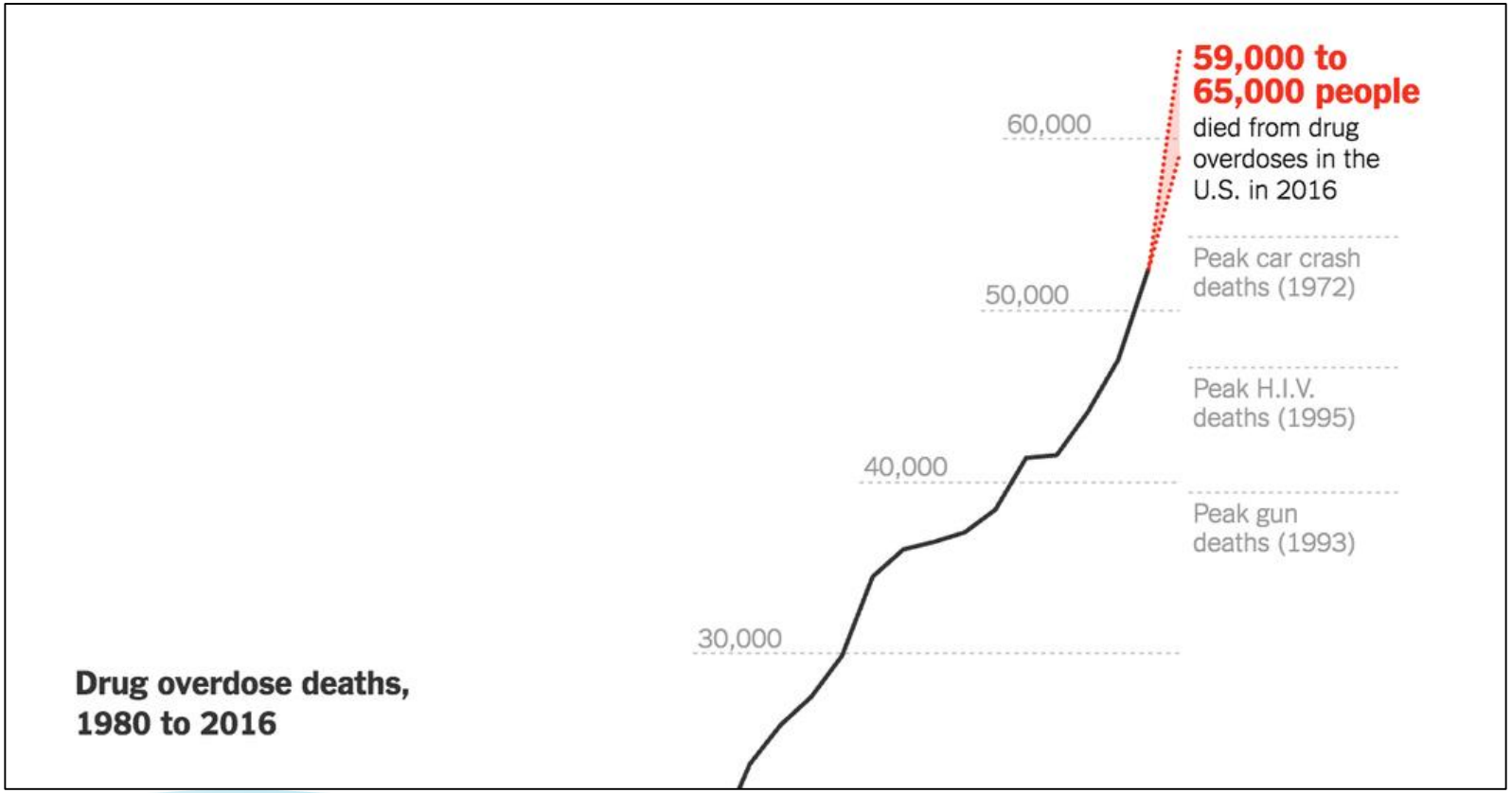
The Mercy Health
Addiction Treatment Collaborative

Building a Collaborative Continuum
&
Developing Internal Capability

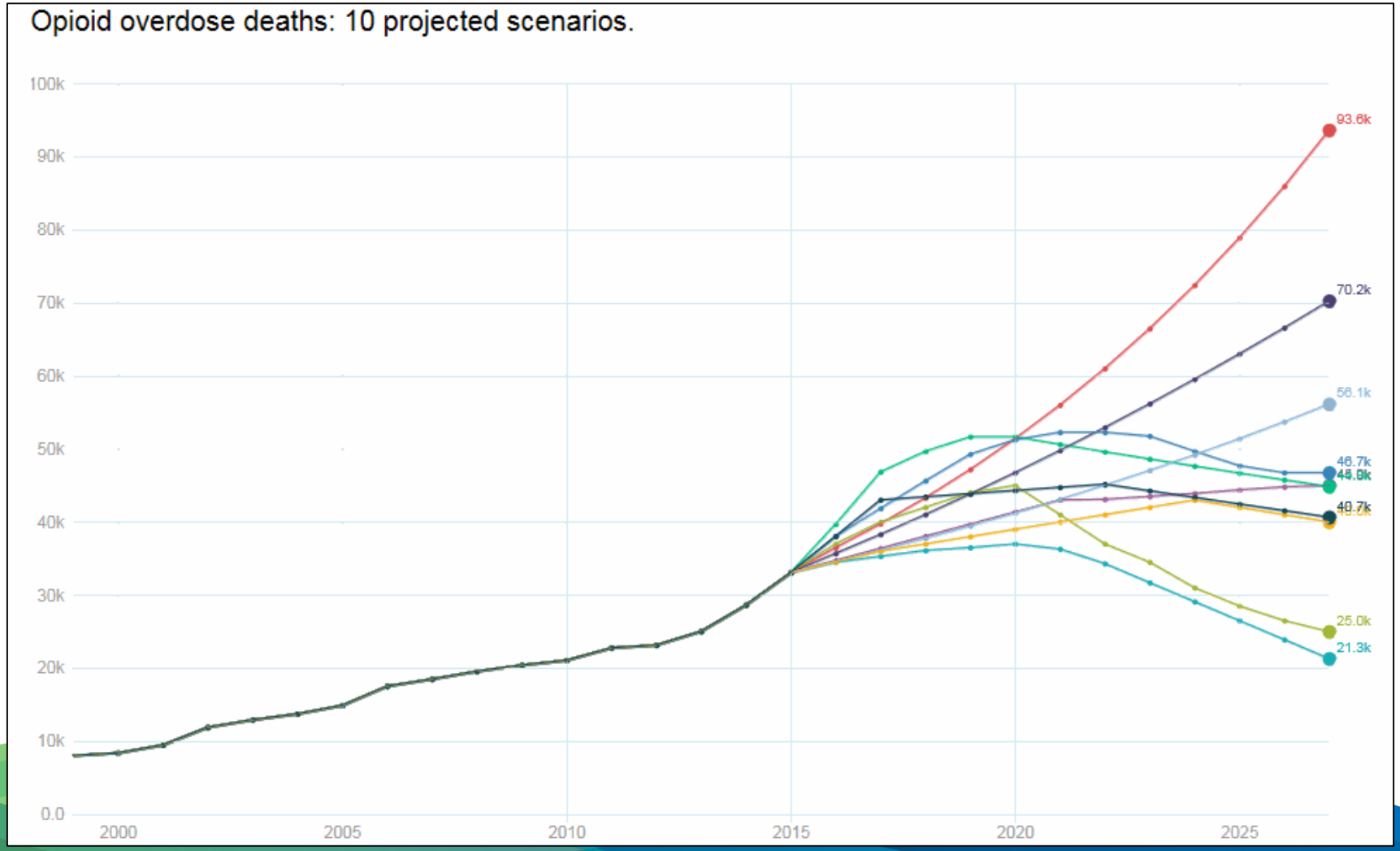
AGENDA

1. Define the scope of the problem.
2. Describe the formation of the Mercy Health Addiction Treatment Collaborative.
3. Delineate the development of Mercy Health's internal capability.

Scope of the Problem

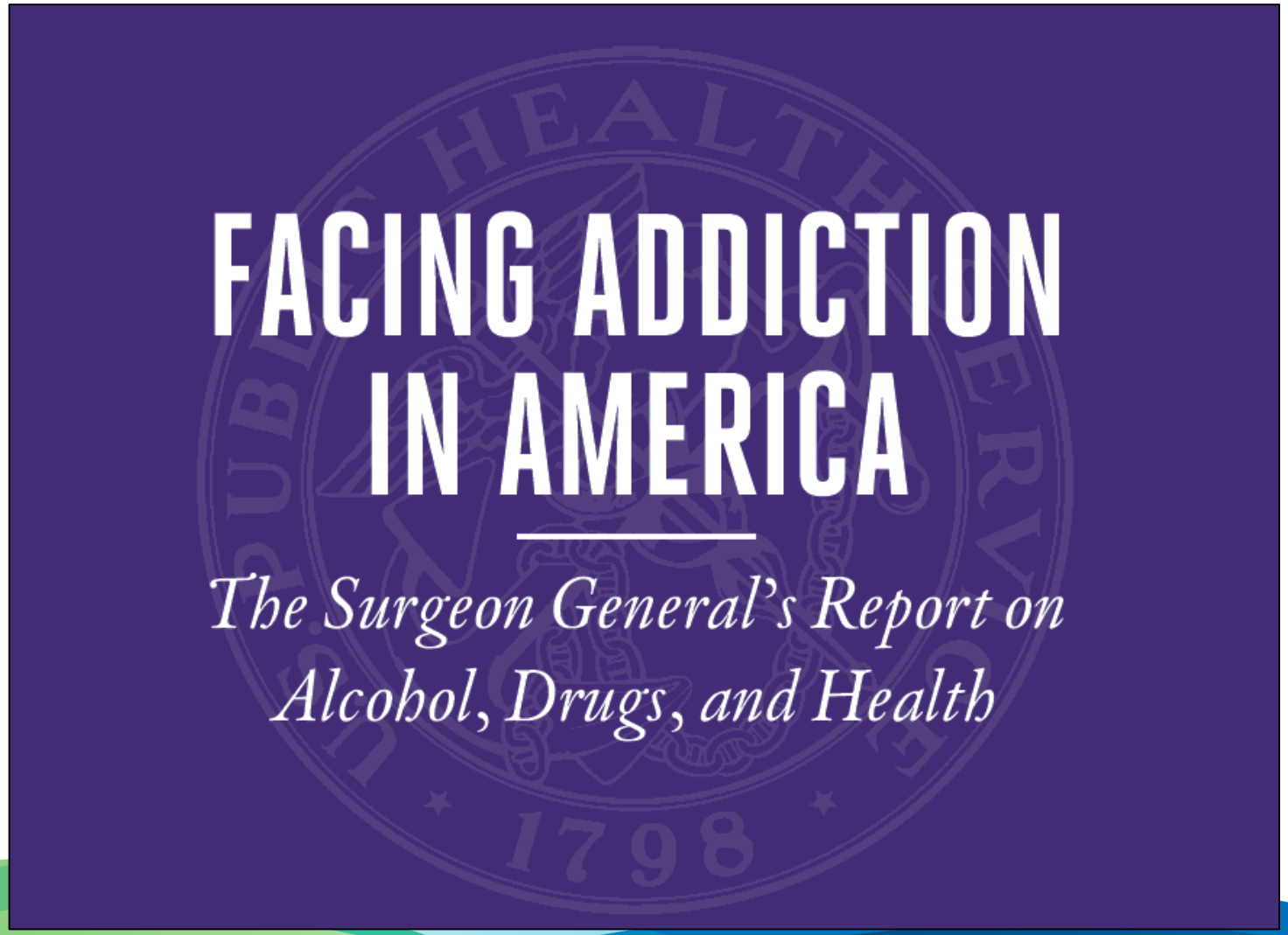


500k deaths by 2027??



We know we have to do something… but what?

- **Health systems historically don't do much in the way of "addiction treatment"**
- **And who would do that long-term care??**
  - Haphazard, seemingly random referral processes are insufficient to address the crisis…


FACING ADDICTION
IN AMERICA
The Surgeon General's Report on
Alcohol, Drugs, and Health

Addiction

Definition from the American Society of Addiction Medicine

- **Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry**.
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.
- **Like other chronic diseases, addiction often involves cycles of relapse and remission.**
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

The General Addiction Treatment Continuum

- **Emergency services**
- **Hospital/inpatient services**
- Residential care (30-day, 6-month, etc.)
- Medication-Assisted Treatment (comprehensive services)
- Chemical-Dependency Intensive Outpatient Program (CD-IOP)
- **Primary Care – management of comorbidities**

Substance use disorders are chronic, relapsing, and potentially-lethal medical conditions.

Treatment must be imminently available and aligned with best-practiced informed by science.

So what do we do about it?
Business as usual: a healthcare arms race?

- **We could build addiction treatment centers.**
- **Or we could collaborate with those already doing the work… if they have any capacity.**
- **Either way, we need to define and execute whatever falls in our wheelhouse.**
  - Inpatient, ED, Primary Care, etc.
  - Outreach, Advocacy, Education, etc.

2017 Timeline for Clinical Collaboration

- **June/July – Initial Request for Information (RFI).**
- **August – First Collaborative group meeting.**
- **September/October – Site visits & agreements signed.**
- **November – First Medical Directors' group meeting.**
- **December – Second Collaborative group meeting.**

- **2018-and beyond- Build out internal capability… and test the "highway."**

Collaboration Agreements

- **Addiction Treatment Provider Responsibilities**
  - Provide data submission updates requested by Mercy Health.
  - Adhere to Care Coordination procedures established by Mercy Health
  - Use ***best reasonable efforts to accept patients*** in need of Addiction Treatment Services when those services are not available by Mercy and are provided by addiction treatment provider.
  - Monthly Medical Directors' Group meeting.

- **Mercy Health Responsibilities**
  - Provide ***remote access to CarePath*** (EPIC) where available.
  - Provide secure text-messaging capability so AOD providers can reach any employed/affiliate Mercy Health providers.
  - Use best reasonable efforts to accept patients in need of services provided by Mercy.

Mercy Health CLINICAL Work Group

An internal CLINICAL Workgroup was responsible for representing diverse clinical constituencies to develop and align on what our capability should look like… for defining our "wheelhouse."

These responsibilities were written and disseminated in the form of an interprofessional "Clinical Practice Guideline." This will standardize internal clinical practices across care sites.

Clinical Practice Guidelines
Keys to Success

1. Each service line has clearly-delineated, standardized clinical protocols and responsibilities across levels-of-care.
2. Our care teams must be appropriately equipped with the tools and knowledge to respond when patient needs are identified.
3. The continuum cannot be fragmented, even if delivered by different facilities or by different organizations.

The most-likely outcome we will encounter would be that Mercy Health *initiates treatment* – and collaborating organizations would *continue treatment.* All 5 Mercy Health hospitals in Cincinnati will be operational with our clinical practice guidelines on June1st, 2018.

MERCYHEALTH

Comprehensive Integrated Syringe Service Programs

Mercy Health Hospitals
- Emergency departments
- Inpatient units

Collaborating Addiction Treatment Provider

- Medication assisted treatment (MAT)
- Outpatient
- Residential

Mercy Health Physicians
- Primary care
- Specialty services

Addiction Treatment Collaborative

10962CINDES 2-18

Hope for the future…

Clermont County overdose deaths:

- **2015 – 94**
- **2016 – 82**
- **2017 – 60 (projected maximum)**

- **Increase from 150 to 550 individuals with opioid use disorder in active MAT between July/2016 thru December/2017.**

Collaborative Agreements signed with:

1. BrightView
2. Center for Addiction Treatment (“CAT House”)
3. City Gospel Mission
4. DeCoach Rehabilitation
5. Greater Cincinnati Behavioral Health (Clermont Recovery Center)
6. Health Experiences
7. Joseph House
8. Lotus Health
9. Margaret Mary Health
10. Modern Psychiatry & Wellness
11. Northland/Ridge
12. Sunrise Treatment Center
13. Talbert House
14. Urban Minority Alcoholism and Drug Abuse Outreach Programs

DISCLAIMER: we coordinate care with any outside provider regardless of participation in the Mercy Health Addiction Treatment Collaborative. Our goal is to improve coordination of and access to high quality care between Mercy Health and other treatment centers. Patient preference should be respected.

Substance use disorders are chronic, relapsing medical conditions.

Treatment works!

www.findlocaltreatment.com

Optimizing Post-Cesarean Pain Control with Evidence Based Guidelines:

The Provision of Opioid Sparing Techniques through Multimodal Analgesia Therapy

Beth Ann Clayton, DNP, MS, CRNA

Carol Baden

Sarah Farmer, BSN, RN

University of CINCINNATI

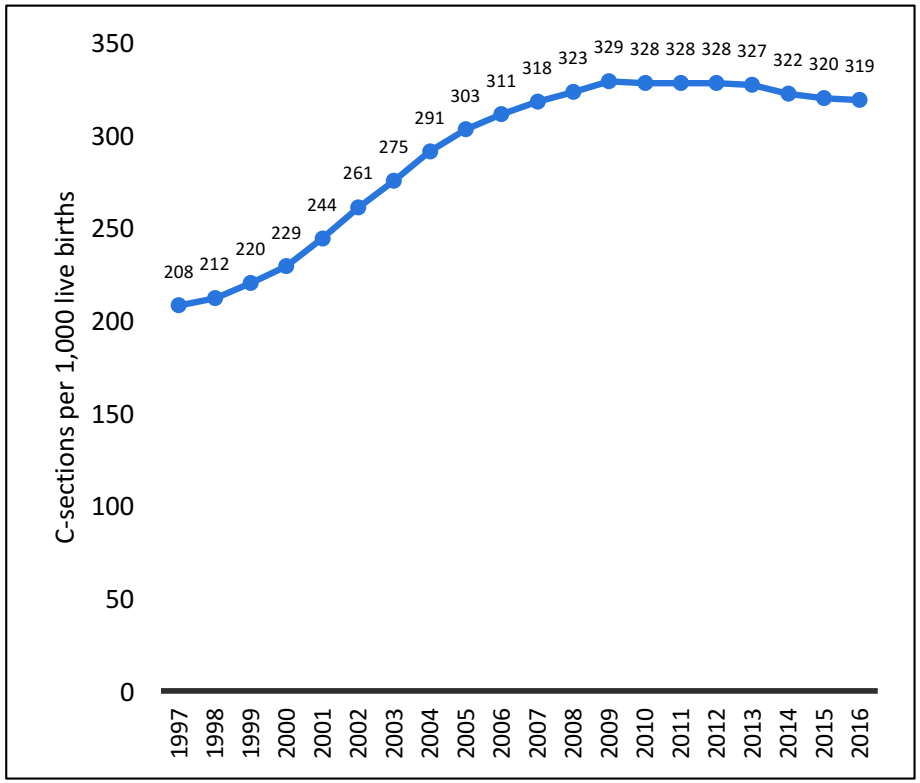
Overview

- Background
- Significance
- Guideline recommendations
- ACOG position statement
- Future impact

University of CINCINNATI

Background

- Large population undergoing cesarean section
- Inadequate post-cesarean analgesia identified in literature
- Inconsistent use of analgesic interventions
- Numerous immediate and delayed public health consequences
- Implementation of evidence based analgesic guidelines is necessary



University of CINCINNATI

Significance

Consequences of inadequate analgesia:

- Impaired breastfeeding
- Decreased ability to care for newborn
- Impaired mother-baby bonding
- Litigation risk

University of CINCINNATI

Significance

Inappropriate Managed Pain:

Increased Risk for Development

Eisenacg et al., 2008

University of CINCINNATI

Significance

Inappropriate Managed Pain:

Increased Risk for Development

Chronic Pain

- Dependence on opioids

Eisenacg et al., 2008

University of CINCINNATI

Chronic Pain

Risk factor for development of chronic pain:

Higher pain scores in the immediate 24 hour post-cesarean section period
(Booth et al., Borges et al., Eisenach et al., Lavand'homme , Sng et al.)

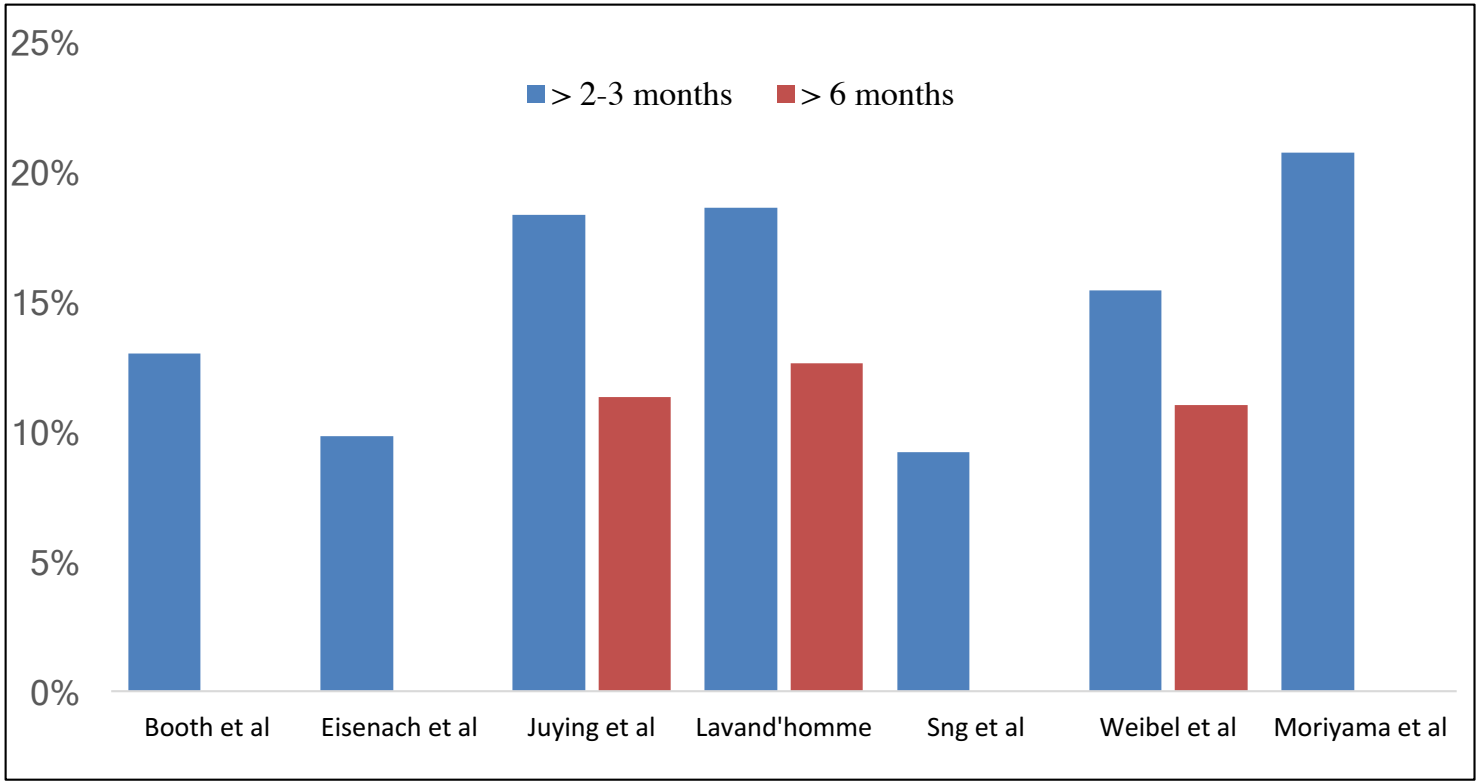
*"**Acute postoperative pain** is among the generally recognized risk factors for **persistent post-surgical pain.** Extensive literature reflects this trend"*
(American Academy of Pain Medicine)

*"**Higher levels of pain in the acute postoperative period** have consistently been found to **predict pain weeks and months after surgery;** this association has been replicated in many surgical cohorts"* (Systematic review of chronic post-surgical pain in *Reviews in Pain*)

University of CINCINNATI

Significance

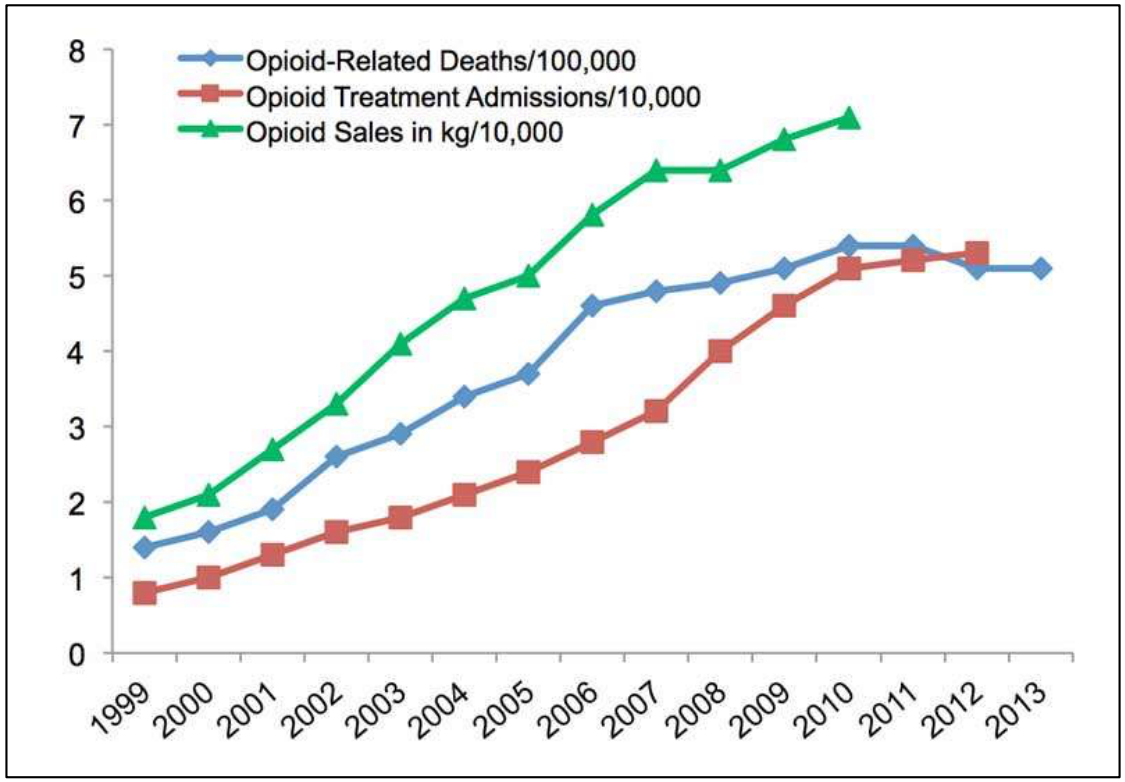
Chronic Post-Cesarean Section Pain



University of CINCINNATI

Significance

Chronic Pain and Opioid Abuse



NIH, CDC

University of CINCINNATI

Prescription Opioids

Prescription opioids dispensed nearly quadrupled from 1999 to 2010.

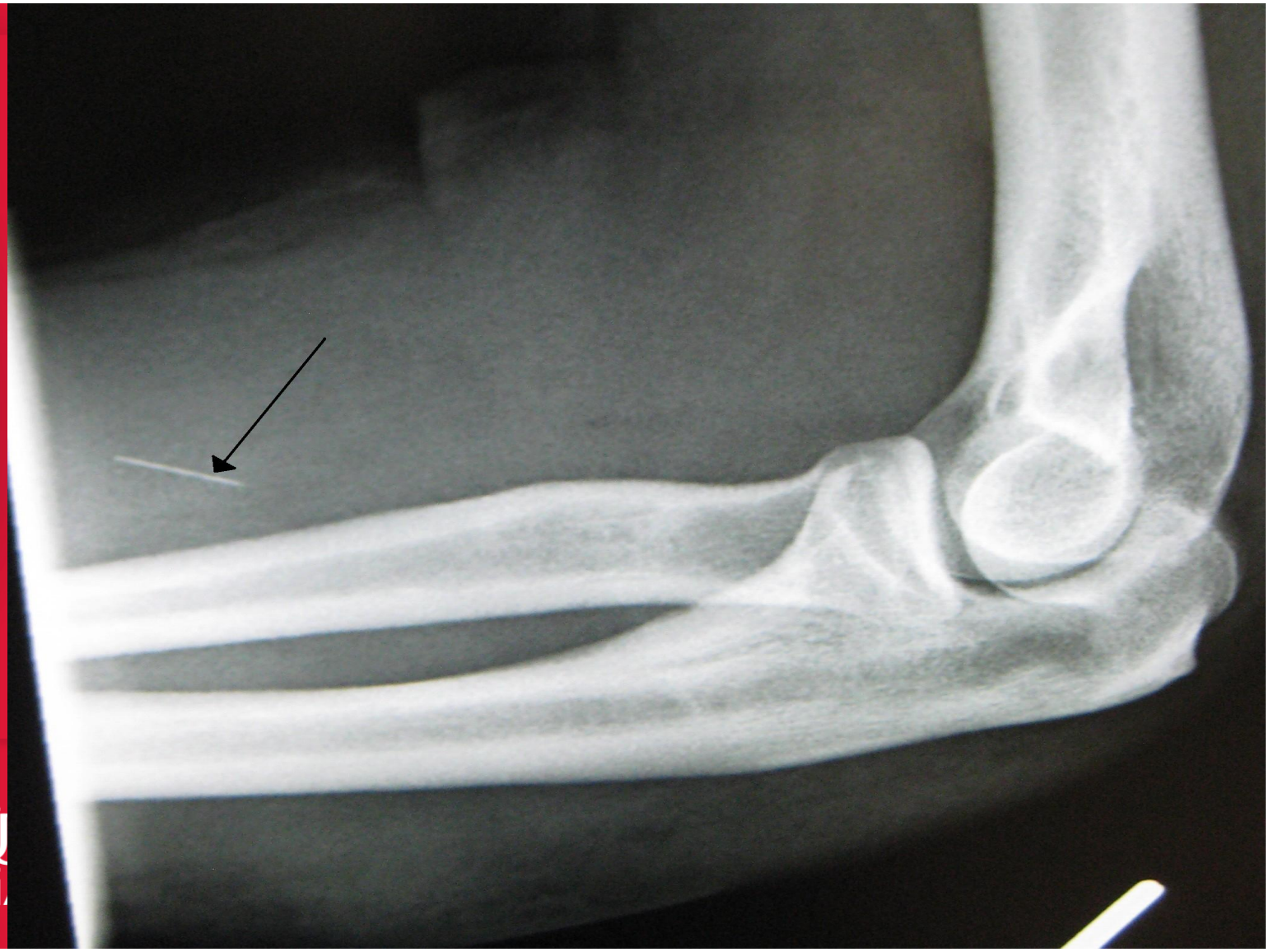
- Overdoses from prescription opioids are driving factor in 18-year increase in opioid overdose deaths
- Majority of opioid abusers begin their addiction with prescription medications, **primarily for chronic pain**
- Chronic postoperative pain occurs in 10-50% of surgical patients
- Numerous factors, including inappropriate prescribing, opioid misuse, and dependence have contributed to the crisis (Vadivelu et al, 2018)

University of CINCINNATI

Opioid-related hospital visits up 99% in less than a decade, US data shows

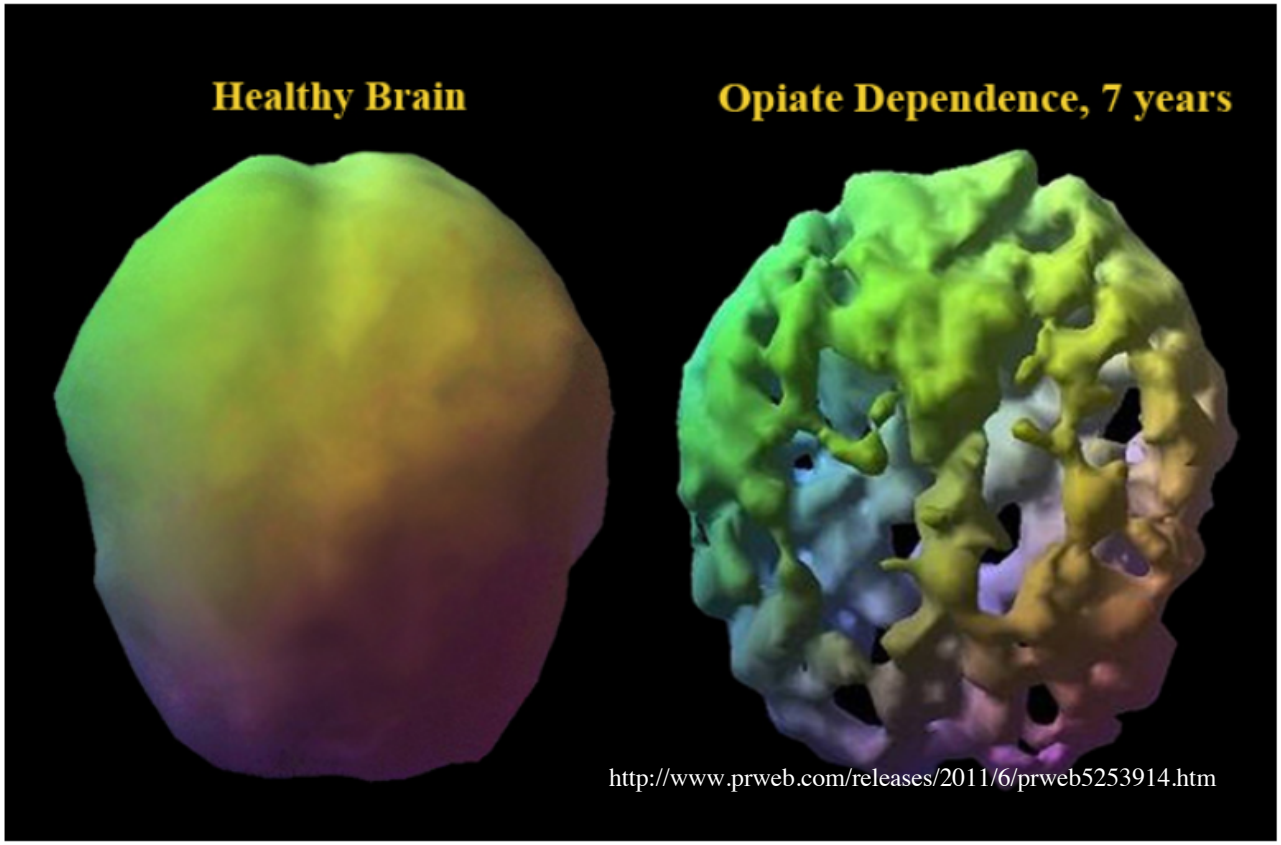
- https://www.theguardian.com/us-news/2017/jun/20/opioids-us-hospital-visits-georgia

University of CINCINNATI



University of
CINCINN

Brain damage from opioid use



University of CINCINNATI

University of CINCINNATI

The brain interrupted:

the Chemical damage

www.webmd.com

The Death Toll in America

More than **174** Americans Die Each Day From Opioid Overdoses

Nationally, 66% of 63,600 drug overdose deaths involved an opioid, 2016

https://www.cdc.gov/drugoverdose/index.html
https://www.usatoday.com/story/news/nation-now/2018/01/29/175-americans-dying-day-what-solutions-opioid-epidemic/1074336001/
https://www.nationalgeographic.com/magazine/2017/09/the-addicted-brain

University of CINCINNATI

The Death Toll in Ohio

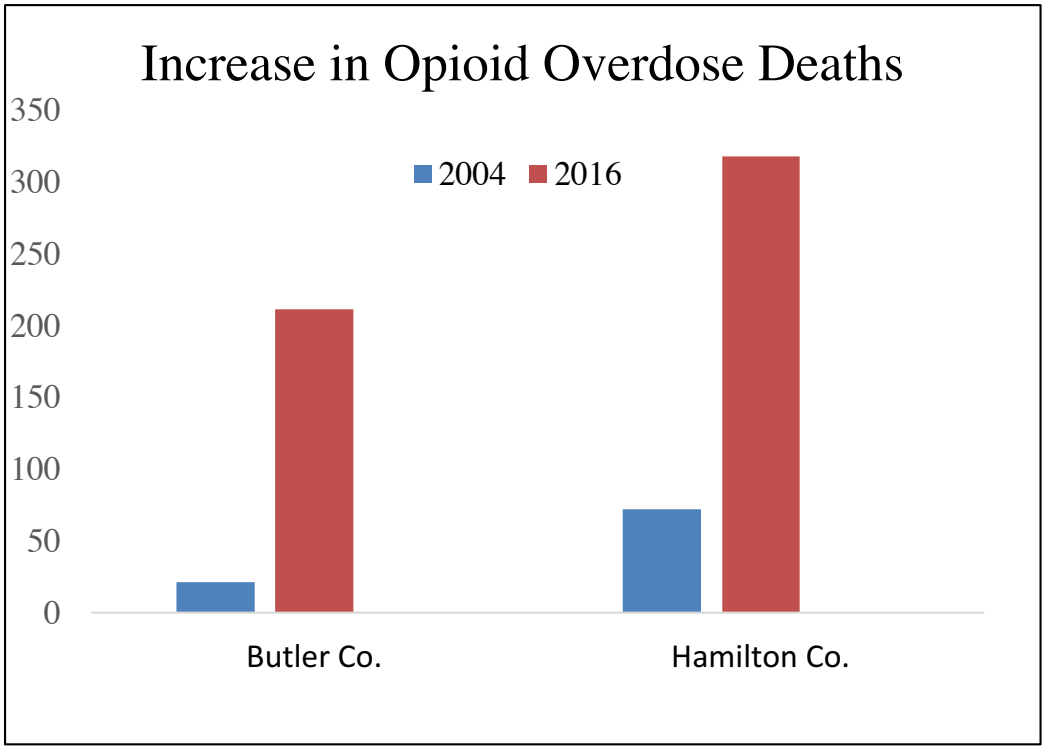
<u>ODH reports Highest Incidence:</u>
Montgomery County
Hamilton County
Butler County

University of CINCINNATI

Significance

Opioid Abuse in Ohio and Butler County

- Ohio has the 2nd highest rate of drug overdose death in the US
- Hamilton and Butler Counties have the highest opioid overdose death rates in Cincinnati

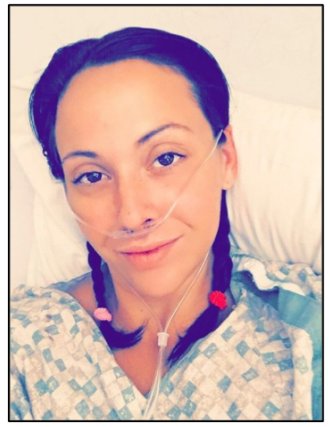


University of CINCINNATI

NPR Story

"I had the C-section, had the kiddo," says Michelle Leavy. "And then they tell me, 'It's OK, you can keep taking the pain medications, it's fine.' "

Leavy, 30, is from Las Vegas. A mother of three and a paramedic, she has dealt with many people with addiction problems. She welcomed the high-dose intravenous narcotics while she was in the hospital and as she went home. She gladly followed doctors' orders and kept ahead of the pain with her Percocet pills.



But then she needed stronger doses. And pretty soon, she realized she was no longer treating pain. "Before I went to work I took them, and to get the kids after school I had to take them," she says. "Then I was taking them just to go to bed. I didn't really realize I had a problem until the problem was something more than I could have taken care of myself."

She said she was becoming like the patients with addiction problems that she transported by ambulance, lying to emergency room doctors to con a few extra doses.

She lost her job and her fiancé, before going to rehab through American Addiction Centers and stitching her life back together.

University of CINCINNATI

Significance

Opioid Abuse in Obstetric Patients

- Since 1999:
  - 500% increase in opioid overdose deaths in women
  - Pregnant women reporting prescription opioid abuse increased from 2% to 28%
- ACOG opinion: **"ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose"**
- Limited studies directly measuring chronic cesarean pain and postpartum opioid dependence
  - Chronic post-surgical pain is correlated with opioid dependence and abuse
  - Chronic cesarean pain is highly correlated with postpartum depression, which increases the risk of substance abuse

University of CINCINNATI

Clinical Practice Variations

Clinical practice variations occur throughout healthcare

Variations in practice can effect outcomes including:

- Patient care
- Quality
- Patient satisfaction score
- Finances

Melnyk & Finehout-Overholt, 2011

University of CINCINNATI

Evidenced Based Practice Guidelines

- One **key factor to reducing variations** in outcomes
  - Availability, uptake and consistent utilization of **clinical evidence** at the point of care

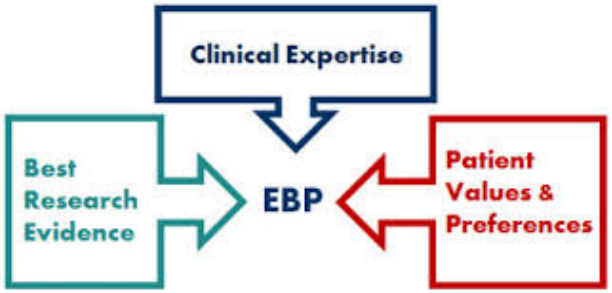
University of CINCINNATI

Melnyk & Finehout-Overholt, 2011

Evidenced Based Practice Guidelines

Help connect current published scientific evidence and clinical decision-making

- Evidenced based practice includes
  - Integration of individual clinical expertise
  - Patient preferences
  - High quality scientific evidence
    - Systematic reviews
    - Meta-analysis



Melnyk & Finehout-Overholt, 2011

University of CINCINNATI

What is the evidence?

University of CINCINNATI

Guideline Recommendations

- Reflective of comprehensive literature review
- Approved American Association of Nurse Anesthetists (AANA) in 2017
- Multimodal analgesia is the most effective means of providing optimum post-cesarean section pain control

University of CINCINNATI

Post-Cesarean Analgesia

Multimodal postoperative pain management, as an element of enhanced recovery after surgery, is important for the immediate and long-term success of patients undergoing cesarean section. Appropriately managed postoperative pain optimizes the mother's ability to be mobile, care for her neonate and breastfeed.[94] Inappropriately managed pain may increase the risk of post-partum depression, thromboembolic event and dependence on opioids that may lead to substance use disorder and chronic pain development.[95-98]

Multiple studies have demonstrated that neuraxial opioids administered as part of the surgical anesthetic provide superior postoperative analgesia when compared with intravenous opioids. Intravenous opioids may be administered if an opioid was not added to the neuraxial technique or if breakthrough pain occurs with a neuraxial technique.

Multimodal analgesia, which includes the combination of several medications with different mechanisms of action, may enhance the effects of a single analgesic and reduce opioid requirements and opioid-related side effects.[96,99,100] A combination of the minimum effective dose of opioid or no opioid, in combination with a non-steroidal anti-inflammatory drug (NSAID), acetaminophen, and dexamethasone provides optimal pain relief.[101,102] A combination of these agents may produce additive or synergistic effects to decrease medication doses, reducing the side effects and the transfer of medication into breast milk. Administer dexamethasone and intravenous acetaminophen after cord clamp.

https://www.aana.com

University of CINCINNATI

Why is it difficult?

www.asam.org

University of CINCINNATI

Guideline Recommendations

Multimodal analgesia

- Greatest analgesic efficacy
- Synergistic effect of individual analgesics
- Decreases opioid and total drug dose requirements
- Decreases adverse opioid induced side effects
- Decreases transfer of individual drug in breast milk

Analgesic Agents

- NSAIDS
- Acetaminophen
- Dexamethasone
- Opioids

University of CINCINNATI

Neuraxial Opioids

- Provide superior postoperative pain relief
  - compared to IV opioids
  - Higher doses may increase side effects w/o analgesic improvement
- Neuraxial Morphine "Gold Standard"

Morphine	100ug (intrathecal) or 2-3.75 mg (epidural)	12-24 hours duration
Fentanyl	10-20 mcg (intrathecal) or 50-100 mcg (epidural)	3-4 hours duration

University of CINCINNATI

NSAIDS

- Produce 30-50% decrease in effective opioid dose
  - Decreasing opioid induced side effects
- Scheduled vs. PRN dosing
  - Greater postoperative pain control
  - Higher patient satisfaction

Ketorolac	30 mg	Every 8 hours	Convert to ibuprofen once able to take oral medications
Ibuprofen	600-800 mg	Every 6-8 hours	

University of CINCINNATI

Acetaminophen

- Produce 10-20% decrease in effective opioid dose
  - Decreasing opioid induced side effects
- Synergistic effect with NSAID administration
- After first dose, there is not a significant advantage to IV over oral

Acetaminophen IV	1 g	Every 6-8 hours	Discontinue once able to take PO
Acetaminophen oral	650-1000 mg	Every 6-8 hours	

University of CINCINNATI

Dexamethasone

- Minor decrease in postoperative pain
- Decrease in postoperative nausea and vomiting
- Potential increase in blood glucose levels
  - No demonstrated effect on infection or wound healing

Dexamethasone	8-10 mg	Once (24 hour duration)	Following umbilical cord clamp

University of CINCINNATI

Difficult Pain Management

Gabapentin

- Anticonvulsant that inhibits excitatory neurotransmitters
- One time oral dose decreases pain scores
- High incidence of sedation

Ketamine

- NMDA receptor antagonist
- Administration prior to cesarean section may decrease pain within the first 24 hours

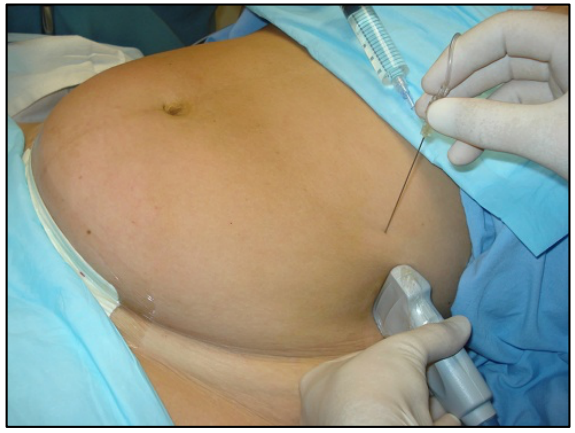
Gabapentin	600 mg	Once preoperative	6-48 hour duration
Ketamine	10 mg or .15 mg/kg	Once preoperative	24 hours duration

University of CINCINNATI

Difficult Pain Management

Nerve blocks & wound infiltration

- Inferior pain control vs. neuraxial opioids
- Transverse abdominus plane (TAP) block
  - Improves postop pain when spinal morphine is not used
  - Addition of TAP blocks to spinal morphine does not definitively improve pain control
  - Duration ~ 12 hours
- Ilioinguinal-Iliohypogastric Block
  - Conflicting evidence over benefit
  - May decrease PRN opioid dose



University of CINCINNATI

ACOG Position Statement

Evidence Based Practice

- Evidence based protocols
- Standardized care
- Data driven quality improvement

Interdisciplinary Collaboration

- Effective communication
- Shared decision making
- Teamwork

ACOG
The American College of Obstetricians and Gynecologists

University of CINCINNATI

Future Impact

- Pilot implementation site
- Future site impact
- Patient impact
- Impending research study
- Dissemination

University of CINCINNATI

University of
CINCINN

Mike DeWine, Ohio Attorney General

Conference Resources: Ideas!

Resources on our trainings, videos, conferences and programs to assist you in your community.

http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Drug-Diversion/Conference-Resources

If you have questions for the Heroin Unit Team we can be reached at:
HeroinUnit@OhioAttorneyGeneral.gov

University of CINCINNATI

The Three Tier Approach

Patricia O'Malley, PhD, RN, CNS, CCRN

1) *Decrease the Opiates Prescribed.*
2) *Ensure access to MAT.*
3) *Expand Naloxone use.*

University of CINCINNATI

Questions

University of CINCINNATI

References

American Association of Nurse Anesthetists (AANA). (2016). Guidelines for the care of the obstetric patient.

American College of Obsteterics and Gynecology (ACOG. (2012). ACOG committee opinion No. 524: opioid abuse, dependence, and addiction in pregnancy. O*bstet Gynecol, 119(5)*. doi: 10.1097/)AOG.0b013e318256496e

Booth, J. L., Harris, L. C., Eisenach, J. C., & Pan, P. H. (2016). A randomized controlled trial comparing two multimodal analgesic techniques in patients predicted to have severe pain after cesarean delivery. *Anesthesia and Analgesia, 122*(4), 1114-1119. doi:10.1213/ANE.0000000000000695

Borges, N. C., Pereira, L. V., Moura, L. d., Silva, T. C., Pedroso, C. F., & de Moura, L. A. (2016). Predictors for moderate to severe acute postoperative pain after cesarean section. *Pain Research & Management*, 5783817. doi:10.1155/2016/5783817

Bruce, J., & Quinlan, J. (2011). Chronic Post Surgical Pain. *Reviews in Pain*, *5*(3), 23–29. http://doi.org/10.1177/204946371100500306

Centers for Disease Control and Prevention (CDC). (2017). Vital signs: drug overdoses – United States, 1999-2016. *MMWR Morb Mortal Wkly Rep, 62(26), 537-42*.

Hah, J. (2017). Preventing persistent post-surgical pain and promoting opioid cessation after discharge. Presented at: the American Academy of Pain Medicine 33rd Annual Meeting, Orlando, Florida.

Juying, J., Lihua, P., Qibin, C., Dong, Z., Li, R., Peipei, Q., & Su, M. (2016). Prevalence and risk factors for chronic pain following cesarean section: a prospective study. *BMC Anesthesiology*, *16*1-11. doi:10.1186/s12871-016-0270-6

Landau, & Bollag. (2013). Chronic pain after childbirth. *International Journal of Obstetric Anesthesia, 22*, 133-145.

Lavand'homme, P. (2006). Postcesarean analgesia: effective strategies and association with chronic pain. *Current Opinion In Anesthesiology*, *19*(3), 244-248.

Martin, C. E, Longinaker, N, Terplan, M. (2015). Recent trends in treatment admissions for prescription opioid abuse during pregnancy. *J Subst Abus Treat*, 48(1):37–42. doi:10.1016/j.jsat.2014.07.007

Rudd R., Aleshire N., Zibbell J.E., Gladden, R. (2016). Increases in drug and opioid overdose deaths—United States, 2000–2014. *Am J Transplant*, *16(4)*, 1323–7.

Sng, B. L., Sia, A. T., Quek, K., Woo, D., & Lim, Y. (2009). Incidence and risk factors for chronic pain after caesarean section under spinal anesthesia. *Anaesthesia & Intensive Care, 37*(5), 748-752.

Valentine, A. R., Carvalho, B., Lazo, T. A., & Riley, E. T. (2015). Scheduled acetaminophen with as-needed opioids compared to as-needed acetaminophen plus opioids for post-cesarean pain management. *International Journal of Obstetric Anesthesia, 24*(3), 210-216. doi:10.1016/j.ijoa.2015.03.006

Weibel, S., Neubert, K., Jelting, Y., Meissner, W., Wöckel, A., Roewer, N., & Kranke, P. (2016). Incidence and severity of chronic pain after caesarean section. *European Journal of Anaesthesiology (Lippincott Williams & Wilkins), 33*(11), 853-865. doi:10.1097/EJA.0000000000000535

Vadivelu, N., Kai, A., Kodumudi, V., Sramcik, J., Kaye, A. (2018) The opioid crisis: a comprehensive overview. *Curr Pain Headache Rep, 22(3)*. doi: 10.1007/s11916-018-0670-z.

University of CINCINNATI