Fighting the Opioid Crisis

Collaboration between

Critical Access Hospital &

Federally Qualified Healthcare Center

May 16, 2018

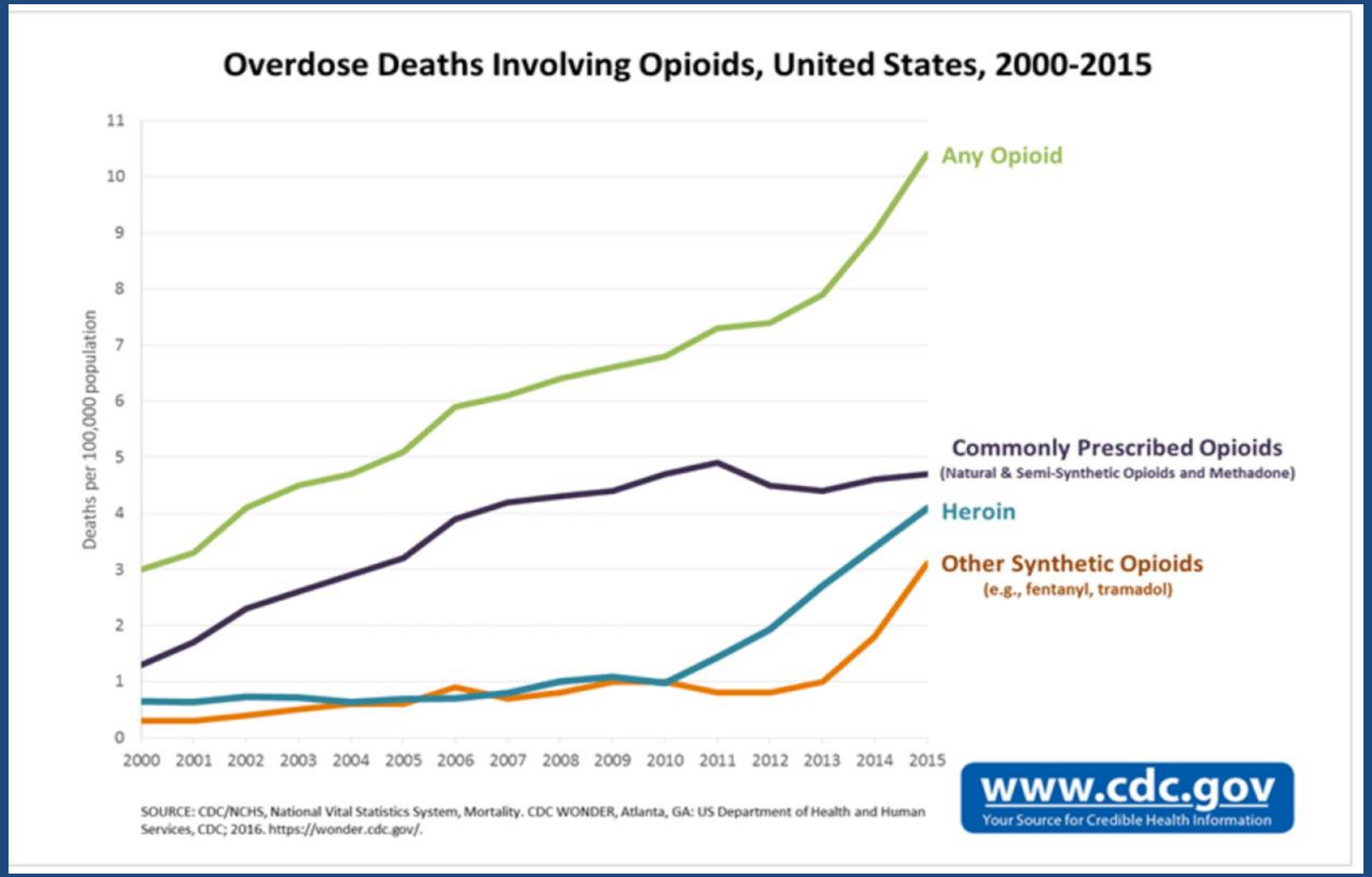
Ellenville Regional Hospital

THE INSTITUTE FOR FAMILY HEALTH

The Opioid Crisis

- **70,000** people died of drug overdose in 2016
  - **400%** increase since 1999
  - Overdose deaths now **leading cause of death for people under 50**
- **Deaths from prescription opioids increased 400% since 1999**
  - Naturally occurring opiates vs. Synthetic opioids
  - Fentanyl overdoses driving deaths—mixed with heroin or cocaine

U.S. Opioid Overdose Deaths



The Opioid Crisis: How and Why

- **Skyrocketing Prescription Opioids**
  - **400% increase in amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices**
    - Significantly greater rates of opioid prescriptions
    - No change in overall pain reported nationally
    - 21-29% patients prescribed opioids for chronic pain misuse them
      - 8-12% develop Opioid Use Disorder
- **Increase in heroin use particularly in 18-25 year olds**
  - 3 out of 4 report abusing prescription opioids prior to heroin use
  - Increased availability, purer formulation, lower price

Background

Ellenville Regional Hospital is a **critical access (CAH)** teaching hospital located in Ulster county, a rural area of the Mid-Hudson Region of New York State. The 25 bed hospital has approximately 14,000 emergency department visits per year and is physically adjoined to a satellite of The Institute for Family Health (IFH).

Within those Emergency Department visits, quantitative and qualitative analysis revealed a significant subpopulation that was driving hospital utilization due to chronic pain. These visits were often resulting in the administration and/or prescription of opioids.

Background *(cont'd)*

ERH collaborated with:

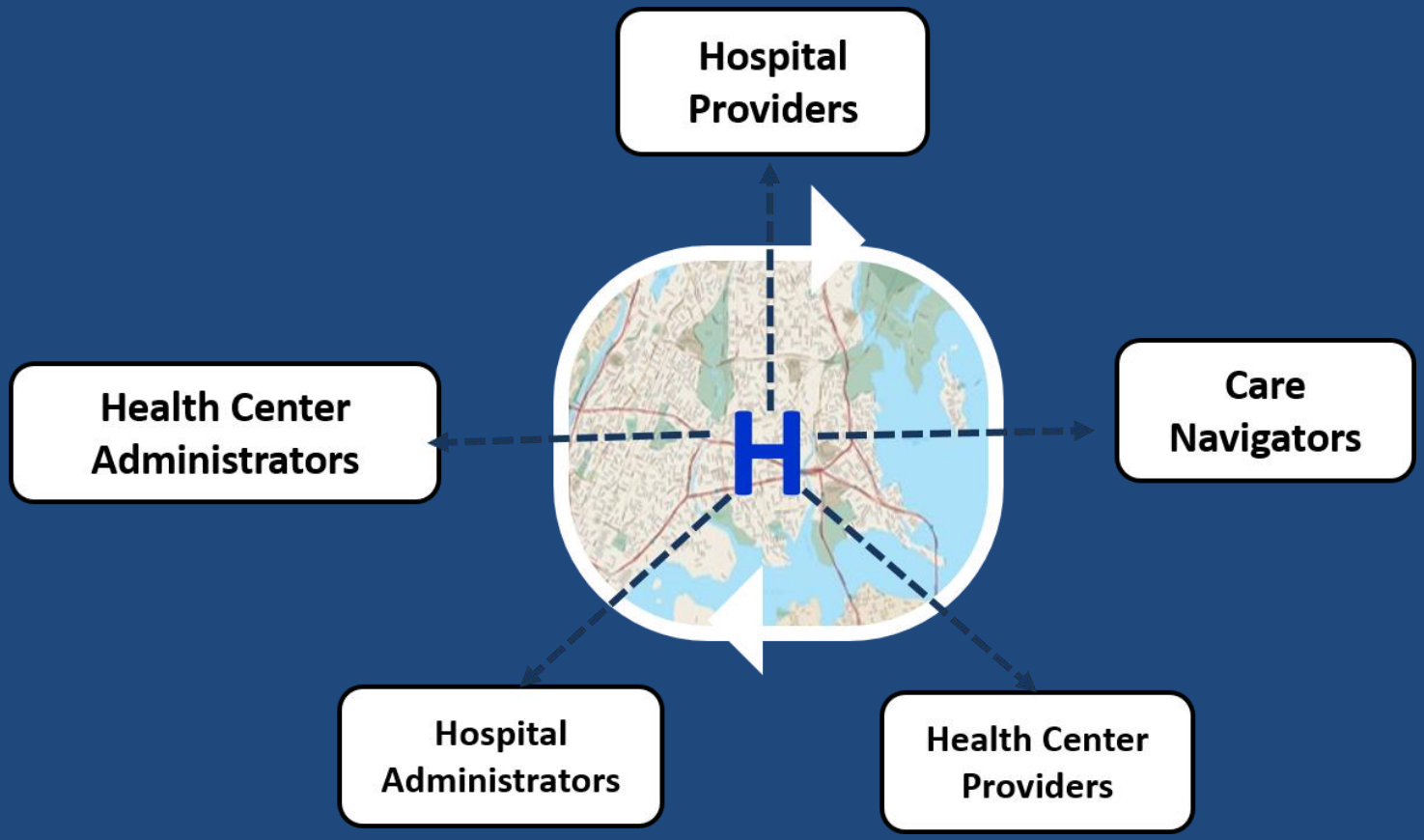
The **Institute for Family Health** (IFH) is one of the largest Federally Qualified Health Centers (**FQHC**) in New York State.

- Ambulatory medical and mental health care at 32 locations and growing
- Over 98,000 patients served annually
- Nationally-recognized for innovations in health workforce development, health information technology, and community health promotion programs.

Project Goal

Reduce Emergency Department High Utilizer Visits by employing a multi-disciplinary, standardized approach and ensuring that appropriate alternatives are accessible to maximize long-term outcomes.

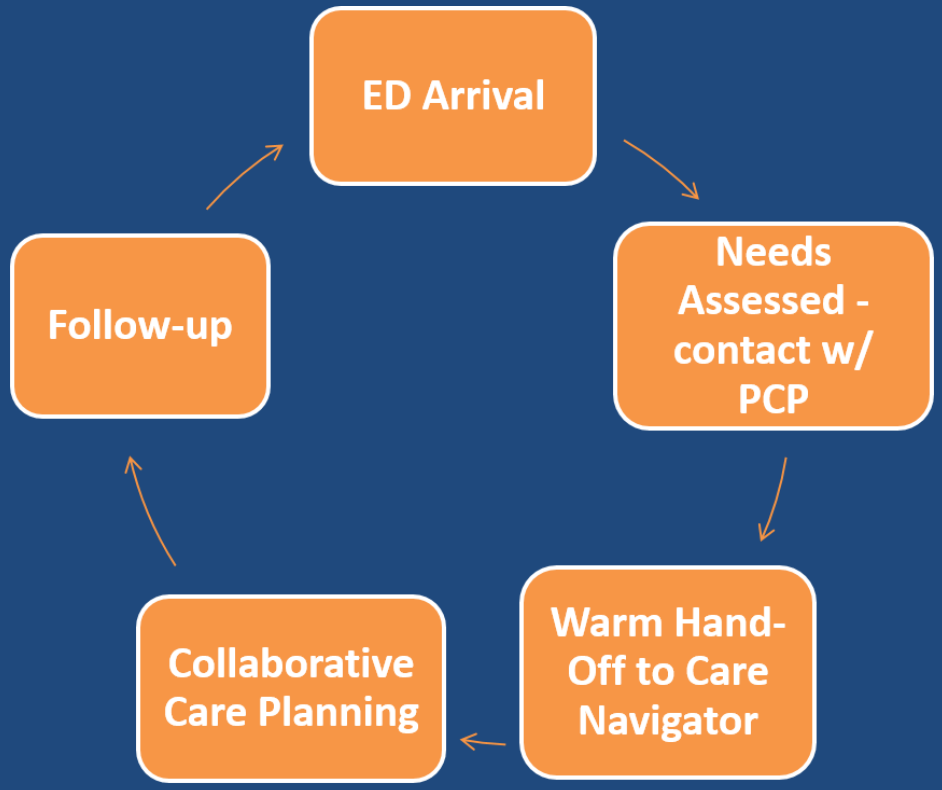
Action Team


Hospital Providers
Health Center Administrators
Care Navigators
H
Hospital Administrators
Health Center Providers

Medical Staff Leadership

- Opiate Protocols researched for best practices
- Protocols developed from “best practices”
- Unanimous agreement among ED providers to adopt Ellenville Chronic Pain Management Policy & Patient Handout
- Approval by the Medical Executive Committee
- Approval by the entire Medical Staff
- Review of project by ERH Board of Trustees
- Outreach to Community Providers

Cohort Patient Pathway



Project Patient Cohort

We selected a cohort of 64 patients as a proxy for the 819 patients who presented with a Pain Diagnosis. Five of the cohort patients have since passed away. The identified cohort was selected by the following variables:

<u>May 2015 – Oct 2015 (Baseline)</u>

- Presentation to the ED for Chronic Pain
- 5 or more visits in this timeframe
- Treated with Opioids

Main subgroups of patients:

- Chronic Pain Management
- Medical Management
- Opiate Addiction
- Mental & Behavioral Health

- 2015 - 14,314 patient visits in the ED
- 9.83% Patients with Pain Diagnosis (819 patients)
- 13.46% Patient Visits for Pain Diagnosis (1927 visits)

Project Data Collection

- **Patients identified in EHR**

- **Specific data elements critical to the project**
  - Patient identifier
  - Diagnosis
  - Interventions
  - Number of visits
  - Drivers of Utilization

ERH Action and Intervention

- Flag all Cohort Patients in EMR
- Patient Triage, Identified as a Max Patient
- Care Navigation Activated (call to Care Navigator)
- Immediate MSE (rule out actual Emergency)
- I-STOP check
- Call to Primary Care Provider
- Off Hours – Communicate via email with Care Navigation (follow-up AM)
- Emergency Department “warm hand-off” with a Care Navigator

IFH Action and Intervention

- Emergency Department “warm hand-off” with a Care Navigator
- Patient education for appropriate ED usage
- FYI created in patient chart to alert IFH providers of opioid status and hospital usage
- Pain management contract between PCP and patient for responsible opiate prescribing
- Linkage to behavioral or mental health and/or other services as needed
- Community provider outreach and coordination for care

Cohort Management

- **Bi-weekly Patient Case Conferences**
  - Each patient care plan
  - Care navigation activities
    - medical visits
    - social services
    - behavioral health
    - home health services
    - health home referral
    - addiction services

Actions

- **Practice Change**
  - Chronic Pain Management Policy & Education Handout
  - Prescription Monitoring Program (ISTOP) check rolled out
  - Pain Management and Other Ancillary Referrals and Consultations
- **Training and Education**
  - In-house training for all disciplines
- **Increased Screening and Referral**
  - SBIRT (screening, brief intervention and referral to treatment) (general SUD)

Actions *(cont'd)*

- **Care Navigation/Care Management:**
  - Initiation and Continuation of Alcohol/Drug Use Treatment including referrals to other ancillary services
  - Training Peer Navigators
  - Enhanced handoffs/engagement between levels of care
- **Clinical Services (New or Expanded):**
  - Buprenorphine expansion—Primary Care and other Outpatient Service locations
  - Expanded Ambulatory Detox

Potential Roles of Healthcare Providers/Institutions

- **General Provider/Staff Training/Education**
- **Overdose Prevention**
  - Register to become Opioid Overdose Prevention Program (kits are free)
  - Hospital pharmacies can dispense naloxone under Deputy Commissioner's standing order for Naloxone Dispensing Protocol
- **Screening and Referral to Treatment**
  - SBIRT—Reimbursed by Medicare/Medicaid/Commercial
  - Primary Care based Collaborative Care – include SUD
- **Buprenorphine expansion**
- **Community/Neighborhood training/education/partnerships**

Challenges

- Cohort development – limit the number of community partners
- Overdose prevention addresses immediate mortality risk but alone is not enough
  - must be coupled with treatment engagement
- Access to treatment does not guarantee utilization of and engagement in treatment
- Social/Economic impact factors
- Stigma and marginalization

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Program Impact- Results

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	Before *(May'15 - Oct'15)*	After *(Jul'17 – Dec'17)*	%Δ
 ED Visits	70 /month	20 /month	-72.8%
 Opioid Orders	64 /month	9 /month	-84.4%

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QUESTIONS & ANSWERS

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