Understanding the Opiate Ecosystem and Leveraging Analytics

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Agenda

• The Facts Behind the Opioid Epidemic
• Statements from Leaders
• Addressing a “Wicked Problem” through an Ecosystem Approach
  • Engage, Establish, Attack, Create and Develop
• The Tide is Turning
• How Can Ohioans Make a Difference
• Closing Thoughts
The Facts Behind the Opioid Epidemic
The Opioid Epidemic

• In 2015 more than 52,000 people died from a drug overdose; of those, 33,091 (63.1 percent) involved a prescription or illicit opioid.

• From 2000 to 2015 more than half a million people died from drug overdoses

• Death rates for synthetic opioids other than methadone (including drugs such as tramadol and fentanyl, referred to as synthetic opioids) increased 72.2 percent

• Heroin death rates increased 20.6 percent

The Opioid Epidemic

• America claims less than 5 percent of the world’s population but consumes roughly 80 percent of the world’s opioid supply.

• Nearly one-half of patients who took opiate painkillers for more than 30 days in the first year of use continued to use them for three years or longer.

• Five percent of prescribers wrote 40 percent of opioid prescriptions filled by members with employer-sponsored drug coverage from 2011–2012.

• In 2012, health care providers in the US wrote 259 million painkiller prescriptions, enough to give every adult in the United States his or her own bottle of pills.

State View of Overdose Deaths per 100,000

**1999**

- Ohio
  - Deaths: 467
  - Population: 11.3M
  - Death Rate: 4.2 per 100,000

**2014**

- Ohio
  - Deaths: 2,744
  - Population: 11.6M
  - Death Rate: 24.6 per 100,000

- 2015 Deaths: 3,310 (+20.6%)
  - > 5x's


NCHS Data Visualization Gallery
County View of Overdose Deaths per 100,000

Maine
Washington County
Population: 34,148
Death Rate:
6.1-8 per 100,000

New Jersey
Ocean County
Population: 504,007
Death Rate:
4.1-6 per 100,000

Maine
Washington County
Population: 31,808
Death Rate:
>20 per 100,000

New Jersey
Ocean County
Population: 586,301
Death Rate:
14.1-16 per 100,000

Statements from Leaders
Statements From Leaders

“When I went to medical school, the one thing I was told was completely wrong. The one thing I was told was if you give opioids to a patient who is in pain, they will not get addicted. Completely wrong. Completely wrong. But a generation of doctors, a generation of us grew up being trained that these drugs aren’t risky.”

Dr. Thomas R. Frieden, Director of the Centers for Disease Control and Prevention (CDC)

Dr. Kessler stated that the opioid epidemic was one of the “great mistakes of modern medicine.”

Dr. David Kessler, Former head of the Food and Drug Administration (FDA)

Statements From Leaders

Food and Drug Administrator Confirmation Hearing
Senate Health, Education, Labor and Pensions Committee
April 5, 2017

Response to Committee questioning on the opioid epidemic:

“I think this is a public health emergency on the order of Ebola and Zika.”

Scott Gottlieb, in line to lead the Food and Drug Administration

Statements From Leaders

“I didn’t originally run for governor to fight opioid addiction, but simply put, it was everywhere I went. I can’t remember the last time I was in a room of more than 20 people where someone didn’t have a story that directly connected them to this crisis.”

_Massachusetts Governor Charlie Baker_

“With New Hampshire losing one of our friends, family members or neighbors nearly every day to the heroin and opioid epidemic, the need for ongoing action to strengthen our efforts to combat this crisis and save lives is urgent.”

_New Hampshire Governor Maggie Hassan_

Our fight against drugs is a tough one, but my promise is that the Attorney General’s office will be relentless every day in our work to better protect our families.

_Kentucky Attorney General Andy Beshear_

Source: Public statements
A lot has been learned over the past two decades regarding the opioid epidemic. The efforts happening today give us hope for tomorrow that we will turn the tide on this epidemic.
Addressing a “Wicked Problem” through an Ecosystem Approach
The Wicked Problem

- Identified through a combination of unique characteristics.
- Nonprofits and governments embrace the ecosystem to address wicked problems.
- The sources are diverse.
- There will never be one answer.
- The problem is emergent and shifting.
- Different parties define the problem differently.

The widespread impact on all areas of society

Opioid addiction increases:
- Patient load
- Strain on emergency rooms and medical offices
- Costs for detoxification programs

The opioid crisis and heroin abuse impact:
- Children and families
- Government programs
- Law enforcement professionals
- Educators
- Health care providers
- Taxpayers

A 2012 study showed that 16% of teens had misused a prescription painkiller at least once.

The increasing number of child welfare cases are due to parental abuse of drugs.

Between 1998 and 2012, the number of drug offenders in federal prisons grew by 63%. By the end of 2012, 52% of federal prisoners were drug offenders.
1. Engage a broad community of “wavemakers”

Innovating, convening, and funding ground-up initiatives

**Best practices for “wavemakers”**

- It is critical that stakeholders engage new partners and collaborate on novel solutions that stakeholders can implement themselves, in their own communities.
- Stakeholders should try to implement solutions that benefit everyone at the table; solutions that are “single-threaded” will likely have limited impact.
2. Establish an ecosystem integrator
Creating the space for aligned action by others

**State Governors**
State governors and their administrations are increasingly serving as “integrators” in the anti-opioid ecosystem. Government can integrate the activities of executive agencies, community organizations, and health care providers.

**Foundations and Companies**
Foundations or companies that focus on public health, economic development, or the welfare of children and families may be well-positioned to drive collaboration across the ecosystem.
3. Attack the problem with a portfolio of interventions

Fighting the opioid epidemic involves many stakeholders, agencies, and programs – the diagram illustrates some of those intersections.
3. Attack the problem with a portfolio of interventions
Positive change is happening all around us

**CDC’s new prescribing guidelines**
- Several states have taken steps to limit first-time prescriptions of opioids
  - MA, CT, ME, NY
  - 7-day supply limit
  - NY Task Force credits CDC changes
  - NJ 5-day supply limit

**TN pain clinics stop using opioids**
- One of the largest health care systems in TN will no longer prescribe long-term opioid pain medication to patients at two of its pain management clinics
  - Switching to non-opioid alternatives which are “equally effective”
  - NSAIDs, CBT, physical and aquatic therapy, massage therapy, weight loss strategies, radiofrequency ablations, etc.

**NJ ER → Opioids as a last resort**
- One of the country’s busiest ERs
- For patients with common types of acute pain – migraines, kidney stones, sciatica, fractures – doctors trying non-opioid alternatives

**WC Research Institute (WCRI) study shows opioid decline**
- Statistically significant reductions in the range of 20 to 31 percent were seen for MD, MA, MI, OK, NC and TX
- Credit given to PDMPs, state reforms, treatment guidelines and drug formularies

Source:
- [https://www.wcrinet.org/](https://www.wcrinet.org/)
4. Create an Innovation Engine
Driving ideas for solutions that upend the problem

New solutions emerge when partners in an ecosystem interact cooperatively and competitively to drive innovation:

| Prize-based Challenges | • Define the challenge, offer a prize, and open for competition  
|                        | • Challenge.gov / SAMHSA recovery support and prevention  
| Pay for Success (PFS)  | • Tie payments for services to outcomes  
|                        | • Homelessness, recidivism, and early childhood education  
| Advanced Analytics     | • Leveraging the power of big data  
|                        | • Preventing addiction and dependency before the habits form  
|                        | • Identifying pill-seeking behavior via outlier analytics  

4. Create an Innovation Engine – Advanced Analytics

Preventing dependency and addiction before the habits form

The challenge for workers compensation insurers at three point contact (3PC):

- Identifying injured workers who have a higher propensity for using an excessive amounts of opioids over the life of their claim

The opportunity:

- Leverage analytics at 3PC to proactively identify claims that have a higher propensity for consuming an excessive amount of opioids
- Utilize peer-to-peer physician contact and prescribing guidelines to minimize risk on the highest scoring claims
- Prevent dependency and addiction before the habits ever form

4. Create an Innovation Engine – Advanced Analytics

Preventing dependency and addiction before the habits form

**The target variable:**
- Total supply days (i.e., the sum of supply days across all drugs prescribed)

**Predictive variables:**
- Comorbidities, job class, injury cause, business characteristics, claim characteristics

**Model segmentation:**
- Injured workers in Decile 10 take **18x’s the supply days** as workers in Decile 1
- Roughly **4% of claims scoring in Deciles 8, 9 & 10 will consume in excess of a decade worth of opioids over the life of their claim!**

4. Create an Innovation Engine – Advanced Analytics

Preventing dependency and addiction before the habits form

**Targeting Opioid Use When Workers Get Hurt**

- Companies that handle claims for those injuries are trying new programs that push workers toward alternative pain treatments and that make it harder to get prescriptions for potentially addictive drugs – all intended to get people back to work without getting them hooked, companies say.

**Travelers Predictive Model Helps Injured Workers Avoid Chronic Pain, Opioid Use**

- The country’s largest workers’ compensation insurer said it has developed a model to predict the likelihood of an injured worker developing chronic pain. The model can then help the workers take steps to avoid chronic pain in recovery and reduce their need for opioids or other painkillers that can be addictive.

- “When someone develops chronic pain, they are prescribed opioids or other painkillers more than 90 percent of the time. **Our goal is to work with injured employees and their doctors to eliminate or substantially reduce the need for painkillers that can slow their recovery or lead to devastating long-term addiction.**”

Source: [WSJ](http://www.wsj.com/articles/targeting-opioid-use-when-workers-get-hurt-1479205803?emailToken=JRrzd/x5aH2Qg9Y9awwJ3UcnyY7UjIcO6LQ1vWk3Hgf1XxuTnlKoe-ngroynd6u3jq5ktmotAZ9u6HGG07AyAz/hA)  
[Insurance Journal](http://www.insurancejournal.com/news/national/2016/04/05/404286.htm)
Let’s Prevent Dependency and Addiction Before the Habits are Formed

“Habits aren’t destiny... habits can be ignored, changed or replaced.”

Charles Duhigg
The Power of Habit

Habits truly aren’t destiny. Let’s help physicians prevent dependency and addiction before the habits are ever formed through the use of advanced analytics, physician peer-to-peer outreach and prescribing guidelines.
4. Create an Innovation Engine – Anomaly Detection
Leveraging anomaly detection to identify drug diversion at urgent care centers

• A state Medicaid agency that was experiencing a growing issue with drug abuse and diversion

**Geospatial visualization**

- **Urgent Care Center**
- **Beneficiaries visiting the urgent care center for narcotic prescriptions, with the size of the dots representing the volume of narcotics purchased**

- Geospatial visualization revealed some beneficiaries repeatedly traveled long distances (e.g., 150 to 200 miles) for narcotic prescriptions from this urgent care center

- Reasonable expectation for patients with urgent care needs would be more like a 10-20 mile radius

- Provider was referred to Medicaid Fraud Control Unit (MFCU) and the “pill mill” was closed down with the prescriber’s license being revoked

4 ➔ 3. Attack the problem – Outlier Analytics
Identifying Physician Outliers

Advisory Board

How Aetna is curbing opioid ‘superprescribers’

• “By nature, doctors are data-driven” according to Aetna’s Chief Medical Officer
• Aetna sent notices to 931 physicians “superprescribers” who fall within the top 1 percent of opioid prescribers in their specialties
  • PA had 138 “superprescribers”
  • MO had 87
  • FL had 78
  • NC had 52
  • Utah had 45
• Aetna analyzed data it collected through insurance claims to determine physicians' opioid prescribing patterns. The data included only those physicians who had prescribed opioids at least 12 times, and it excluded specialists who typically prescribe large amounts of opioids as part of their practices, such as oncologists. In total, the data included 8.6 million claims.

Source: https://www.advisory.com/daily-briefing/2016/08/05/how-aetna-is-curbing-opioid-super-prescribers
4  3. Attack the problem – Not so Advance Analytics

Analyzing the top prescribed drugs and taking action

The California Doctors Who Found a Way to Quit Overprescribing Opioids

- Eight doctors meet in a room in 2009 to review the most prescribed drugs by Kaiser Permanente doctors, expecting drugs related to the treatment of people with hypertension and diabetes to be on the list. But to the doctors in the room, the slides told a bleak story: Narcotics were being dispensed in numbers and doses higher than any of them had ever seen.

- Taking advantage of the HMO’s massive health-data system and its status as both insurer and health provider, the Southern California Kaiser doctors set about tapering the number of patients on high doses of narcotic painkillers. They reprogrammed computer software for doctors, developed new urine tests for patients and empowered pharmacists to question potentially excessive prescriptions.

- Prescriptions of opioid pills such as Vicodin and Percocet in amounts greater than 200 tablets dropped from 2,500 a month to almost zero, according to the HMO. So, too, have prescriptions that include potentially dangerous combinations of muscle relaxants, anti-anxiety medications and opioids, as well as prescriptions of brand-name opioids in general.

5. Develop initiatives embedded in well-functioning markets
Creating a sustainable model for addressing the opioid crisis

Ecosystems need to create a climate in which developers of innovative tools against opioid addiction can thrive in the open market.

Wavemakers will be the critical drivers behind market-oriented solutions to the opioid crisis.

In efforts to address “wicked problems,” success has relied not just on effective interventions, but also on interventions that were sustainable in the context of real-world markets.
The Tide is Turning
Dr. Murthy sent a letter to every prescriber in the nation where he stated “we have the unique power to help end this epidemic.”

“This is one of the greatest health crises of our time, the opioid epidemic.”

“The problem is we have been giving out opioids both appropriately and inappropriately over the last several decades.”

“We know that opioids are not a good solution for chronic pain.”

*Dr. Vivek Murthy, Former Surgeon General*
Prescribing Opioids for Chronic Pain

Adapted from CDC Guideline

Opinion statement is for information and education purposes only. Scientific evidence showing the benefits to treat chronic pain.

In general, DO NOT PREScribe Opioids for Chronic Pain

Risk of addiction is balanced against potential benefit in a minority of patients.

Before Prescribing

1. Assess pain & function
   - Use validated pain scale. Example: MEP scale shows where the score: average 3 (medical and psychological) needs to be balanced (1-10).
   - Overprescribing does not enhance patient function.
   - Overprescribing does not help patients.
   - Find the right opioid for your patients.

2. Consider if non-opioid therapies are appropriate:
   - Use NMAAs, TCA, SNRIs, and antidepressants, exercise or physical therapy, cognitive behavioral therapy.

3. Talk to patients about treatment plan
   - Set realistic goals for pain and function
   - Discuss benefits, side effects, and risks
   - Inform patients about the importance of follow-up appointments

4. Evaluate risk of harm or misuse.
   - Consider other factors such as medical conditions, substance use disorder, pain management interventions, and patient history.

5. When you prescribe
   - Start with immediate-release (IR) opioids at the lowest dose for the shortest duration.
   - IR opioids are preferred over long-acting (LA) opioids or sustained-release formulations.
   - Long-acting opioids can be given once daily or as needed.
   - Use the lowest dose that controls pain and is not harmful.

6. Monitor patients regularly:
   - Review the medication with the patient.
   - Discuss any side effects or concerns.
   - Adjust the dosage as needed.

7. When to stop treatment:
   - If the patient is not improving or the benefits are outweighed by the risks.
   - If the patient is not taking the medication as prescribed.

8. Consider alternative treatments:
   - Other medications, therapies, or lifestyle changes.

9. Monitor patients regularly:
   - Review the medication with the patient.
   - Discuss any side effects or concerns.
   - Adjust the dosage as needed.

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    - If the patient is not improving or the benefits are outweighed by the risks.
    - If the patient is not taking the medication as prescribed.

11. Consider alternative treatments:
    - Other medications, therapies, or lifestyle changes.

Additional Resources:
   - CDC Guideline for Prescribing Opioids for Chronic Pain
   - SAMHSA Pocket Guide for Medication-Assisted Treatment (MATT)
   - NIDA Guidelines

Bridges to Recovery

Join the Movement

Learn from the experts on medication-assisted treatment and how it can help you.

www.turnthetiderx.org

www.cdc.gov/substanceuse

www.samhsa.gov

www.nida.nih.gov

Source: http://turnthetiderx.org/#
The Impact of the CDC’s Prescribing Guidelines

• CDC releases new guidelines (March 2016)
  • “When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.”

• Several states have taken steps to limit first-time prescribing of opioids
  • MA, CT, ME, NY, OH etc.
  • 7-day supply limit
  • NY Task Force credits CDC changes
  • NJ 5-day supply limit

Source: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
http://fightingopiatabuse.ohio.gov/
http://www.nytimes.com/2016/03/17/opinion/a-strong-response-to-the-opioid-scourge.html?_r=0
Narcan (Naloxone) Use is on the Rise

**What is Narcan™ (naloxone)?**

Narcan™ (naloxone) is an opiate antidote. **Opioids** include heroin and prescription pain pills like morphine, codeine, oxycodone, methadone and Vicodin. When a person is overdosing on an opioid, breathing can slow down or stop and it can very hard to wake them from this state. Narcan™ (naloxone) is a prescription medicine that blocks the effects of opioids and reverses an overdose. It cannot be used to get a person high. If given to a person who has not taken opioids, it will not have any effect on him or her, since there is no opioid overdose to reverse. For additional medical information about how naloxone works [click here](http://stopoverdoseil.org/narcan.html). There are also many naloxone training and informational videos available, [click here](http://stopoverdoseil.org/narcan.html) to browse our resources.

**How does Narcan™ (naloxone) work?**

If a person has taken opioids and is then given Narcan™ (naloxone), the opioids will be knocked out of the opiate receptors in the brain. Narcan™ (naloxone) can help even if opioids are taken with alcohol or other drugs. After a dose of Narcan™ (naloxone), the person should begin to breathe more normally and it will become easier to wake them. It is very important to give help to an overdosing person right away. Brain damage can occur within only a few minutes of an opioid overdose as the result of a lack of oxygen to the brain. Narcan™ (naloxone) gives concerned helpers a window of opportunity to save a life by providing extra time to call 911 and carry out rescue breathing and first aid until emergency medical help arrives.

**New York Task Force Report**

Recommendation #19:

**Expand Access to Overdose-Related Medication**

**MA Governor’s Report:**

Working Group Finding #9:

**Increasing Access to Naloxone Will Save Lives**

**Recommendations Related to Naloxone:**

- Investigate the feasibility of having Naloxone in public spaces
- Improve affordability of Naloxone
- Encourage Naloxone to be co-prescribed with opioids

Sources:

- [http://stopoverdoseil.org/narcan.html](http://stopoverdoseil.org/narcan.html)
- [www.mass.gov/stopaddiction](http://www.mass.gov/stopaddiction)
Ohio - Saving Lives through Naloxone

- Gov. Kasich has signed multiple bills into law that increase access to naloxone – a drug overdose antidote – for use by first responders and families of addicted individuals.
- Ohio pharmacies with a standing order from a physician can now dispense naloxone over the counter.
- The 2016-17 state budget dedicates $1 million to make naloxone available to law enforcement and first responders through Ohio’s local health departments.

Source: [http://mha.ohio.gov/Portals/0/Acute%20Prescriber%20Guidelines%20FINAL%20PRINT.pdf](http://mha.ohio.gov/Portals/0/Acute%20Prescriber%20Guidelines%20FINAL%20PRINT.pdf)
Opioids Starting to Take a Back Seat

• New Jersey Emergency Room using opioids only as a last resort
  • One of the country’s busiest ERs
  • For patients with common types of acute pain – migraines, kidney stones, sciatica, fractures – doctors trying non-opiate alternatives
  • Teaching ER docs new protocols

• Tennessee pain clinics stop using opioids
  • One of the largest health care systems in TN will no longer prescribe long term opioid pain medication to patients at two of its pain management clinics
  • Switching to non-opiate alternatives which are “equally effective”

**Bridges to Recovery**

**Source:**
- https://www.ceiwc.com/safety-university/safety-posters/5x7%20100%20DPI/Opioid%20Drug%20Addiction%20Can%20Get%20Bigger%20&%20Badder_5x7_100dpi.jpg

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**Prescribing Opioid Painkillers in the Emergency Department**

For Your Safety, We Do Not:

- Prescribe long-acting opioid painkillers that require tablets to be swallowed (abuse via swallowing or injection).
- Prescribe more than a short course of opioid painkillers.
- Refill lost, stolen or destroyed prescriptions.

Prescription opioid painkillers can be just as dangerous as illegal drugs.

- Opioid painkillers can cause constipation, drowsiness, and increased sensitivity to pain.
- People who become dependent are at risk for accidental overdose.
- A overdose of opioid painkillers can cause a person to stop breathing and die.

Keep your prescription opioid painkillers safe!

- Keep opioid painkillers out of children and out of reach of others who take prescription drugs.
- Keep opioid painkillers out of reach of children and out of reach of others who take prescription drugs.
- Keep opioid painkillers out of reach of children and out of reach of others who take prescription drugs.

Problem with painkillers?

Help is available — call 1-800-LIFENET.

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**No Shoes, No Shirt, No Narcotics**

There is no such thing as a small opioid addiction. It can quickly get bigger and badder.

- Opioid therapy is not a first-line or routine therapy for chronic pain.
- Talk to your doctor about ways to manage your pain that don’t involve prescription opioids.
- Ask yourself — is my temporary chronic pain really worth becoming addicted to opioids and the resulting life-threatening consequences?

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**STOPIOD operandi**

Chesapeake, Virginia
How Can Ohioans Make a Difference
Fight the Stigma With The Families You Serve

• Stamp out the Stigma
  • The Three R’s (recognize, reeducate and reduce) depend on each other to effectively Stamp Out Stigma surrounding mental illness and substance use disorders.

• MA Governor’s Opioid Working Group
  • The stigma associated with a substance use disorder (SUD) is a barrier to individuals seeking help and contributes to: the poor mental and physical health of individuals with a SUD; non-completion of substance use treatment; higher rates of recidivism; delayed recovery and reintegration processes; and increased involvement in risky behavior.

• MA HHS State Without StigMA campaign

Source: http://stampoutstigma.com/pledge.html
Get Educated on Narcan (Naloxone) Use

Training Videos
- Multnomah County Sheriff’s Office naloxone training
- Injectable Narcan training video [Multnomah County Health Dept.]
- Nasal Narcan training video [Multnomah County Health Dept.]
- Using Adapt Nasal Narcan to Reverse Opiate Overdose [Multnomah County Health Dept.]

Opiates include:
- Heroin
- Methadone
- Oxycodone
- Vicodin
- Percocet
-Codeine
- Fentanyl

Does not reverse overdose from drugs like:
- Cocaine
- Meth
- Alcohol
- Benzodiazepine

Signs of an overdose:
- Not breathing, or breathing is very slow
- Turning pale, blue, or gray, especially lips or fingernails
- Making snoring, gurgling, or choking sounds
- Becoming limp
- Throwing up
- Not responding to yelling or other stimulation

Review:
1. Check for responsiveness
2. Call 911
3. Breathe for them for 30 seconds
4. Give 1st full dose of naloxone
5. Continue breathing for them for 3 minutes
6. Give them a 2nd full dose, if necessary
7. Monitor to make sure they do not overdose again
8. Put them in the recovery position

Source:
https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx
https://www.youtube.com/watch?v=F7ggQlby_M&feature=youtu.be
Know Non-Opioid Alternatives are an Option

**Nonopioid Treatments for Chronic Pain**

- Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that non-opioid treatments, including non-opioid medication and nonpharmacological therapy can provide relief to those suffering from chronic pain and are safer.

**Managing Pain Without Overusing Opioids – Implementing Safe, Effective and Less Risky Analgesic Strategies**

- BOTTOM LINE: rates of opioid-related overdose deaths are at all-time highs. The unselective use of opioid analgesics for chronic non-cancer pain, promoted for years, is now being reconsidered. Primary care physicians must recognize that some patients and some pain conditions are unlikely to benefit from chronic opioid therapy.

Source:
Know Non-Opioid Alternatives are an Option

• Non-Opioid Medications (e.g., Ibuprofen, aspirin, Tylenol, Lyrica, etc.)
• Acupuncture
• Massage Therapy
• Cognitive Behavioral Therapy (CBT)
• Nerve Ablation
• Scrambler Therapy
• Lifestyle Adjustment (e.g., nutrition, physical activity, weight loss, etc.)
Prescription Drug Monitoring Programs (PDMPs) Make a Difference

- PDMPs are electronic databases that can provide the opioid and controlled substance history for a physician’s patients and personal prescribing practices
- The AMA strongly encourages the use of prescription drug monitoring programs (PDMPs), but only as one part of the decision making process when considering whether to prescribe an opioid.

• FL (E-FORCSE)
  http://www.hidesigns.com/flpdmp/practitionerpharmacist/
• KY (KASPER)
  http://chfs.ky.gov/os/oig/KASPER.htm
• NY (I-STOP)
  http://www.health.ny.gov/professionals/narcotic/prescription_monitoring/
• Ohio (OARS)
• TN (CSMD)
• WV (CSAPP)

• Reports from states like KY, OH, NY and TN suggest a significant drop in doctor shopping after the implementation of PDMPs

PDMPs Make a Difference

Health Affairs

**Prescription Drug Monitoring Programs Are Associated With Sustained Reductions In Opioid Prescribing By Physicians**

• Study covered point-of-care prescribing practices for pain medication in 24 states that had implemented a PDMP during the study period of 2001 through 2010

• “We found that the implementation of a prescription drug monitoring program was associated with more than a 30 percent reduction in the rate of prescribing of Schedule II opioids. This reduction was seen immediately following the launch of the program and was maintained in the second and third years afterward.”

Brandeis Univ.

**Briefing on PDMP Effectiveness**

• Cites over 60 sources providing further evidence supporting the conclusion that PDMPs are an effective tool in addressing the prescription drug abuse epidemic.

• Data from the Virginia PDMP show that in the period following a rapid increase in PDPM data utilization, the number of individuals meeting criteria for doctor shopping dropped by 44%.

Source: [http://content.healthaffairs.org/content/35/6/1045](http://content.healthaffairs.org/content/35/6/1045)
[http://www.pdmpassist.org/content/coe-releases-updated-briefing-pdmp-effectiveness](http://www.pdmpassist.org/content/coe-releases-updated-briefing-pdmp-effectiveness)
Leverage Solutions from Every Industry

• However, our hope is that through the use of predictive analytics (i.e., the ability to identify, in the first few days of receiving a claim, individuals most likely to become high consumers of opioids), prescribing guidelines and physician peer-to-peer outreach, we can help increase insurers’ and treating physicians’ awareness as they work to help prevent injured workers from struggling with dependency and addiction before the behaviors or habits ever form.

• As former British Prime Minister Benjamin Disraeli once said, “What we anticipate seldom occurs; what we least expect generally happens.” The science and passion exists today to better anticipate opioid trends and help prevent opioid dependency and addiction before it happens.
Familiarize Yourself With Medication Assisted Treatment (MAT) Options and Treatment Centers

- Methadone
- Naltrexone (Vivotrol)
- Buprenorphine
- Buprenorphine/Naloxone

Source: Kevin Bingham IPhone
**Understand the Benefits of Medication MAT**

**WHEREAS, Every dollar spent on treatment is estimated to result in up to $11 in savings to the public and in medical costs.**


**Economic Benefits of Investing in Treatment**

Research shows that every dollar spent on substance abuse treatment saves $4 in healthcare costs and $7 in law enforcement and other criminal justice costs. On average, substance abuse treatment costs $1,583 per patient and is associated with a cost offset of $11,487, representing a greater than 7:1 ratio of benefits to costs.

Source: [http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2015&sessInd=0&billBody=S&billTyp=R&billNbr=0267&pn=1530](http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2015&sessInd=0&billBody=S&billTyp=R&billNbr=0267&pn=1530)

[https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf](https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf)
Join the Movement

• Attend informational sessions
• Help a task force
• Support legislative activity
• Volunteer
• Raise funds
• Share helpful Apps
• Promote new CDC guidelines
• Support Narcan use
• Help fight the stigma

Mercy Behavioral Health Care Sponsors Speakers Chris Herren, Sec. Marylou Sudders, and Dr. Robert Roose

Caritas Gala
Pathway to Care: Addressing the Opioid Crisis

Join us for an evening of dinner, dancing, auctions, live entertainment, and raising money for a great cause! The inaugural Caritas Gala will benefit Mercy Behavioral Health Care's Pathway to Care: Addressing the Opioid Crisis project.
Closing Thought

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has.”

Efforts of government officials, health care professionals and others help make a difference every day. As a child support enforcement case worker, you have the power to positively impact custodial and non-custodial parents.
Speaker Bios
Kevin M. Bingham
Principal, Deloitte Consulting
kbingham@deloitte.com       www.linkedin.com/pub/kevin-bingham/1/852/557

• Co-chairperson, Casualty Actuarial Society’s Innovation Council
• Leader of Deloitte Consulting’s medical professional liability and claim predictive modeling practices with a focus in public sector analytics
• Advisory board member and chairman of the annual Medical Professional Liability ExecuSummit
• Speaker, trainer and regular contributor to Contingencies Magazine, Inside Medical Liability Magazine, Claims Magazine and other publications on important industry issues. To date, Mr. Bingham has published almost 80 articles including:
  • Seven articles on the opioid epidemic
  • Multiple articles on the use of advanced analytics to help improve the lives of others
• Speaker and Keynote at more than 100 conferences/seminars/webinars
• Board Member, Lea’s Foundation for Leukemia Research
• Author of How to Raise an Everyday Hero: Quotes for Bedtime and Beyond, 155 page book for parents and children leveraging the power of quotes and inspirational stories
Mia Pareek  
Manager, Deloitte Consulting  
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- Currently working with the State of Ohio on Behavioral Health Redesign initiative to rebuild community behavioral health system capacity
- Have experience working on Medicaid and commercial healthcare initiatives across multiple States and Health Insurance Plans
- Speaker at the Medicaid Enterprise Systems Conference, 2015 - “Reaching Across Boundaries to Provide Access to Healthcare”
- Facilitator at Medicaid Enterprise Systems Conference, 2016 - “Effective use of Health Information Technology and Stakeholder Engagement for Large Medicaid Transformation Initiatives”