioids effective for chronic pain?

The slide features three thick, wavy green lines that sweep across the bottom half of the page. One line is a dark forest green, another is a medium olive green, and the third is a light sage green. They overlap and curve upwards from left to right, creating a modern, abstract design.

Long-term opioids for chronic non-cancer pain -1

- 26 studies/4893 pts (through 2009)
- One RCT (comparing 2 opiates)
- Findings:
 - Overall reduction in pain
 - Addiction in 0.27% (prescreened)
 - Quality of life/functional status “inconclusive”

Long-term opioids for chronic non-cancer pain -2

- Effectiveness vs risk of long-term opioid Rx for chronic pain
 - No long term high quality studies
 - No direct evidence of for or against long-term improved pain, QOL, function
 - Studies of varying quality show increases in risk

» Chou 2015. Ann Int Med 162: 276

Authors conclusions:

Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function; evidence supports a dose-dependent risk for serious harms

Legal requirements



Legal requirements

- Prescription Drug Monitoring Programs
 - Vermont Prescription Monitoring System
- Vermont
 - 2015 and prior:
 - Mandatory VPMS for chronic prescriptions
 - Best practice prescribing rules
 - consent forms, treatment agreements, risk assessment
 - 2016: Rulemaking in process
 - Limits on size of acute prescriptions
 - VPMS for every controlled substance prescription
 - Naloxone for >90 MME (morphine milligram equivalents) or every opioid prescription

Population Management & Practice Improvement

How are we currently doing?



Population management of chronic disease

Concept

Prescriber perspective

Basic epidemiology

“I didn’t realize this was such a big problem”

Questions

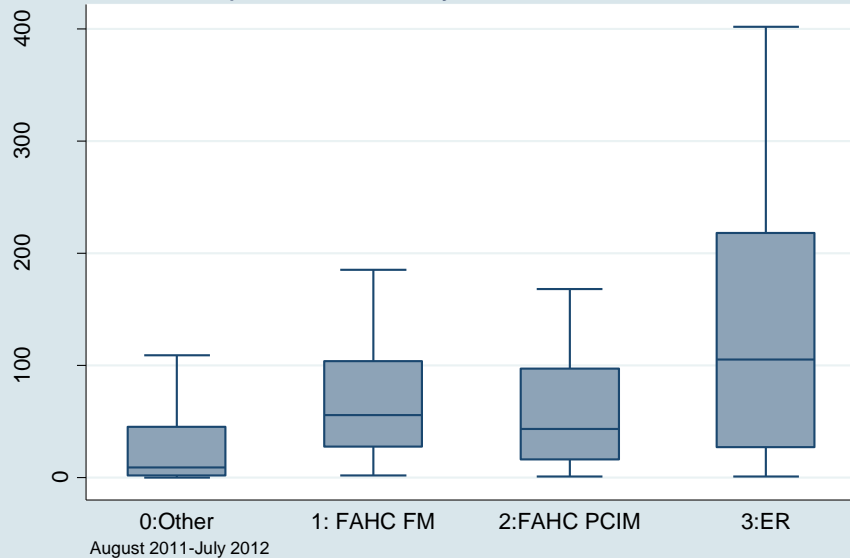
- Who is prescribing?
- Are there high risk populations?
- How can we do a better job?

Study Population

- Subjects
 - 30,000 primary care patients, 1/3 of whom received an opioid in 2011-2012
- Prescribers
 - Nine primary care offices in FM & IM (138 prescribers)
 - Specialists (370 prescribers)
 - Emergency Medicine (40 prescribers)

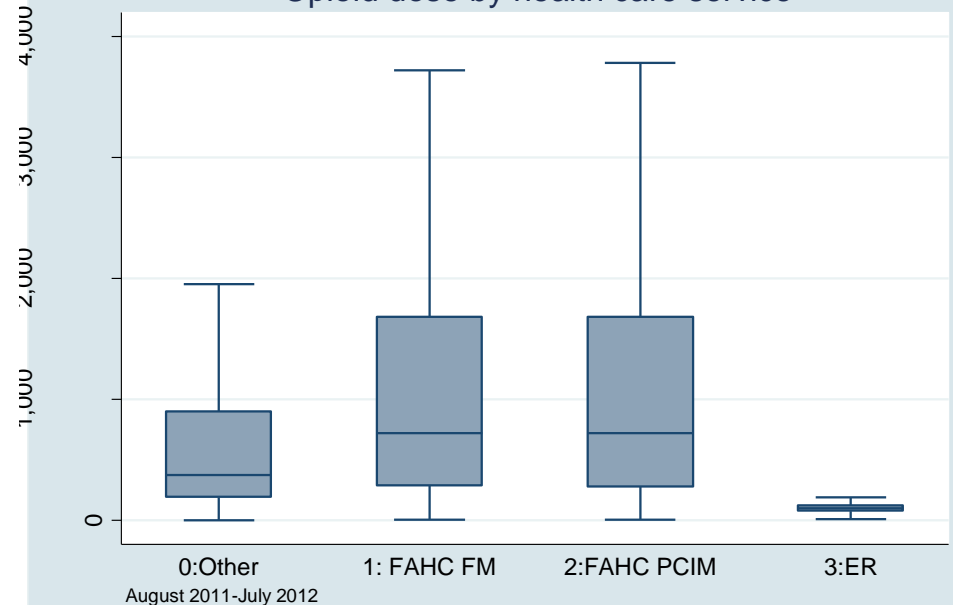
Opioid Prescribing – Who is prescribing?

Opioid Patients by Health Care Service



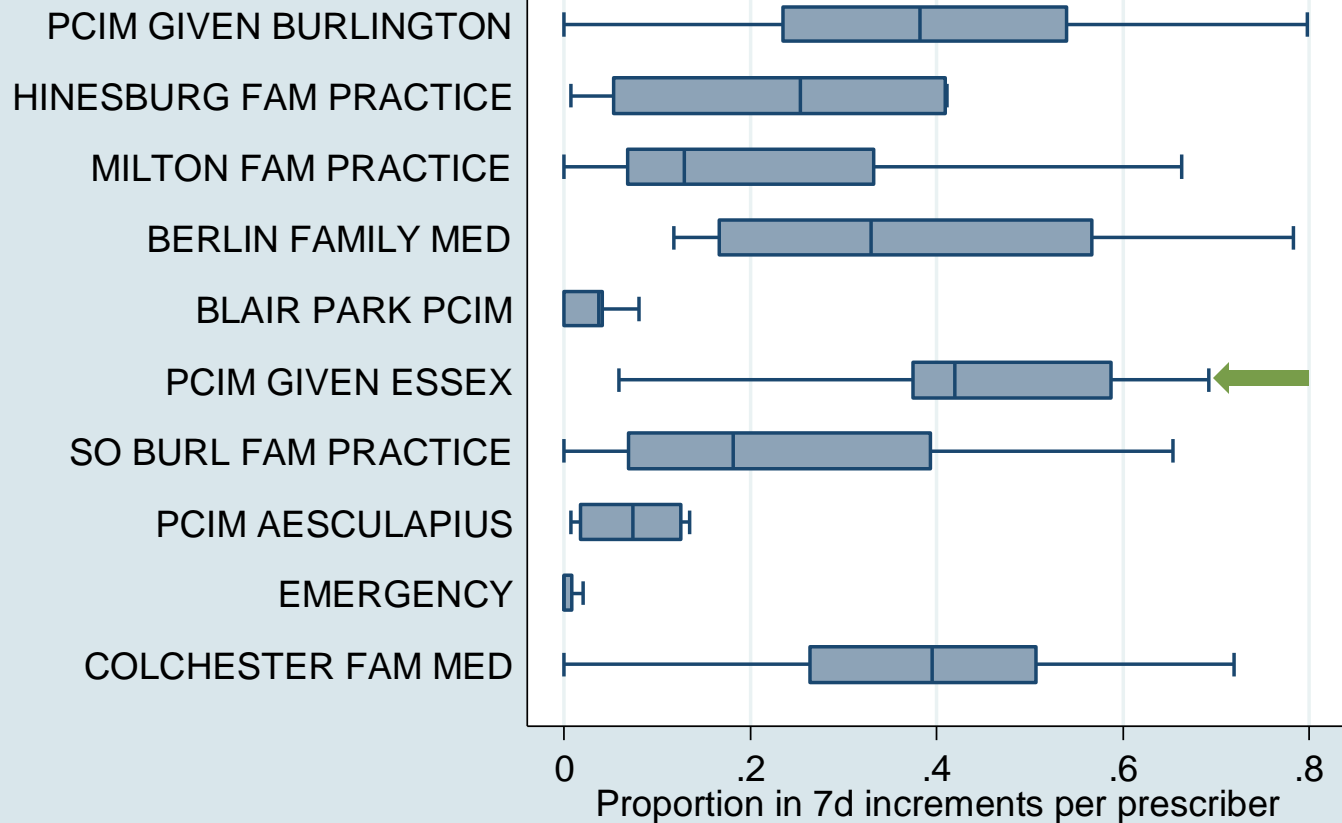
Half of the total opioid amount was prescribed in primary care, 48% in specialty care and 1% in emergency medicine

Opioid dose by health care service



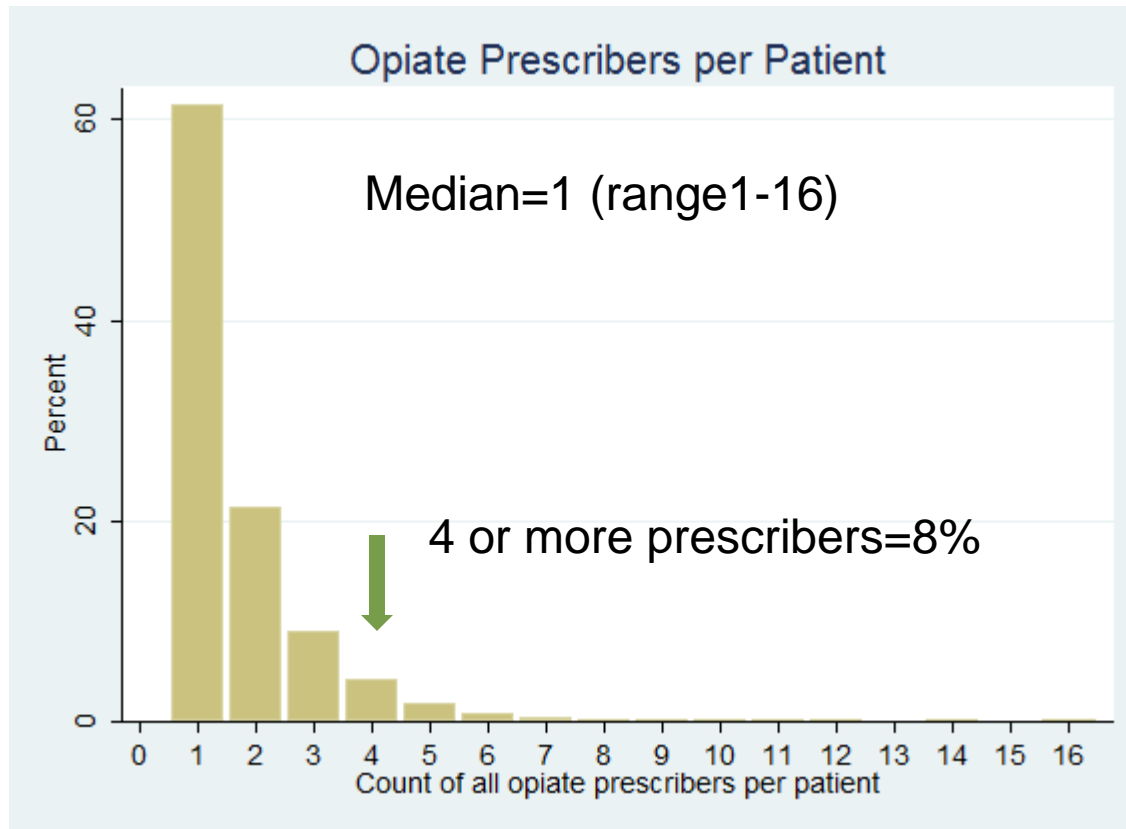
Rx Seven

Seven day prescribing by location



August 2011-July 2012

“Red flags” by patient



- High dose opioids for non-cancer pain (3%)

“Red flags” by prescriber

- Methadone patients/prescriber
 - Median=0; Range 0-57
 - Half of the patients are prescribed by top 20 prescribers
- High dose prescribing

Caution if not adjusting for the population

Summary population report

Prescribing characteristic	Your practice	UVMHC primary care (median) N=92	All Vermont PCP N=~750
Unique patients for whom you have Rx'd an opiate	87	44	
Proportion of your patients who have four or more prescribers	8%	8%	
Proportion of prescriptions in 7 day increments	69%	26%	
Unique patients for whom you Rx'd methadone	1	0	

Detail population report (Dr. “Osler”)

Name	DOB	# opiate Rx by PCP	# opiate Rx total	# red flags	# opiate prescribers	Dominant prescriber	Other prescribers
Jones, John	06/02/42	12	12	0	1	Dr. Osler	-
Smith, Elvis	03/12/45	24	44	4	5	Dr. Pain	Dr. Pain; Dr. Oncology; Dr. Surgeon; Dr. Ortho
Lake, Mary	06/22/57	13	26	0	2	Dr. Osler	Dr. Galen

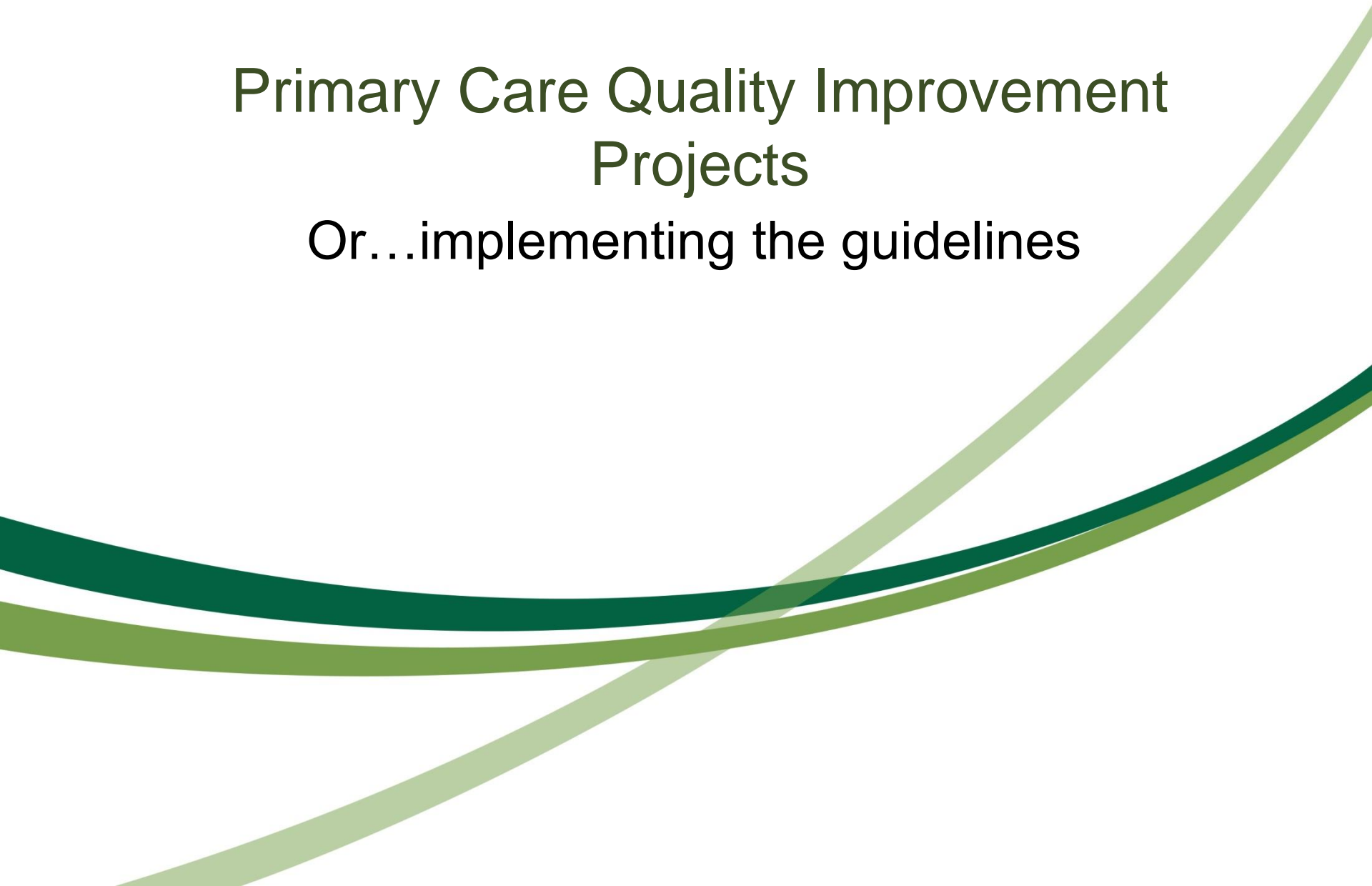
Chronic Opioid Protocol

This report displays all patients who have the chronic opioid protocol health maintenance modifier. The RXs my Dept Authorized, Unique Auth Provs, Current Med Year fields are filtered to prescriptions ordered between 8/30/2015 and 8/27/2016. This report is grouped by primary clinic, PCP and patient.

Patient Name MRN	DOB	RXs my Dept Authorized	Unique Auth Provs	Current Med?	Total RXs Last Yr	Last PCP Visit	Last PCP Dept Visit	Urine Drug Screen (date)	Pain Score (date)	Pain Score (result)	VPMS Query (date)	Functional Asses (date)	Pill Count (date)	Meth Sub Bup Curr Med?	COMM (date)	Consent (date)	Agmt (date)
ESSEX ADULT PRIM CARE																	
MACLEAN, CHARLES																	
Anxiety	18	1	No	18	8/9/16	8/9/16		8/9/16	6	10/26/15				No	10/26/15		4/4/11
	20	5	Yes	20	7/1/16	8/3/16		8/10/16	0	12/15/15	5/15/14			No	12/21/15	12/7/11	12/7/11
	3	1	No	3	5/26/16	5/26/16		8/4/16	0	5/24/16	1/8/15			No	9/25/14	9/25/14	9/25/14
	0		No		8/1/16	8/1/16		7/7/16	4					No			
	27	2	Yes	27	4/21/16	4/21/16		4/21/16	3	4/11/16	12/23/14			No	12/23/14	12/23/14	12/23/14
DM & LBP & neurop & surg	27	10	Yes	42	6/28/16	6/28/16	1/25/16	7/25/16	7	11/10/15	10/27/14			No	11/10/15	10/27/14	10/27/14
	16	1	Yes	16	8/4/16	8/4/16		8/15/16	0	3/24/16	3/24/16			No	3/24/16	7/3/14	7/3/14
	12	2	Yes	12	1/25/16	1/25/16	6/9/09	1/25/16	0	8/17/15	1/25/16			No	1/25/16	12/5/14	12/5/14
	15	3	Yes	15	7/1/16	7/1/16		7/27/16	0	12/23/14	1/13/15			No		3/29/16	3/29/16
	30	2	Yes	30	4/26/16	8/23/16		8/23/16	10	4/26/16				Yes	9/15/14	12/16/11	12/16/11
Methadone	0		No		11/9/15	11/18/15	6/15/12	5/5/16	0	12/23/14				No			
	14	3	Yes	14	7/7/16	7/29/16		7/29/16	10	5/8/14	5/8/14			No	11/11/14	8/2/12	8/2/12
	18	5	Yes	18	8/15/16	8/15/16		8/15/16	9	8/21/14	8/21/14			No	12/15/15	8/21/14	8/21/14
	13	1	Yes	13	5/16/16	5/16/16		5/16/16	5	12/23/14	2/16/15			No		2/16/15	2/16/15

Primary Care Quality Improvement Projects

Or...implementing the guidelines





Office of Primary Care and Area Health Education Centers (AHEC) Program

Opioid Prescription Management Toolkits

Opioid Prescription Management Toolkit for Chronic Pain Sustainable Solutions for Vermont

Practice Fast Track and Facilitators Toolkits

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What are these toolkits and why were they created?

These toolkits collect the best practice strategies for managing opioid prescriptions in primary care (and other) ambulatory settings. The strategies resulted from a two-year project (The Opioid Prescribing Quality Improvement Project, 2012-2014) to identify the most helpful methods used to create predictable and well-managed opioid prescribing patterns for physicians, nurse practitioners, and physician assistants and their patients.

What are some of the best practice strategies for managing opioid prescriptions?

New regulations about the prescribing of chronic opioids require the use of consent forms/treatment agreements and use of the prescription monitoring system. The standard of care supported by boards of medical practices across the country recommend, under certain circumstances, a variety of practice strategies to safely prescribe and monitor chronic opioid treatment. These strategies include assessing risk for misuse, use of pill counts and urine drug testing, best-practice documentation, and standardizing prescribing intervals to minimize communication issues among patient, office staff and prescriber, and others.

What are some of the results from the opioid prescribing two-year project?

All ten practices enrolled in the project reported positive results from the best practice strategies they chose to implement from the toolkit. The strategies helped prescribers standardize their approach and increase confidence in managing opioid prescriptions, helped practices change their support systems, and increased provider and staff satisfaction regarding the way opioid prescriptions are managed.

Who should read these toolkits and how are they different?

Fast Track Toolkit: This toolkit is intended for ambulatory care practices whose leaders, providers, and staff want to improve the process of managing opioid prescriptions for their chronic pain, non-palliative care patients. It is for practices with a team ready to make a quick start on a few of the 17 strategies and provides practical advice on getting started, how to adjust practice workflow, and how to implement changes. The toolkit includes an extensive appendix with policies, sample tools, and references.

Facilitator Toolkit: This toolkit is intended for practices that have not yet made a decision to work on opioid prescription management and need to develop a rationale, leadership support, and team to work on this topic. It provides three stages of development: preparation, design (of workflow), and implementation. It provides detailed guidance on measurement, team facilitation, work flow analysis, and follow up. It is best used by facilitators, staff, or leaders interested in supporting a transformative change in opioid prescription management. It includes the same appendix as the Fast Track Toolkit, with additional materials to support facilitation.



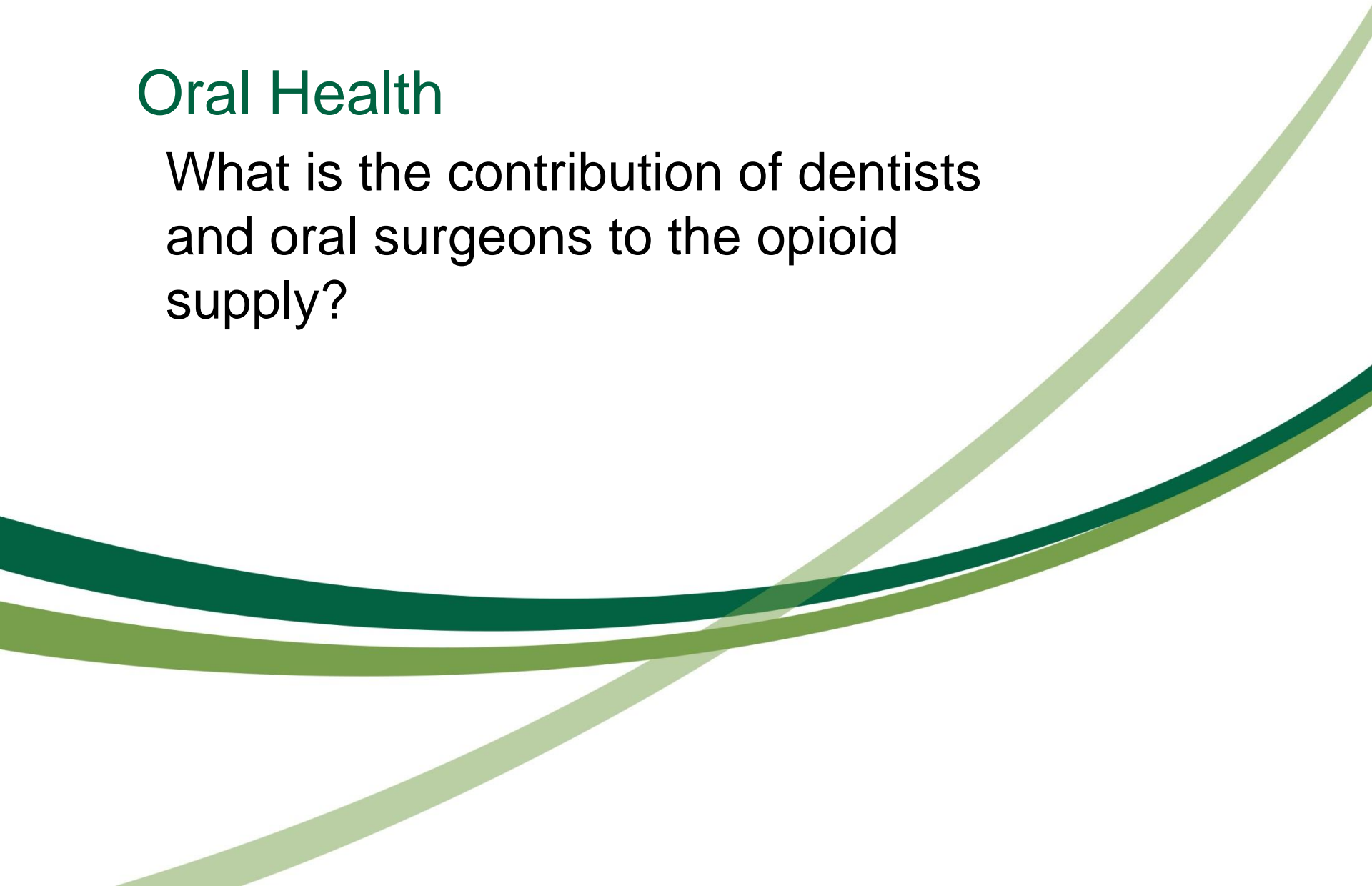
Improving Opioid Prescribing Toolkit - Practice Fast Track (PDF)



Improving Opioid Prescribing Toolkit - Facilitator Manual (PDF)

Oral Health

What is the contribution of dentists and oral surgeons to the opioid supply?



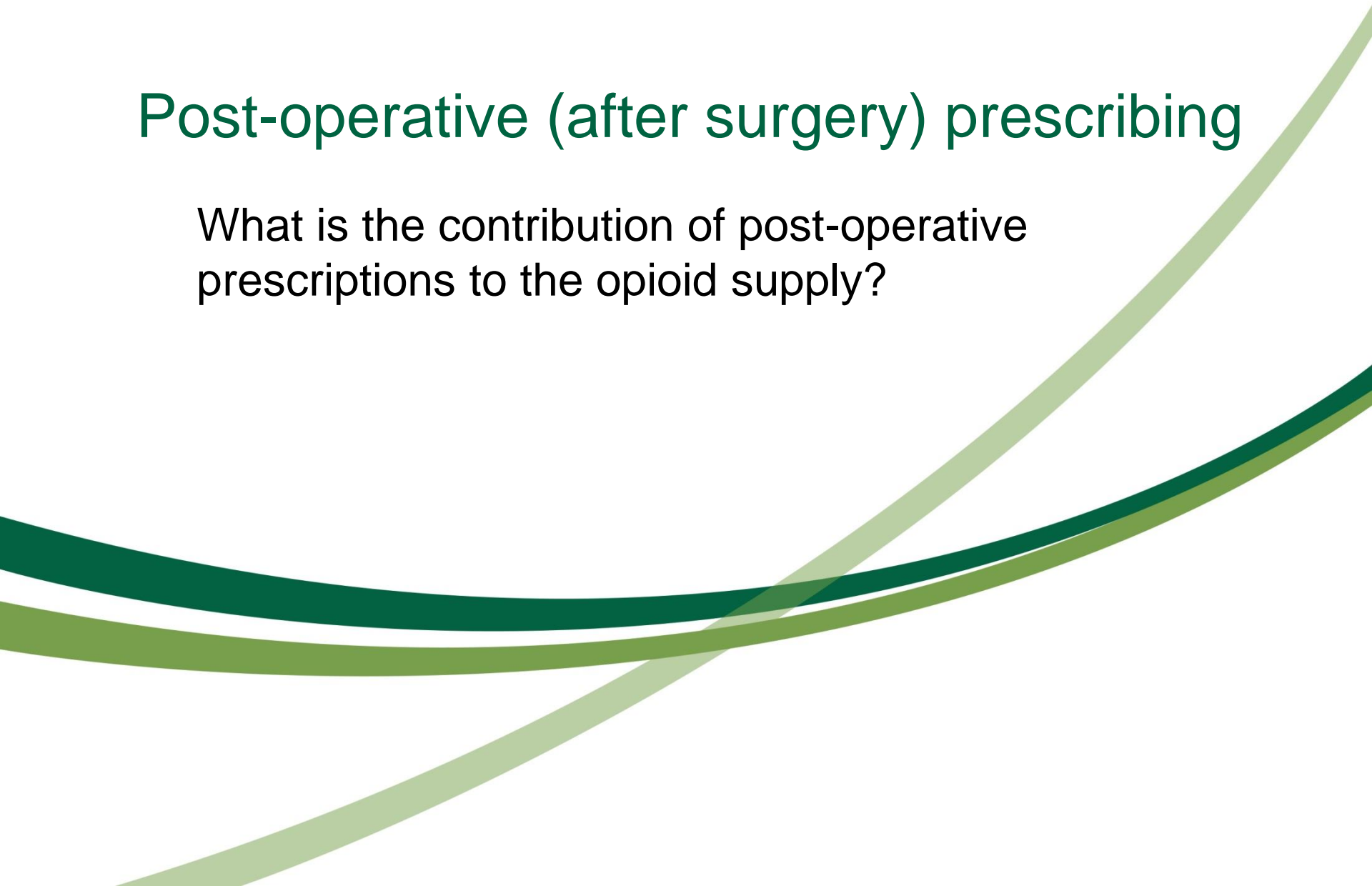
Annual opioid prescribing by discipline

Prescribing metric	General Dental	Oral surgery	
Number of Rx, median	21	490	

Source: VPMS (2014) and UVM Medical Center (2011-2012)

Post-operative (after surgery) prescribing

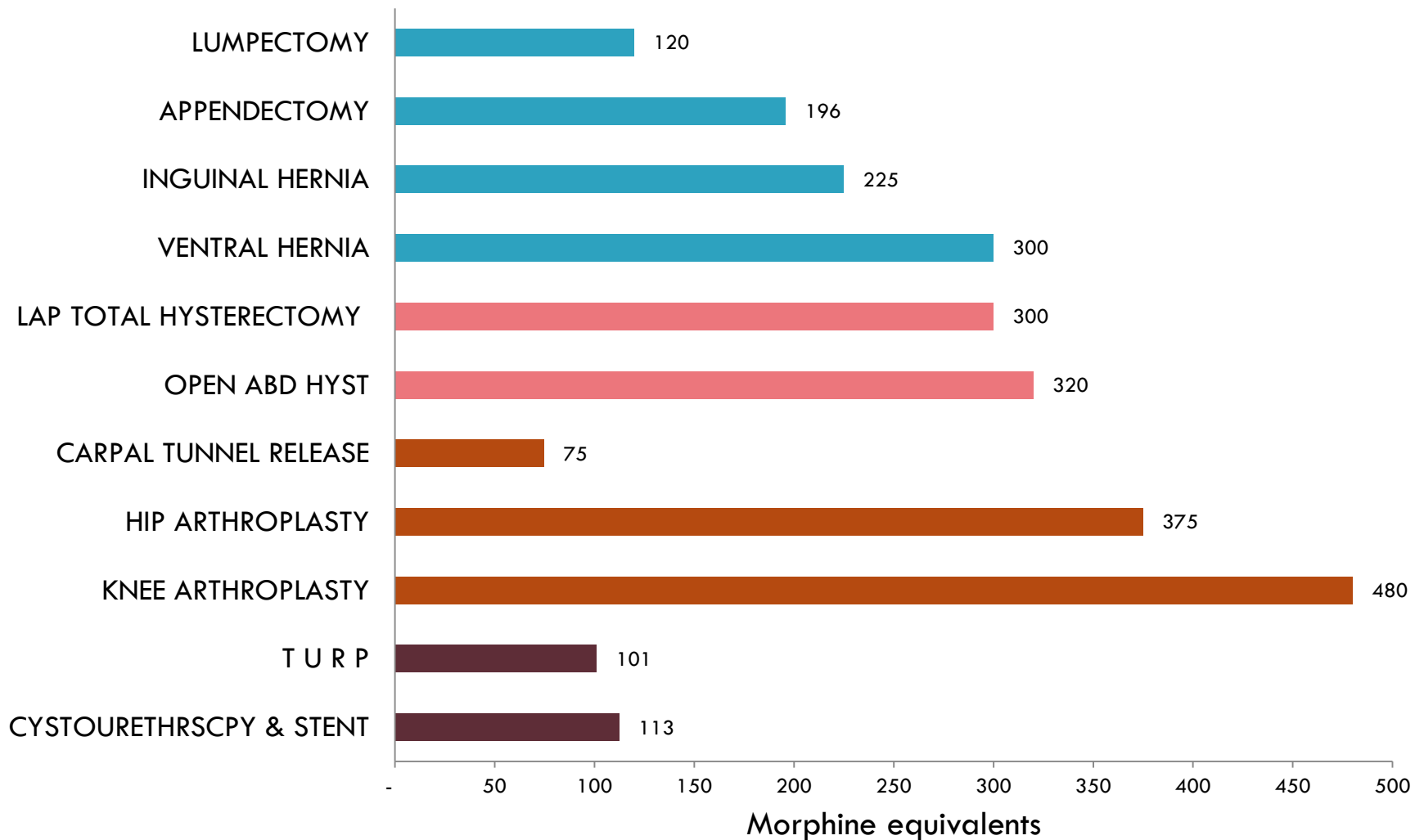
What is the contribution of post-operative prescriptions to the opioid supply?



Prescribing data

- 9858 patients underwent 11,287 procedures
- 2/3 outpatient procedures
- 20% patients were discharged without opioid Rx
- Most commonly prescribed opioids:
 - oxycodone (52%)
 - hydromorphone (31%)
 - hydrocodone (10%)

MME/Rx for common procedures



Patient perspective

- Phone call one week post-op
- *“How many pills do you have left?”*



Thanks for your attention

Responding to the opioid crisis: solutions for the “downstream problem” of opioid addiction

Patricia Fisher MD
Medical Director for Case Management
University of Vermont Medical Center

Substance use disorders

Loss of control

- more than intended
 - amount
 - time spent
- unable to cut down
- giving up activities
- craving

Physiology

- tolerance
- withdrawal

Consequences

- unfulfilled obligations
 - work
 - school
 - home
- interpersonal problems
- dangerous situations
- medical problems

formerly “Dependence”

formerly “Abuse”

• A **substance use disorder** is defined by having 2 or more • in the past year resulting in distress or impairment.

• Severity is rated by the number of symptoms present:

2-3 = mild
4-5 = moderate
6+ = severe

Spectrum of use



None or
low risk

At risk

Mild

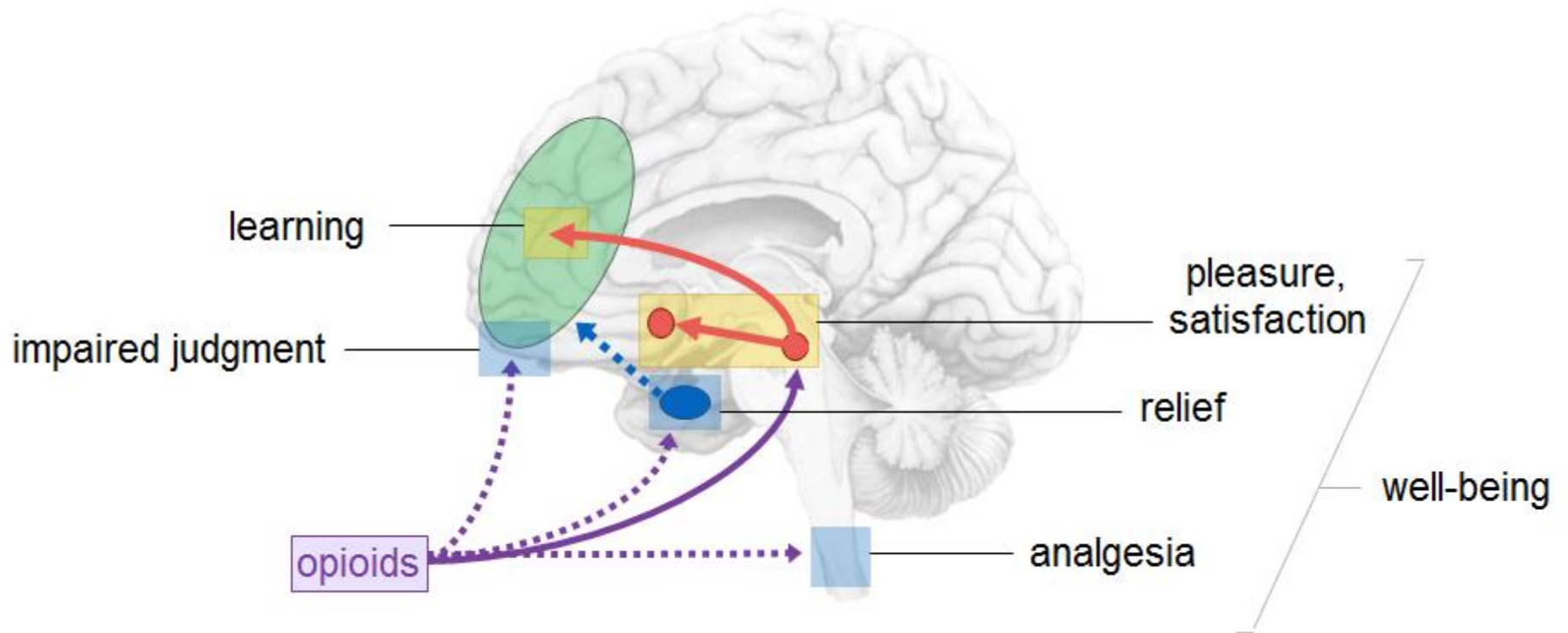
Moderate

Severe

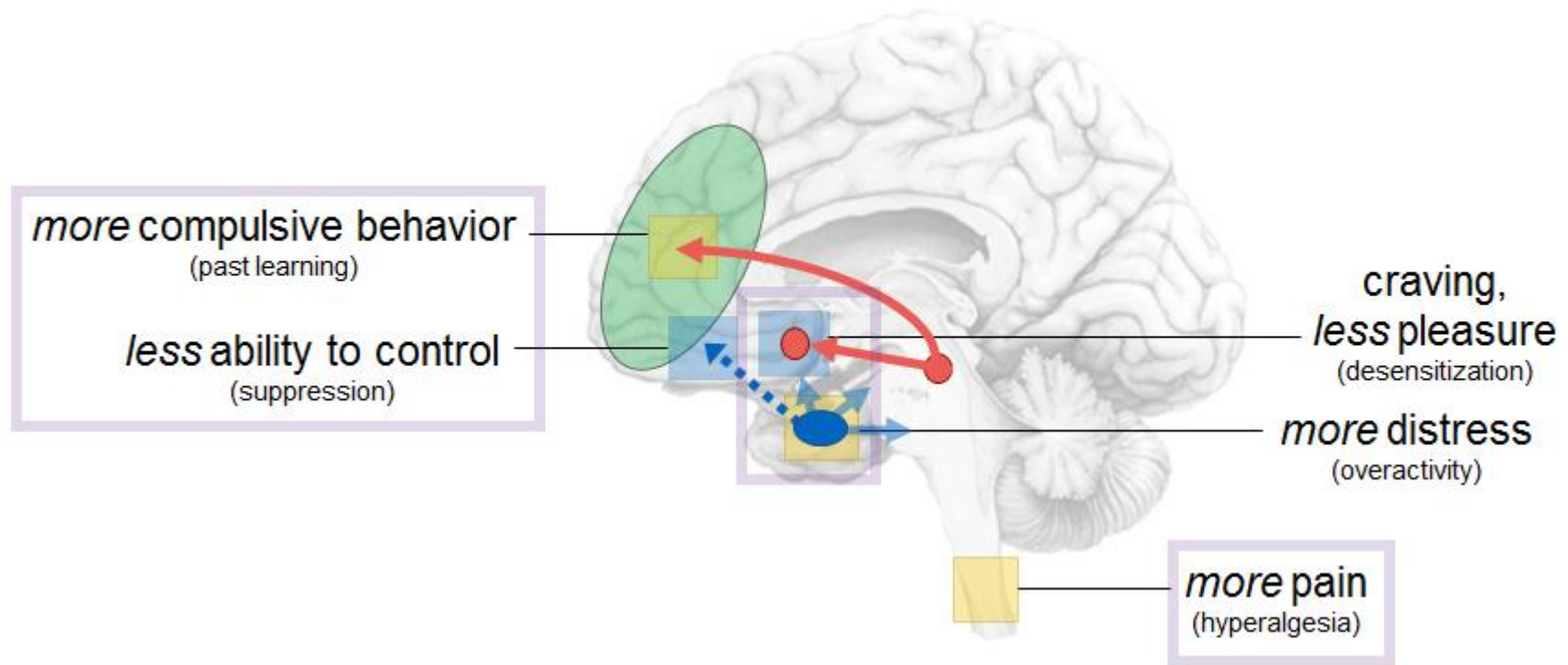
Increasing amounts, higher-risk
substances or situations

Craving, loss of control,
consequences

Intoxication



Addiction



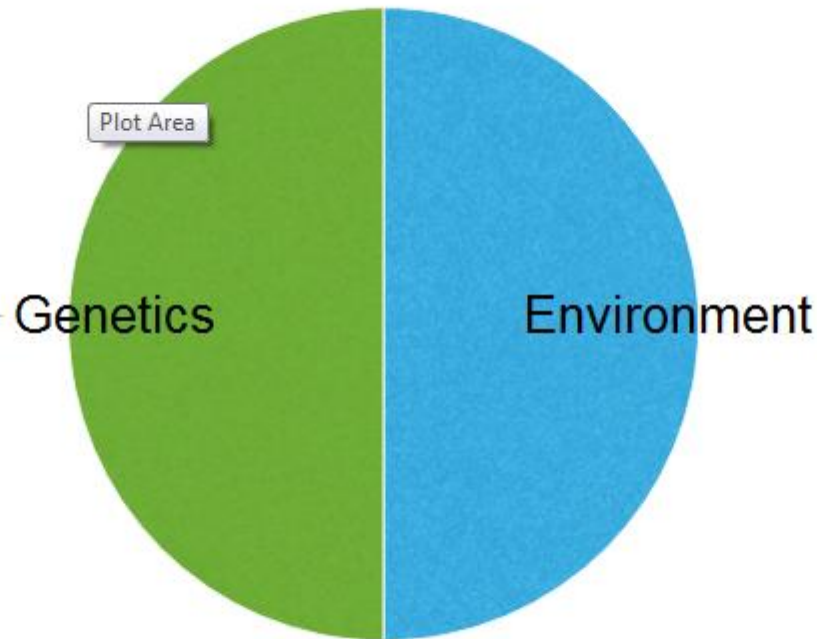
Who becomes addicted?

Biochemical

- opioid receptors
- dopamine
- other transmitters
- intracellular signals

Behavioral

- novelty seeking
- harm avoidance
- impulsivity
- psychiatric disorders



Social influence

- parents
- siblings
- friends

Adversity

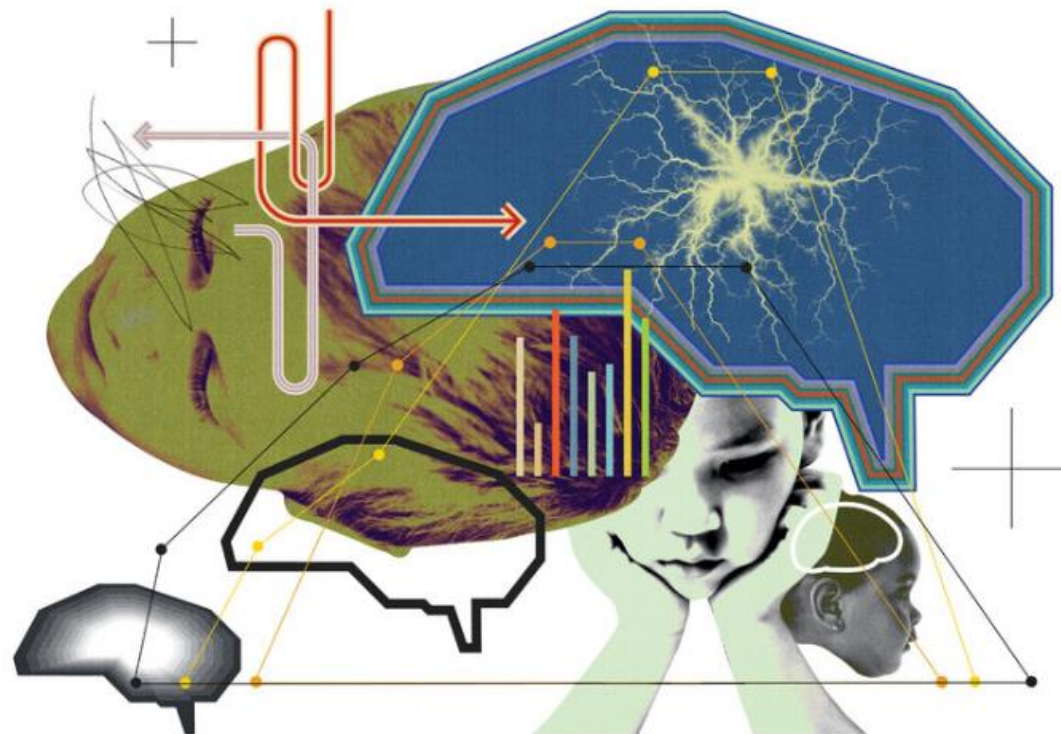
- psychiatric disorders
- stress
- lack of positive experiences

Availability

- illicit sources
- prescription
- family and friends

The 4 Traits That Put Kids at Risk for Addiction

By MAIA SZALAVITZ SEPT. 29, 2016



Sensation seeking
Impulsiveness
Anxiety sensitivity
hopelessness

Recovery

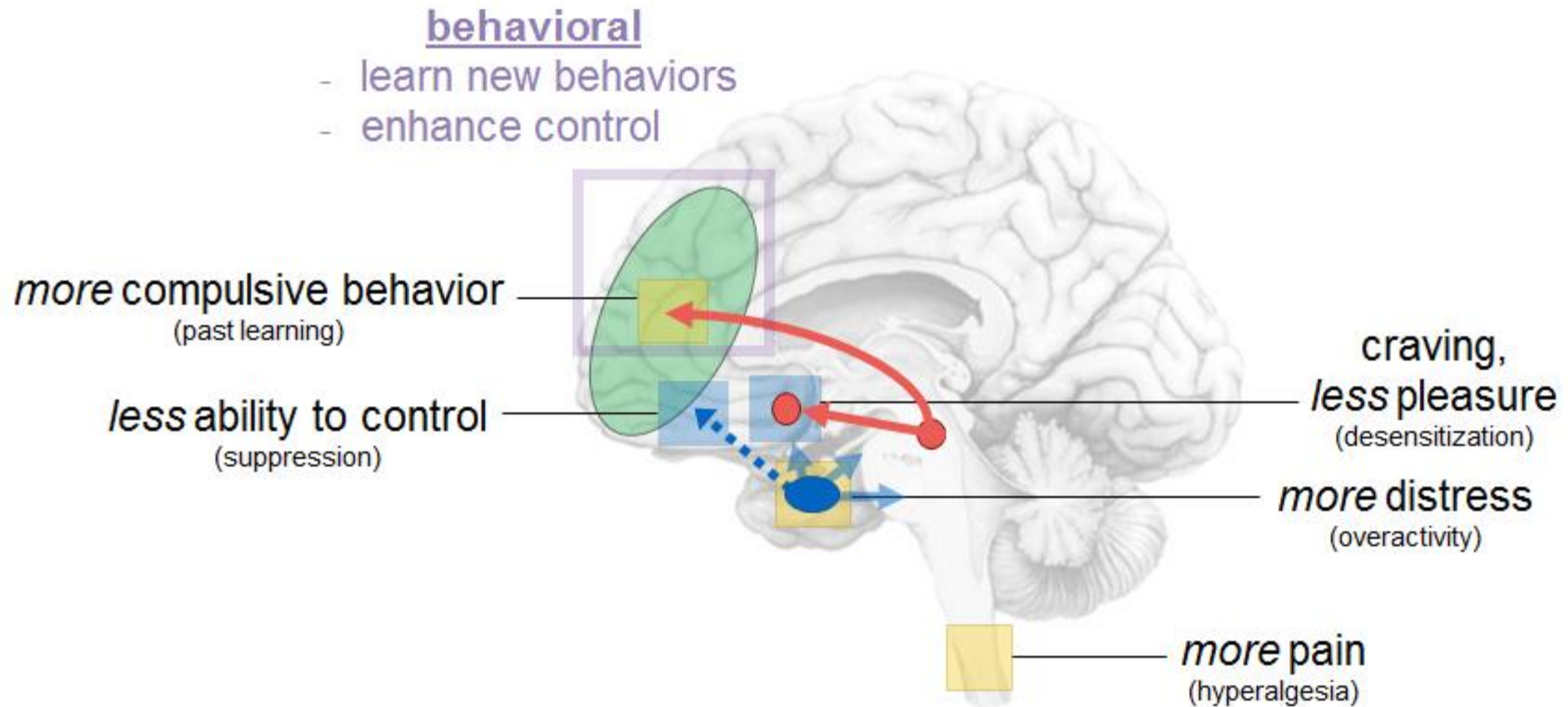
What is recovery?

- retention in treatment?
- less substance use, or none at all?
- improved general health?
- better functioning in work and relationships?
- higher quality of life?
- lower personal and societal costs?
- survival?

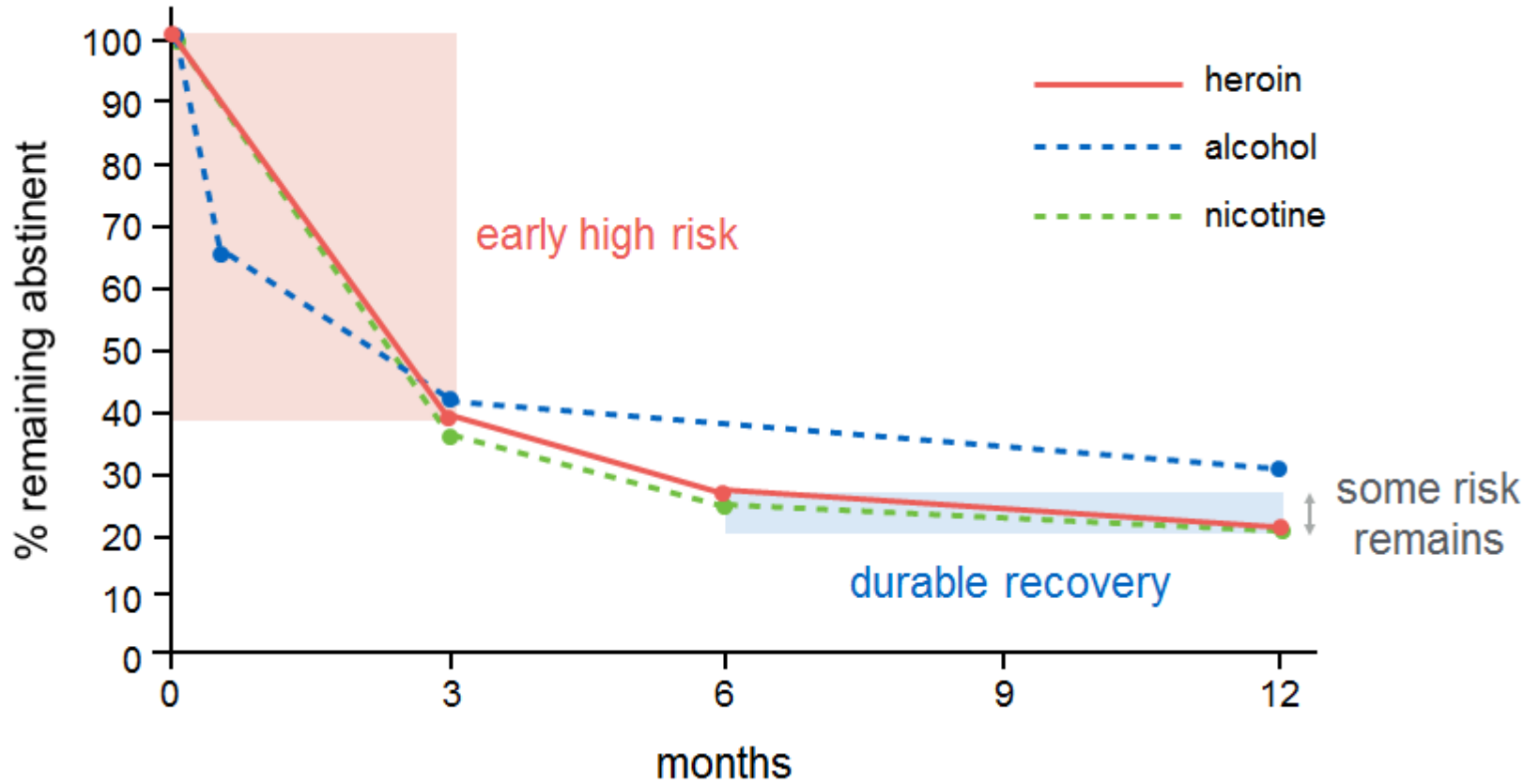
All of these can and often do improve with treatment.

Abstinence is less common—by many reports, 20-50% after 1 year.

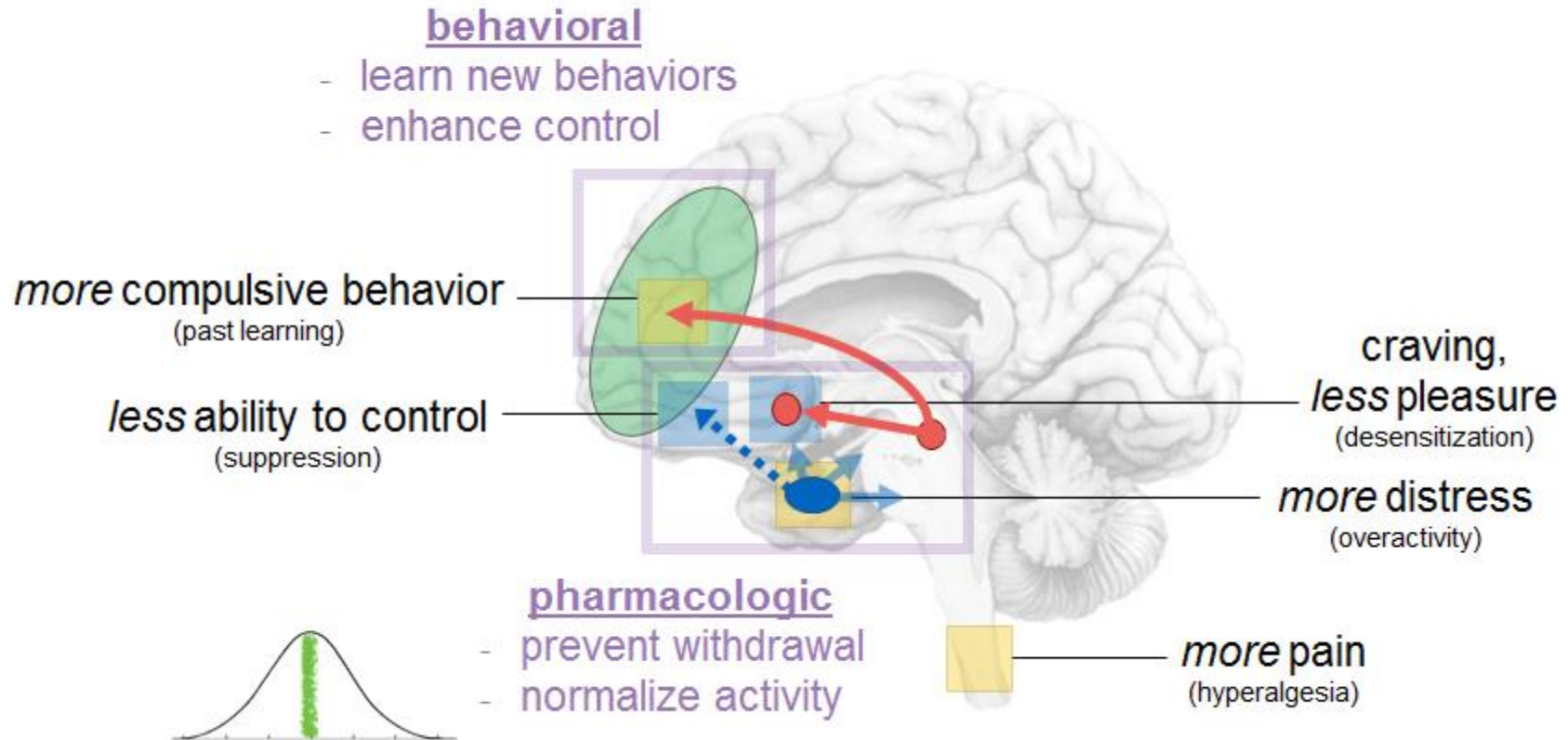
Treatment with therapy alone



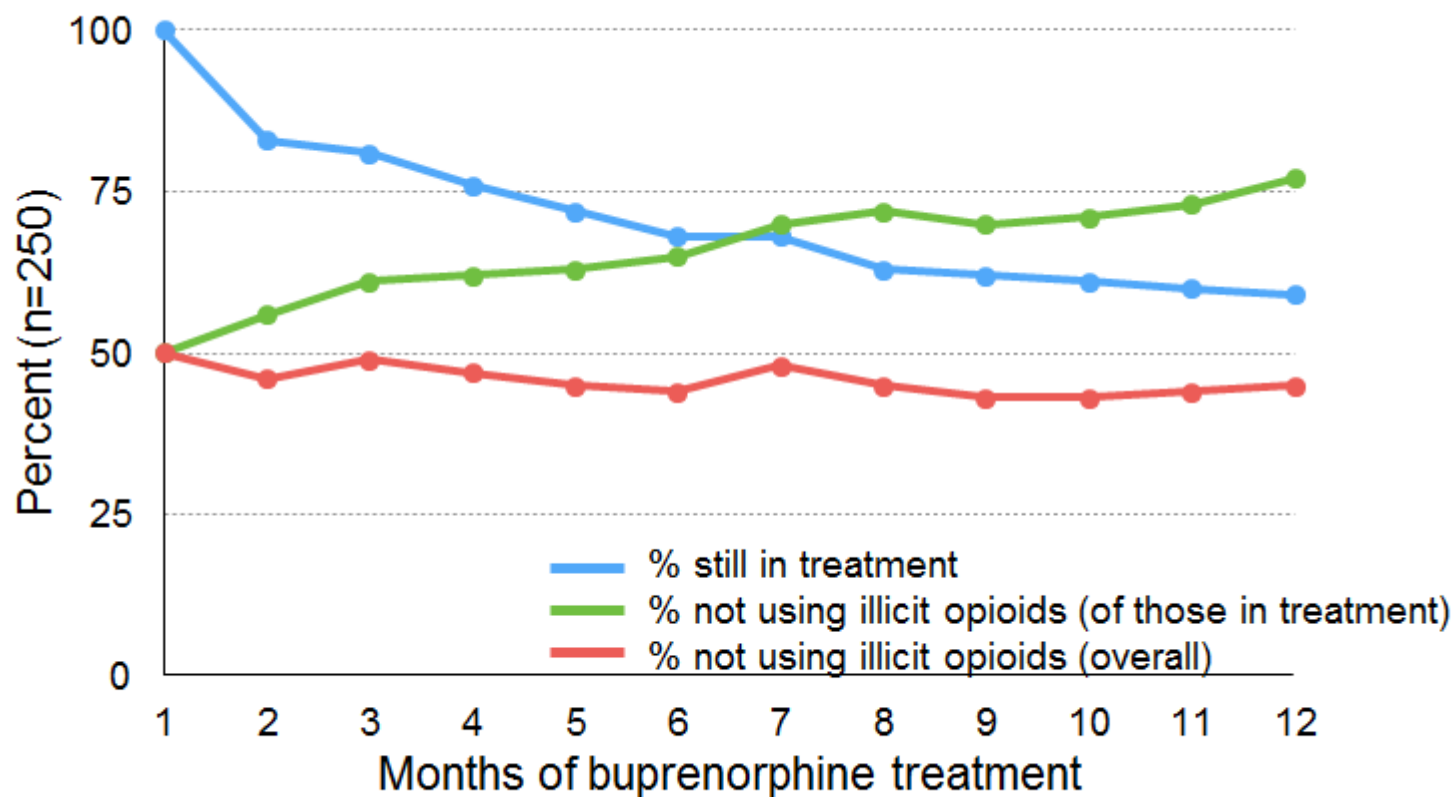
Natural history



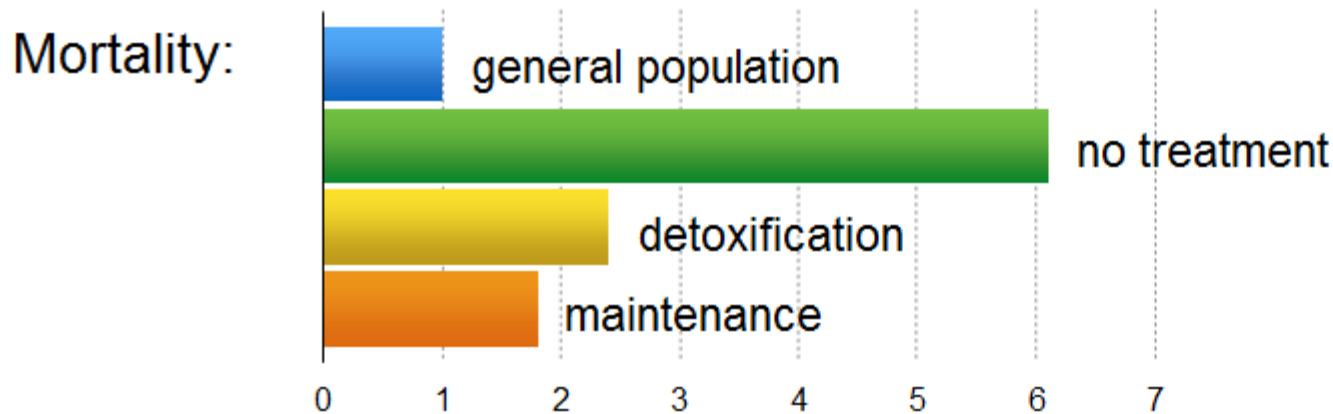
Treatment with therapy and medication



Medication-assisted treatment (MAT)



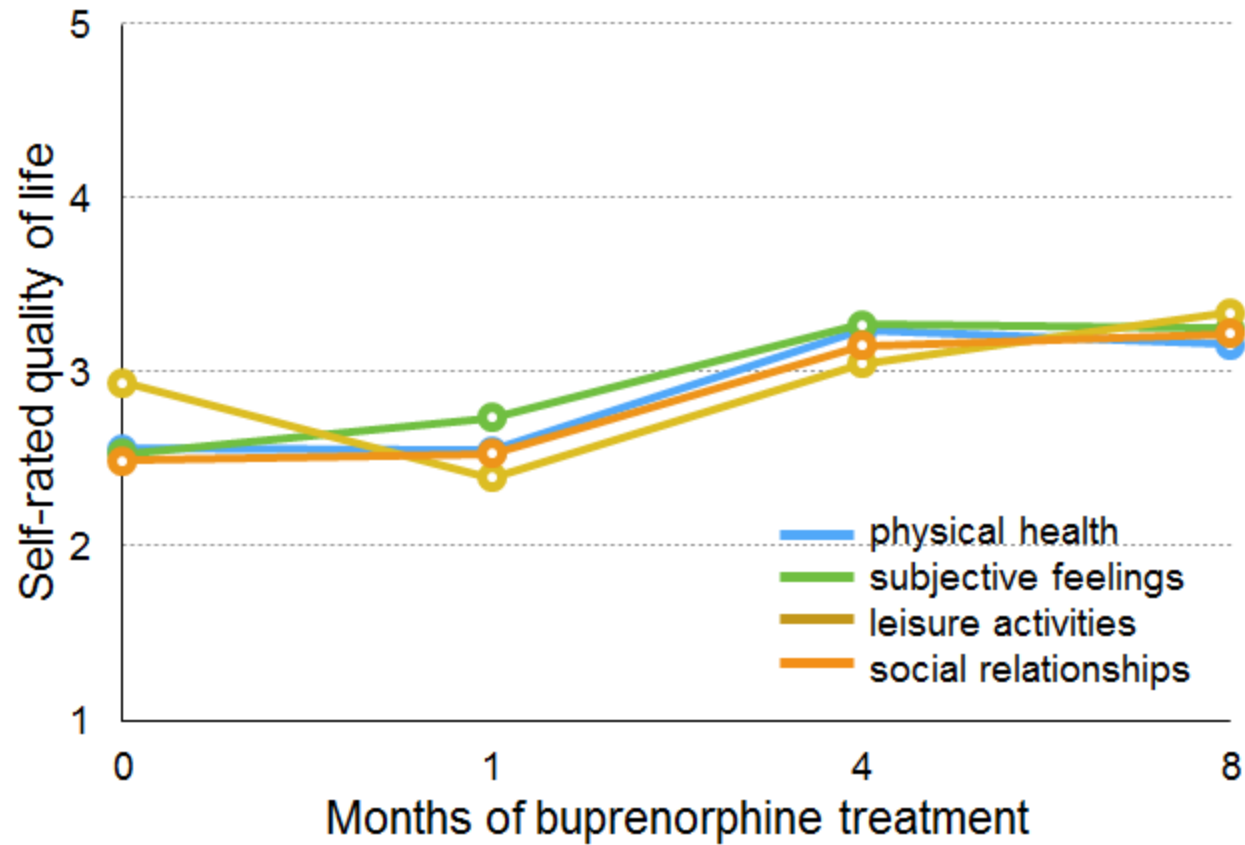
Other outcomes



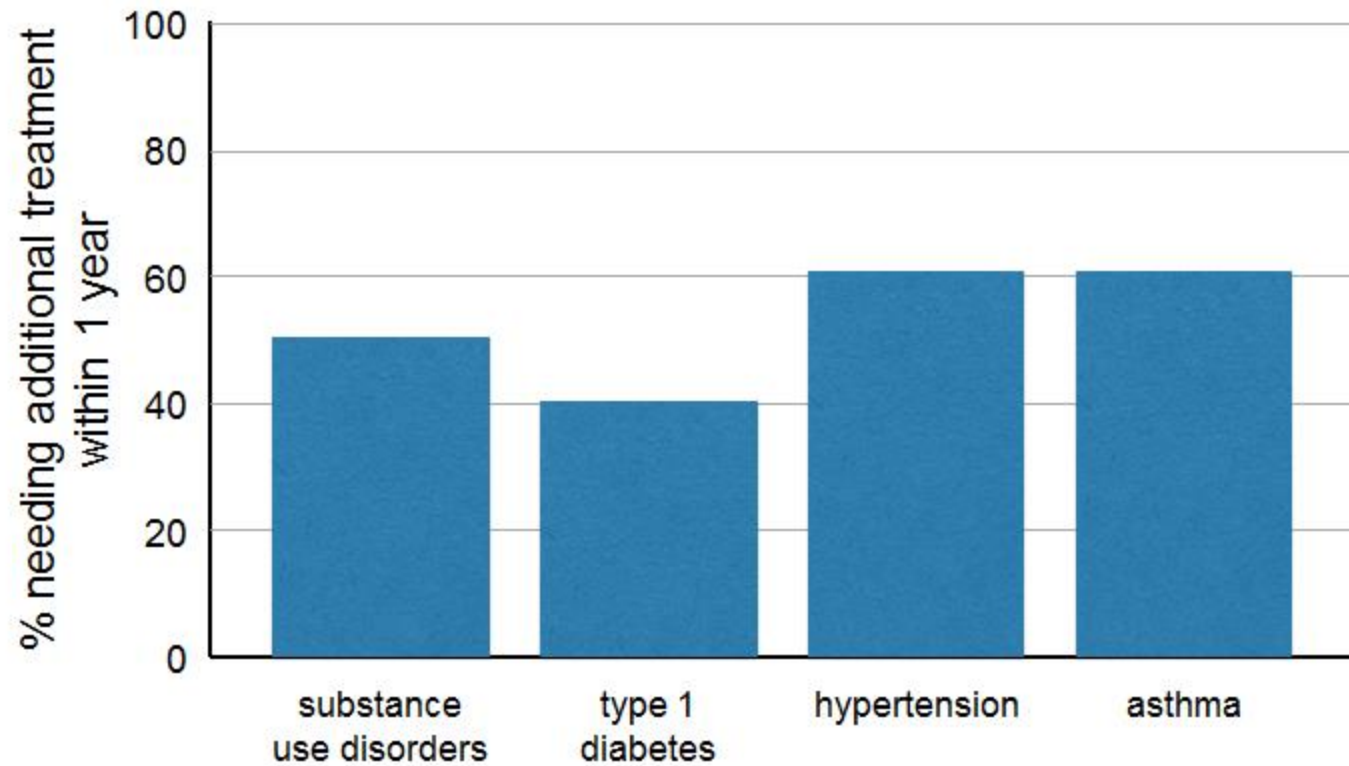
- Cost:
- One year of buprenorphine/naloxone: \$2755
 - Net cost, including all health care and services: -\$400

Quality of life

Quality of life



Relapse



Medication-assisted treatment (MAT)



Hub

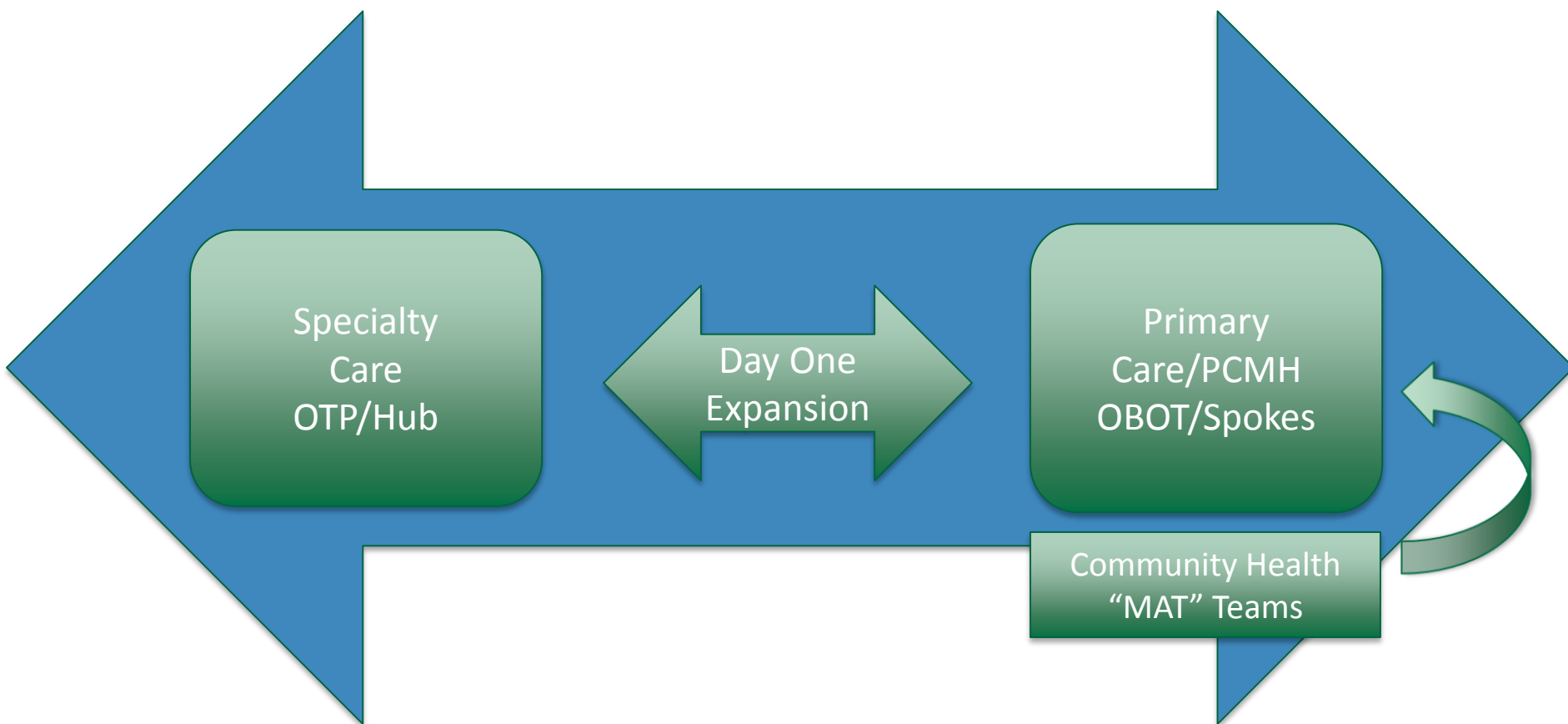
Spoke



OTP: Opioid Treatment Program
Methadone or Buprenorphine
High risk or unstable patients

OBOT: Office based treatment program
Buprenorphine or Naltrexone
Low risk or stable patients

The spectrum of addiction treatment



Vermont Progress

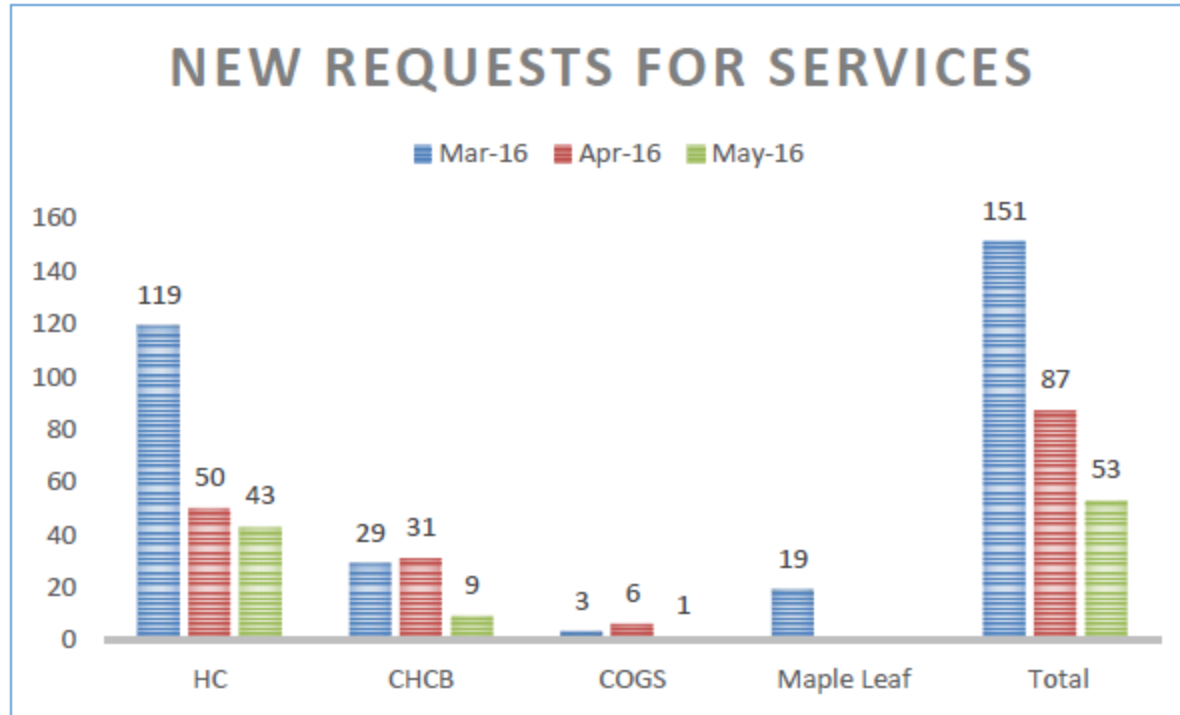
January 2014

- 1000 patients in hub and spokes

January 2016

- 6000 treated patients
- New hub in St Albans coming soon
- Ongoing training of providers for spokes
- Maple Leaf Farms to increase capacity

Medication Assisted Therapy



Measure:

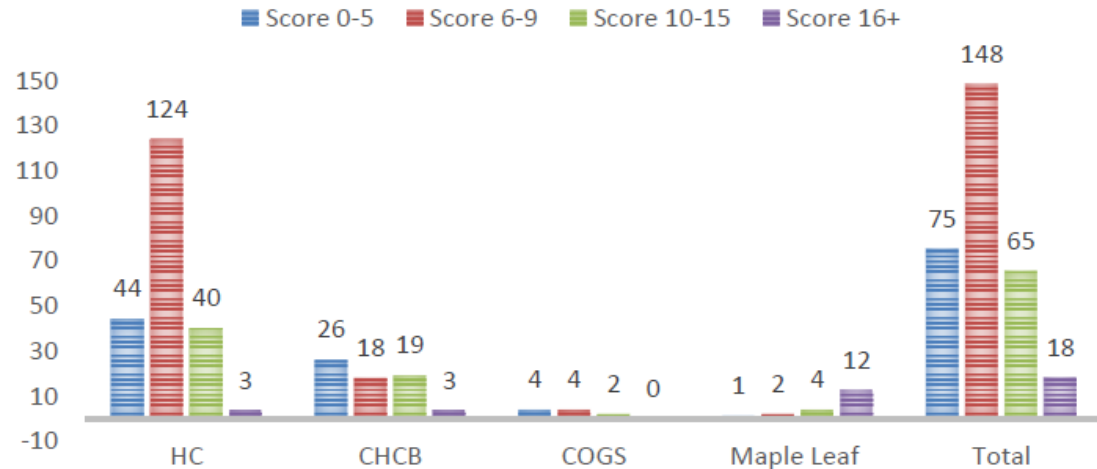
The number of new people requesting MAT services at each treatment provider during a given month

Medication Assisted Therapy

Measure:

For those people who requested services during this quarter, how did they individually score for severity using the Treatment Needs Questionnaire tool

QUARTERLY TREATMENT NEEDS QUESTIONNAIRE SCORES



Current Quarter: March-May 2016

The Future

- Upstream: a new respect for opioids
 - Smarter opioid prescribing
 - New CDC guidelines April 2016
 - Routine assessment and monitoring of all patients
 - Patient education about expectation for pain, risks of opioids and proper disposal of medication
 - If opioids are not helping manage pain or are having adverse effects they should be discontinued
 - Educational forums for providers and nursing
 - Public education about the dangers of opioids including lifelong dependence, risk of overdose and death
 - Naloxone to prevent overdose deaths
 - Prescribing protocols in electronic health record including standardizing medication type and amount for procedures
 - Rural opioid use—kids are more susceptible
 - Increased identification of those at risk for addiction
 - Improved safe keeping and disposal of medications in homes
 - Improved accessibility for alternative treatments for pain
 - Improved access to mental health treatment
 - Finding ways to manage pain without opioids

The Future

- Downstream: Improved access to treatment for addiction
 - Chronic disease model to manage addiction
 - Continued efforts at de-stigmatization: a person using a drug is just that—a person using a drug. How do we work with them?
 - Less regulation around the prescribing of buprenorphine
 - Decriminalizing/“decarceration” addiction-related crimes
 - Harm reduction for those not interested in sobriety? How do we reduce their risk of overdose and death?
 - Better re-entry programs for those coming out of incarceration
 - Improved support for people and families struggling with addiction
 - Inviting “addicts” to the table when making policies that affect them
 - Syringe exchange
 - Strong community collaborations

Acknowledgements

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(medicine/dentistry)

- Including UVM Med Ctr & CVMC
- Community prescribers

- **Vermont Blueprint for Health**

- Jenny Samuelson
- Pam Farnham
- Regional facilitators

Resources



- CDC guidelines
 - <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>
- www.PainEDU.org
 - SOAPP, COMM (screening tools for misuse)
- Safe and Effective Opioid Prescribing for Chronic Pain (BU)
 - www.opioidprescribing.com
- Prescriber's Clinical Support System for Opioid Therapies
 - www.pcass-o.org/
- Vermont Prescription Monitoring System
 - http://healthvermont.gov/adap/VPMS_reports.aspx
- Brandeis PDMP Center of Excellence
 - <http://pdmpexcellence.org>

Together we can

CHANGE THE FUTURE

