Putting the Opioid Crisis in Context: Unwitting Enablers, Innocent Victims and Underutilized Resources

Horner DVP Symposium *The Opioid Crisis*

The University of Tennessee Health Science Center

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Conflict of Interest/Disclaimer

I have no conflicts of interest to declare, only biases earned by working 50 years in the U.S. health care system.

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Opioid Addiction and Abuse:
The Crisis in Context

- 20 million Americans have a substance use disorder, 2 million with an opioid use disorder and 16 million are heavy alcohol users – SAMHSA
- Deaths due to opioid overdose in CHS service region 23.8 per 100K; death rate attributed to smoking was 335.0 - TN Gov data
- Death rate by guns/homicide (21.3 in Shelby County) is 25% higher than death by opioid overdose (17.0) – CDC data
- People with a mental illness live 10 years less than the general population – CDC
- Poverty is a reliable predictor of mortality

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Taking Advantage of the Opioid Crisis

- New financial resources for the healthcare system – opportunities for innovation
- Broaden the clinical model – ACES, pain management
- Improve coordination with other systems – law enforcement and the Courts, social service agencies
- Blend behavioral healthcare and primary care

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Jesse Walker, M.D. – Unwitting Enabler

- A saint if there ever was one
- Identifying the problem prescriber
- 67% of Buprenorphine (Suboxone) is prescribed in primary care
- Treating the problem – detox is not enough

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Medication You are Unlikely to Receive

To All Our Patients:

Please be advised that because of our concern for your health and well-being, it is unlikely that we will be able to provide the following medications for you:

OXYCOTIN	**XANAX (ALPRAZOLAM)**
OXYCODONE	**VALIUM (DIAZEPAM)**
HYDROCODONE	**ATIVAN (LORAZEPAM)**
PERCOCET	**KLONOPIN (CLONAZAPAM)**
LORTAB	**RESTORIL (TEMAZEPAM)**
MORPHINE	**LIBRIUM (CHLORDIAZEPOXIDE)**
TYLENOL #3	**TRANZENE (CLORAZEPATE)**
SOMA	**STIMULANTS FOR ADULTS**
AMBIEN	**LUNESTA**
METHADONE	**VICODIN**
ULTRAM (TRAMADOL)	**NEURONTIN (GABAPENTIN)**

SUBOXONE (unless a member of our substance abuse program)

If you are on any of these medications (or related substances) or feel you need one of the above medications, please understand that your provider may not prescribe these medications for you. These medications all have the potential for long-term complications and we do not want to put our patients at risk for these problems.

PATIENT SIGNATURE ________________________________ DATE____________________

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John H. – An Innocent Victim

- No one wants to be an addict.
- “It was a good high, especially at first. I didn’t expect it to last 20 years.”
- “I was in a fog the whole time, but nobody knew I was.”
- “I’ve wasted my life.”
- “Of course I played with the dose. I’m sure most addicts do.”
- “It cost $400 out-of-pocket for a 5-minute appointment to get my prescription every month.”

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Underutilized Resources in SUD Treatment

- Primary Care
- Psychiatry
- Peers
- Team-based Care
- Community Health Centers (FQHCs)

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National Scope of Federally Qualified Health Centers

- 1,400 organizations, 10,000 service locations
- 28 Million patients
- 1 in 7 uninsured Americans, 1 in 7 Medicaid enrollees and 1 in 7 rural Americans
- Most Health Centers provide Behavioral Health Services
- 48% of Health Centers provide MAT

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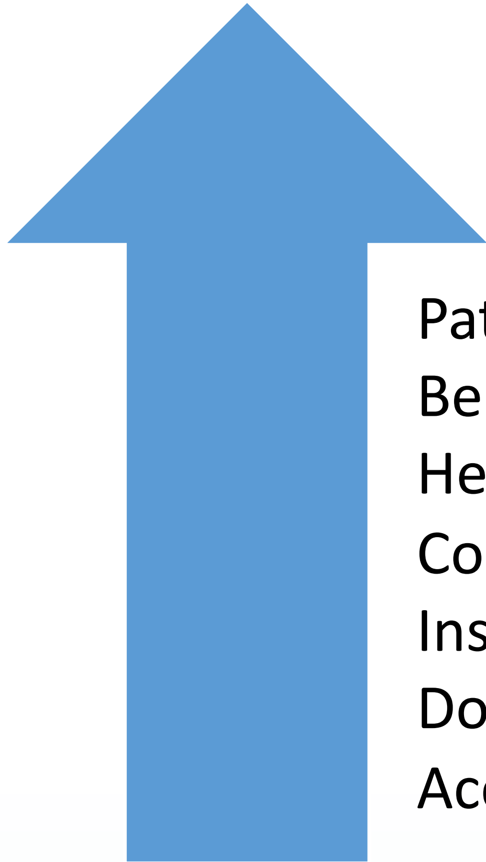
The Reality of Primary Care



Patient Panel Size
Behavioral Comorbidity
Health Complexity
Coordination Demands
Insurance Requirements
Documentation Demands
Accountability

Time
Resources
Reimbursement

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The Nature of Primary Care

- Main point of access to care for all healthcare, including behavioral health conditions
- Principal setting for treatment of behavioral health conditions
- Locus of bi-directional interplay of medical and behavioral disorders, health behaviors, social determinants
- Complexity of care requires a team

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Cherokee Health Systems: an Integrated Delivery System

Improving Access and Outcomes for the Underserved

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Primary Service Area

Kentucky
Virginia
Missouri
Arkansas
Tennessee
North Carolina
Mississippi
Alabama
Georgia

CAMPBELL
CLAIBORNE
UNION
GRAINGER
HAMBLEN
ANDERSON
KNOX
JEFFERSON
COCKE
SEVIER
BLOUNT
LOUDON
MONROE
MCMINN
HAMILTON

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Patients Seen: 78,611 **Patient Visits:** 409,363

Current Number of Employees: 715

Provider Staff:

Psychologists - 47	Cardiologist - 1	Psychiatrists - 8
Primary Care Physicians - 27	Nephrologist - 1	NP (Psych) - 9
NP/PA (Primary Care) - 53	OB/GYNs - 3	LCSWs - 68
Community Workers - 37	Pharmacists - 13	Dentists - 3

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The Behaviorally Enhanced Healthcare Home
Core Principles

- Behavioral Health Consultant (BHC) is an embedded member of the primary care team
- Consulting psychiatrist supports the primary care team
- Primary Care Provider (PCP) and BHC share patient panel and population health goals
- Shared support staff, physical space, and clinical flow
- Behavioral access and collaboration is in Primary Care
- Primary Care team-based co-management and care coordination
- Shared clinical documentation, communication, and treatment planning

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Addiction Medicine Healthcare Home

- Addiction Medicine
- Behavioral Health
- Primary Care
- Psychiatry
- Pharmacy
- Nursing
- Care Management
- Peer Support

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Staff Roles and Responsibilities

- Addiction Specialist/ Primary Care Provider : overall responsibility, review referrals, initial evaluations, treatment planning, DEA X-number; routine preventive and chronic health care, care coordination
- Behavioral Health Consultant: review referrals, conduct IOP, assess behavioral needs, provides routine BHC care
- Psychiatrist: diagnostic and medication consultation, direct care when indicated
- Pharmacist: medication safety and consultation
- Nursing: screen routine preventive and primary care health needs, lab test monitoring, clinic management, care coordination
- Community Health Coordinator: recovery environment review and assistance, care coordination, referral assistance
- Peer Support Specialist: assessment and follow-up, outreach, group visits

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Continuum of Behavioral Health Support

- Individual Behavioral Interventions – often first line, can be provided by Behavioral Health Consultant or specialty therapist, many have comorbid concerns (e.g., depression, anxiety, PTSD)
- Peer Support - engagement, modeling, coordination of care, self-management skills, emotional support, developing action plans & patient advocacy
- Group Therapy – following stabilization, length and frequency can vary (EOP, IOP, Group Medical Visits)
- Psychiatric Medication Management – consultative or as an adjunct to addiction care
- Community Health Coordination – expanded case management role

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Conclusions and Reflections

- Treating addiction is like treating any other chronic condition: some things work for some of the people some of the time.
- Detox is not treatment.
- Complexity is the norm.
- Primary care is the best platform for treating most addictions.
- In the initial stage of treatment, engagement is more important than evidence-based practice.
- It takes a team.

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Our populations of greatest need are silent.

Who will speak for them?

Who will care for them?

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