What Are Opioids?

- Natural or synthetic chemicals that act on opiate receptors in the brain to reduce pain and can produce euphoria
- Prescription narcotics used to treat moderate to severe pain like oxycodone, hydrocodone, fentanyl, morphine, methadone and others
- Includes illegal drugs like heroin and illegally made and distributed fentanyl
Causes of Death in the United States

• Opioids — 2016
  ➢ 64,070 U.S. drug overdose deaths
    – 42,249 opioid-related overdose deaths
    – 1,400 in Missouri
    – 21 percent increase since 2015
    – 300 percent since 1999

• Influenza — 2010-2015
  ➢ Annual range of excess deaths from influenza and pneumonia is 4,000 - 20,000

• Motor Vehicle Accidents — 2014
  ➢ 33,736

• Firearms — 2014
  ➢ 33,594

Sources:
https://www.cdc.gov/flu/about/disease/2015-16.htm
https://www.cdc.gov/nchs/fastats/injury.htm
3 Waves of the Rise in Opioid Overdose Deaths

Wave 1: Rise in Prescription Opioid Overdose Deaths
Wave 2: Rise in Heroin Overdose Deaths
Wave 3: Rise in Synthetic Opioid Overdose Deaths


States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2001

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2002

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2003

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2004

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2005

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

**2006**

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2007

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

**2008**

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

**2009**

**Source:** Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More DRUG-INDUCED Than Motor Vehicle-Related Deaths

2010

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2011

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More \textbf{DRUG-INDUCED} Than Motor Vehicle-Related Deaths

\textbf{2012}

Source: \textit{Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.}
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2013

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2014

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths

2015

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
States with More **Drug-Induced** Than Motor Vehicle-Related Deaths

2016

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016.
Counties with More Opioid Overdose Than Motor Vehicle Accident Deaths 2013-2015

Six counties with significantly more opioid overdose than MVA deaths:
- Includes five of our seven most populous counties and Pulaski County which has one of the state’s highest concentration of veterans and active service members.

- St. Charles County: 260 Deaths (2.2x)
- St. Louis County: 798 Deaths (2.2x)
- St. Louis City: 526 Deaths (3.2x)
- Jefferson County: 302 Deaths (1.8x)
- Pulaski County: 45 Deaths (1.4x)
- Greene County: 171 Deaths (1.04x)
Counties with More Opioid Overdose Than Motor Vehicle Accident Deaths 2014-2016

29 counties with significantly more drug overdose than MVA deaths between 2014 and 2016:

- Includes nine of our 10 most populous counties and Pulaski County which has one of the state’s highest volume of veterans and active service members.

Source: CDC WONDER. Counties with more drug-induced deaths include: Adair, Bates, Boone, Buchanan, Butler, Cass, Clay, Clinton, Cole, Crawford, Franklin, Greene, Grundy, Jackson, Jefferson, Lincoln, Livingston, Marion, Montgomery, Perry, Platte, Pulaski, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Wayne and Webster.
Opioid Dependence Risk in Kansas and Missouri Counties


Figure 5: Opioid Dependence Risk in Missouri and Kansas Counties Estimated With Principal Component Analysis of Unemployment, Drug-Related Mortality, Morphine Milligram Equivalents Prescribed Per Capita and Hospital Utilization for Opioid Misuse (component 1 shown in map)
Opioids Among the Workforce

MISSOURI HOSPITAL ASSOCIATION
Missouri’s rate dropped from 3.9 percent to 3.7 percent over the same time period.

# Top Ten Workers’ Compensation Opioid Drugs – Missouri

<table>
<thead>
<tr>
<th>Name of Opioid Drug</th>
<th>Brand or Generic</th>
<th>Percent of Drug Payments</th>
<th>Percent of Drug Prescriptions</th>
<th>PPU Missouri</th>
<th>PPU Region</th>
<th>PPU Countrywide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone HCl-Acetaminophen (APAP)</td>
<td>G</td>
<td>4.3%</td>
<td>5.3%</td>
<td>$1.34</td>
<td>$1.39</td>
<td>$1.76</td>
</tr>
<tr>
<td>Oxycontin®</td>
<td>B</td>
<td>4.0%</td>
<td>0.8%</td>
<td>$8.17</td>
<td>$7.60</td>
<td>$8.43</td>
</tr>
<tr>
<td>Hydrocodone Bitartrate-APAP</td>
<td>G</td>
<td>3.3%</td>
<td>11.1%</td>
<td>$0.55</td>
<td>$0.54</td>
<td>$0.58</td>
</tr>
<tr>
<td>Tramadol HCl</td>
<td>G</td>
<td>2.5%</td>
<td>5.9%</td>
<td>$0.75</td>
<td>$0.74</td>
<td>$1.16</td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>G</td>
<td>1.6%</td>
<td>1.9%</td>
<td>$1.03</td>
<td>$1.13</td>
<td>$1.27</td>
</tr>
<tr>
<td>Fentanyl Citrate</td>
<td>G</td>
<td>1.0%</td>
<td>-</td>
<td>$19.59</td>
<td>$1.32</td>
<td>$4.80</td>
</tr>
<tr>
<td>Nucynta®</td>
<td>B</td>
<td>0.8%</td>
<td>-</td>
<td>$5.52</td>
<td>$5.63</td>
<td>$6.07</td>
</tr>
<tr>
<td>Morphine Sulfate</td>
<td>G</td>
<td>0.7%</td>
<td>0.4%</td>
<td>$2.24</td>
<td>$1.76</td>
<td>$2.24</td>
</tr>
<tr>
<td>Fentanyl Transdermal System</td>
<td>G</td>
<td>0.7%</td>
<td>0.2%</td>
<td>$23.02</td>
<td>$20.35</td>
<td>$21.89</td>
</tr>
<tr>
<td>Opana ER®</td>
<td>B</td>
<td>0.6%</td>
<td>-</td>
<td>$10.71</td>
<td>$8.73</td>
<td>$10.31</td>
</tr>
<tr>
<td>APAP-Codeine Phosphate</td>
<td>G</td>
<td>-</td>
<td>1.1%</td>
<td>$0.61</td>
<td>$0.44</td>
<td>$0.47</td>
</tr>
<tr>
<td>Tramadol HCl/APAP</td>
<td>G</td>
<td>-</td>
<td>0.3%</td>
<td>$0.88</td>
<td>$0.66</td>
<td>$0.78</td>
</tr>
<tr>
<td>Hydromorphone HCl</td>
<td>G</td>
<td>-</td>
<td>0.2%</td>
<td>$0.61</td>
<td>$1.70</td>
<td>$1.97</td>
</tr>
</tbody>
</table>

Source: Medical Data Report, Opioid Utilization Supplement for Missouri, National Council on Compensation Insurance, October 2017
Opioid Distribution

Percent Opioid Prescription and Payment Distribution

Schedule 1: No current medical use
Schedule 2: High potential for abuse
Schedule 3: Low abuse potential and moderate to low physical and psychological dependence
Schedule 4: Low abuse and physical and psychological dependence

Source: Medical Data Report, Opioid Utilization Supplement for Missouri, National Council on Compensation Insurance, October 2017
Reducing Opioid Prescriptions

Percent Drug Claims with at Least One Opioid Prescription

Source: Medical Data Report, Opioid Utilization Supplement for Missouri, National Council on Compensation Insurance, October 2017
June 22, 2018, the House of Representatives passed and sent 50 bills to the Senate focused on the opioid crisis.
I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, knowing how to use naloxone and keeping it within reach can save a life.

BE PREPARED. GET NALOXONE. SAVE A LIFE.
Policy Changes
2018 Legislative Session - Effective August 28

• Passed and signed by Gov. Greitens - HB 2280
  ➢ Authorizes as much as 12 additional months of Medicaid coverage of substance abuse and mental health treatment for post-partum women who receive substance abuse treatment within 60 days of giving birth and who adhere to the treatment program.
  ➢ The added coverage is contingent on federal approval.
2018 Legislative Session — Passed

- SB 951 and SB 718
  - Subject to appropriations, creates an opioid abuse treatment and prevention program involving advanced practice registered nurses, physician assistants and assistant physicians in collaboration with physicians
  - Revises standards for the prescribing of buprenorphine in medication-assisted treatment of opioid addiction under collaborative practice arrangements
  - Drug “take-back” program
2018 Legislative Session — Passed

• SB 951 and SB 718
  ➤ Blocks the inclusion of pain scores in quality of care and patient satisfaction data the Department of Insurance is authorized to collect
  ➤ Requires health insurers to offer their enrollees coverage of medication-assisted treatment of substance abuse disorders for an additional premium

• SB 826 — Limits initial prescriptions of opioids to a duration of seven days, with specified exceptions
Policy and Advocacy

PDMP Participation

2017
- Implementation 1-6 (2017)

2018
- Implementation 7 (01/01/18)
- Implementation 8 (02/01/18)
- Implementation 9 (03/01/18)
- Implementation 10 (04/01/18)
- Implementation 11 (TBD)
- No Legislation
Practice Changes

Prevention – Treatment – Recovery
Patient Education

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. 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 nonopioid treatments, including nonopiod medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in pain management
- Use disease-specific treatments when available (e.g., tricyclic antidepressants for neuropathic pain)

Use first-line medication options preferentially

- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional limits, or psychiatric risk factors

NONOPIOID MEDICATIONS

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>MAGNITUDE OF BENEFITS</th>
<th>HARMs</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Small</td>
<td>Hepatotoxic, particularly at higher doses</td>
<td>First-line analgesic, probably less effective than NSAIDs</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Small/moderate</td>
<td>Gastrointestinal, renal</td>
<td>First-line analgesic, less GI toxicity</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>Small</td>
<td>Sedation, dizziness, asthma</td>
<td>First-line agent for neuropathic pain, pregabalin suppressor for fibromyalgia</td>
</tr>
<tr>
<td>Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors</td>
<td>Small/moderate</td>
<td>TCA-like antipsychotics and cardiac side effects, GI toxicity, weight gain</td>
<td>First-line for neuropathic pain, TCAs and SNRIs for fibromyalgia, TCAs for mood disorders</td>
</tr>
<tr>
<td>Topical agents (lidocaine, capsaicin, NSAIDs)</td>
<td>Small/moderate</td>
<td>Capsaicin initial flare, burning, irritation of mucous membranes</td>
<td>Considered as alternative first-line, thought to be safer than systemic medications. Lidocaine for local anesthesia, topical capsaicin for mucosal/skin and neuropathic pain</td>
</tr>
</tbody>
</table>

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

- Self-care and education in all patients: advise patients to remain active and limit bed rest
- Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications:
- First-line: Acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Osteoarthritis

- Nonpharmacological treatments: Exercise, weight loss, patient education
- Medications:
  - First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
  - Second-line: Intramuscular hyaluronic acid, capsaicin
  - Limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient

Fibromyalgia

- Patient education: Address diagnosis, treatment, and the patient's role in treatment
- Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications:
- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

Practice Changes

- **2015 Guidance**
  - ED opioid prescribing
  - 90 percent adoption of most guidelines

- **2016 Guidance**
  - Chronic pain
  - Acute pain
  - Naloxone distribution

- **2017 Education**
  - Neonatal abstinence syndrome
  - Addiction as a condition

- **2018 Initiative**
  - Medication-assisted treatment with coordination of support and treatment services
CDC Guidelines for Chronic Pain

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonopioid pharmacologic therapy and nonpharmacologic therapy, as appropriate.

2. train opioid therapy for chronic pain, clinicians should obtain treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that offsets risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS
- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks and availability of nonopioid therapies with patient.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dose of immediate-release opioids and provided 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.

6. Long-term opioid use can begin with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and provided 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.

7. Clinicians should evaluate and assess harms with patients within 1-4 weeks of starting opioid therapy for chronic pain or in areas.

CLINICAL REMINDERS
- Evaluate risk factors for opioid-related harms.
- Check PMP for high dosages and prescriptions from other providers.
- Use urine drug testing to identify prescribed substances and undiagnosed use.
- Avoid concurrent benzodiazepine and opioid prescribing.
- Arrange treatment for opioid use disorder if needed.

ASSESSING RISK AND ADDRESsing HARMs OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate the management plan to mitigate risk, including consideration of a treatment schedule that decreases the risk of opioid overdose, such as history of overdose, history of substance use disorder, or opioid overdoses (≥5% of opioid use), or concurrent benzodiazepine use, as present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PMP) data to determine whether the patient is receiving opioid doses or dangerous combinations that put him at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription on every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (opioid medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) to patients with opioid use disorders.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Use of Naloxone in Response to Opioid Overdose

- Naloxone reverses the effects of an opioid overdose.
- As of August 28, 2017, anyone may access naloxone at a Missouri pharmacy via a statewide standing order.
- The MO-HOPE and MORE Projects distribute naloxone and provide training on its administration.

Sources: [https://opioids.mo.gov/naloxone](https://opioids.mo.gov/naloxone)  [https://mohopeproject.org/](https://mohopeproject.org/)
Medication-Assisted Treatment

• What Is It?
  ➤ Medication-assisted treatment (MAT) incorporates the use of FDA-approved medications and behavioral therapy in the treatment of Opioid Use Disorder (OUD).

• Which Agencies Endorse MAT?
  ➤ Substance Abuse and Mental Health Services Administration
  ➤ American Medical Association
  ➤ National Institute on Drug Abuse

Source: https://www.samhsa.gov/medication-assisted-treatment
Obstacles to MAT

- **Access**
  - Need for more waiver-trained prescribers to use buprenorphine for treatment
  - Community services for support and treatment

- **Funding**

- **Stigma**
  - A shift from abstinence-models (12-step)
  - Lack of awareness of evidence-based treatment

“Medication First” Model

- Address withdrawal symptoms
- Reduce cravings
- Enable the patient to focus and engage in counseling and social support groups
- Increase treatment retention
- Supported by the Missouri Department of Mental Health
- Key component of the Opioid STR Grant

Source: https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/59bab107f09ca461180d6429/1505407240927/Opioid+STR+Implementation+Guide_nonDMH.pdf
Best Practice in Care Coordination — EPI CC Project

- Patient overdoses and arrives in the ED.
- An ED buprenorphine-waivered physician is contacted.
- Buprenorphine induction occurs in the ED.
- A Recovery Coach is contacted and meets with the patient in the ED.
- The ED physician provides the patient with a bridge prescription of 3-5 days of buprenorphine.
- The Recovery Coach assists the patient with a timely referral to outpatient MAT, behavioral therapy, and support groups.
Peer Support in Recovery

• Certified Peer Specialists will be qualified to support individuals in recovery from substance use, mental health or co-occurring disorders.

Source: www.missouricb.com
STR Medication First Success

- 16 treatment agencies are funded, providing treatment at 44 sites
- Statewide, STR has provided treatment for 1,922 individuals with OUD
- Of those, 1,320 individuals (69%) still are receiving treatment and/or support
Housing, MAT and Recovery

- Missouri partner: National Alliance for Recovery Residences
  - Missouri Coalition of Recovery Support Providers is an official affiliate of NARR
- NARR-accredited recovery homes in Missouri
  - Eastern: 8 houses, 71 beds
  - Western: 8 houses, 103 beds
  - Southwest: 7 houses, 68 beds

Source: https://missouriopioidstr.org/recovery/
# Missouri Peer-Based Recovery Community Centers

<table>
<thead>
<tr>
<th>Region</th>
<th>Centers</th>
<th>Hours of Operations</th>
<th>Number of Recovery Activities</th>
<th>Number of Individuals Served</th>
</tr>
</thead>
</table>
| Eastern (St. Louis) | • St. Louis Empowerment Center  
• Missouri Network for Opiate Reform and Recovery | 387                | 52                           | 2,064                       |
| Southwest (Springfield) | • Springfield Recovery Community Center                          | 268                | 92                           | 813                         |
| Western (Kansas City) | • Healing House, Inc.                                                 | 249                | 152                          | 2460                        |
Call To Action: Engage With Your Health Plan

- What are your plan’s coverage policies for pain management?
  - Opioids?
  - Non-opioid pain management (physical therapy, non-opioid medication, etc.)
- What is your coverage of abuse-deterrent opioids?
- How is your health plan working to identify/reduce/prevent opioid misuse?
- What is your coverage for substance use disorder treatment?
- How does your plan support safe drug disposal?
Contact Information

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