FIFTH VITAL SIGN

A COMMUNITY HEALTH CENTER TAKES STEPS TO ADDRESS THE OPIATE CRISIS
WHY WORRY?

- Opioids were involved in 33,091 deaths in 2015 nationally.
- Drug overdose has exceeded MV crashes as cause of death consistently since 2007.
- In approximately 1 in 5 drug overdose deaths, no specific drug is listed on the death certificate.
- Number of prescriptions for opioids has escalated from around 76 million in 1991 to nearly 259 million in 2015.
- US is about 4% of world population yet accounts for about 80% of the world’s hydrocodone consumption.
- In 2015, the five states with the highest rates of death due to drug overdose were West Virginia (41.5/100,000), New Hampshire (34.3/100,000), Kentucky (29.9/100,000), Ohio (29.9 /100,000), and Rhode Island (28.2 per 100,000).
The number of drug overdose deaths increased >440% from 1999-2012 in Ohio.

Number of Heroin Overdose Deaths increased 2012-2015

Prescription Opioid Overdose Deaths declined 2012-2015

80 million fewer doses of opioids were dispensed in 2015 Compared to 2011.

Counties with the most fentanyl-related unintentional overdose deaths were Hamilton (195), Summit (111), Butler, Montgomery, Cuyahoga, Clermont, Clark, Lucas, Franklin (40), Stark (26), Trumbull, Lorain, and Greene.
In 2016, we served a total of 12,200 patients, of which 4,800 were adults.

A total of 55,000 encounters in 2016.

20,000 encounters were rendered to adults.

At least 30% of these encounters had chronic pain as one of their diagnoses.

We are located in the heart of the epidemic.

Total number of overdose deaths in Springfield:
2016 - 70
2017 - 61
OUR APPROACH AND STEPS

Community

• Active participation in both the Community Health Needs Assessment and Community Health Improvement Plan conducted by our local health district.

• Represent in the substance abuse task force with a goal of reducing fatal overdoses by 75% in the next 3 years.

• Build strong relationships with local Alcohol and Drug Rehab facility, Local hospital system, Mental Health Agency, EMS, DJFS, Health district etc. with health information exchange through EMR interfacing and shared care coordination.

• Provide much needed healthcare leadership in the community.
As a whole we have set the tone to fight the epidemic.

Policies and procedures in place to treat pain in a safe and effective manner.

Educating our Board members about the opioid crisis and measures to combat.

Educating all staff about the pathophysiology of addiction and how to respond to an overdose situation.

Stocking Narcan at all our sites.
Provider prescribing practices were reviewed. Reports were shared with individual providers. An open discussion was encouraged.

Education was provided around opioids at monthly provider meetings, reaching a consensus that as a team we would choose non-opioid strategies as first-line to treat pain.

OARRS registration was made mandatory for all prescribing providers and their support person was added as a delegate to aid in running the reports.
2016

Peer reviews were conducted in the 2nd qtr. results were shared, education and tools provided, peer reviews repeated in the 4th qtr. to see changes in behaviors.
Our numbers improved from 2nd to 4th qtr.
Never were any refills given out.
Very rarely was there more than one opioid.
Having a Controlled substance contract in place was our weak spot.
Urine drug screens and pill counts were incorporated as a part of the treatment plan.

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<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Is there a documented diagnosis supporting the prescribed medication?</td>
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<td>Were there refills given when the opioid was prescribed?</td>
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<td>Are there other stimulants/opioids being prescribed to this patient?</td>
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<td>Has OARRS been checked and documented within the past 3 months?</td>
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<td>Is there documentation for a recommended follow-up appointment within 3 mo.'s of when the RX was originally filled?</td>
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<tr>
<td>Is there a signed controlled substance agreement on file in the patients chart?</td>
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CLINICIANS

2017

• All staff training on how to respond to an overdose scenario, with in-depth training for clinicians and other support personnel.

• Hands-on Narcan administration competency training for all licensed individuals including behavioral health providers.
DIFFICULTIES ALONG THE WAY

• Embracing Addiction as a disease process by providers and other staff as well.
• Holding providers accountable to their prescribing practices.
• Numerous hours of unbillable care coordination.
• Lack of adequate resources in the treatment and recovery realm.
• Educating prescribing providers to not stop opioids abruptly for reasons other than diversion.
• Raising awareness in the community as well internally around dual-diagnosis
“Rocking Horse has decided to treat pain in a safe and effective manner, as part of a solution to the opioid epidemic”
HOW DO WE PLAN TO DO THIS?

- Physical health  On-site chiropractic services to start in 4-6 weeks as an adjunct to primary care.
- MAT  On-site substance abuse assessments, Vivitrol for appropriate individuals, AOD counseling
- Physical therapy  PTA under the supervision of the Chiropractor.
- Psychiatry  Continuing and expansion of behavioral health services aiming at dual-diagnosis.

GOAL: Treating co-occurring Mental Health, Substance Use Disorder, and Physical Health Concerns
TAKE AWAY

Pain management

Addiction Rx

Overdose reversal