NC Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)

Coordinating Workgroup Meeting

November 9, 2017

Welcome! and Introductions of Attendees

- Welcome!
  - –Steve Mange
  - –Susan Kansagra
- Introductions of Attendees
  - –Your name
  - –Your organization/affiliation

Post Reversal Response/ED to Treatment Connection

Action Learning, Continuation

Jai Kumar, NC Hospital Association

A Crisis in Crisis Care:

Opioids and Behavioral Health in EDs

Jai Kumar, MPH

Julia Wacker, MSW, MSPH

North Carolina Hospital Association

NCHA North Carolina Hospital Association

NCHA in the State Action Plan

Care linkages	Work with health systems to develop and adopt model overdose discharge plans to promote recovery services and link to treatment care	NCHA, LME/MCOs
	Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists	DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD
Treatment access	Increase state and federal funding to serve greater numbers of North Carolinians who need treatment	All

The Coalition for Model Opioid Practices in Health Systems

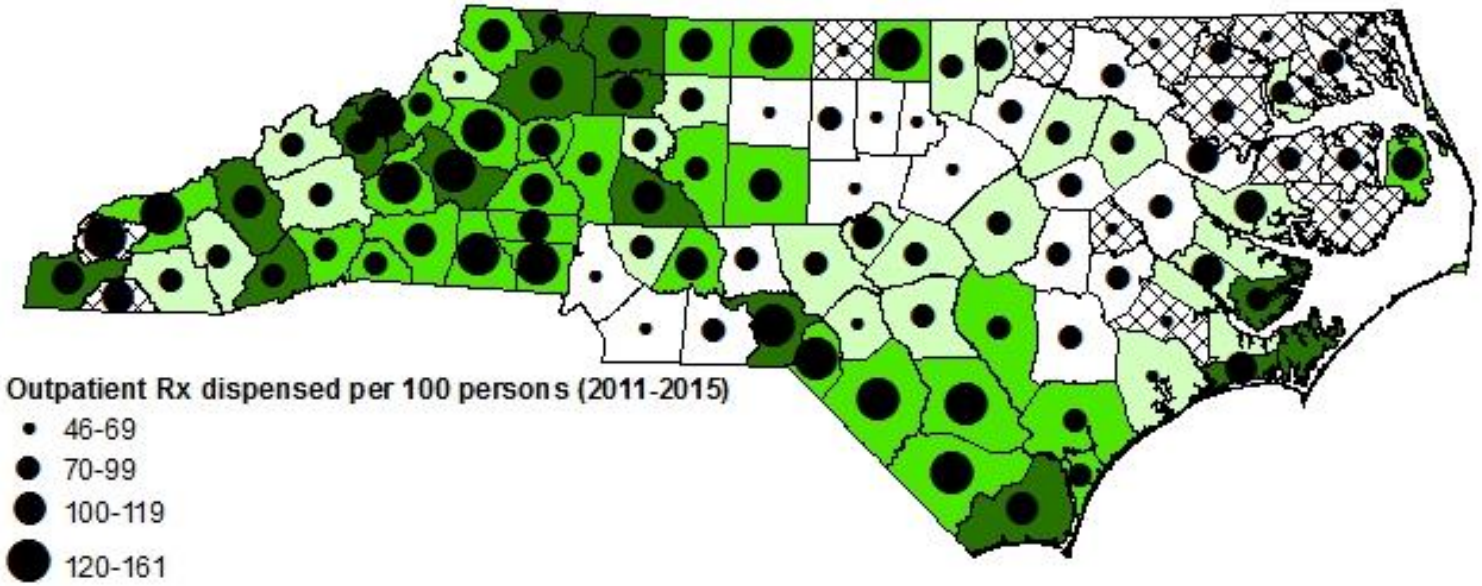
GOAL	OBJECTIVES	STRATEGIES	TACTICS
CULTURE CHANGE Support implementation of health system opioid stewardship committees	**Prevention & Safe Pain Management**	Clinical Toolkit	Create a statewide set of tools through review of existing resources; Provide resources for clinical staff on de-escalation tactics when prescribing opioids to patients
		Education	Create & disseminate PSA video campaign; Provide clinician training on pain mgt. & addiction
		Technical Solutions	Assist with EHR optimization; Coordinate CSRS to EHR integration
		Provider Standards of Care	Develop a standardized prescribing schedule; Create naloxone co-prescribing standards
	Health System Response	Stigma Reduction Efforts	Conduct a workforce audit on current state of behavioral health stigma; Identify patient/family health system champions
		Addiction Identification	Standardize harm reduction protocols; Create risk scoring models & patient profiles for various sevice lines
		Placement & Intervention Strategies	Develop & conduct community resource audits; Assist with implementing a comprehensive pregnancy treatment model; Create ED to behavioral health hand-off procedure
		Expanded MAT Efforts	Increase clinician awareness & mentoring support; Increase advocacy presence for substance use disorder (i.e., MAT, Funding, etc.)
	Healthcare Worker Diversion	Prevention & Workforce Wellness	Develop employee wellness program best practice resources; Produce diversion awareness education framework
		Diversion Program Structure	Provide minimum diversion program standards and policy guidance; Create investigation protocol framework
		Monitoring & Surveillance	Develop risk audit toolkit; Develop guidelines for data collection/analysis and internal identification of diversion
		Reporting	Provide guidance for required, regulatory board, and law enforcement reporting

NCHA North Carolina Hospital Association

Injury & Violence PREVENTION Branch

Rates of Unintentional/Undetermined Prescription Opioid Overdose Deaths & Outpatient Opioid Analgesic Prescriptions Dispensed

North Carolina Residents, 2011-2015



Source: Deaths- N.C. State Center for Health Statistics, Vital Statistics, 2011-2015, Overdose: (X40-X44 & Y10-Y14) and commonly prescribed opioid T-codes (T40.2 and T40.3)/Population-National Center for Health Statistics, 2011-2015/Opioid Dispensing- Controlled Substance Reporting System, NC Division of Mental Health, 2011-2015

Analysis: Injury and Epidemiology Surveillance Unit

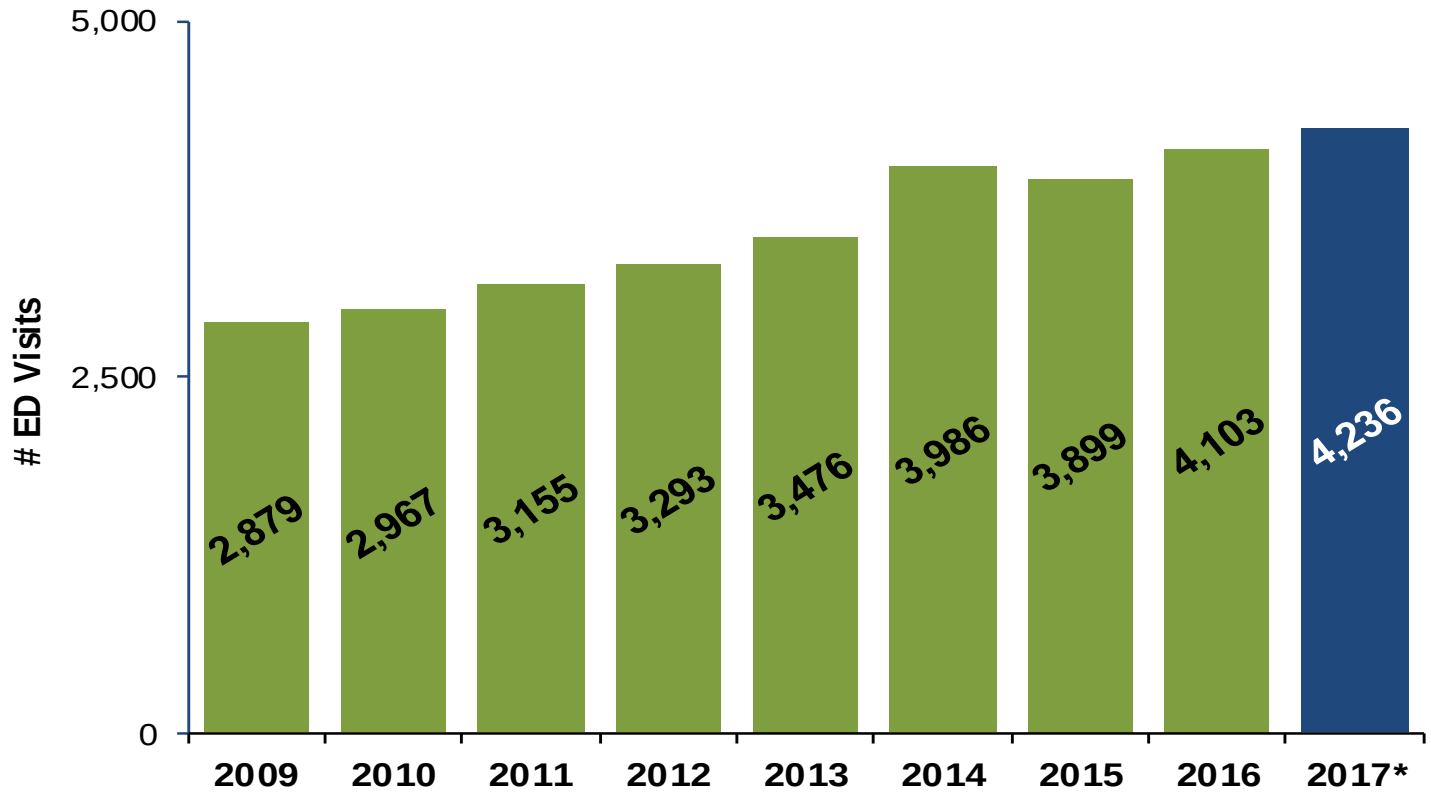
Average mortality rate:
6.4 per 100,000 persons

Average dispensing rate:
82.9 Rx per 100 persons

North Carolina Injury & Violence PREVENTION Branch

NCHA

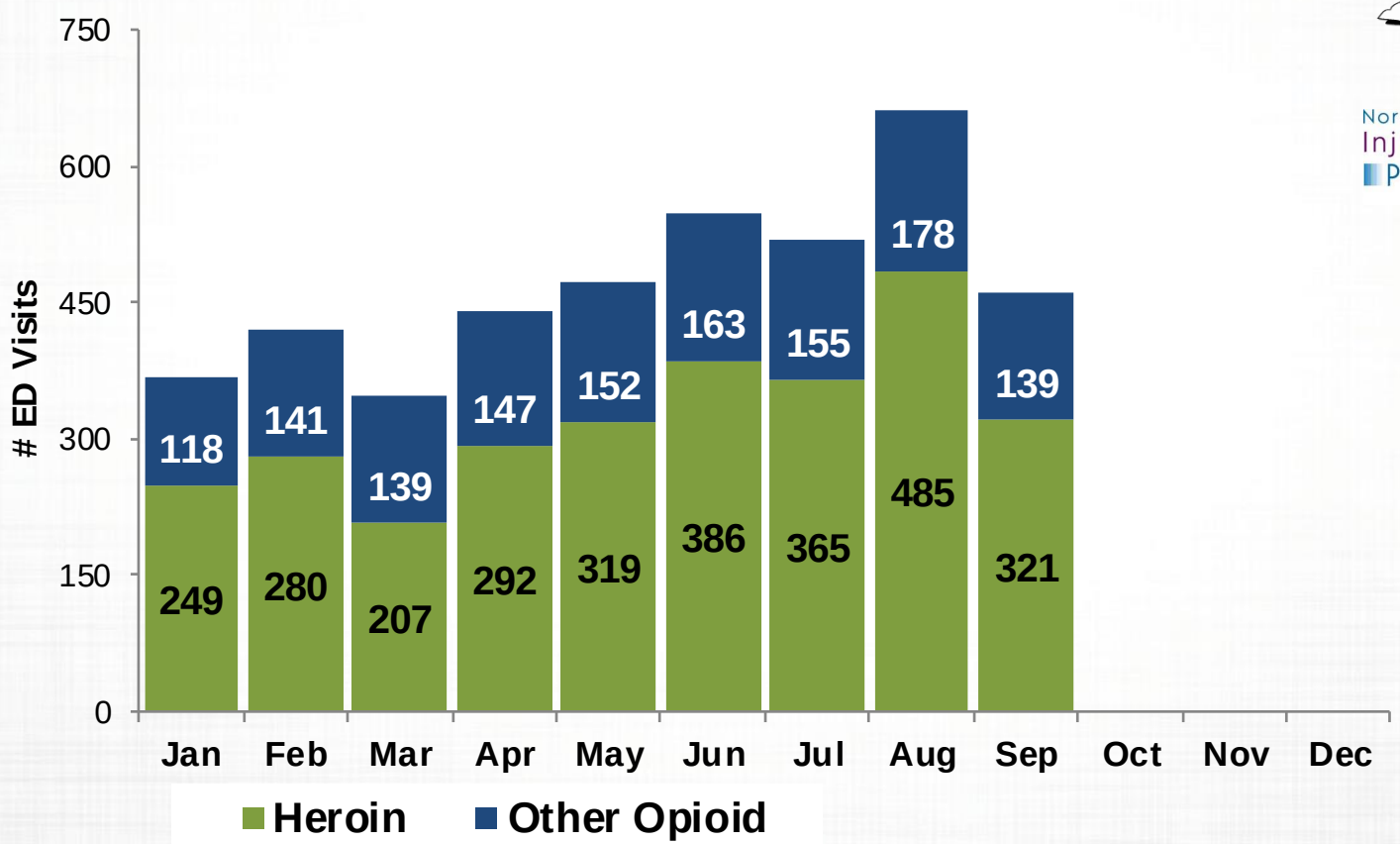
Opioid Overdose ED Visits by Year: North Carolina, 2009-2017 YTD



Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT). Counts based on diagnosis (ICD-9/10-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose cases include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics.
Analysis by Injury Epidemiology and Surveillance Unit

YTD: Year to Date
**Provisional Data: 2017 ED Visits*

Monthly Opioid Overdose ED Visits by Opioid Class: 2017 YTD



NC DETECT

North Carolina Injury & Violence PREVENTION Branch

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Analysis by Injury Epidemiology and Surveillance Unit

NCHA

Opioid Overdose ED Visits by Insurance Coverage: 2017 YTD

Insurance Coverage	
Private insurance	14%
Medicaid/Medicare	27%
Uninsured/Self-pay	50%
Other/Unknown	9%

Data Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT). Counts based on diagnosis (ICD-9/10-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose cases include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics.

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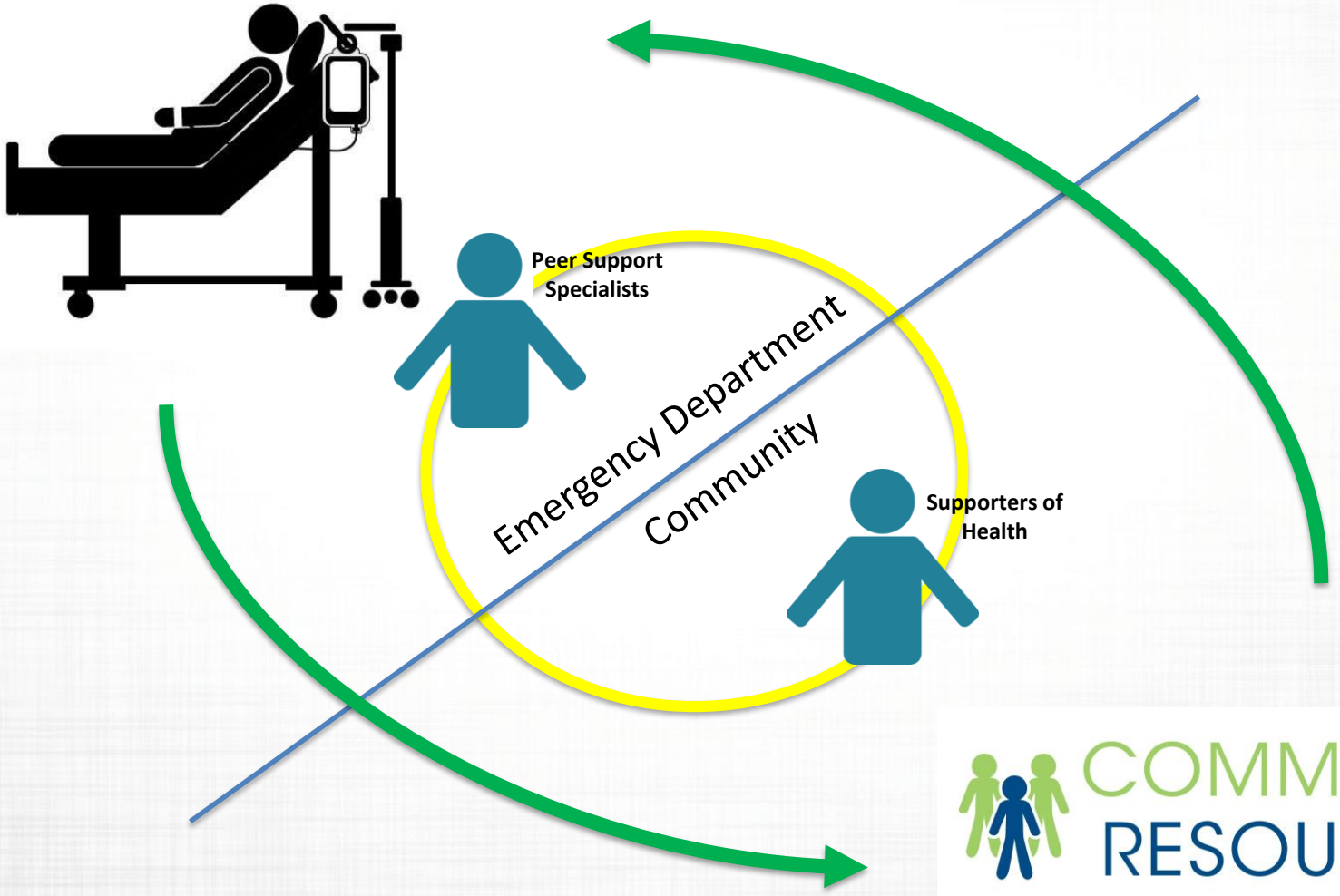
Peer Support Integrated Model



A Collaborative Approach

- Peer Support & Supports of Health are certified by LME/MCO and employed by the health system
- Hospital case management/social work to set up linkages in care while peer support act as health navigators & initiate **HOT** Handoffs
- Community Supporters of Health act as liaisons to ensure SUD patients make it to treatment

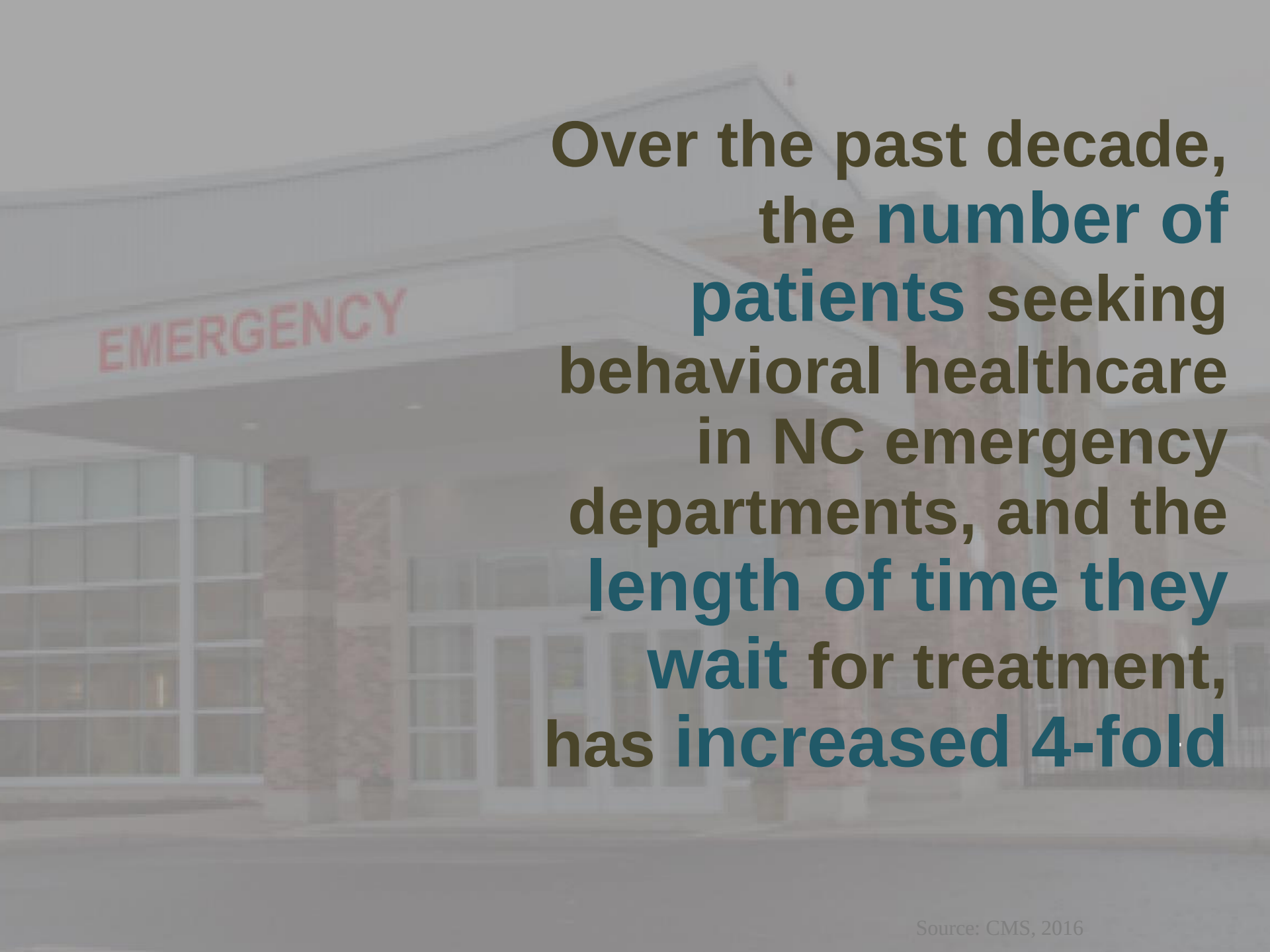
Problem Analysis

Is this the right model?

Involuntary Commitment

Action Learning and Problem Analysis

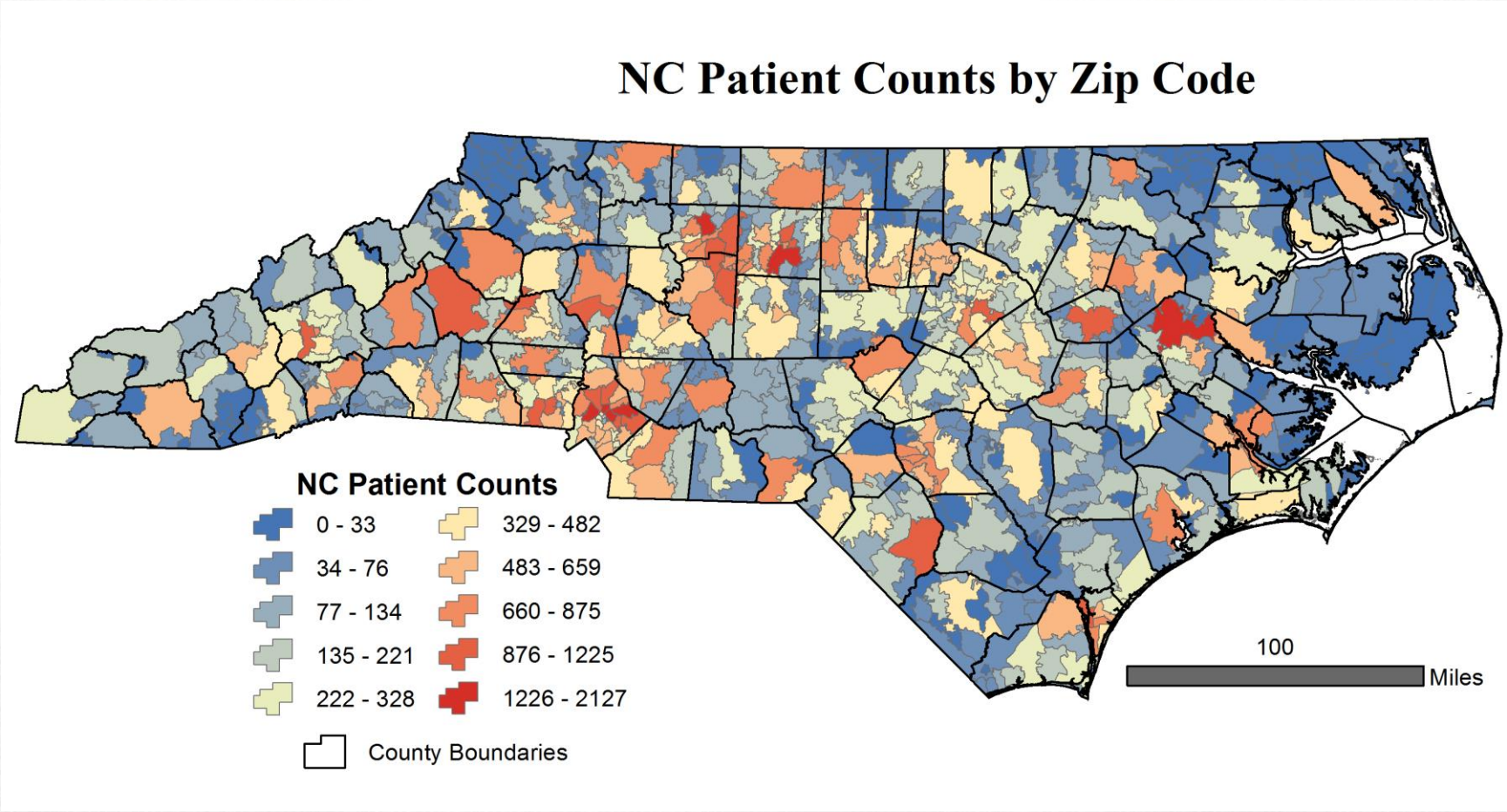
Julia Wacker, NC Hospital Association



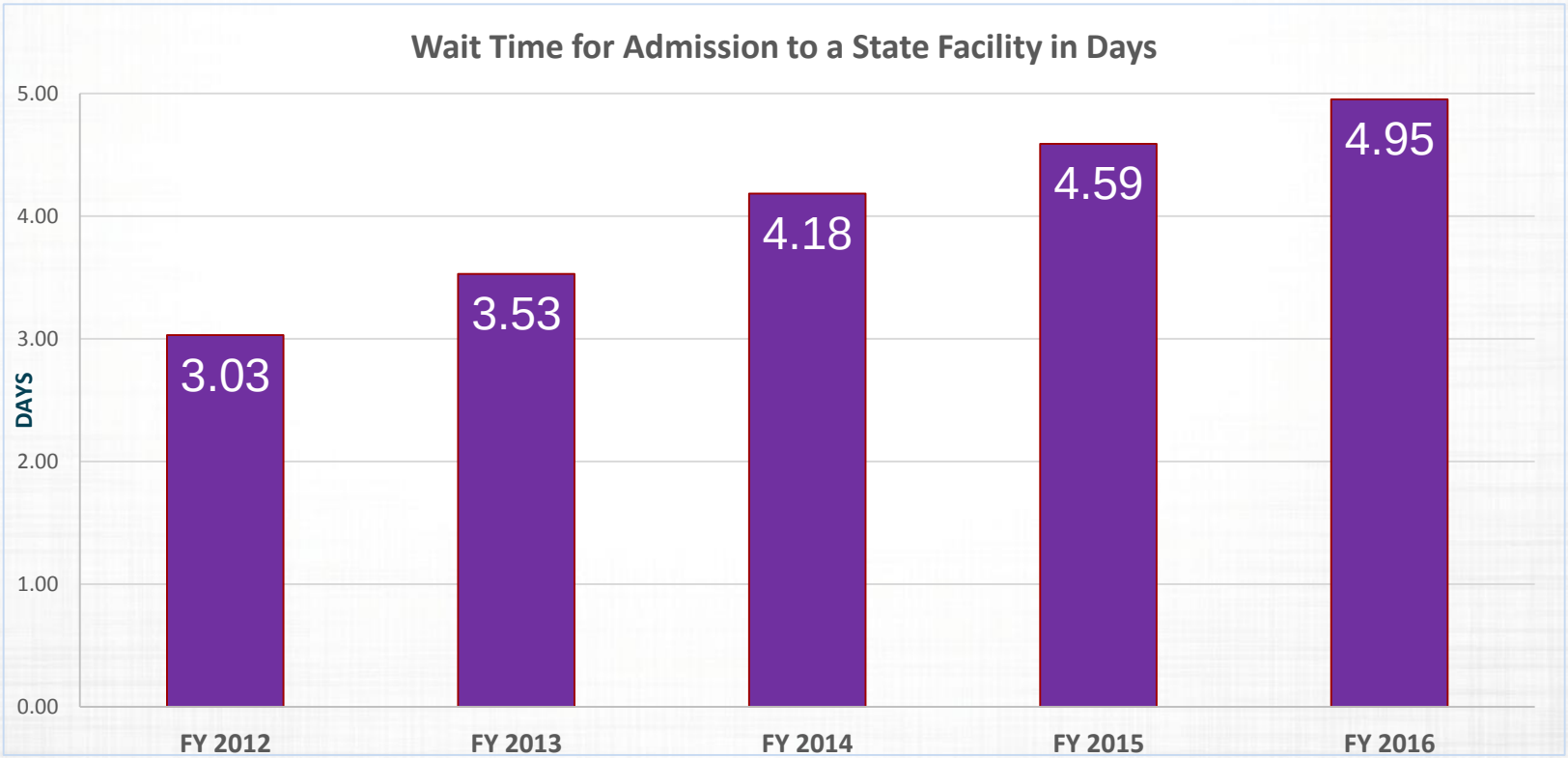
Over the past decade, the number of patients seeking behavioral healthcare in NC emergency departments, and the length of time they wait for treatment, has increased 4-fold

Source: CMS, 2016

2015 ED Visits by Patient Zip



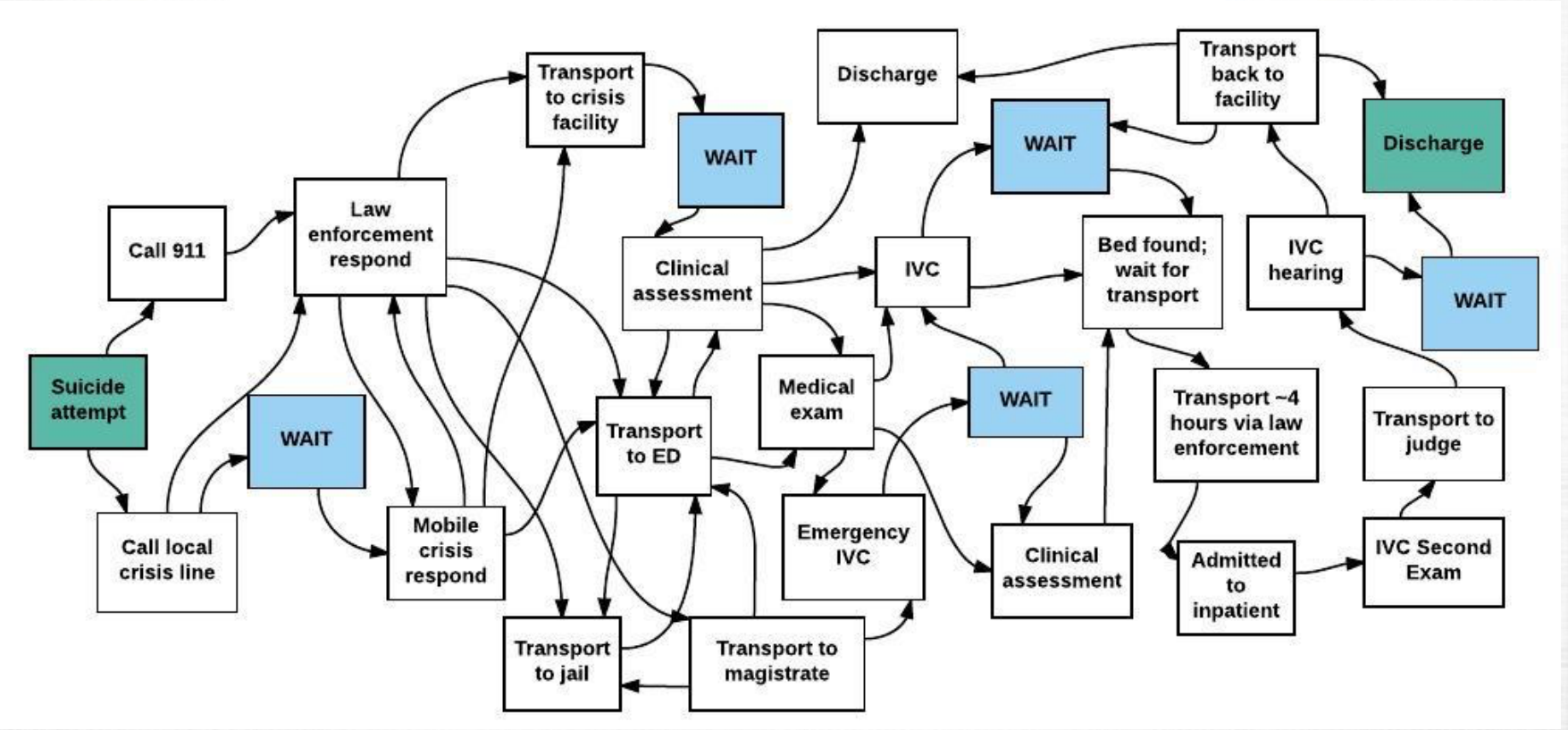
Average ED Wait Times in NC



Source: State Hospital Referral Database

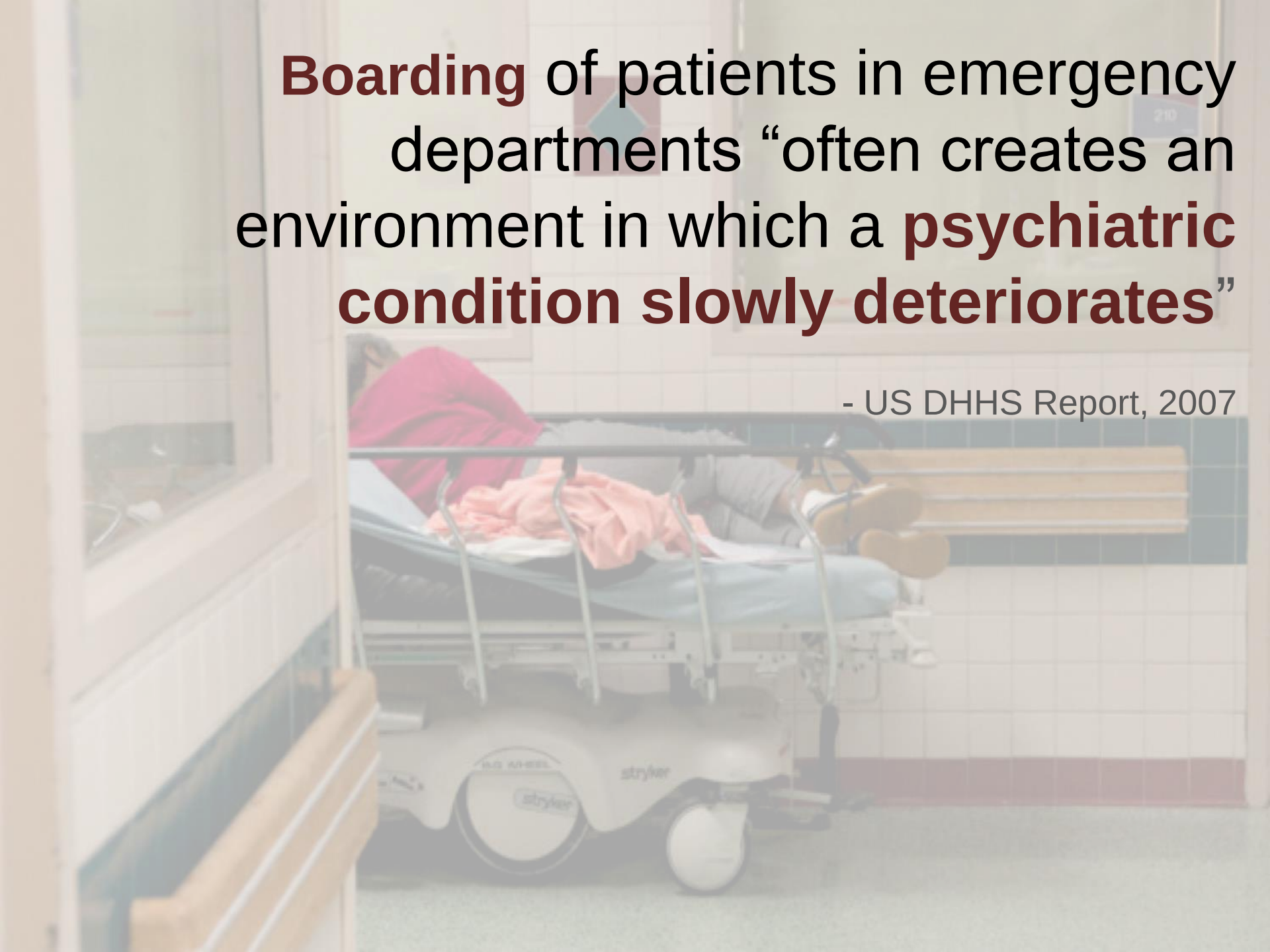
The Impact

NC's Behavioral Health Crisis Response System



System in Conflict with the Evidence

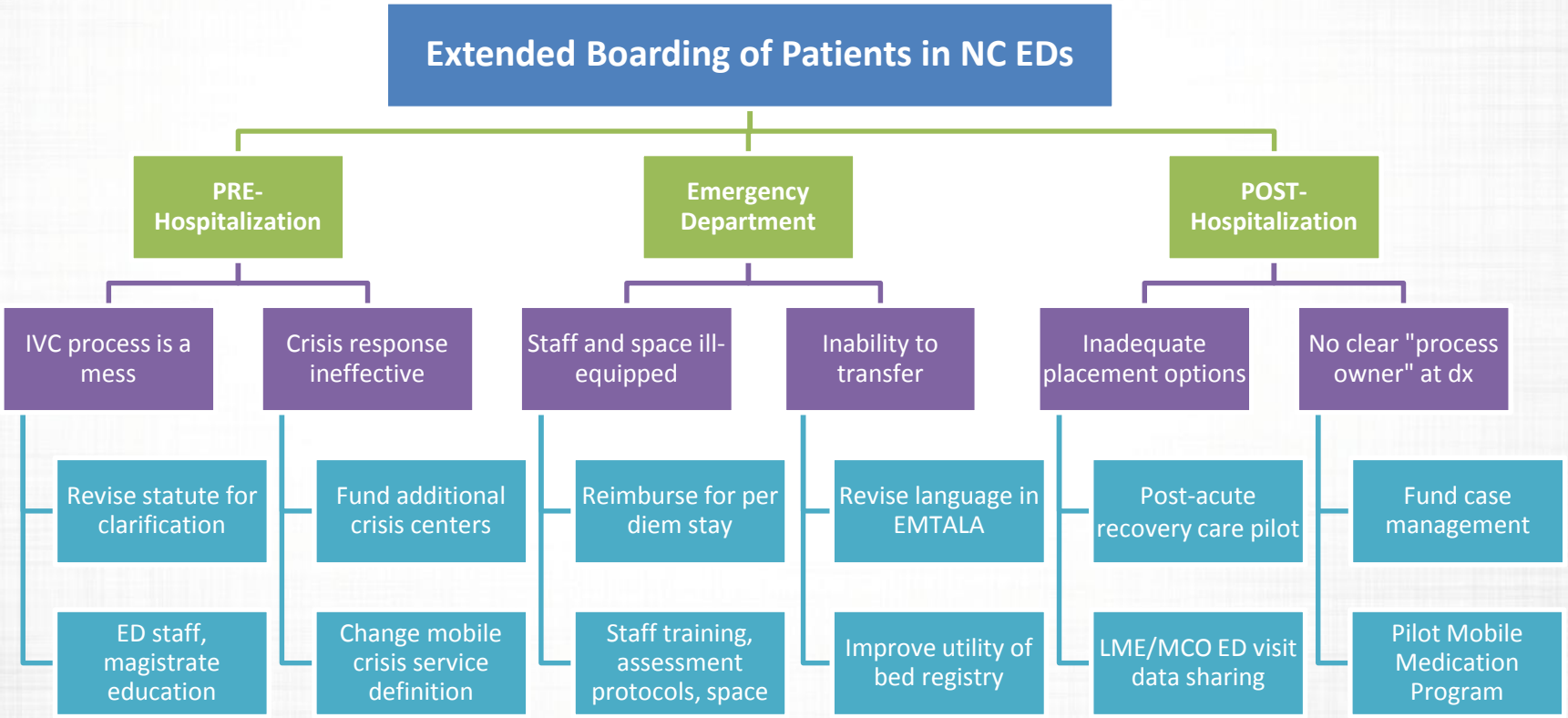
- 65-80% of patients in crisis can be more quickly stabilized outside of a hospital
- BH patients twice as likely to be admitted
- Involuntary = ↓ treatment outcomes
- Mixed evidence that short-term inpatient treatment is effective



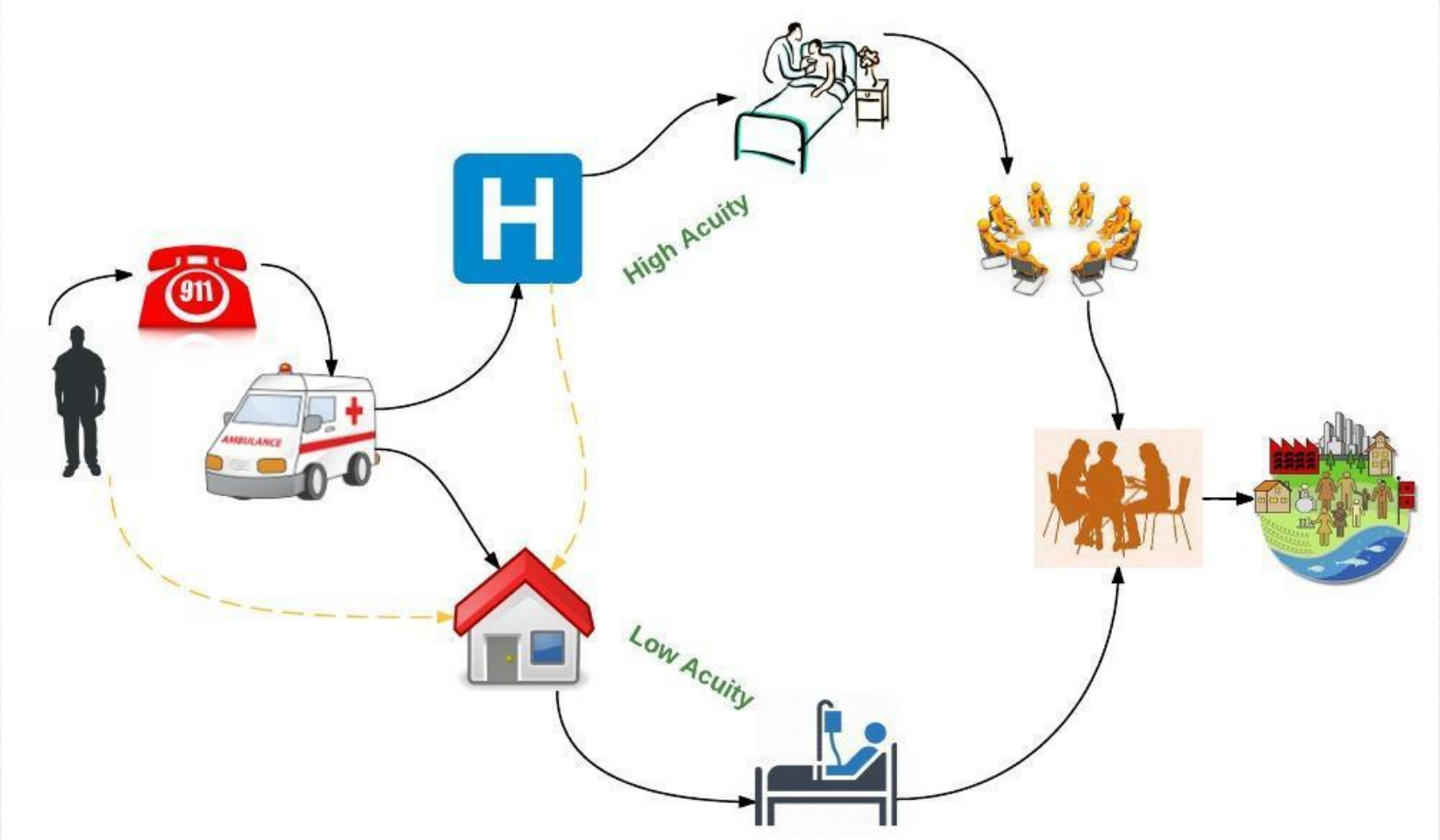
Boarding of patients in emergency departments “often creates an environment in which a **psychiatric condition slowly deteriorates**”

- US DHHS Report, 2007

NCHA Behavioral Health Agenda



Goal: Full Continuum of Care



SB 630: Involuntary Commitment

- Incentivize coordination of services
- Decriminalize behavioral health crises
- Maximize use of trained workforce
- Ensure protocols reflect best practices
- Address inefficiencies for timely treatment

IVC & Patients with SUD

- A review of 18 SUD/IVC studies revealed treatment-oriented measures (referral, retention), showed benefits of compulsory treatment relative to non-compulsory treatment,
- The majority of studies investigating criminal behavior and substance use showed no differences between the two types of treatment
- The benefits were only seen when treatment was for an extended period of involuntary commitment (30-90 days).

Problem Analysis

What are our next steps?

Nidhi Sachdeva

Action Plan Implementation and Reporting

- Need point of contact for every action item listed in the Opioid Action Plan
- Please sign up in a blank OR confirm you're the right person listed
- Likely requests for quarterly updates for Legislative reports and Governor's Office
- Updates consolidated and shared with OPDAAC Coordinating Workgroup
- To streamline the process, a brief reporting "form"

Reporting

- Progress update since last report
- Challenges?
- Immediate next steps
- Assistance needed?

Steve Mange

Looking Ahead: 2018 Legislative Short Session

Wrap up, THANK YOU!, and What's next

- Next Full OPDAAC Meeting
  - December 15 at Durham Regional Hospital
  - Registration OPEN
- Next OPDAAC Coordinating Meetings
  - January 11, 2018 at NC Hospital Association
  - February 8
  - April 12