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Q&A Summary:
The Role of the Health Care Team in Solving the Opioid Epidemic

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Contents

How are you all able to work together? How does this work in the real health care world where there is little to no collaboration and communication between providers, pharmacists, nurses and social workers? Who is the primary point person for care and coordination: primary care or a substance use disorder (SUD) treatment center? Great ideas, but who on the ground is coordinating the people in the team?

Admittedly, the collaboration between health care professionals (HCPs) is not simple. Jones and Phillips (2016) pointed out that interprofessional collaborative practice includes a shared leadership model, because it depends on whatever tasks need to be completed at a given time. Leadership will look different for each patient and at any given time in a specific patient's plan of care. (Source: Jones B, Phillips F. Social Work and Interprofessional Education in Health Care: A Call for Continued Leadership. *Journal of Social Work Education.* 2016;52:18-29).

It will sometimes take a lot of work to coordinate with a whole health care team and ensure buy-in from each individual. What seems to help the most is to have senior leader buy-in and a leader and/or physician or lead nurse champion who can rally the teams who need to collaborate. Sometimes data are needed to show the leadership the importance of creating a culture of collaboration around specific initiatives, such as an opioid use disorder (OUD) programs. Managed care HCPs often have data that can help influence leaders. When approaching other HCPs where there seem to be barriers, make it a two-way conversation: how can you help them and how can they help you?

Team-based care reduces the incidence of burn out in treating substance-abusing and opioid-addicted patients. That is a challenge in organizations where team-based care is not supported, and it does need leadership and consensus across an organization to be successful. Six building blocks for success in team-based primary care clinic settings were defined in the Building Effective Collaborative Teams in Health Systems study, and these building blocks can apply across other health care settings. They are: 1. Leadership and consensus; 2. Revise policies and standard work, which means everyone has standard work within their role to manage clinical contact with patients; 3. Track patients using a registry or other population management system to ensure patients do not fall through the cracks; 4. Prepared, patient-centered visits that support empathic communication and support difficult conversations with patient; 5. Care for complex patients by identifying and developing resources for patients, including medical/behavioral health resources; 6. Measure your success by using quality measures, continuously monitoring progress and improving with experience. (Source: Building Effective Collaborative Teams in Health Systems. 2017. www.agencymeddirectors.wa.gov/Files/CollaborativeCareConference2017/MacCollPrinciples_BuildingCollaborativeTeams.pdf).

This is one of the biggest obstacles to good treatment. If HCPs are not in the same group, any HCP can arrange a conference call to coordinate care and then establish the "captain of the ship," assign roles and assign deliverables for follow up. Also, check if the payer will provide care coordination. Unfortunately, most facility providers do not get involved in aftercare, so, for follow up, the therapist should coordinate. Payers are in the best position since they have previous data and can coordinate communication.

How do we as case managers engage "the average person" like the case study example of John Andrew (JA), who has an SUD, when he/she sees that only as pain management? What would the steps be? Would we be allowed to "flag" a member's account if there is a possible addiction occurring?

Even though we call JA an “average person,” we should look at him as a unique individual with unique circumstances, a unique medical history and a unique biopsychosocial make up. He may be receiving what his provider views as effective pain management. Not everyone taking opioids is an addict, but there may be an opportunity to consider alternate treatments to maximize JA’s well-being. The recommended primary role of the case manager is education; working with the provider to identify the possibility of opioid abuse and creating an optional treatment plan. Flagging his account is probably not the best approach, because it would label the patient unnecessarily and would not promote an individual approach to plan his care. (Source: Case Management's Role in Curbing Opioid Epidemic Increases: Key component is education. *Case Management Advisor*. 2017;28:1-2).

How can a nurse case manager assist a member in getting his/her pain managed as well as prevent addiction to opioids?

The recommended primary role of the case manager is education and goal setting; working with the provider to create the best treatment plan. A nurse case manager can add additional information by understanding how the patient has managed pain in the past, how pain is currently dealt with and how effective the current methods are. A nurse case manager may also suggest a referral to a pain management specialist, a pain management education program and additional education on goal setting to maintain a healthy lifestyle. (Source: Case Management's Role in Curbing Opioid Epidemic Increases: Key component is education. *Case Management Advisor*. 2017;28:1-2).

Why are methadone and buprenorphine products used so frequently and not naltrexone? Why would you not start on a medication regimen of naltrexone for opioid-dependent patients instead of a buprenorphine product?

Naltrexone can only be used to treat OUD in patients who have been opioid free for a period of time before initiating treatment; this limits the number of patients that can initiate medication-assisted treatment (MAT) with this drug. However, methadone and buprenorphine products for OUD can be initiated as treatment without the opioid-free requirement.

Any thoughts on synthetic drugs?

Some prescription synthetic opioids, such as fentanyl, have important uses in certain management situations. Misuse and addiction to synthetic opioids is becoming a larger contributor to the opioid crisis, especially with the emergence of illicitly manufactured synthetic opioids. These illicit drugs are extremely potent, and overdose deaths due to these drugs are rapidly increasing. One concern for HCPs when treating a patient who is addicted is that a

patient using fentanyl will have a strong dependency. This will make treatment and tapering more difficult, as the patient is more likely to experience severe withdrawal symptoms. Strong psychosocial support for these patients when treating addiction is crucial.

Generally, what are the pros/cons of buprenorphine products vs methadone?

Choosing to use methadone or a buprenorphine product for MAT of OUD depends on several factors, including the resources and providers to which the patient has access. For example, methadone treatment is performed in specialized clinics, whereas buprenorphine can be prescribed or dispensed in a physician's office by certified prescribers. Buprenorphine has a dose ceiling such that the likelihood of overdose is low. How the patient takes the medication might also matter, since methadone is an oral pill, but buprenorphine products are available as sublingual tablets, buccal film and in other formulations. Buprenorphine may be more expensive than treatment with methadone as well. Medication is just one factor in the overall treatment plan for OUD, and there is greater success when patients are also receiving behavioral therapy.

How can you justify prescribing methadone when it is just replacing one chemical dependence for another with alterations in personality, cognition and judgment?

Medications used within MAT programs for OUD are highly regulated. These programs use medications to relieve withdrawal symptoms and cravings by providing a safe and carefully controlled dose of medication. When used at the correct dose, these medications do not impair mental or physical functioning.

What should we recommend to friends who need to discard leftover opioids once they are well? Why can opioids not be flushed down the toilet?

First, visit the Drug Enforcement Administration (DEA) drug take-back website or call your local police station for information about local collection sites and times to dispose of left over medications. If it is difficult to find a collection location or time, take the medication out of its original container, mix with an inedible substance such as cat litter or coffee grounds (do not crush the pills), put this into a separate sealed container and throw it in the trash. Make sure the original container (eg, prescription bottle) has identifying information removed or covered, and throw it away separately from the medications. Only a small number of medications can be flushed down the toilet, and the patient information for those drugs will indicate this. Most medications should not be flushed because of environmental concerns, as they may not be removed by wastewater treatment plants or septic systems. More information about medication disposal can be found on the US Food and Drug Administration (FDA) website.

Other than acute pain, when should opioids be used to treat pain?

Opioids can be considered for treating chronic pain that does not respond to nonopioid therapies, and they are especially effective at treating cancer and end-of-life pain. When considering the use of opioids to treat chronic pain, following the US Centers for Disease Control and Prevention (CDC) Guidelines for initiating treatment and monitoring patients is very important to prevent addiction.

What are some commonly used opioids? What are the alternatives to opioids?

Examples of commonly used opioids include morphine, oxycodone, hydrocodone and fentanyl. Heroin is also an opioid. There are several nonpharmacologic alternatives to treat pain, such as physical therapy, acupuncture, cognitive behavioral therapy, and many others. When a medication is needed, many nonopioid options exist for most types of pain, such as over-the-counter acetaminophen or ibuprofen for headaches or muscle pain, or an antidepressant for neuropathic pain. Take a look at the guidelines from professional societies on treating pain, ask your pharmacist for more examples or consult colleagues on your health care team to discuss other options.

What is the success rate of buprenorphine products for MAT? What is the average length of therapy?

Available literature evaluating the rates of patients who complete MAT has demonstrated efficacy. The length of therapy will vary for each patient, and sometimes long-term use of buprenorphine during the maintenance phase is warranted.

What do you recommend for patients whose providers now feel paranoid about prescribing opioids and refuse to manage pain even when it is warranted?

Work with your provider to help them understand your pain. Talk openly with your provider to learn about what is causing your pain. Together, you can develop a pain management plan that encompasses more than taking medication. Be able to answer and ask questions about your pain, such as what makes it better, what makes it worse, how it starts, etc. Work on developing other effective ways to manage pain without opioids, such as patient/family education, community support groups, exercise, yoga, massage, deep breathing, meditation, prayer, spiritual support, imagery, distraction, humor, music and ice or heat.

I find the stigma to be a major barrier in getting support. What can we do to help remove this stigma? How can we educate others?

General tips for preventing stigma in working/relating to others are: 1. Learn more and educate others; 2. Speak out, challenge inaccuracies, educate others and guide them to sources of information; 3. Keep hope alive: share about evidence-based treatment and recovery; 4. Treat people with dignity. Substance-related disorders affect family, friends and communities. Treat those with substance abuse like you would treat anyone else; 5. Think about the whole person. Someone who is struggling with addiction is more than their illness; 6. Watch your language. Words can harm. Labels can lead to stigma; 7. Do not sensationalize addiction or recovery. Describe in thoughtful, accurate ways; 8. Do not generalize about people who have addiction. They are unique individuals with varied needs and goals.

A good resource is the Addiction Technology Transfer Center (ATTC) Network Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma (available at attcnetwork.org/regcenters/productDocs/2/Anti-Stigma%20Toolkit.pdf).

What recommendations do you have for dealing with members who are not ready to admit to substance dependency or are not motivated for recovery, but who are in need of help? How can we support the family members?

Keep the primary focus on the outcomes the members care about. Conversations can focus on improving overall quality of life, participation in life events/activities that are important to them, protecting them from opioid-related harm (use of naloxone or Narcan) and working on their short-term goals (eg, stable housing; someone to talk with, such as a behavioral health/SUD professional or a peer specialist; reducing pain). Employ open-ended questions to learn more and show concern for the patient's well-being. Build a relationship to address overall health comprehensively, engaging with patients when opportunities present.

Provide family members with resources to keep their loved one safe, such as Narcan/naloxone, along with education about how to administer the medication. Encourage them to learn about addiction, illness, challenges in recovery and how they can effectively support their loved one. If a family member is able to influence the person, encourage him/her to get an accurate assessment of the problem from an addiction specialist or other qualified HCP. When the person with SUD is ready for treatment, know about and select treatment that is supported by research (eg, MAT accompanied by wraparound services, such as behavioral health and SUD treatment and care).

Educate family members that relapse is not failure, but is often part of the journey to recovery. Relapse occurs, but recovery is still possible. Compare SUD to other chronic relapsing conditions, such as diabetes, to encourage greater understanding of addiction as an illness, not a moral failing or lack of willpower. Encourage family members to seek out supportive communities for recovery that focus on loved ones and family members. Encourage them to seek therapy services, if desired, and to take care of themselves as well (see improvingopioidcare.org).

I work with a lot of teenagers in our community. How young are they starting on this? What should I be looking for? Any additional advice? What about those using opioids for reasons other than pain?

A good website with significant resources for teens, family, teachers, etc. is the National Institute of Drug Abuse for Teens (teens.drugabuse.gov). Talk to teens about substance abuse and drugs, and share with them the science behind addiction. One of the keys for teens is prevention. Vulnerability during adolescence can lead to peer pressure and social challenges and contribute to already present shifts in emotion. Keep opiate prescriptions locked away and dispose of unused medication properly. Work on supports and interventions that enhance teens' social skills, encourage self-control and create opportunities for furthering emotional and educational development. Screen for mental illnesses, looking for early signs of challenges. Opioids, unless clinically indicated for a serious illness or injury, should generally be avoided, especially in adolescence. Recent studies by the *Journal of the American Medical Association* indicate ibuprofen or other over-the-counter pain relievers are as effective in managing pain. Protect our youth from exposure by encouraging the use of nonopioid alternatives for pain.

It was mentioned to direct members to resources in the community to help these patients. What resources exist that we could give to our patients for those of us who do not encounter opioid addiction often?

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a website (findtreatment.samhsa.gov) that shows the location of residential, outpatient and hospital inpatient treatment programs for drug addiction and alcoholism throughout the country. This information is also accessible by calling 1-800-662-HELP.

The National Suicide Prevention Lifeline (1-800-273-TALK) offers more than just suicide prevention; it can also help with a host of issues, including drug and alcohol abuse, and can connect individuals with a nearby professional.

The National Alliance on Mental Illness (nami.org) and Mental Health America (mentalhealthamerica.net) are alliances of nonprofit, self-help support organizations for patients and families dealing with a variety of mental disorders. Both have state and local affiliates throughout the country and may be especially helpful for patients with comorbid conditions.

The American Academy of Addiction Psychiatry and the American Academy of Child and Adolescent Psychiatry each have physician locator tools posted on their websites at aaap.org and aacap.org, respectively.

Faces & Voices of Recovery (facesandvoicesofrecovery.org), founded in 2001, is an advocacy organization for individuals in long-term recovery that strategizes on ways to reach out to the medical, public health, criminal justice and other communities to promote and celebrate recovery from addiction to alcohol and other drugs.

The Partnership at Drugfree.org (drugfree.org) is an organization that provides information and resources on teen drug use and addiction for parents to help them prevent and intervene in their children’s drug use or find treatment for a child who needs it. They offer a toll-free helpline for parents (1-855-378-4373).

The American Society of Addiction Medicine (asam.org) is a society of physicians focused on increasing access to addiction treatment. Their website has a nationwide directory of addiction medicine professionals.

The National Institute on Drug Abuse (NIDA) has a National Drug Abuse Treatment Clinical Trials Network (drugabuse.gov/about-nida/organization/cctn/ctn) that provides information for those interested in participating in a clinical trial testing a promising substance abuse intervention. You may also visit clinicaltrials.gov.

NIDA's DrugPubs Research Dissemination Center (drugpubs.drugabuse.gov) provides booklets, pamphlets, fact sheets and other informational resources on drugs, drug abuse and treatment.

The National Institute on Alcohol Abuse and Alcoholism (niaaa.nih.gov) provides information on alcohol, alcohol use and treatment of alcohol-related problems. (niaaa.nih.gov/search/node/treatment).

(Source: drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/where-can-family-members-go-information).

What are some of the cost burdens related to the opioid epidemic?

Health care accounts for about one-third of costs attributable to the prescription opioid epidemic, and one-fourth of costs are borne by the public sector, according to the analysis by Curtis Florence, PhD, and colleagues at the National Center for Injury Prevention and Control. They hope their findings will help in understanding the economic impact of opioid overdose, abuse and dependence and in guiding strategies aimed at reducing the burden of the epidemic. "More than 40 Americans die each day from overdoses involving prescription opioids. Families and communities continue to be devastated by the epidemic of prescription opioid overdoses." said CDC Director Tom Frieden, MD, MPH. "The rising cost of the epidemic is also a tremendous burden for the health care system."

Study Shows High Societal Costs of Opioid Epidemic
Using data from a wide range of sources, the researchers estimated the "monetized burden" of prescription opioid overdose, abuse and dependence in the United States. Costs were analyzed from a societal perspective, including direct health care costs, costs related to lost productivity and costs to the criminal justice system.

Based on the latest data, nearly two million Americans met criteria for prescription opioid abuse and dependence in 2013. In the same year, there were more than 16,000 deaths from prescription opioid overdose. Both figures were substantially higher than in 2007, which was the most recent previous year for which comprehensive estimates were available. Aggregate costs for prescription opioid overdose, abuse and dependence were estimated at over $78.5 billion (in 2013 dollars). Total spending for health care and substance abuse was over $28 billion, most of which ($26 billion) was covered by insurance.

In nonfatal cases, costs for lost productivity—including reduced productive hours and lost production for incarcerated individuals—were estimated at about $20 billion. Nearly two-thirds of

the total economic burden was due to health care, substance abuse treatment and lost productivity for nonfatal cases. Fatal overdoses—including costs related to health care and lost productivity—accounted for $21.5 billion.

Overall, nearly one-fourth of the aggregate economic burden was funded by public sources. That included costs funded by public insurance (Medicaid, Medicare and veterans' programs) and other government sources for substance abuse treatment.

There were also $7.7 billion in criminal justice-related costs, nearly all of them borne directly by state and local governments. The authors also note reduced tax revenues due to opioid-related productivity losses. (Source: October 2016 issue of *Medical Care*. The journal is published by Wolters Kluwer Health: Lippincott Williams and Wilkins and is available at sciencedaily.com/releases/2016/09/160914105756.htm).

How can we focus education for providers toward appropriate prescribing practices? How can we educate physicians to treat holistically so people do not get to the point of addiction?

There are many education resources for providers available. SAMHSA maintains a robust website listing available courses and funds continuing medical education (CME) courses on prescribing opioids for chronic pain developed by local and state health organizations across the United States. Most of these courses also include resources that address practice management, legal and regulatory issues, opioid pharmacology and strategies for managing challenging patient situations.

The following are sponsors of SAMHSA-supported CME courses on prescribing opioids for chronic pain (courses may require registration):

- The American Academy of Addiction Psychiatry (AAAP) (aaap.com) provides a number of CME opportunities (aaap.org/education-training/cme-opportunities/) for MAT professionals seeking training on prescribing opioids for chronic pain
- The American Osteopathic Academy of Addiction Medicine (AOAAM) (aoaam.org) offers a number of SAMHSA-supported prescribing courses, including a self-study series (aoaam.org/?page=PCSSMAT&hhSearchTerms=%22PCSS-MAT%22) developed by the Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) (pcssmat.org)
- The American Society for Pain Management Nursing (ASPMN) (aspmn.org) sponsors prescribing courses (aspmn.org/education/Pages/pcssowebinars.aspx) developed by the Providers' Clinical Support System for Opioid Therapies (PCSS-O) (pcss-o.org)
- The American Society of Addiction Medicine (ASAM) (asam.org) sponsors a number of prescribing courses for MAT service providers. ASAM's education website (asam.org/education) offers more than 300 hours of CME learning through live and online instruction
- The Prescribe to Prevent program (opioidprescribing.com/naloxone_module_1-landing) is available at OpioidPrescribing.com

The Division of Pharmacologic Therapies (DPT) (samhsa.gov/medication-assisted-treatment/about), which is part of the SAMHSA Center for Substance Abuse Treatment (CSAT) (samhsa.gov/about-us/who-we-are/offices-centers/csat), also provides buprenorphine training for physicians (samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training).

In addition, the ATTC Network (nattc.org), which is funded by SAMHSA, has a training and events calendar (attcnetwork.org/calendar/search.aspx) to help you stay abreast of future prescription courses.

Holistic care without the use of opioids to manage pain is critical. Providing nonopioid alternatives for effective chronic pain management is a crucial and needed resource. Encouraging providers to be well educated and thoughtful in their care of patients with addiction is critical. Some well thought out suggestions were presented in this article: Health Care Providers Must Act Now to Address the Prescription Opioid Crisis, in the *New England Journal of Medicine* on April 19, 2017. (available at: catalyst.nejm.org/act-now-prescription-opioid-crisis).

Addiction can lead to manipulation behaviors. What can be done to identify and educate enablers in support and peer groups?

Chronic exposure to drugs of abuse disrupts the way critical brain structures interact to control and inhibit behaviors related to drug use. Just as continued abuse may lead to tolerance or the need for higher drug dosages to produce an effect, it can also lead to addiction, which can drive a person using drugs to seek out and take drugs compulsively. Drug addiction erodes a person's self-control and ability to make sound decisions, while producing intense impulses to take drugs. Manipulation results, as the goal is to get the drug and take it. Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. Drugs change the brain, including its structure and how it works. These brain changes can be long lasting and lead to the harmful behaviors, including manipulation, seen in people who abuse drugs. The approach is to assess for SUD, engage with the person and educate and facilitate approaches and pathways to evidence-based treatment (see drugabuse.gov).

Are doctors who prescribe you opioids supposed to try to wean you off if they decide to stop prescribing them to you?

Absolutely.

Are there any instances when opioid use is justified long term?

Yes. Palliative care and hospice or pain where all other treatments have failed.

Can you explain how this is a brain disease and that addiction is not a choice?

This is a classical question and no longer a debate. Science shows it is a disease of the brain. It remains to be clarified why some people are motivated to seek treatment and others are not.

You mentioned to be cautious when treating/managing depression while treating OUD simultaneously. Do you recommend treatment for OUD or depression first? Most of our patients with OUD also suffer from depression or another psych disorder. What is the correct progression of treatment for depression/substance abuse?

In treating comorbid depression, it is recommended to detox and stabilize the patient first, so that you can the better assess the depression and then begin treatment.

Are we creating another problem with MAT vs nonmedication alternatives? Are there plans to create more team models that can work together?

MAT has been shown to be safe and effective in treating opioid dependence. The treatments do not result in a high and are easier to taper and discontinue. MAT is now considered "best practice" for treating opioid addiction. Additional help from team models can enhance the effectiveness of treatment.

How can we educate physicians that there are other modalities to remedy chronic pain than opioids? What do you think about these alternatives as part of the treatment plan: medical marijuana, chiropractic, acupuncture, kratom or neurostimulators?

All have a role in pain treatment, BUT it is not great to offer an addict with pain marijuana or kratom. Also consider mindfulness, yoga, transcranial magnetic stimulation.

It seems that one of the first hurdles, after a professional has a suspicion of problematic use, is determining the readiness of the member for participating in services. This may be an issue for professionals who are going outside their comfort zone because they do not usually find themselves taking a lead in addiction. Then comes the treatment plan. Suggestions?

Evaluating for drug dependence should be part of medical education as well as motivational interviewing and assessing a patient's "readiness for change." Patients need to be engaged immediately when presenting to the medical system (since motivation is highest then). Patients should begin treatment upon presentation at the emergency room or hospital even if it is not related to addiction. Starting a recovery app can be helpful to get the patient to treatment.

Should the primary care physician manage the pain medications, or should the patient be referred to a pain management specialist?

The treatment team should make this decision.

What about women who are addicted and become pregnant? What should the care plan be for mom and baby?

A gradual taper if possible as soon as addiction is determined. Be prepared to treat newborn for withdrawal.

Are overdoses more accidental, due to the opioid no longer working to control the pain, or more intentional due to suicide and depression?

Most overdoses of opioids are accidental. However, opioid addiction can cause depression.

How can we as HCPs avoid or prevent the addiction cycle?

Educate patients, identify people at risk early on, begin treatment immediately and educate providers about best practices and addiction treatment.

If you have questions regarding this document or the content herein, please contact: moreinfo@optumhealtheducation.com.