

# **THE OPIOID EPIDEMIC: RECOMMENDATIONS TO INCREASE ACCESS TO TREATMENT**

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### BACKGROUND

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The opioid epidemic's toll on residents and families is enormous. In 2015, unintentional drug overdoses caused the deaths of a record 3,050 Ohioans, up from 2,531 in 2014.<sup>ii</sup> Unintentional deaths related to fentanyl, a Schedule II synthetic narcotic that in its prescription form is estimated to be 30 to 50 times more potent than heroin, more than doubled in Ohio from 503 in 2014 to 1,155 in 2015.<sup>ii</sup> Lucas County, the largest county in Northwest Ohio, had the state's eighth highest number of fentanyl-related unintentional overdose deaths in 2015 with 41.<sup>ii</sup>

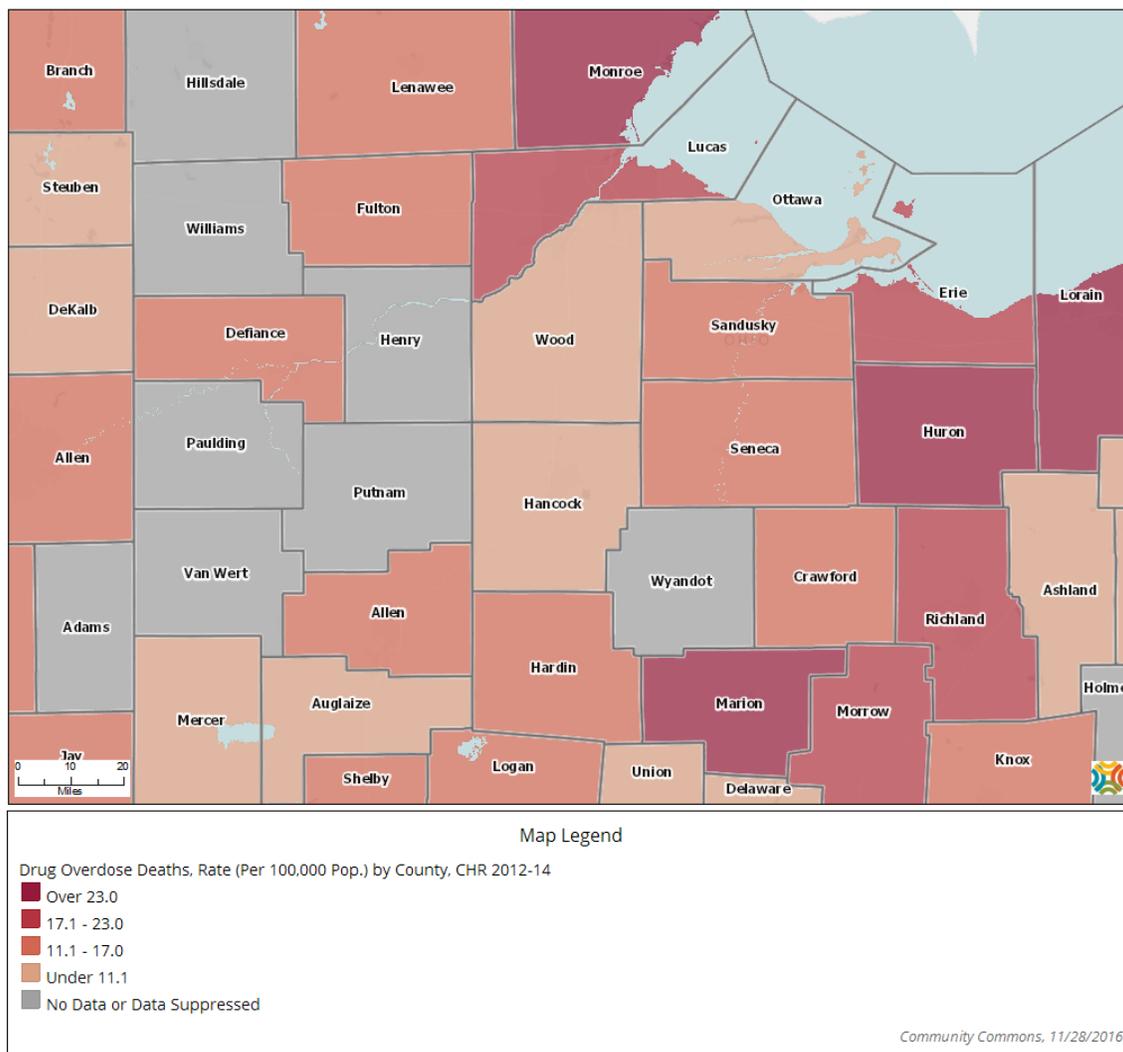
Prescription opioids are highly available in Northwest Ohio, with oxycodone and Percocet® being the most popular in terms of wide-spread illicit use.<sup>iii</sup> Fentanyl and Dilaudid® are desirable but not easily obtainable, while Vicodin® is easy to obtain but not desirable.<sup>iii</sup> A prescription opioid addiction often can lead to heroin use.

Regionally, from January 2015 through March 2016, there were 11,399 cases of opioid use, abuse, and dependence reported by 18 hospitals in Northwest Ohio.

#### **Drug Overdose Death Rate**

The map on the next page shows the drug overdose death rate for counties throughout northwest Ohio and southeast Michigan.

Drug Overdose Death Rate by County

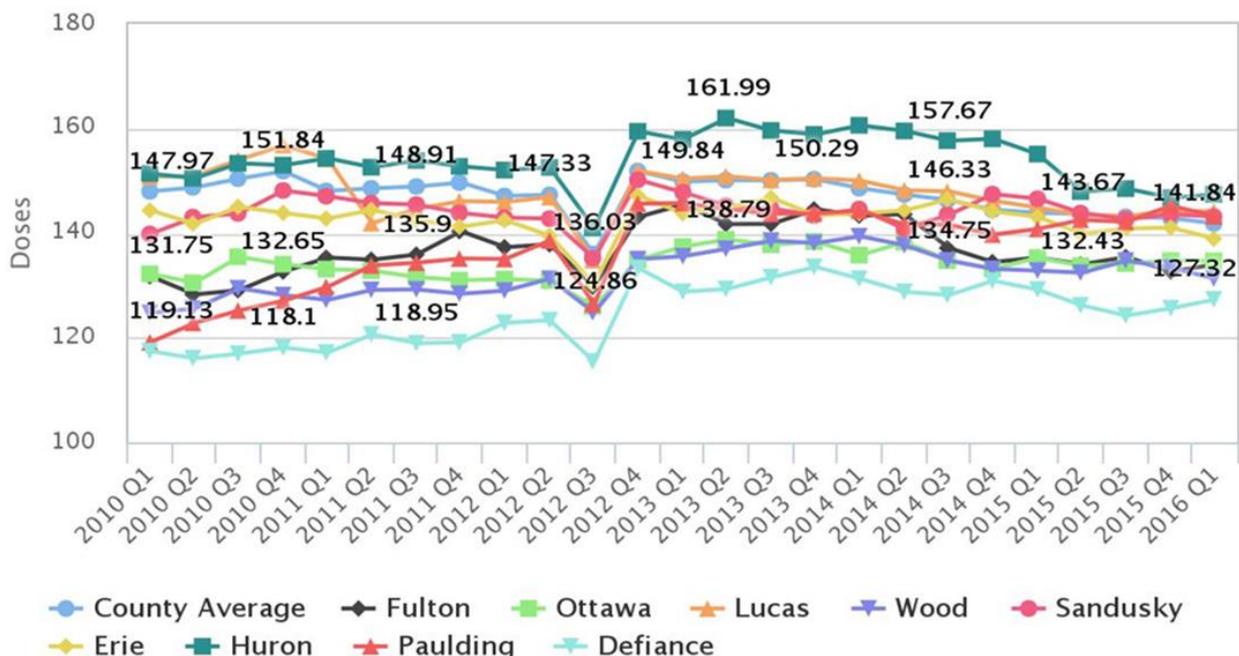


### Ohio Automated Rx Reporting System (OARRS)

In response to the growing misuse and diversion of prescription drugs, the State of Ohio Board of Pharmacy created Ohio’s Prescription Drug Monitoring Program (PDMP), known as the Ohio Automated Rx Reporting System (OARRS) in 2006. OARRS collects information on all outpatient prescriptions for controlled substances dispensed by Ohio-licensed pharmacies and personally furnished by licensed prescribers in Ohio. In 2015, there were 81 million fewer opioid solid doses dispensed to Ohio patients than in 2011, and there were 9.5 million more prescriber queries in OARRS than in 2011.<sup>ii</sup> Also, the number of people “doctor shopping” for opioids and other controlled substances decreased from 2,205 in 2011 to 720 in 2015.<sup>ii</sup> The chart below

compares several Northwest Ohio counties to the statewide county average for opioid doses dispensed per Ohio patient from 2010 through the first quarter of 2016.

### Opioid Doses Dispensed Per Ohio Patient by County and Quarter



source: Ohio Automated Rx Reporting System

### Comprehensive Addiction and Recovery Act (CARA)

Another positive step for addiction treatment occurred in 2016 when Ohio Senator Rob Portman’s Comprehensive Addiction and Recovery Act (CARA) was signed into law by President Obama. CARA leverages evidence-based law enforcement and healthcare services in response to the heroin and opioid epidemic, and key provisions include:

- Raising the prescribing limit for buprenorphine from 100 to 275 patients, intended to give addicts greater access to buprenorphine, especially in rural areas where few doctors are certified to prescribe the drug.
- Giving prescribing authority for buprenorphine, a medication-assisted addiction treatment, to trained nurse practitioners and physician assistants.
- Expanding the availability of naloxone, an overdose reversal drug, to law enforcement agencies and other first responders.

- Requiring the Veterans Administration to follow opioid prescribing guidelines and put in place stronger oversight and accountability for quality of care; expanding treatment for veterans in the criminal justice system because of an addiction.
- Expanding treatment and family-based services for pregnant women and postpartum women struggling with addiction.

### **Ohio House Bill 325**

Additionally, Ohio House Bill 325 – which has been passed by the Ohio House of Representatives – would require healthcare professionals to encourage pregnant women to enroll in drug treatment programs and the Department of Mental Health and Addiction Services to give priority to treating pregnant women addicted to drugs. The Bill, which is now in the Ohio Senate Oversight and Reform Committee, would also prohibit public children services agencies from filing an abuse/neglect complaint regarding a newborn solely because the mother used a controlled substance while pregnant, if she also enrolled in a drug treatment program before the end of the 20<sup>th</sup> week of pregnancy and met other conditions. Also, the Bill prohibits evidence of the use of a controlled substance obtained through a screening or test to determine pregnancy or provide prenatal care from being admissible in a criminal proceeding.

### **Access to Addiction Treatment in Northwest Ohio**

In Northwest Ohio, detoxification services are available at hospitals to stabilize patients in the emergency department or on a medical floor. When the situation is no longer life threatening, there is limited access to the appropriate level of care and treatment. Often, this is exacerbated because the patient is not interested in further treatment and leaves against medical advice – and because health insurance does not cover the needed services.

The next level of care is sub-acute, which is provided to people in good mental and medical health who are generally more physically stable and committed to a recovery program. In Northwest Ohio, Zepf Center has a 16-bed unit; Rescue Mental Health & Addiction Services has a 1-2 bed unit designed to be transitional; and Arrowhead Behavioral Health has a 48-bed unit with 34 beds for substance abuse and 14 for psychiatric services. By law, Arrowhead Behavioral Health has been unable to receive Medicaid payments for substance abuse patients because the residential treatment facility has more than 16 beds; the institutions for mental diseases (IMD) exclusion is being altered for beneficiaries in Medicaid managed care plans receiving inpatient treatment for no more than 15 days. In late 2016 and early 2017, four organizations announced plans that will result in 64 additional beds in Lucas County. A service gap exists at the sub-acute level in some counties in Northwest Ohio, including long-term

residential programs, short-term treatment centers and recovery housing. This gap is widened by payment and legislative barriers. However, in July 2017, Ohio Medicaid is scheduled to add detoxification per diem to the community benefit plan, room and board costs will still be excluded.

## ABOUT THE TASK FORCE

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The Northwest Ohio Opioid Addiction Treatment Planning Task Force was formed by members of the Hospital Council of Northwest Ohio in April 2016. The Task Force's focus is to address the lack of access to community-based withdrawal and substance use treatment for residents who overdose on opioids, one component of a multifaceted strategy to reduce opioid abuse and improve outcomes of those seeking treatment for substance use. Indeed, the lack of access to community-based withdrawal and substance use treatment affects everyone who misuses any form of alcohol and drugs. In 2015, substance use disorders affected 20.8 million Americans nationwide – nearly 8% of the adolescent and adult population and similar to the number of people with diabetes.<sup>iv</sup>

The lack of access to community-based withdrawal and substance use treatment for opioids is a complex local, state and national issue that the Northwest Ohio Opioid Addiction Treatment Planning Taskforce investigated and developed this paper to bring light to the issue and possible solutions that will require a multi-stakeholder response.

### Task Force Membership

The Task Force includes representatives from Arrowhead Behavioral Health, Bellevue Hospital, Buckeye Community Health Plan, Firelands Regional Medical Center, Four County ADAMHS Board (Defiance, Fulton, Henry, Williams), Hancock County ADAMHS Board, Harbor Behavioral Health, Hospital Council of Northwest Ohio, Lucas County Correctional Treatment Facility, Lucas County Mental Health and Recovery Services Board, Lucas County Sheriff, Mercy Health, New Concepts, Paramount, Paulding County Hospital, ProMedica, Sandusky/Seneca/Wyandot ADAMHS Board, University of Toledo, University of Toledo Medical Center, Wood County ADAMHS Board, and Zepf Center. Ohio Representative Robert Sprague also participates in the Task Force, as does a member of the recovery community.

## Task Force Process

The Task Force met over the course of 2016 and conducted initial research on services currently available and best practices. An assessment was performed of existing withdrawal and treatment programs by county, including types of treatment programs, capacity and payment sources. Three work groups were formed to consider rules and regulations, reimbursements, and pilot projects to provide Northwest Ohio residents access to community-based withdrawal and substance use treatment for opioids.

To better understand the scope of the problem in Northwest Ohio, eighteen (18) Northwest Ohio hospitals shared data on hospital admissions with opioid use, abuse and dependence diagnoses with the Task Force. This data collection found that in this 18-month period there were 11,379 diagnoses, and 84% were from Lucas County hospitals. (Please note: One patient may be represented multiple times in the data.)

Northwest Ohio Hospital Admissions January 2015-March 2016			
Diagnosis	Northwest Ohio	Outside Lucas County	Lucas County
Opioid Use	355	53	302
Opioid Abuse	2,210	370	1,840
Opioid Dependence	8,834	1,459	7,375

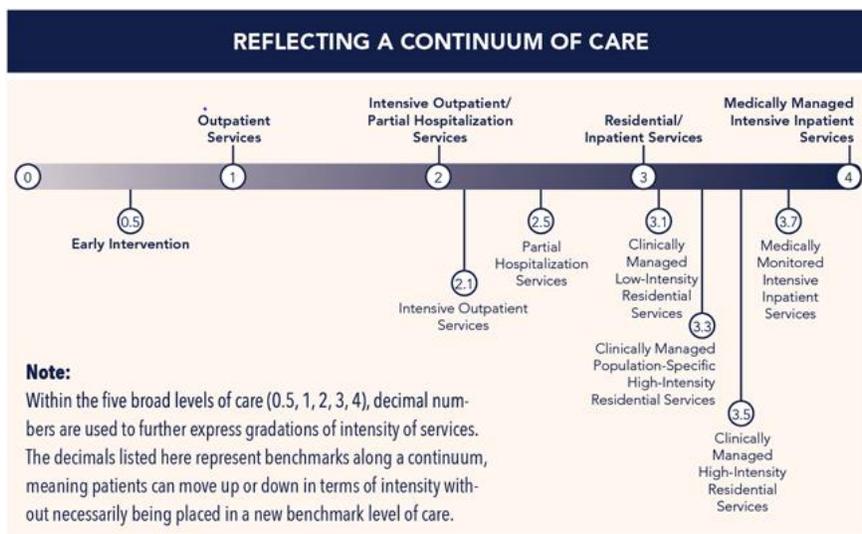
Source: Northwest Ohio Opioid Addiction Treatment Planning Task Force

## Northwest Ohio Commitment to Evidence-Based Treatment

Northwest Ohio organizations and providers are committed to providing the best care possible based on the Substance Abuse and Mental Health Services Administration's recommended *Treatment Improvement Protocols*. They also are proponents of the American Society of Addiction Medicine's national set of criteria for providing outcome-oriented and results-based care in the treatment of substance use. These criteria are widely used and comprehensive guidelines for placement, continued stay and transfer/discharge of patients with substance use and co-occurring conditions.

The American Society of Addiction Medicine's treatment criteria create comprehensive and individualized treatment plans. These treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided; the structure, safety and security provided; and the intensity of treatment services provided.

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT		
ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:		
1	<b>DIMENSION 1</b>	<b>Acute Intoxication and/or Withdrawal Potential</b> Exploring an individual's past and current experiences of substance use and withdrawal
2	<b>DIMENSION 2</b>	<b>Biomedical Conditions and Complications</b> Exploring an individual's health history and current physical condition
3	<b>DIMENSION 3</b>	<b>Emotional, Behavioral, or Cognitive Conditions and Complications</b> Exploring an individual's thoughts, emotions, and mental health issues
4	<b>DIMENSION 4</b>	<b>Readiness to Change</b> Exploring an individual's readiness and interest in changing
5	<b>DIMENSION 5</b>	<b>Relapse, Continued Use, or Continued Problem Potential</b> Exploring an individual's unique relationship with relapse or continued use or problems
6	<b>DIMENSION 6</b>	<b>Recovery/Living Environment</b> Exploring an individual's recovery or living situation, and the surrounding people, places, and things



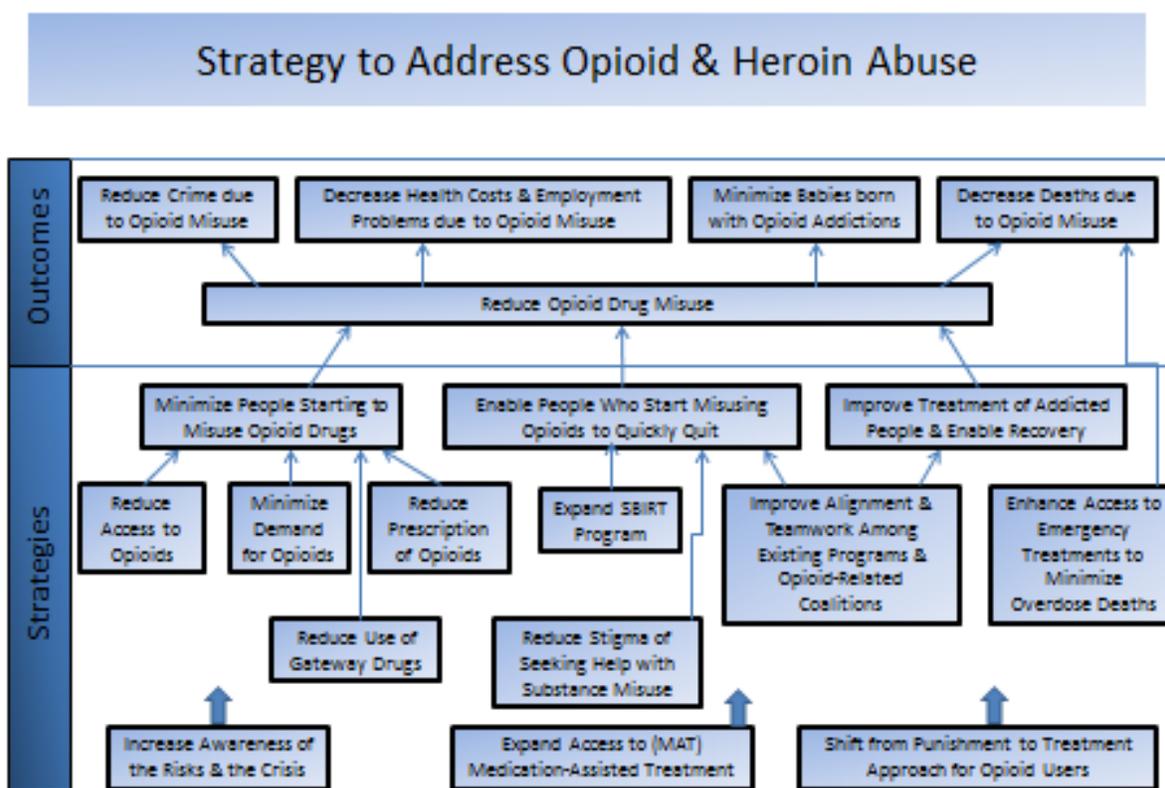
Through this strength-based multidimensional assessment, the criteria addresses each patient's needs, obstacles and liabilities, as well as strengths, assets, resources and support structure.

However, it is challenging to implement criteria from the Substance Abuse and Mental Health Services Administration and the American Society of Addiction Medicine. Barriers include a

lack of payment for services; regulations that restrict the ability to implement services effectively; and systemic gaps in communications and services along the continuum of care.

### Northwest Ohio Commitment to a Comprehensive Approach to the Opioid Epidemic

While the Task Force’s focus is on increasing access to community-based detox and treatment, this is just one component of successfully addressing the opioid issue. The Task Force supports a comprehensive approach, such as the Strategy to Address Opioid and Heroin Abuse developed by Insightformation, Inc. outlined below. The work of this Task Force needs to be part of a larger systemic approach to reduce opioid misuse and abuse.



Reference  
[Vimca.com/insightformation](https://www.vimca.com/insightformation)

## RECOMMENDATIONS

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In response to the opioid epidemic, the Northwest Ohio Opioid Addiction Treatment Planning Task Force recommends the following strategies to increase access to community-based withdrawal and substance use treatment services and improve the system of care in Northwest Ohio. The Task Force recognizes that withdrawal management and treatment are just two components of the multifaceted strategies that must be implemented to reduce opioid misuse and abuse and improve outcomes of those seeking addiction services. Some of these proposed strategies will require changes in federal regulations, while others will require systemic changes and investments to pilot evidence-based programs that could be replicated to scale to combat the opioid epidemic. Dedicated funding is needed to implement these recommendations. A main reason these recommendations have not been implemented is the lack of funding for evidence-based treatment and lack of dedicated funding to implement new approaches in prevention, treatment and systems coordination.

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### **TREATMENT ACCESS AND CAPACITY RECOMMENDATIONS**

Any exposure to treatment should be considered an “opportunity for recovery.” Whenever possible, peer support should be provided to increase the opportunity for a positive clinical outcome. Treatment success is greatly improved if clients have immediate access to their assessed level of care. To achieve this, treatment capacity must be increased and made available post withdrawal management to avoid relapse. The following recommendations are designed to increase both treatment access and capacity:

- ***Maintaining the 2014 expansion of Medicaid eligibility in Ohio – and substance abuse treatment as an essential health benefit – to provide low-income residents access to substance abuse treatment.***

Beginning in 2014, Ohio expanded Medicaid eligibility to include adults with income between 101% and 138% of the federal poverty level. This increased access for low-income Ohioans to receive healthcare coverage for substance abuse treatment. As a result, Medicaid enrollees with substance use disorders were more likely to report improvement in overall access to care, prescription medication and mental health care than those enrollees without substance use disorders.<sup>v</sup> This improvement was even more evident for Group VIII (Medicaid expansion) enrollees with an opioid use disorder who were more likely to report improvements in: overall access to care; access to prescription medications; and access to mental health care.<sup>v</sup> The improvement measured in Ohio is consistent with research indicating improved access to treatment

for opioid and other substance use disorders because of changes in state and federal health policies.<sup>v</sup>

The Affordable Care Act (ACA) also established 10 mandatory essential health benefits (EHBs) for newly eligible Medicaid enrollees, as well as most individual and small group health plans. Though states have flexibility in determining the details of their EHBs, substance abuse treatment is a required benefit category. ACA also requires applicable plans to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA or the “Parity Act”). Together, MHPAEA and the ACA will expand behavioral health coverage for 62.5 million Americans by 2020 – and allow 32.1 million individuals to access substance abuse benefits for the first time.<sup>vi</sup> They also will expand behavioral health coverage for 30.4 million Americans with existing behavioral health benefits.<sup>vi</sup>

The 10 mandatory essential health benefits and Medicaid Expansion are threatened by the current efforts to repeal and replace the Affordable Care Act.

- ***Increasing long-term residential programs, short-term treatment centers and recovery housing.***

The availability of options for residential support is imperative to the success of treatment, especially when the client is not in a supportive home environment. Long-term residential programs provide a supportive, supervised environment; the success of a short-term treatment center is dependent on connections to care following a stay. Ideally, withdrawal management would be provided in either long- or short-term residential settings. Otherwise, withdrawal management must be conducted in either an inpatient or outpatient setting, with access to medication-assisted treatment if indicated. In either an inpatient or outpatient setting, however, there is an opportunity for continuity of care to be compromised.

Neither short- nor long-term residential treatment is reimbursed by Medicaid. Typically, a provider bills for the services provided during the residential stay, and there is a separate charge for room and board typically funded by an ADAMHS Board and/or private funding. Additional funding is needed to expand residential programming.

Meanwhile, recovery housing is a less staff-intensive alternative and is more successful for an individual who has numerous days with negative screens. The benefit of recovery housing is the exposure to peers who have similar struggles, successes and opportunities. Recovery housing is also not a reimbursable service. While some models are self-sustaining, recovery housing with paid staff requires supplemental funding,

typically from an ADAMHS Board. Increased capacity will require funds for the purchase/rental of the homes, as well as operational funding. Once capacity exists for recovery housing, the challenge is retaining individuals in their treatment program and sustaining the funding for the housing and support services.

Approximate existing capacity for these services in Northwest Ohio is outlined in the following chart.

Residential Treatment and Recovery Housing in Northwest Ohio				
County	Long-Term Residential Beds	Short Term Residential Beds	Women's Beds	Men's Beds
Defiance	32	10	16	16
Hancock	12	0	4	4
Huron	0	0	7	0
Lucas	0	0	33	10
Ottawa	0	0	0	10
Paulding	Accessible by contract but not located in Paulding for all			
Putnam	Funded for Recovery Housing in Dec. 2016 (Researching two beds)	0	0	0
Sandusky	0	0	5	5
Seneca	0	0	0	10

Source: County ADAMHS Boards

- Expanding use of medication-assisted treatment, and training family practice groups and primary care providers to provide management of addictions.***

There are two primary medications used in the treatment of opiate addiction: Suboxone and Vivitrol. There is limited capacity to provide medication-assisted treatment in Northwest Ohio and a need to expand the number of physicians willing to prescribe either medication. Medication alone, however, is not recommended; medication-assisted treatment should be coupled with substance use treatment services. Increasing the number of private practitioners willing to do the prescribing could be accomplished through two main options:

1. Physicians prescribe the medication from their offices in coordination with a substance use treatment agency. This could be guided by a memorandum of understanding outlining the procedures that will be followed, including release of information, communication/feedback and client participation requirements.
2. Private physicians could contract their time on an hourly basis with local treatment agencies; the treatment agency would pay physicians an hourly rate. Clients would receive services at the contracting agencies, making it easier to coordinate other needed treatment services.

Medication-assisted treatment is reimbursed by Medicaid and private insurance. Below is a table that outlines the number of physicians and patient capacity available in each county for Suboxone.

Prescribing Suboxone in Northwest Ohio				
County ADAMHS Board	Provider Agencies	Number of Prescribing Physicians	Total Number of Patients	Currently Available
Defiance	Does not pay for Suboxone			
Erie	Does not pay for Suboxone			
Hancock	Century Health	1	30	3
	A Renewed Mind	1	70	5
Huron	Does not pay for Suboxone			
Lucas	Harbor	1	100	75
	Unison	2	200	68
	UMADAOP	2	500	125
	Zepf	2	275	10*
	A Renewed Mind	2	50	10
	New Concepts	3	500	250
				*10 new patient slots per week
Ottawa	Does not pay for Suboxone			
Putnam		0	0	0
Sandusky	Board does not pay for Suboxone (Dr. Hoy). Working to expand with two other physicians	1	100	0
Seneca	None	0	0	0

Source: County ADAMHS Boards

Below is a table that outlines the number of physicians available in each county to prescribe Vivitrol, which is not monitored by the number of patients under treatment.

Prescribing Vivitrol in Northwest Ohio			
County ADAMHS Board	Provider Agencies	Number of Prescribing Physicians	Available to Released Inmates
Defiance	Bryan Health Center Recovery Services	1	Yes
		3	
Erie	Firelands	1	Yes
Hancock	Century Health A Renewed Mind	1	Yes
Huron	Firelands Oriana House	1	Yes
		1	Yes
Lucas	Harbor	1	Y
	Unison	4	Y
	UMADAOP	1	Y
	Zeph	6	Y
	A Renewed Mind	3	Y
	New Concepts	2	Y
Ottawa	Firelands	1	Yes
Paulding	Paulding County Hospital	1	Upon referral by Westwood Behavioral Health
Putnam	Pathways Counseling Center	1	Yes
Sandusky	Firelands & Oriana House	2	Yes
Seneca	Firelands & Rigel Recovery Services	2	Yes

Source: County ADAMHS Boards

- ***Expanding treatment services to the criminal justice population.***

Jail diversion programs, innovative programs like the Lucas County Sheriff’s Office’s Drug Abuse Response Team (DART), crisis intervention teams for substance use and drug courts need to be increased in numbers and expanded in capacity. Individuals involved with the criminal justice system may interact with the treatment services system at several intercept points. There is opportunity for treatment at each of these intercepts.

The first intercept is the point of crisis. During any crisis intervention service, there is an opportunity to engage an individual in treatment by completing Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs.

If the client is placed in jail, the length of stay is often too short for “treatment,” but there usually is enough time for an inmate to participate in “treatment readiness” and “skills streaming” groups. Both types of groups are designed to help engage the client into treatment following release. Many counties have developed Vivitrol protocols, where all the necessary clinical work for medication-assisted treatment is completed while an individual is in jail. Upon release, the client can immediately go to a treatment agency for a Vivitrol shot. Services provided in local jails are not reimbursable by any payer source. Ideally evidenced-based treatment services would be provided to incarcerated individuals.

Drug courts take a public health approach by using a specialized problem-solving model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service and treatment communities work together to help addicted offenders into long-term recovery. If a client is involved with drug court, the coordination of treatment services is provided by the drug court staff with local treatment agencies. Compliance with treatment is monitored on a regular basis.

Below is a chart that outlines the availability of treatment services at local jails.

Treatment Services and Drug Courts in Northwest Ohio Criminal Justice System				
County	Jail	Treatment Services Provided	Agency Providing Services	Number of Drug Courts
Defiance	CCNO	Yes	Recovery Services	
Erie	EC Detention	Yes	Firelands	1 Diversion Program
	EC Jail	Yes	Firelands & Bayshore	
Hancock	Hancock County Justice Center	Yes	Century Health	2*
Huron	Common Pleas Municipal	Yes	Firelands	1
		Yes	Firelands	1
Lucas	Lucas County Corrections Center	Yes	Empowered for Excellence, New Concepts, and A Renewed Mind	4-1 Juvenile Treatment Court, 1 Family Drug Court, 2 Lucas County

				Common Pleas Drug Courts
<b>Ottawa</b>	OC Misdeem Jail	Yes	Firelands & Bayshore	
<b>Paulding</b>	Paulding County Jail	Yes	Westwood Behavioral Health	1
<b>Putnam</b>	Putnam County Sheriff's Dept.	Yes	Pathways Counseling Center	o *(New Common Pleas Judge campaigned he will start a drug ct.)
<b>Sandusky</b>	Sandusky County Jail	Yes	Firelands	2
<b>Seneca</b>	Seneca County Jail	Yes	Firelands	o (working on one)

\* Also one Family Dependency Court.

Source: County ADAMHS Boards

### **SYSTEM COORDINATION RECOMMENDATIONS**

We cannot only focus on increasing access to treatment to solve the opioid crisis. One activity did not cause the opioid crisis, and one strategy is not going to solve it. The opioid crisis is a multi-faceted problem which requires a multi-faceted solution. Addressing addiction requires a systems approach. All components of the system – prevention, prescribing guidelines, law enforcement and treatment – must be coordinated across communities on local, regional statewide and national levels. The following recommendations are designed to increase coordination across Northwest Ohio.

- ***Increasing community capacity to address substance abuse comprehensively by developing a regional infrastructure to improve collection, sharing and response to surveillance data, as well as leveraging prevention, intervention, and treatment strategies and programs.***

To avoid duplication of effort, the Task Force recommends expanding the focus of the Northwest Ohio Healthcare Emergency Management Coalition (NWO-HEMC), a self-governed and voluntary coalition of organizations that provide or support health services in the 18 counties of Ohio Homeland Security Region 1, to coordinate opioid use/overdose data surveillance and response. NWO-HEMC strives to meet the demand for healthcare services during man-made or natural emergencies, and the coalition is led by a multi-disciplinary steering committee with representatives from public health, emergency management agencies, hospitals and other healthcare partners. The coalition is staffed by the Toledo-Lucas County Health Department, the regional public health coordination agency, and the Hospital Council of Northwest Ohio, the regional

healthcare coalition coordination agency. The Northwest Ohio Healthcare Preparedness Committee, comprised of representatives from regional acute care hospitals, specialty hospitals and other healthcare providers, is a standing committee of NWO-HEMC that meets monthly. NWO-HEMC meets three times a year.

Since opioid overdose outbreaks fall under several disaster preparedness scenarios, including man-made mass casualty incidents, opioid use/overdose is being included as a standing agenda item for both NWO-HEMC and the Northwest Ohio Healthcare Preparedness Committee. The regional coalition provides an ongoing forum for sharing best practices and strategies to increase treatment access and reduce opioid addiction and death rates. The standing agenda item will provide ongoing monitoring of the scope of this issue within Northwest Ohio. Unresolved issues identified through the regional coalition and committee meetings will be documented and communicated to regional and state authorities for further review and consideration. Coalition partners will identify data points to measure overdose rates, specific drug types, deaths from overdoses, treatment program referrals and placements over time; a task force will be needed to identify and coordinate the collection of data outcome measures by March 2017. Membership can be expanded to include other key stakeholders in addressing the opioid crisis.

Additionally, NWO-HEMC could:

- Establish a **Northwest Ohio Adverse Drug Event Surveillance System** since it is difficult to accurately quantify the scope and magnitude of adverse drug events, as well as to measure access and the unmet need for withdrawal and substance use treatment services. Data specific to Northwest Ohio is needed to accurately quantify the scope of opioid overdose/use within the region; individual data collection efforts exist but are not well coordinated. Regional data sources could be used to implement targeted best practices for increasing access to treatment and reducing the rates of opioid addiction and deaths. Data also could be used to secure additional funding sources to provide ongoing education for healthcare providers. A potential resource for regional monitoring and planning is the Prescription Behavioral Surveillance System (PBSS), in which Ohio and nine other states participate. The PBSS provides epidemiological analyses of de-identified data from state prescription drug monitoring programs to target and evaluate interventions aimed at reducing prescription drug abuse and diversion. Startup funds to hire a database consultant and an annual operating budget for a database management contractor are needed.

- Provide coordination for **ongoing educational opportunities for Northwest Ohio healthcare providers**. This could provide a discussion forum for sharing best practices both to increase access to treatment and to reduce opioid addiction and death rates in Northwest Ohio. Barriers to implementing best practices could be identified. Efforts to standardize addiction risk assessment strategies, drug screening protocols, and opioid prescription surveillance and prescription practices all could result in improved outcome measurements within Northwest Ohio. The state-of-the art Interprofessional Immersive Simulation Center located on the University of Toledo Health Sciences Campus, which provides education for a variety of medical school and interdisciplinary students, is one community resource that could be utilized for a regional multi-disciplinary educational event. Funding is needed to hold educational opportunities.
- Expand the mission of the coalition to provide regional coordination and implementation of more evidence-based prevention and risk reduction programs starting in grade schools through high school. Funding is needed to expand prevention and risk reduction education and programs.
- Due to the uncertainty of ongoing federal disaster planning funds, funding is needed to staff the coalition to coordination the regional efforts outlined above.
- ***Establishing coordination among providers and payers to make sure patients transition to appropriate treatment, including strategies such as a protocol for medication-assisted treatment in primary care provider offices, prescribing guidelines, and a protocol to introduce referrals after detox treatment to case management and recovery services.***
  - **Protocol for medication-assisted treatment:** Medication-assisted treatment is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and they can help some people to sustain recovery, according to the Substance Abuse and Mental Health Services Administration.

Primary care providers can play an important part in treating patients with substance use problems.<sup>vii</sup> They may refer patients to specialized drug or alcohol treatment programs, including counseling, self-help groups or and methadone

programs.<sup>vii</sup> But they may not be adequate. Medication-assisted treatment by primary care providers paired with standard counseling or self-help groups may improve outcomes over counseling or support alone; recent research has shown patients who receive medication plus brief physician-delivered counseling and advice without formal treatment can achieve similar outcomes to those who receive specialized counseling.<sup>vii</sup>

- **Prescribing guidelines:** One ongoing strategy to address inappropriate opioid use is reducing the number of prescriptions written. The Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines (Emergency Guidelines) were developed through a multidisciplinary effort that involved associations, emergency departments, hospitals, state entities, physicians, nurses and other clinicians. These guidelines are designed to prevent “doctor shopping” for prescription opioids and other measures, such as encouraging prescribers to check the Ohio Automated Rx Reporting System (OARRS) that was established in 2006 to help providers monitor what other controlled medications a patient may be taking.

Since Ohio implemented the prescribing guidelines, the Centers for Disease Control and Prevention (CDC) has issued 12 recommendations to reduce the risks associated with long-term opioid therapy for chronic pain. Of primary importance, non-opioid therapy is preferred for treatment of chronic pain, and opioids should be used only when benefits for pain and function are expected to outweigh risks.<sup>viii</sup> Additionally, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks; clinicians also should evaluate benefits and harms of continued opioid therapy with patients at least every 3 months or more frequently.<sup>viii</sup>

- **Protocol for care coordination, case management and recovery services:** A standard protocol for providers, health insurers, the criminal justice system, insurance providers and social service providers needs to be developed to assist individuals seeking treatment or recovery services at any point. Several approaches could be piloted to design a sustainable system at the county and regional levels. For example, the Lucas County Sheriff’s Office’s Drug Abuse Response Team (DART) program could be implemented throughout the region to assist those treated for overdose at emergency departments and whenever personal safety is a concern. The DART program works closely with treatment providers and could expand this coordination to include insurance providers to

secure case management and treatment for their clients. As another example, community health workers working through the Hospital Council of Northwest Ohio's Northwest Ohio Pathways HUB could be utilized to assist the Medicaid population with accessing services and addressing health-related social needs. And mental health agencies could pilot a population-based approach for access to recovery services. All pilots must work together to share information and address system gaps. Funding will be needed for pilots and data sharing.

- ***Launching a regional educational campaign on opioid prescription guidelines and the Ohio Automated Rx Reporting System (OARRS) to decrease opioid prescriptions and improve compliance and monitoring.***

The State of Ohio Board of Pharmacy created Ohio's Prescription Drug Monitoring Program (PDMP), known as the Ohio Automated Rx Reporting System (OARRS), in 2006 to address the growing misuse and diversion of prescription drugs. OARRS collects information on all outpatient prescriptions for controlled substances dispensed by Ohio-licensed pharmacies and personally furnished by licensed prescribers in Ohio. Drug wholesalers are also required to submit information on all controlled substances sold to an Ohio licensed pharmacy or prescriber. The data is reported every 24 hours and is maintained in a secure database.

OARRS is a tool that can be used to address prescription drug diversion and abuse. It serves multiple functions, including as a patient care tool, drug epidemic early warning system, and drug diversion and insurance fraud investigative tool. As the only statewide electronic database that stores all controlled substance dispensing and personal furnishing information, OARRS helps prescribers and pharmacists avoid potentially life-threatening drug interactions. OARRS also assists in identifying individuals fraudulently obtaining controlled substances from multiple health care providers, a practice commonly referred to as "doctor shopping." Additionally, OARRS can be used by professional licensing boards to identify or investigate clinicians with patterns of inappropriate prescribing and dispensing, as well as to assist law enforcement in cases of controlled substance diversion.

- ***Cultivating a drug and alcohol treatment "Center of Excellence" to establish protocol for workforce development, provide consultation services, and develop curriculum and specialty certificates in drug and alcohol treatment.***

Recruiting and retaining physicians and other medical personnel to engage in the treatment of substance use is difficult, especially with medication-assisted treatment and withdrawal management. It's especially difficult in the area of treating pregnant

women. Funded by the Ohio Department of Health & Addiction Services, a Center of Excellence would assist the state in establishing protocol for workforce development, provide consultation services, and develop curriculum and specialty certificates in drug and alcohol treatment. This center would maximize resources to educate entities and build relationships in the community so the entire state can benefit and fight this epidemic.

Like other Centers of Excellence, one focused on substance use treatment could provide assistance throughout the state in the following areas:

- **Consultation services to local physicians:** Few rural areas have access to physicians who are willing to treat individuals with substance use disorders and/or prescribe medications that can be beneficial. The Center of Excellence could provide access to consulting physicians to respond to questions they have, obtain clinical advice, or seek a second opinion on complex issues, etc. This could provide enough support to increase the number of physicians willing to provide medication-assisted treatment, withdrawal services and prenatal care to women who also have substance use disorders.
- **Grand rounds:** Webinar-based grand rounds could be offered where treatment providers could present difficult cases and receive feedback/input on areas for improvement. These grand rounds also could include the provision of continuing education credits, providing additional incentive to participate.
- **Ongoing opportunities for continuing education:** The Center of Excellence could serve as a distribution point related to the science of substance use treatment.
- **Data collection and analysis:** The Center of Excellence could be a point of data collection related to treatment and the opiate epidemic. For example, the Center of Excellence could serve as the repository for results of overdose death reviews in order to identify trends and inform treatment and prevention services.

The Center of Excellence's success would be linked to its ability to increase the workforce capacity in addiction and health equity via physicians, nurses, counselors, peer support, and other professionals and services. Consequently, the number of clients served would increase, and there would be an increase in the availability of services and reduction in wait times.

Startup and operating funds are needed for an executive director or manager; staff; continuing education units; data collection and analysis; and other operational/administrative expenses. The cooperation of hospitals, mental health boards and agencies would be required to make this successful, including loaning content experts to the Center of Excellence and marketing the availability of staff.

- ***Conducting universal toxicology screening upon pregnancy and for pregnant women entering a hospital for delivery of an infant.***

When infants are born, their exposure to an illegal substance by their mothers may go undetected. To prevent the use of “for cause” testing, which runs the risk of infants going undetected for exposure, universal screening should be applied to all women upon finding out they are pregnant and when entering a hospital for the delivery of an infant. If an infant has been exposed to a substance, outreach to engage the mother into treatment and the infant into needed services can be completed at the earliest point in the infant’s life. Treatment also could make the difference between the infant remaining with the mother and being removed by Children’s Services. Northwest Ohio hospitals that currently employ universal toxicology screening for women in labor include Blanchard Valley Hospital, Wood County Hospital and St. Luke’s Hospital.

There is no requirement for universal toxicology screening, so pregnant women with substance use issues may go to hospitals where universal screening is not practiced. Thus, there is a possibility that use will go undetected, resulting in the mother and infant not being linked to services immediately. If use is detected, meanwhile, arranging follow-up and aftercare is more challenging if the mother did not deliver in her county of residence.

Policy change is required. Ideally, this could become a policy change at the state level, allowing for good data collection on infant exposure to substances. Toxicology screening is a billable expense to Medicaid and private insurances, and it is billed via the provider conducting the screening.

### ***REGULATIONS RECOMMENDATIONS***

To increase access to community-based withdrawal and substance use treatment services, several federal laws need to be updated and others need to stay in force. Despite efforts to alter federal regulations regarding opioid treatment, three regulations continue to stand as barriers to providing Northwest Ohio residents with coordinated, community-based medical detoxification and addiction treatment services. Federal laws related to patient confidentiality,

for example, prohibit a mental health provider from disclosing without consent that a patient who was arrested is receiving medication-assisted treatment for an opioid addiction, such as naltrexone. As a result, a jail's medical personnel may prescribe an opioid-based medication for pain because they were unaware of the person in custody has an addiction. While these laws need to be updated, the provision in the Affordable Care Act (ACA) that specifies coverage of mental health and substance use treatment as one of its ten essential health benefits needs to be retained.

- ***Updating three federal laws, including two that affect parity.***
  - **42 CFR Part 2** is a roadblock to coordinated care, and the substance abuse confidentiality regulations are more stringent than those for physical health diagnoses. With 42 CFR Part 2 – which applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program – written consent to share information requires 10 elements. These include the specific purpose or need for the disclosure and a description of how much and what kind of information will be disclosed.
  - **The institutions for mental diseases exclusion** has prohibited Medicaid from paying for inpatient treatment in a residential treatment facility with more than 16 beds. A federal rule regarding issued in April 2016 now allows Medicaid managed care plans to cover 15-day inpatient mental health and addiction services, which is inconsistent with prevailing parity laws. A patient with Medicaid coverage admitted for cancer treatment, for example, would not have a 15-day limit.
  - **DATA-2000** allows physicians to become eligible to prescribe specially approved opioid-based medications specifically for the treatment of opioid addiction. Buprenorphine/naloxone (Suboxone®) and buprenorphine (Subutex®) became the first medications to be approved and affected by this law. Yet physicians, who pass an 8-hour course and meet other qualifications to become eligible to apply for a special waiver, have only been able to treat 30 patients the first year following certification and 100 patients thereafter. In 2016, licensed physicians who have had a waiver to treat 100 patients for at least a year could become eligible for an annual limit of 275 patients under Ohio Senator Rob Portman's Comprehensive Addiction and Recovery Act (CARA), which is good progress. DATA-2000's first-year cap allowing eligible physicians to treat just 30 patients also should be increased. No other medications have such restrictions, including

the prescription medications people get addicted to in the first place. More family practice and family care providers also need to be educated about trained to become eligible to apply for the waiver; trained nurse practitioners and physicians assistants can now prescribe buprenorphine.

- ***Consistently enforcing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which extended parity to include substance abuse or chemical dependency. Additionally, extending MHPAEA to require all medical/surgical health insurers to provide mental health and substance use disorder benefits.***

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MHPAEA requires insurers to ensure that financial requirements, such as co-payments and deductibles, and treatment limitations that are applicable to mental health or substance use disorder benefits are no more restrictive than those applied to substantially all medical/surgical benefits. However, patients, providers and consumer advocates allege that health plans may appear in compliance with the MHPAEA, but there is a pattern of denials of mental health and substance use treatment and lack of access to network providers.<sup>ix</sup> They claim that plans use subtle ways to make mental health and substance use treatment less available than treatment for other conditions, including more frequent utilization review, “fail first” requirements, and applying stricter medical necessity criteria.<sup>ix</sup> Patients also report having trouble getting timely access to network providers for mental health and substance use treatment.<sup>ix</sup>

Meanwhile, MHPAEA does not mandate that a plan provide mental health or substance use disorder benefits. Additionally, MHPAEA does not apply to issuers who sell health insurance policies to employers with 50 or fewer employees or who sell health insurance policies to individuals. All medical/surgical health insurers should provide mental health and substance use disorder benefits.

- ***Maintaining Affordable Care Act (ACA) provisions that expanded Medicaid eligibility, and maintaining coverage of mental health and substance use treatment as one of its 10 essential health benefits.***

These recommendations begin and end with ACA and these two regulations, which provide the foundation to address access to community-based withdrawal and substance use treatment services. ACA applied the Mental Health Parity and Addiction Equity Act (MHPAEA) to issuers in the individual market and qualified health plans offered through a Marketplace, including the Small Business Health Options Program (SHOP). Additionally, the ACA specified coverage of mental health and substance use treatment as one of its 10 essential health benefits. Thus, all health insurance plans in the individual and small-employer market — both inside and outside of the

Marketplaces — must include coverage for the treatment of mental health and substance use disorders. The ACA went beyond the MHPAEA by mandating coverage instead of requiring parity only if coverage is provided. To satisfy the essential health benefit requirement, issuers must comply with the MHPAEA.

## CONCLUSION

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These recommendations are dedicated to the mothers, fathers, brothers, sisters, husbands, wives and friends who have lost a loved one to addiction. Addressing the opioid epidemic is a complex challenge that Northwest Ohio is grappling with by working together across the region while reaching out to local, state and federal government, funders and community members. By engaging health leadership, clinicians, policy makers, funders and local communities, we can create an environment that views addiction as a chronic condition that requires care, compassion and treatment – not as a personal failure.

To work with the Northwest Ohio Opioid Addiction Treatment Planning Task Force to implement these recommendations, please contact Jan Ruma, Vice President of the Hospital Council of Northwest Ohio, at 419-842-0800 or [jruma@hcno.org](mailto:jruma@hcno.org).

## GLOSSARY OF TERMS

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### **Community-based withdrawal and substance use treatment services:**

**Continuum of care:** An integrated system of care that guides and tracks each patient through a comprehensive array of health services spanning all levels of intensity of care.

**Medication-assisted treatment:** Medication used to treat opioid and/or alcohol use disorders, such as naltrexone, buprenorphine and methadone.

**Naxolone:** Used to treat an overdose in an emergency situation by blocking or reversing the effects of an opioid.

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<sup>ii</sup> Ohio Department of Health. *2015 Ohio Drug Overdose Data: General Findings*. August 2016.

<sup>iii</sup> Ohio Substance Abuse Monitoring Network. *Drug Abuse Trends in the Toledo Region*. June 2015 – January 2016.

<sup>iv</sup> U.S. Department of Health and Human Services, Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, Executive Summary*. November 2016.

<sup>v</sup> Ohio Department of Medicaid. *Ohio Medicaid VIII Assessment: A Report to the Ohio General Assembly*. January 2017.

<sup>vi</sup> Carnevale Associates LLC. *The Affordable Care Act: Shaping Substance Abuse Treatment*. April 2013.

<sup>vii</sup> Rand Health. *Summit: Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primary Care*. 2016

<sup>viii</sup> Centers for Disease Control and Prevention. *CDC Guideline for Prescribing Opioids for Chronic Pain — United States*. March 2016.

<sup>ix</sup> Health Affairs, Robert Wood Johnson Foundation. *Health Policy Brief: Enforcing Mental Health Parity*. November 2015.