



# Opioid Crisis: Shifting From Shock to Solutions

August 15, 2018



# What Are Opioids?

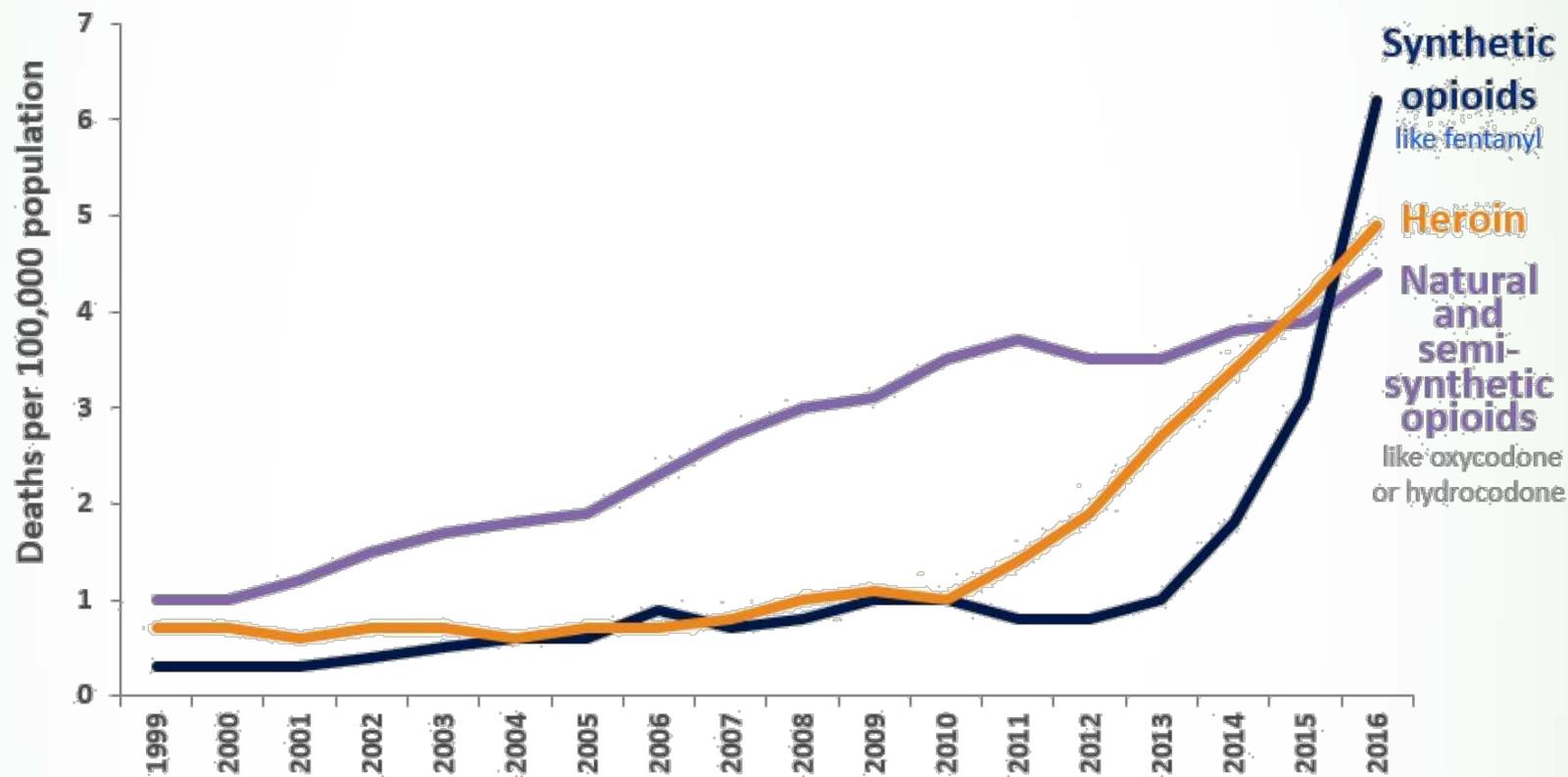


# Causes of Death in the United States

- 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.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>  
<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



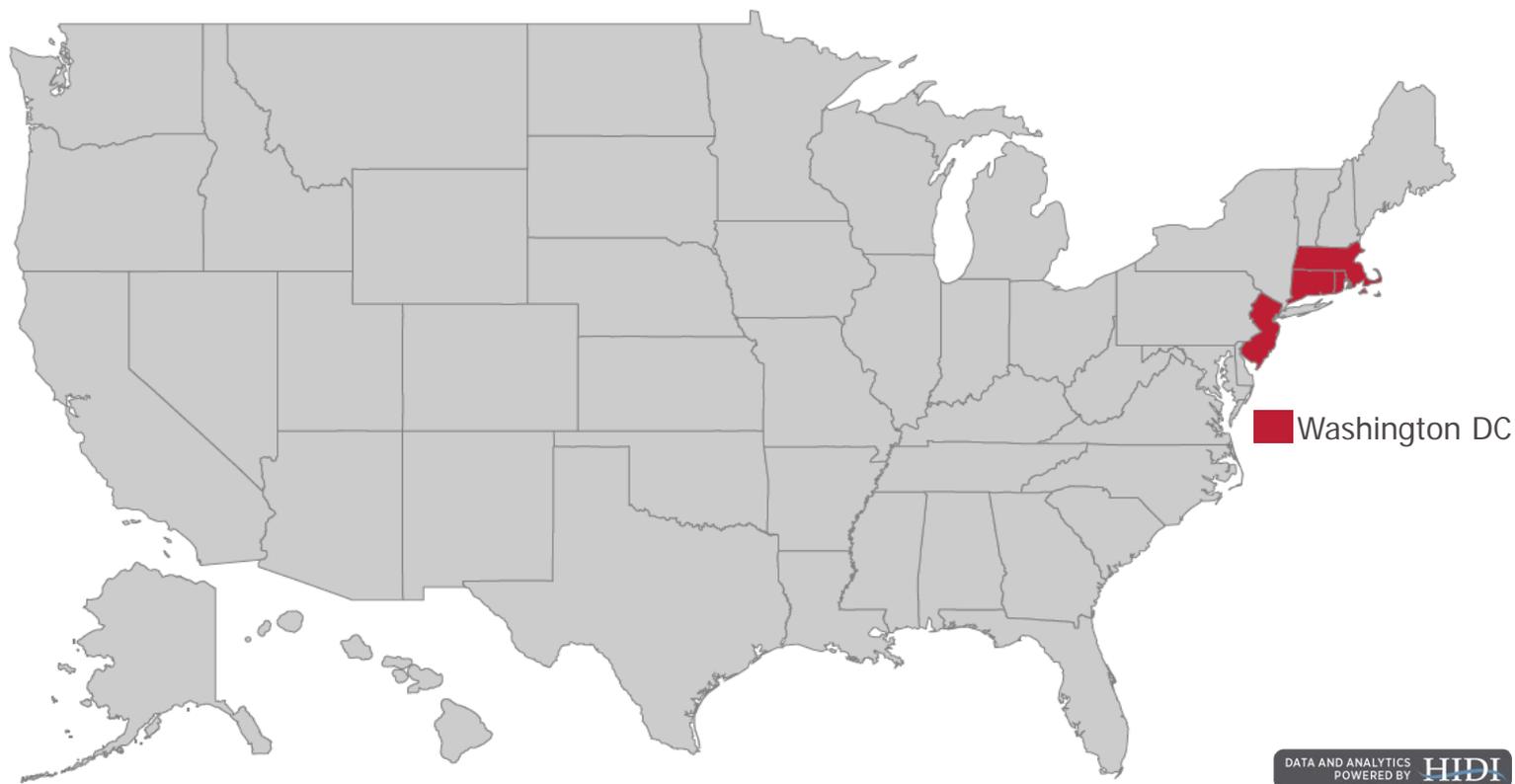
Wave 1: Rise in Prescription Opioid Overdose Deaths

Wave 2: Rise in Heroin Overdose Deaths

Wave 3: Rise in Synthetic Opioid Overdose Deaths

SOURCE: National Vital Statistics System Mortality File.

# States with More **DRUG-INDUCED** Than Motor Vehicle-Related Deaths 2001



2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 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.

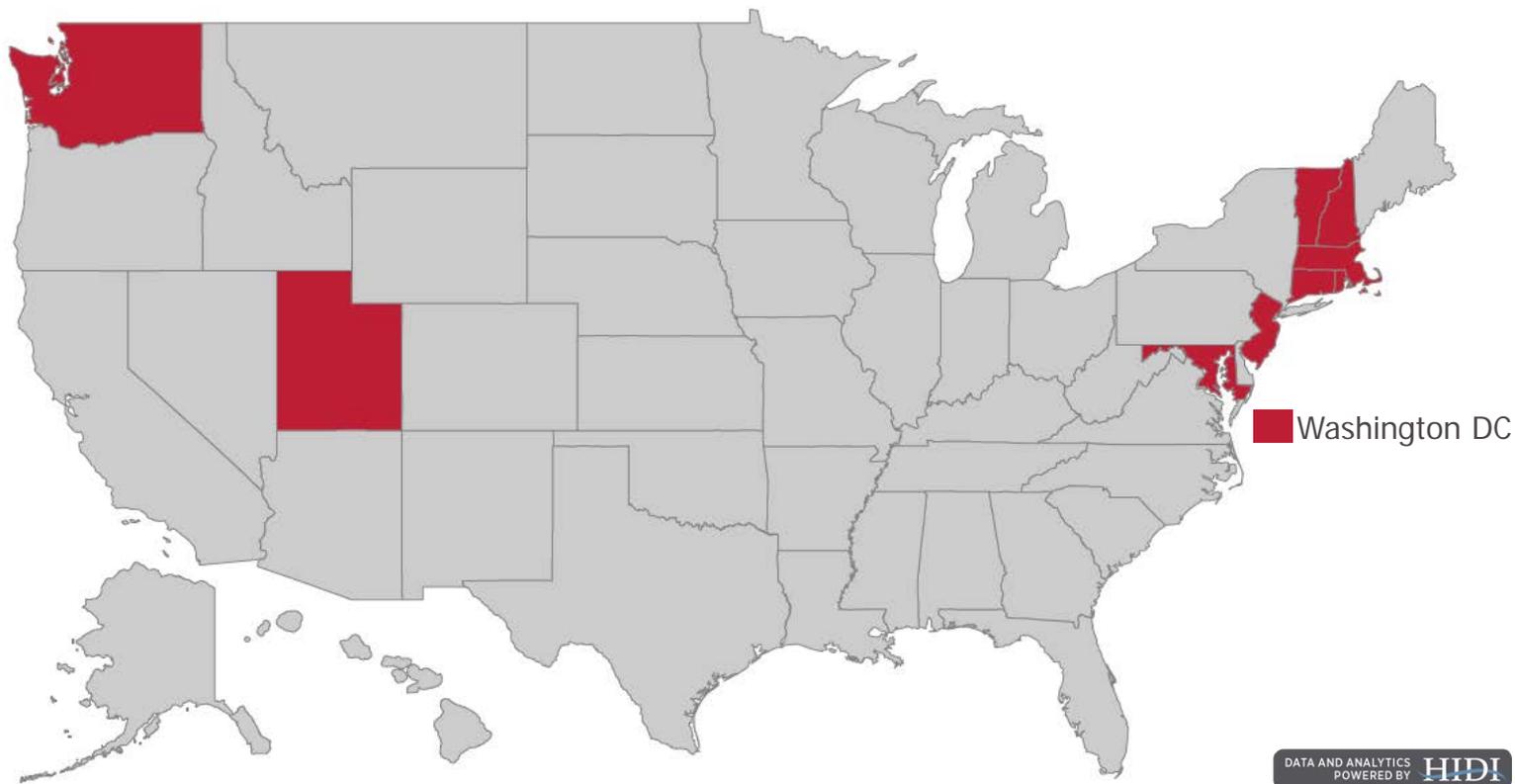
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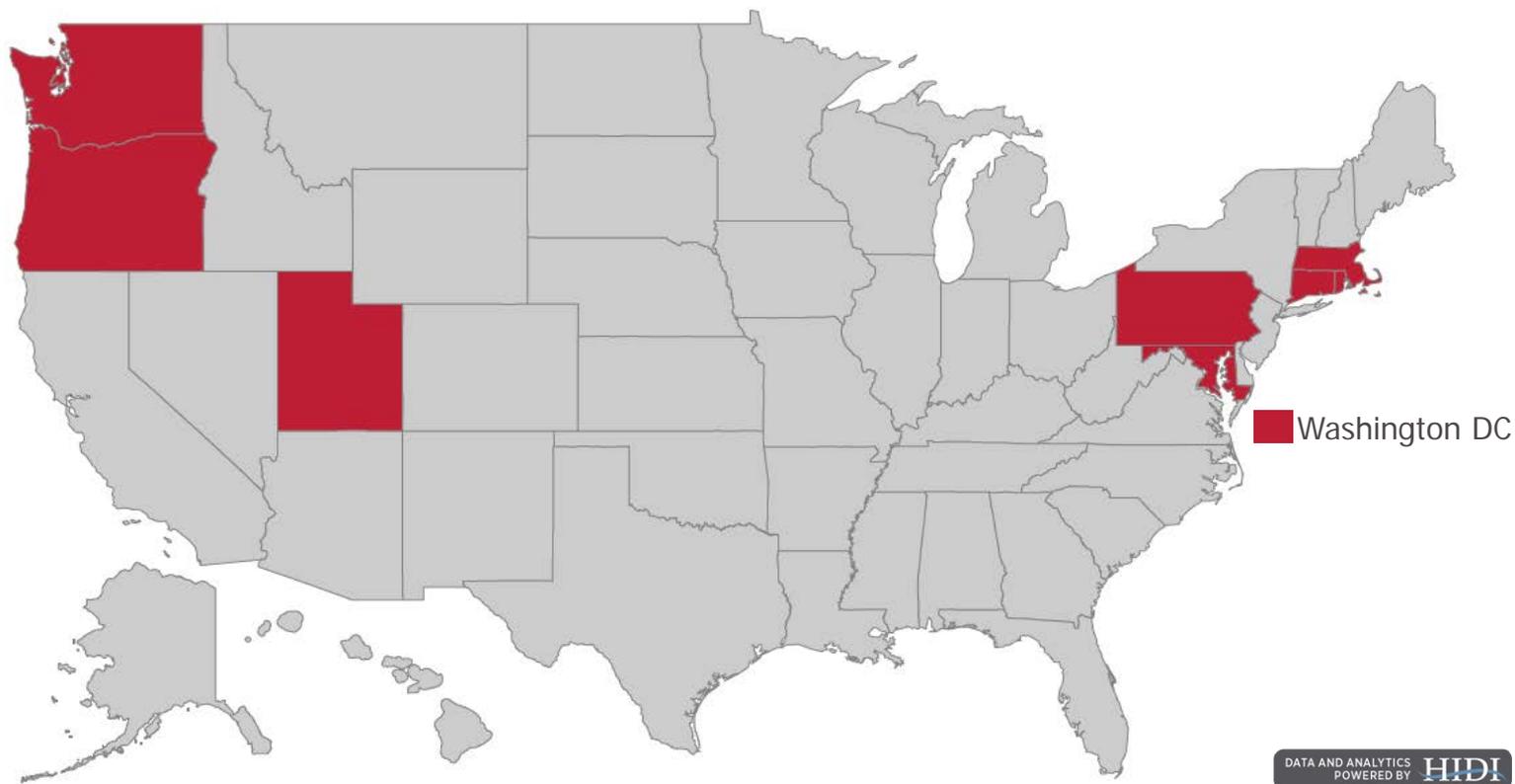
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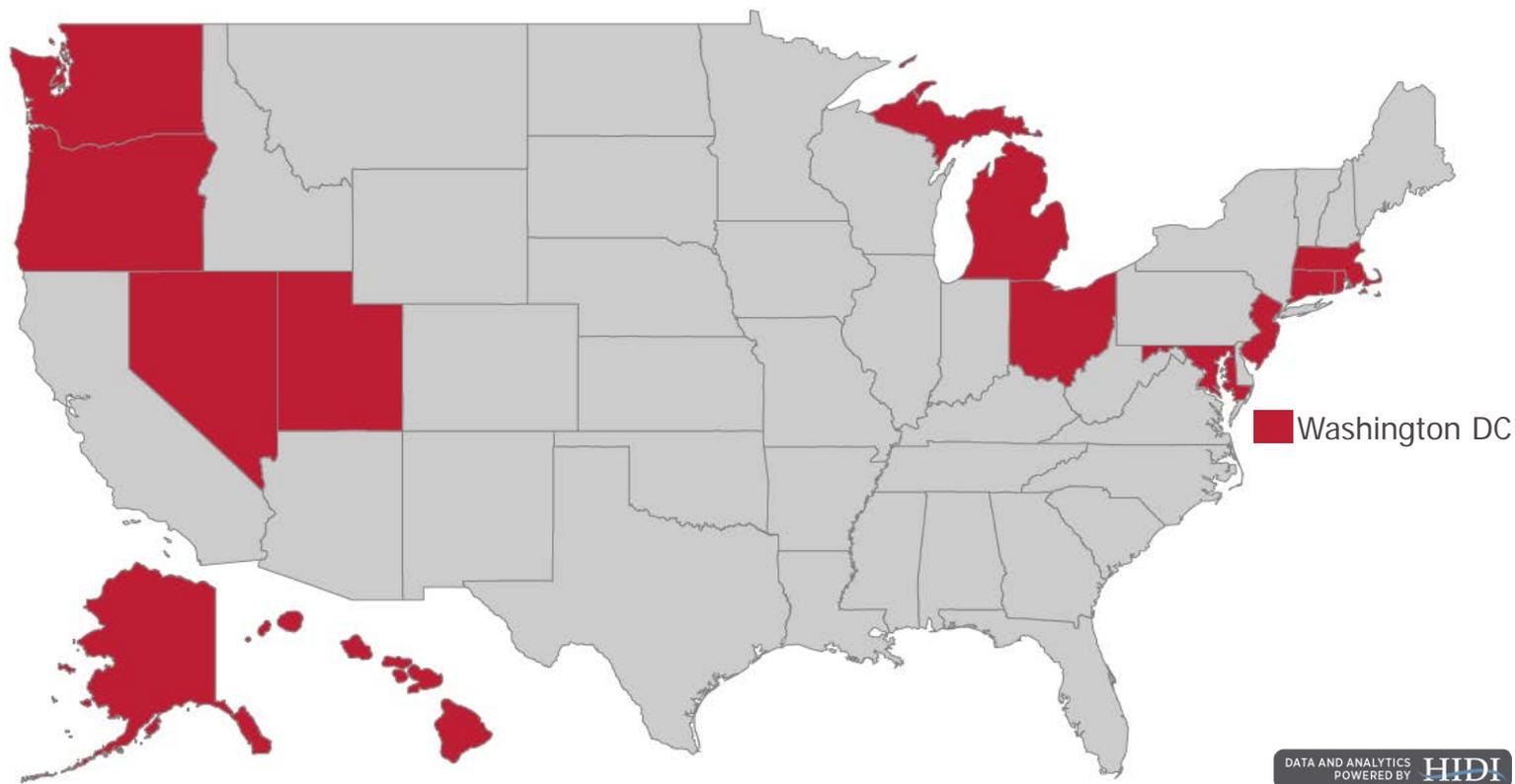
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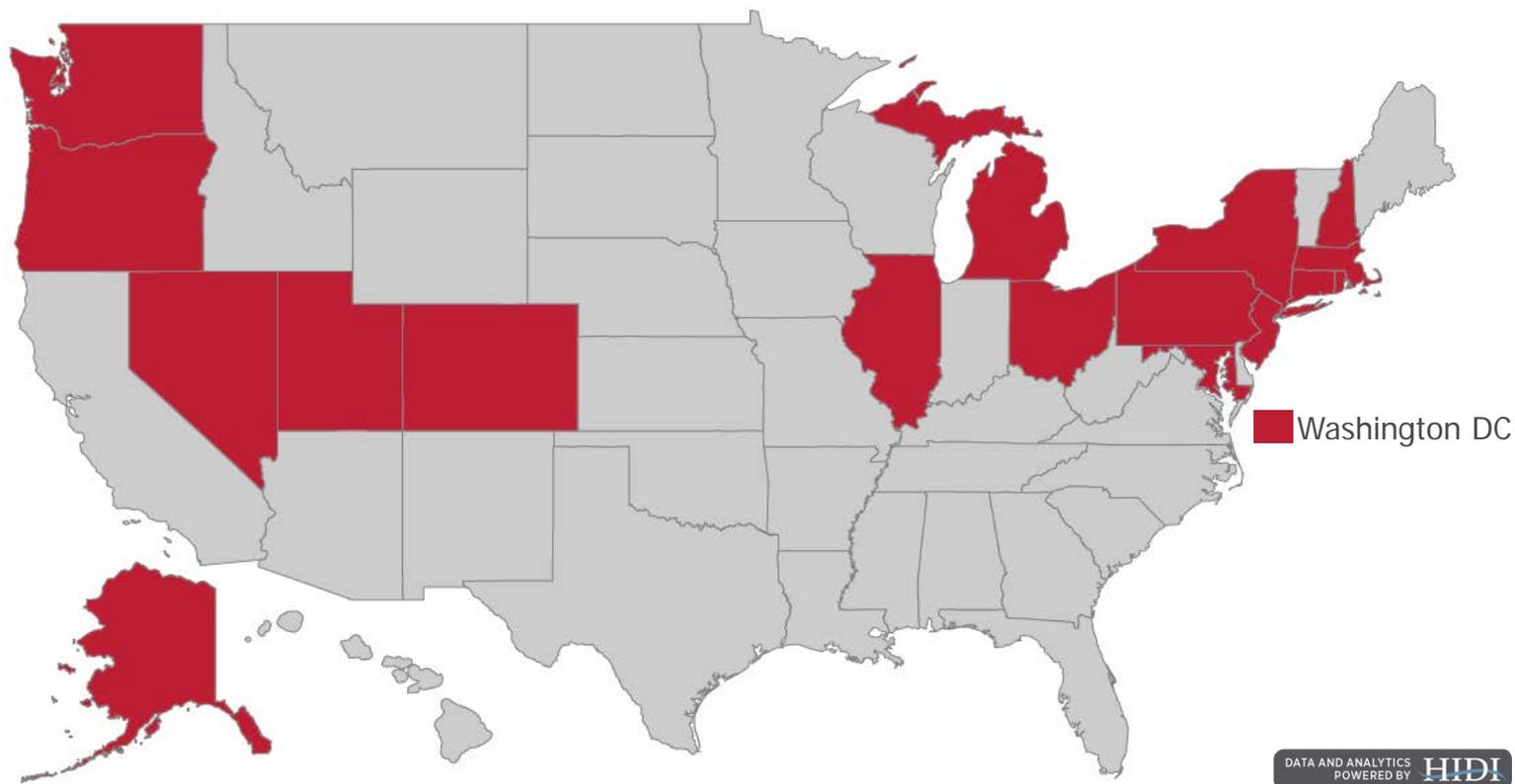
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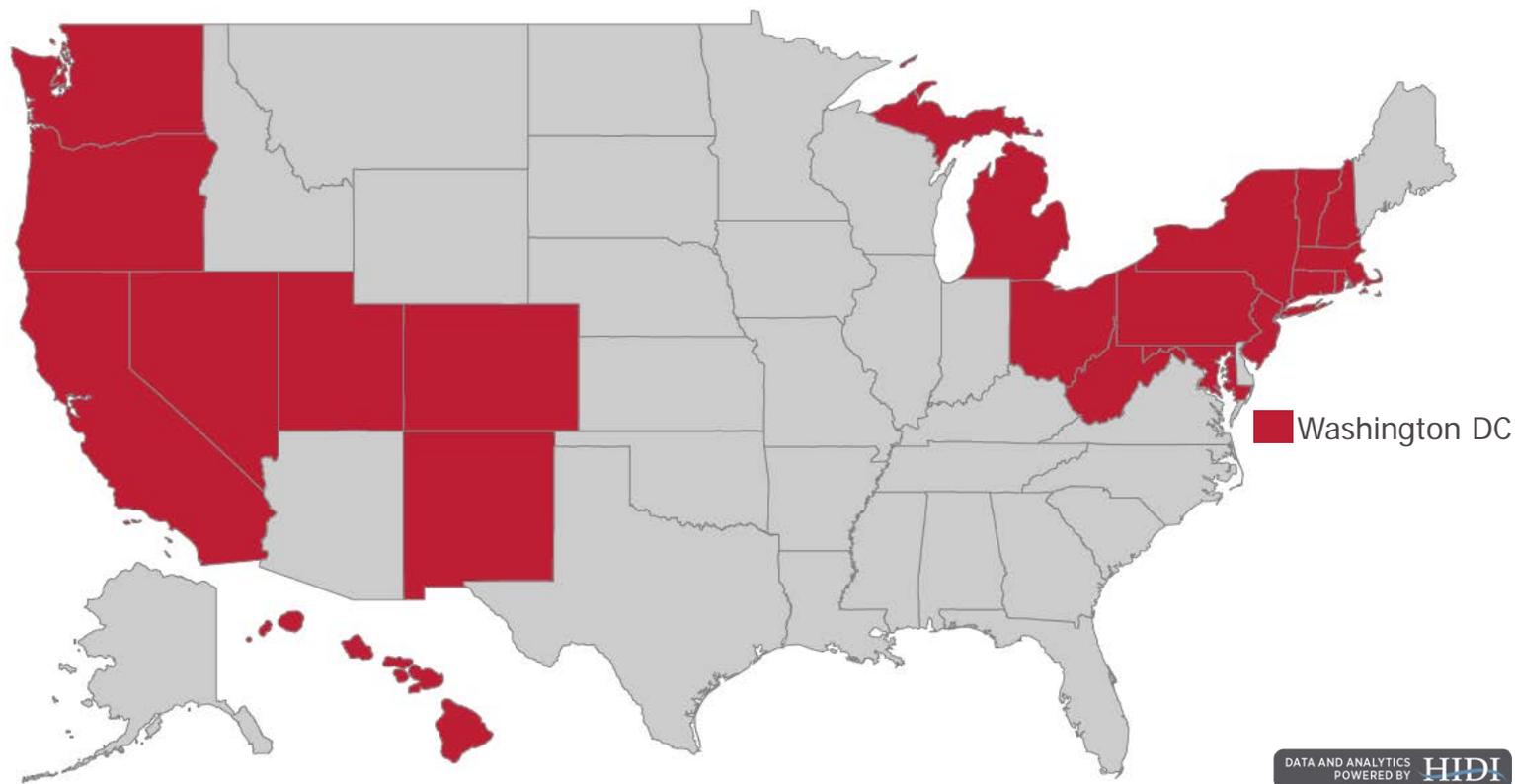
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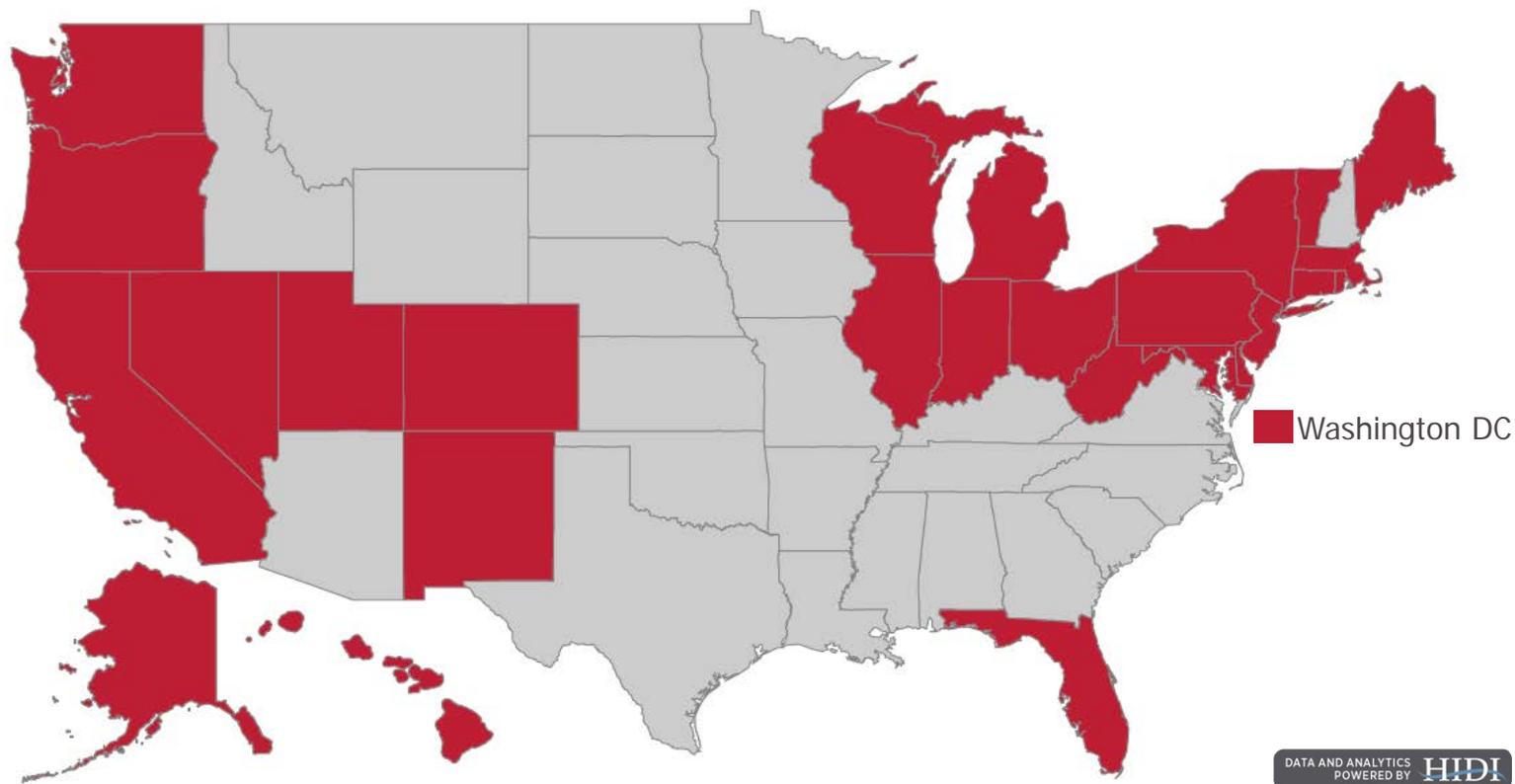
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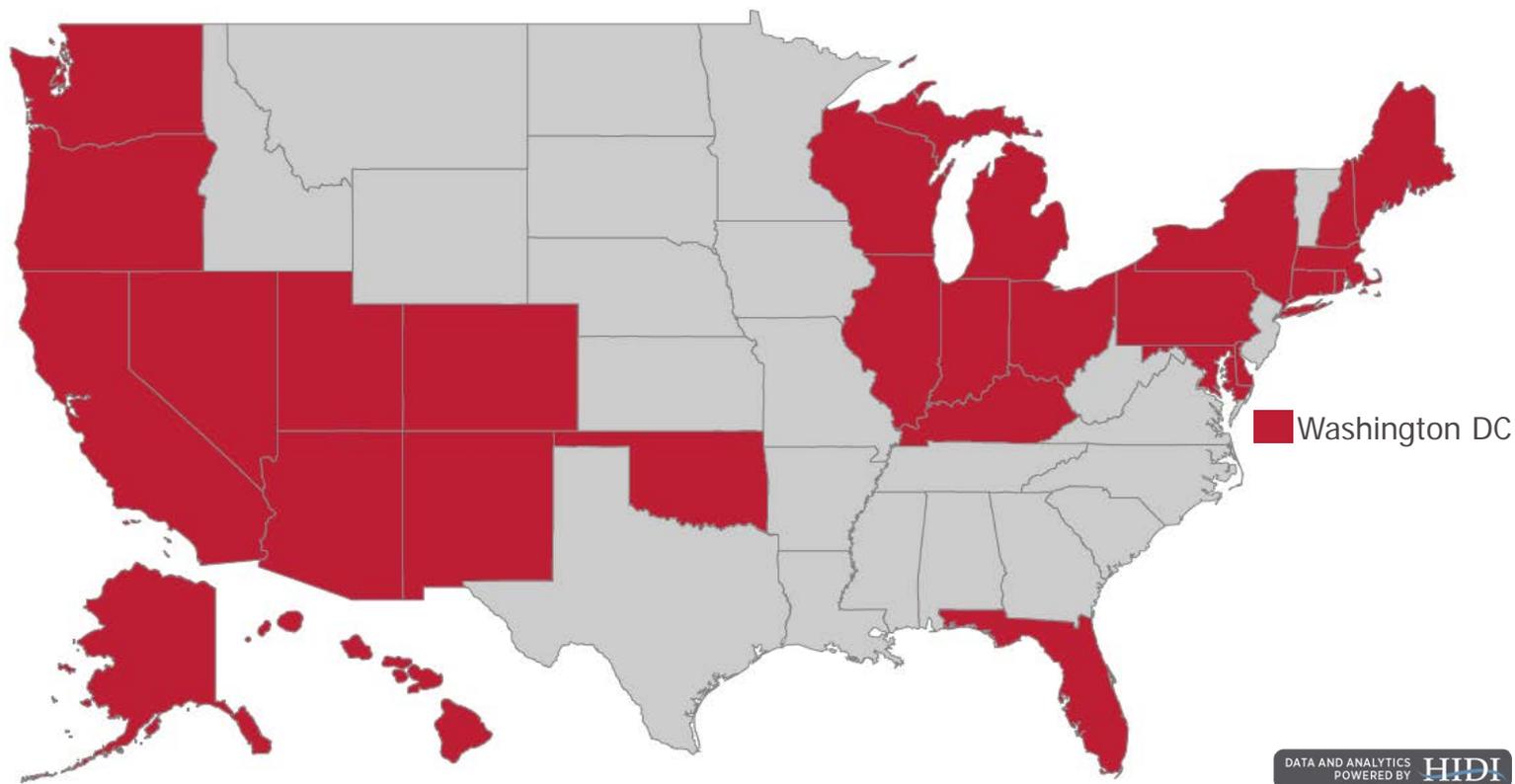
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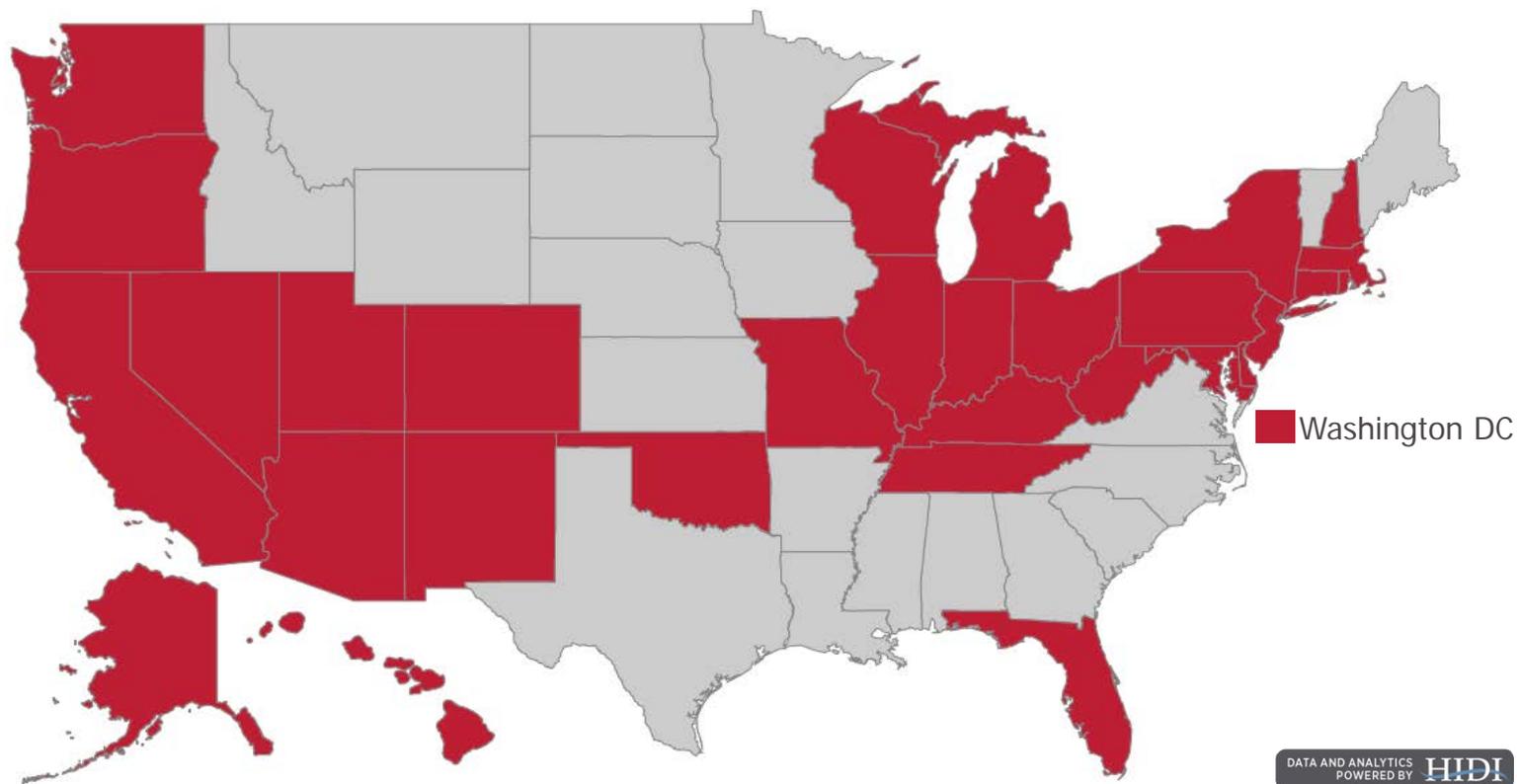
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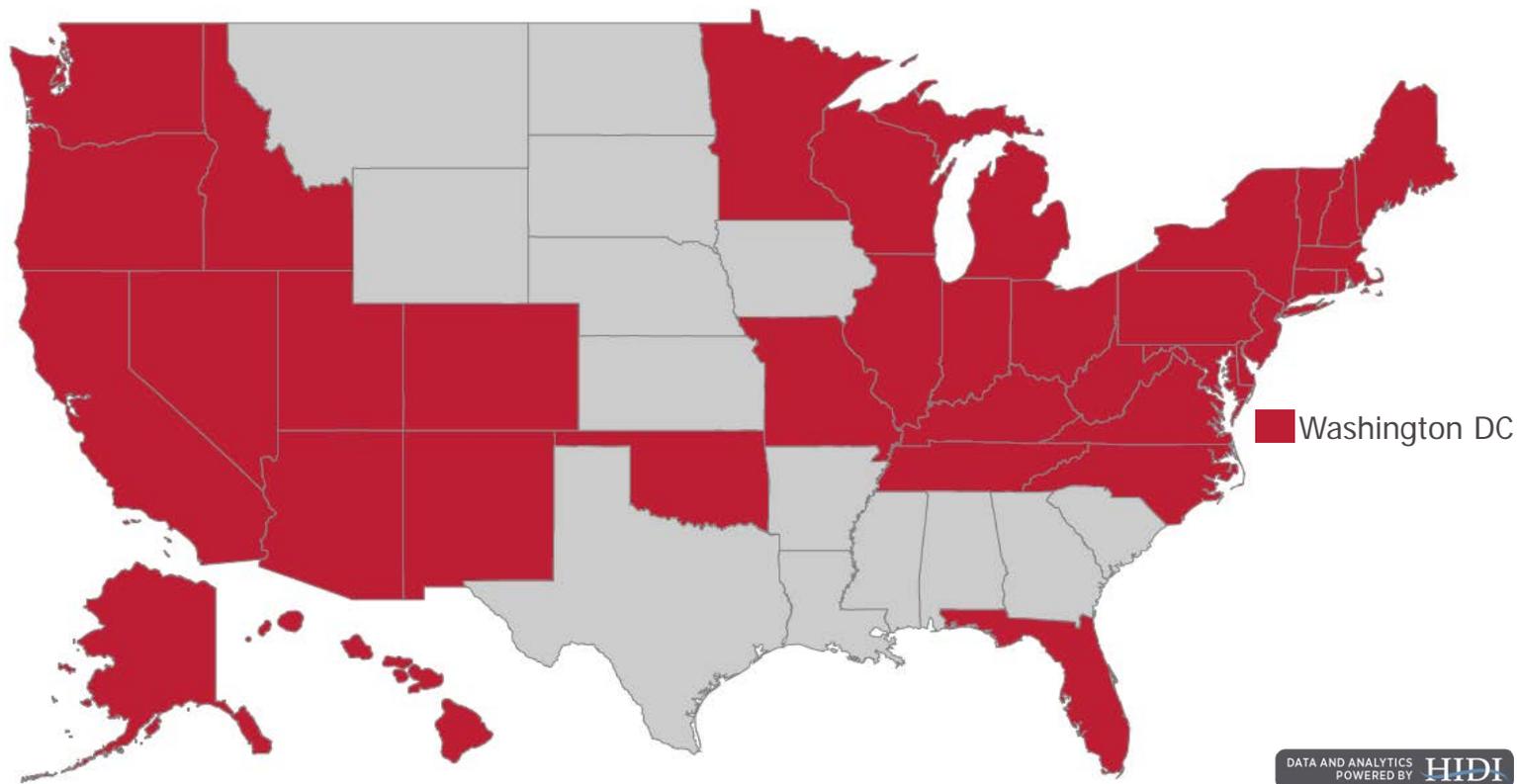
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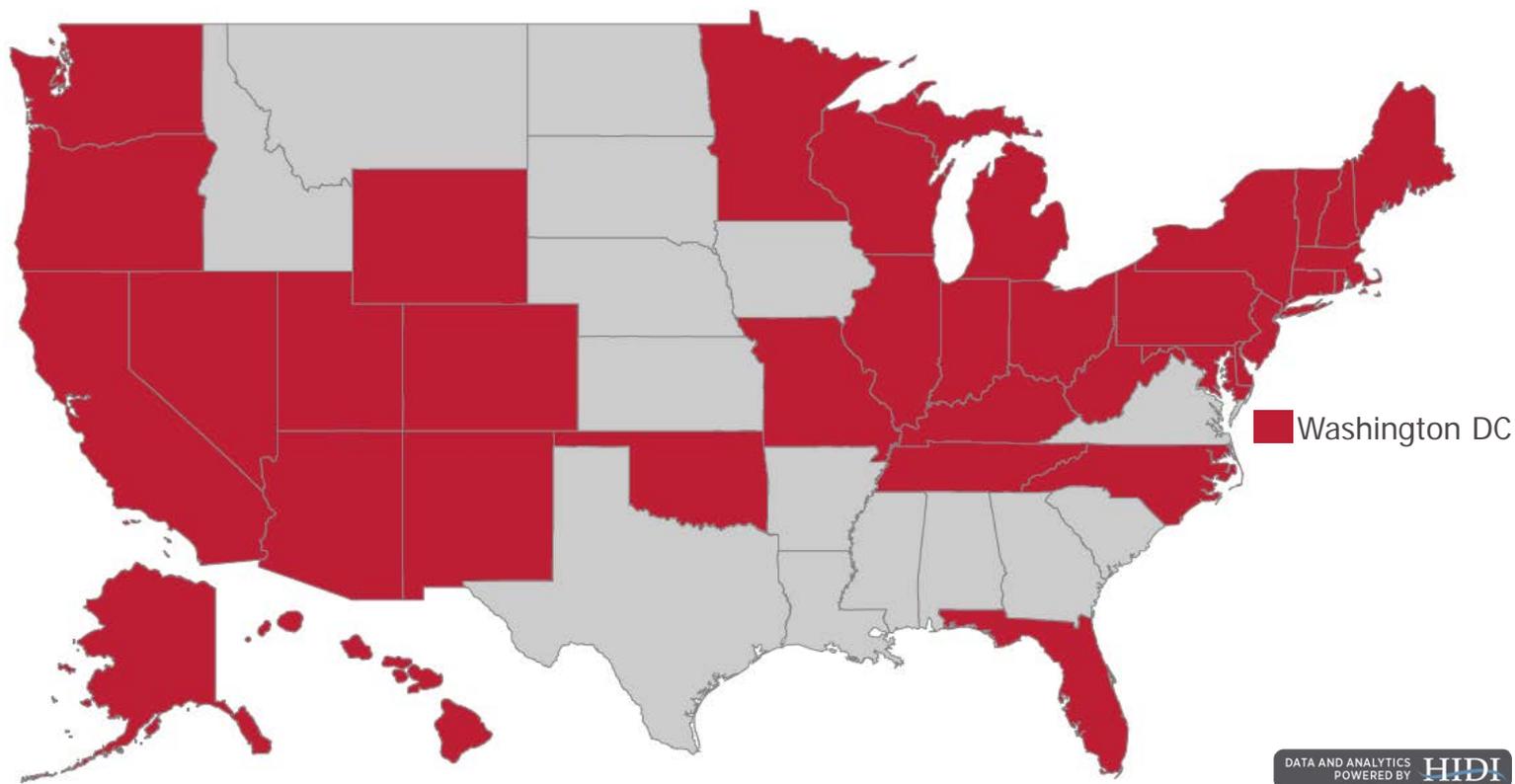
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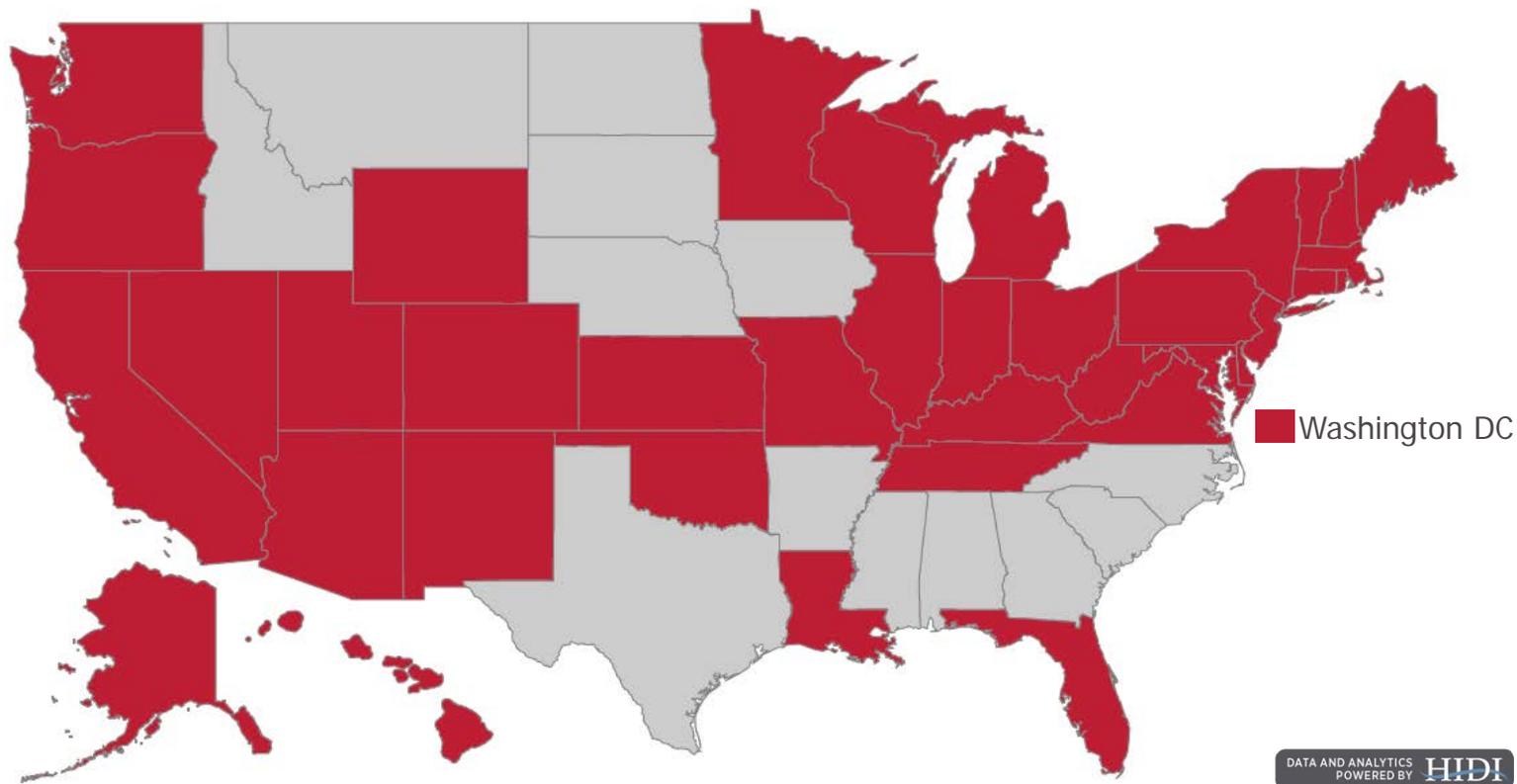
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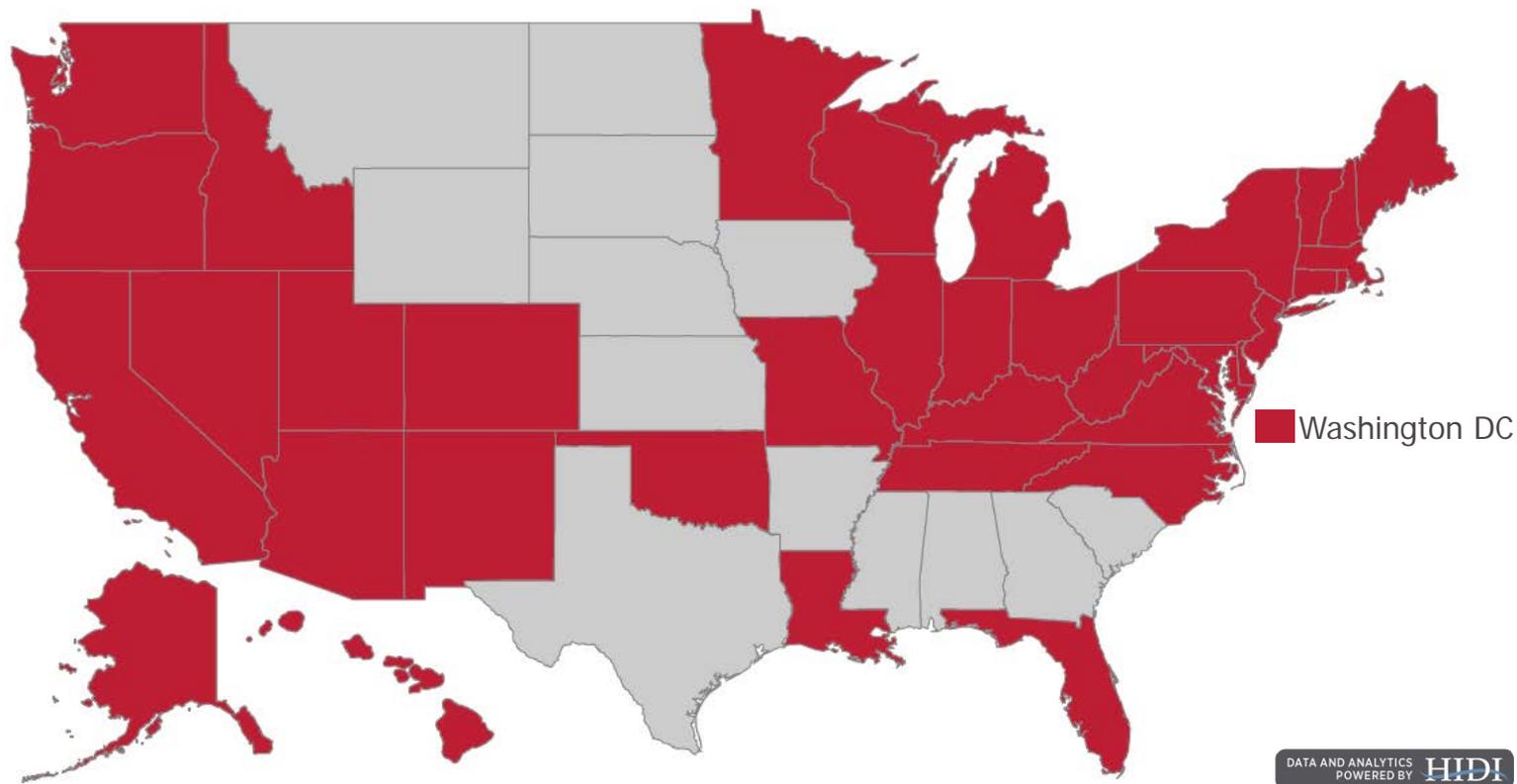


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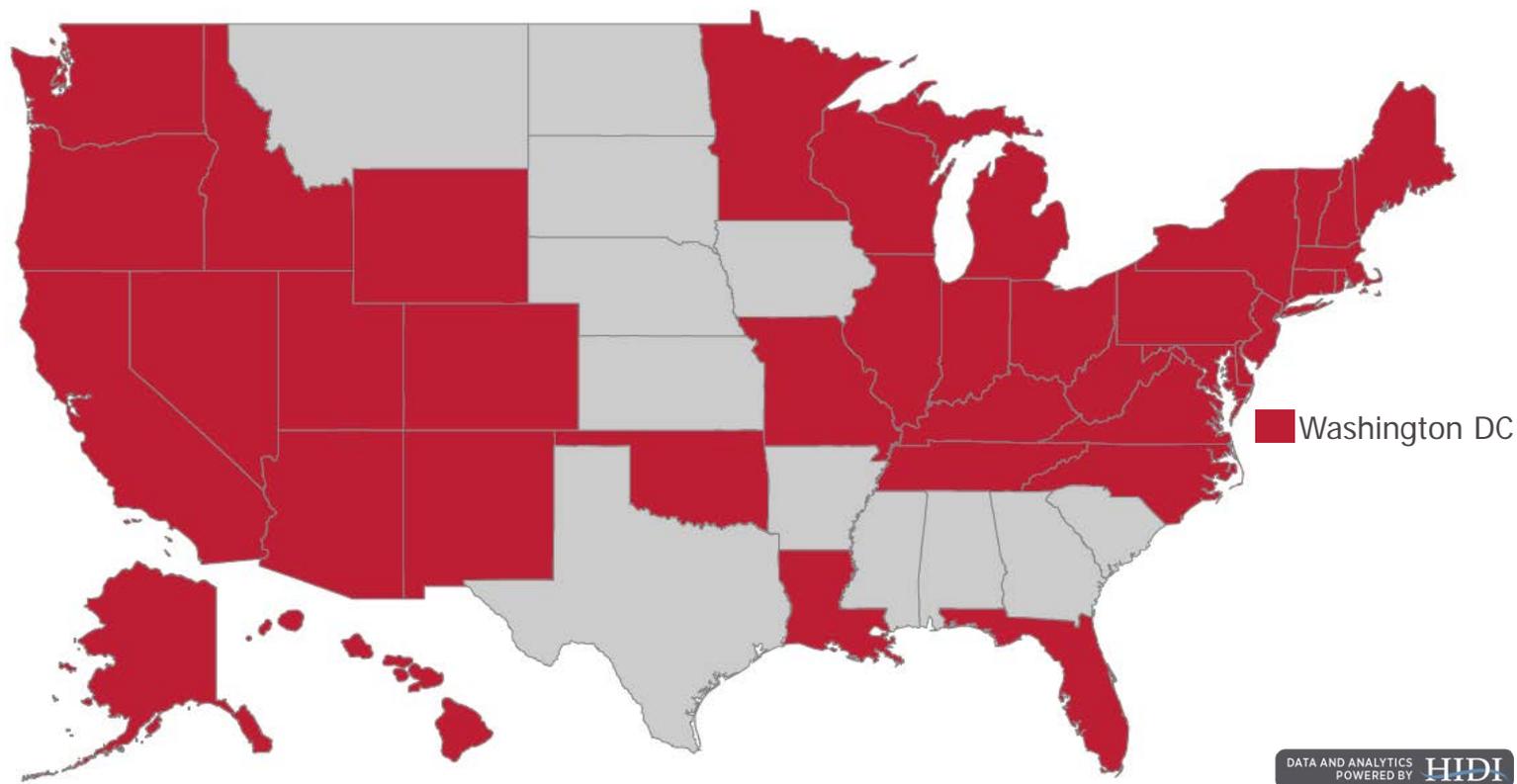
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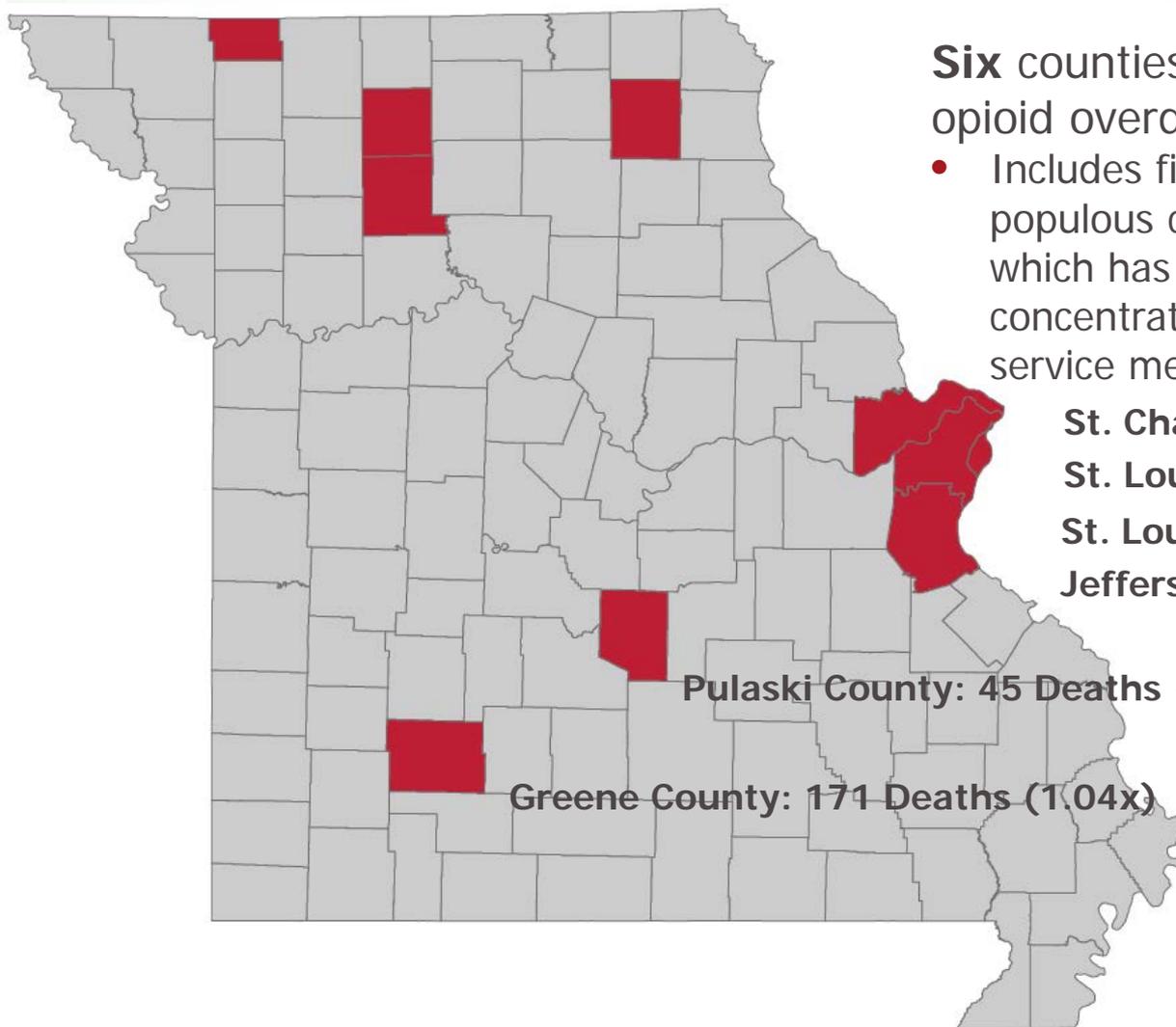
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# Counties with More Opioid Overdose Than Motor Vehicle Accident Deaths 2013-2015



**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)**

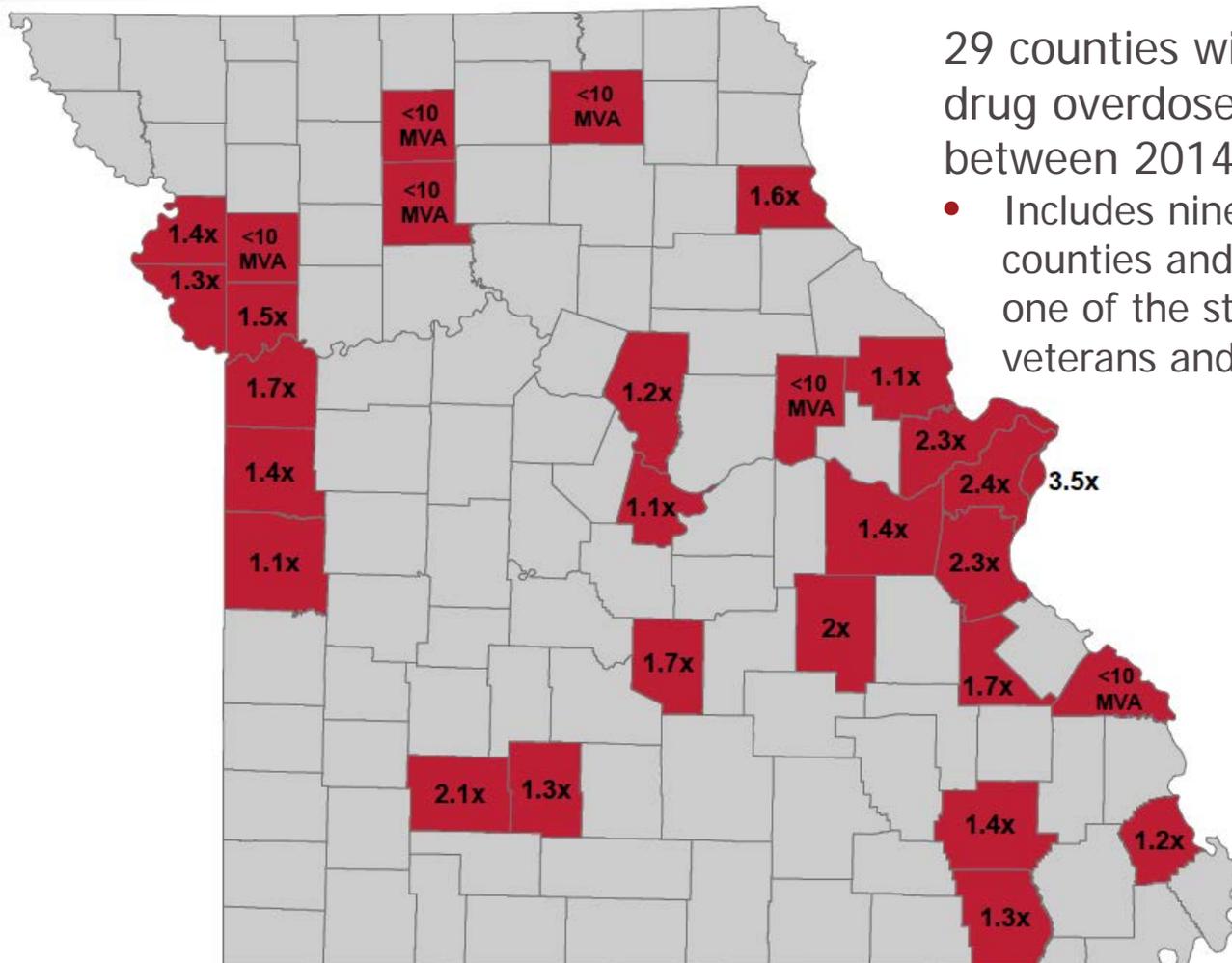
**St. Louis City: 526 Deaths (3.2x)**

**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

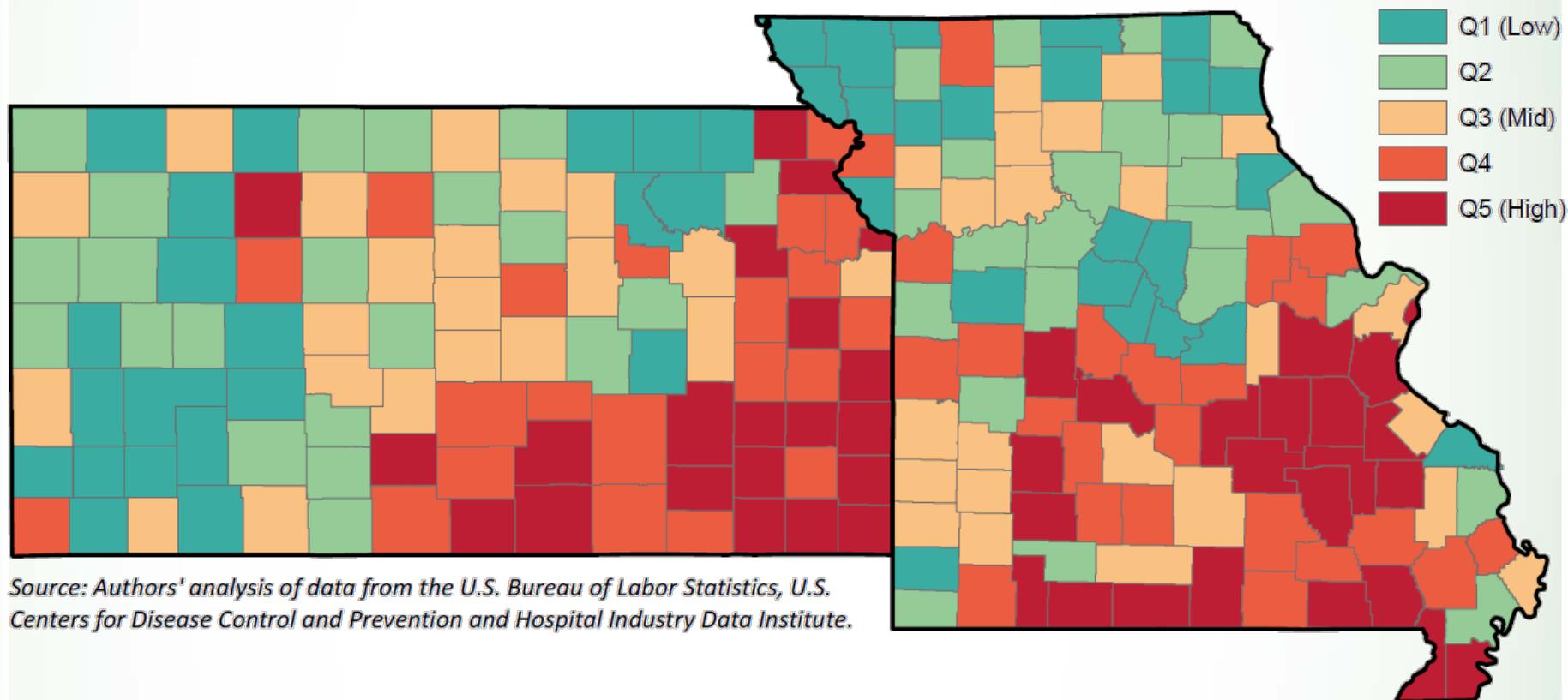


29 counties with significantly more drug overdose than MVA deaths between 2014 and 2016:

- 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



Source: Authors' analysis of data from the U.S. Bureau of Labor Statistics, U.S. Centers for Disease Control and Prevention and Hospital Industry Data Institute.

**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)

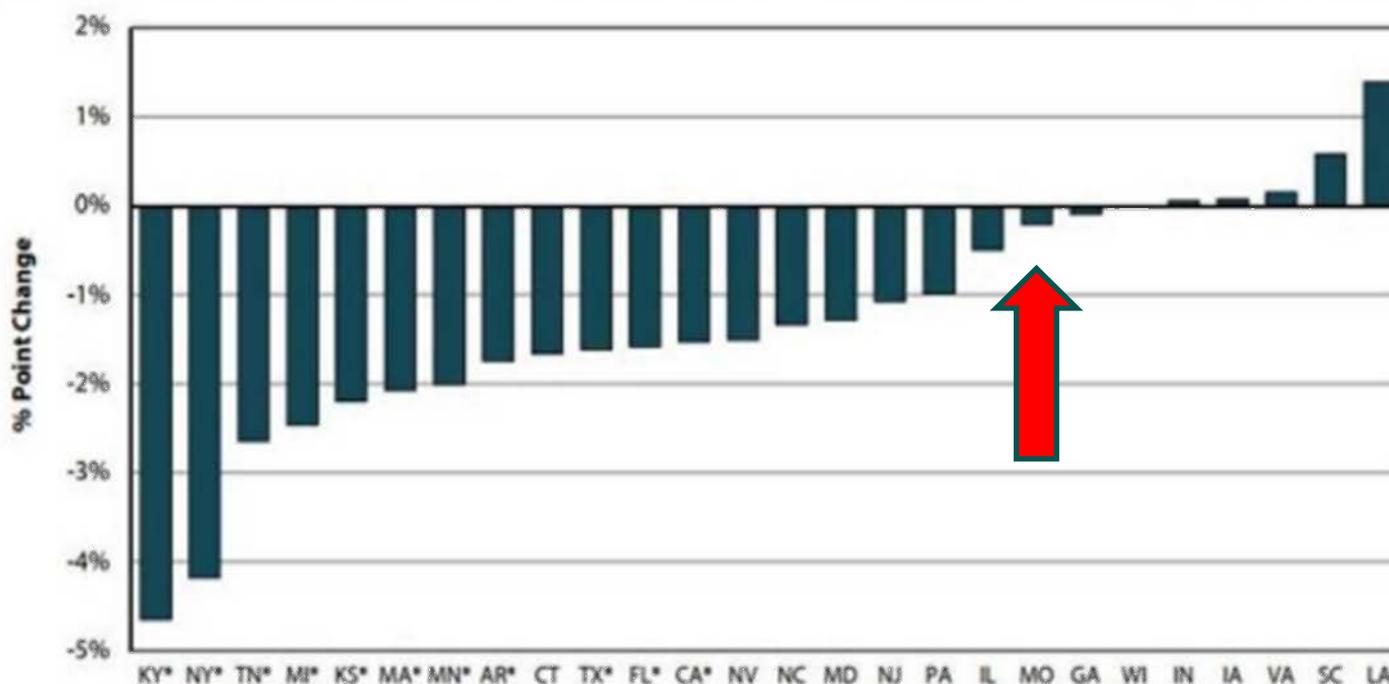


# Opioids Among the Workforce



# Opioid Use Reduction in Workers' Compensation

**Figure A Changes in the Prevalence of Longer-Term Opioid Dispensing<sup>a</sup> between 2010/2012 and 2013/2015**



Missouri's rate dropped from 3.9 percent to 3.7 percent over the same time period.

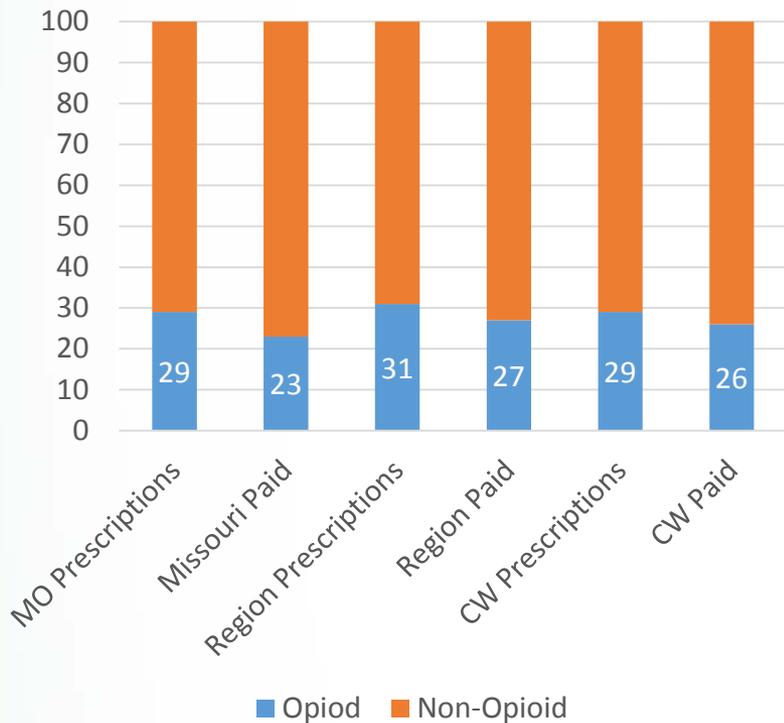
## Top Ten Workers' Compensation Opioid Drugs – Missouri

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

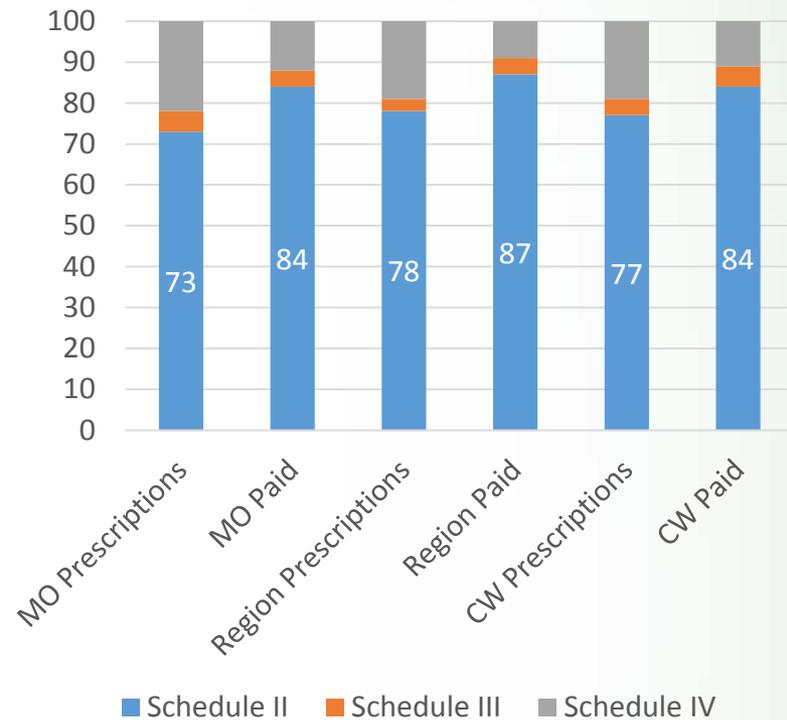
Source: Medical Data Report, Opioid Utilization Supplement for Missouri, National Council on Compensation Insurance, October 2017

# Opioid Distribution

Percent Opioid Prescription and Payment Distribution



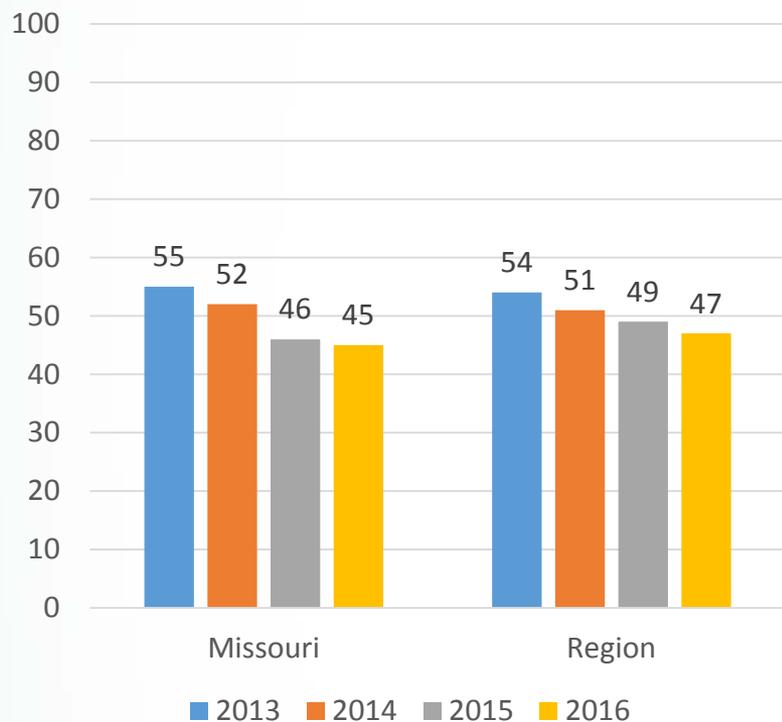
Percent Distribution of Opioids by Drug Schedule



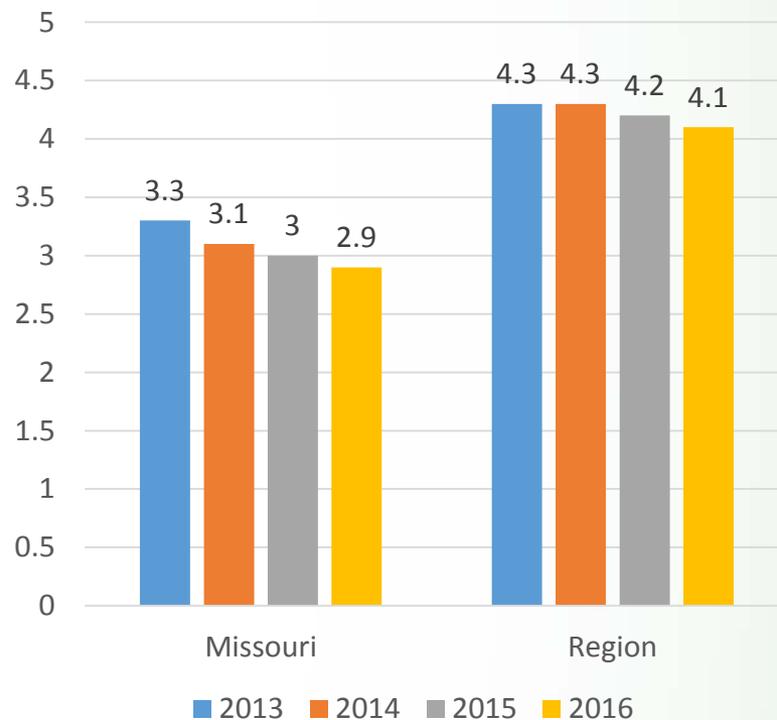
- Schedule 1: No current medical use
- Schedule 2:** High potential for abuse
- Schedule 3: Low abuse potential and moderate to low physical and psychological dependence
- Schedule 4: Low abuse and physical and psychological dependence

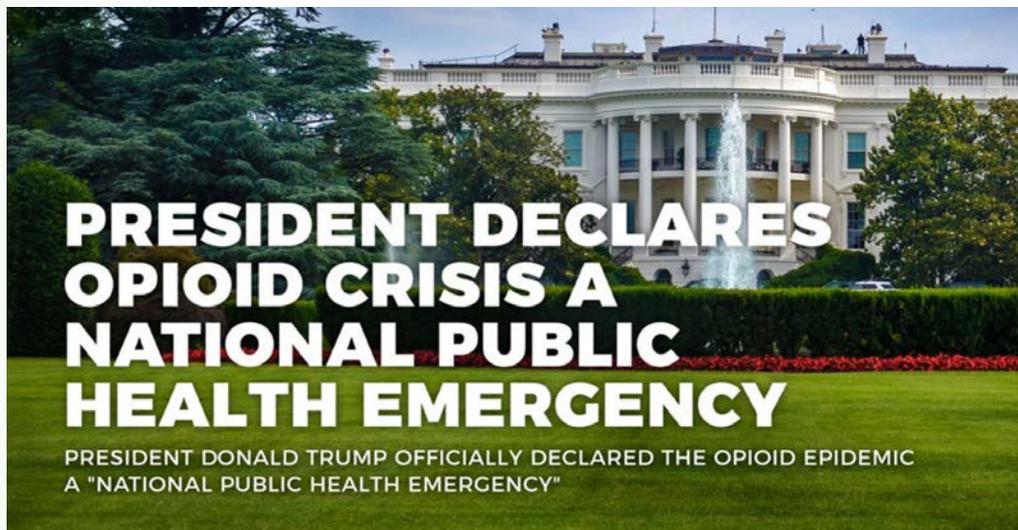
# Reducing Opioid Prescriptions

Percent Drug Claims with at Least One Opioid Prescription



Decreasing Number of Opioid Prescriptions Per Opioid Claim





June 22, 2018, the House of Representatives passed and sent 50 bills to the Senate focused on the opioid crisis.

## HHS 5-POINT STRATEGY TO COMBAT THE OPIOIDS CRISIS

- BETTER DATA
- BETTER PAIN TREATMENT
- PREVENTION, TREATMENT & RECOVERY
- MORE OVERDOSE REVERSERS
- BETTER RESEARCH



# Surgeon General Advisory



*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





# 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 nonopioid 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 their pain management

Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine 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 deficits, or psychosocial risk factors

### NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors	Small-moderate	TCA's have anticholinergic and cardiac toxicities, SNRIs safer and better tolerated	First-line for neuropathic pain, TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flame/burning, irritation of mucous membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

### RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

#### Low back pain

**Self-care and education in all patients;** advise patients to remain active and limit bedrest

**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)

#### Migraine

#### Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

#### Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

#### Neuropathic pain

**Medications:** TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

#### Osteoarthritis

**Nonpharmacological treatments:** Exercise, weight loss, patient education

#### Medications

- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular 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



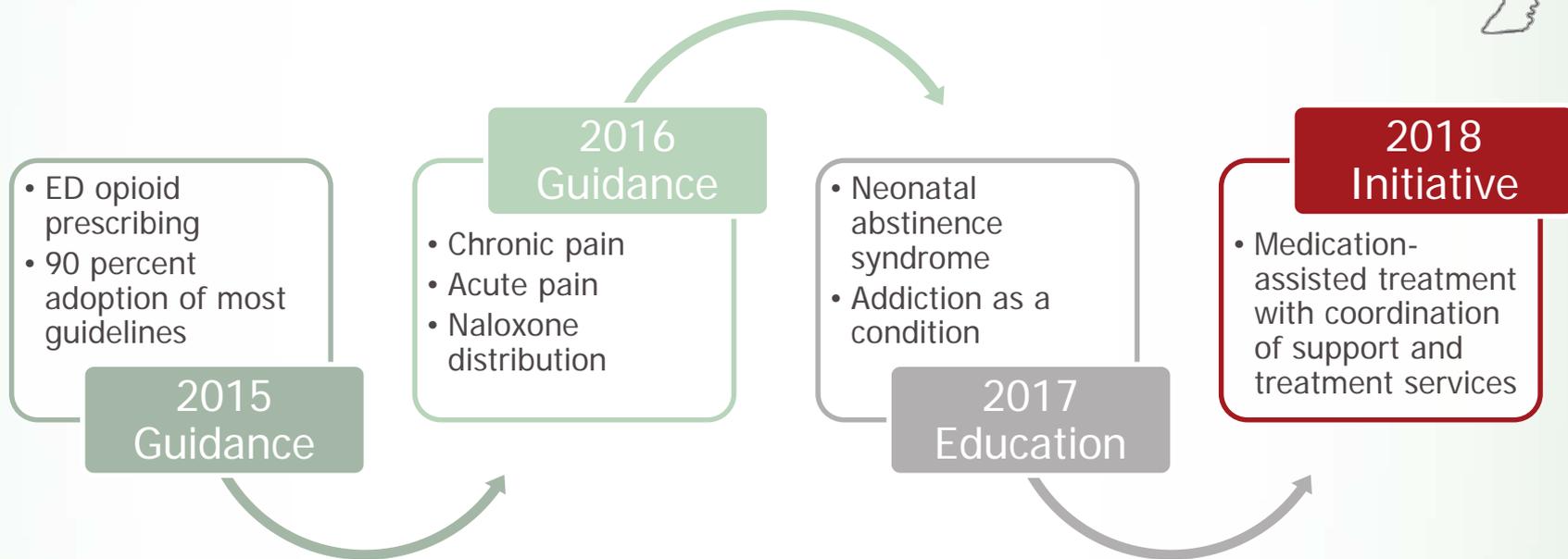
U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

OS-000001 April 01, 2016

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

# Practice Changes



# CDC Guidelines for Chronic Pain

## GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

### DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 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 nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2** Before starting opioid therapy for chronic pain, clinicians should establish 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 outweighs risks to patient safety.
- 3** Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic 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




 U.S. Department of Health and Human Services  
 Centers for Disease Control and Prevention

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

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

**CLINICAL REMINDERS**

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

- 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 dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day.
- 6** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe 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 benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.



### 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 into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present.
- 9** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to 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 to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- 11** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- 12** Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

**CLINICAL REMINDERS**

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

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://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.



MO-HOPE Project

Sources: <https://opioids.mo.gov/naloxone>  
<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



# 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

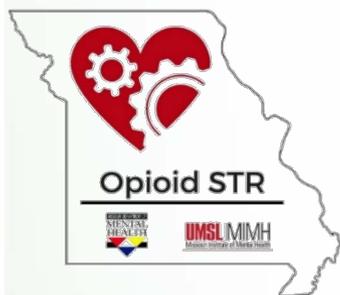


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# Best Practice in Care Coordination — EPICC Project

- 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.

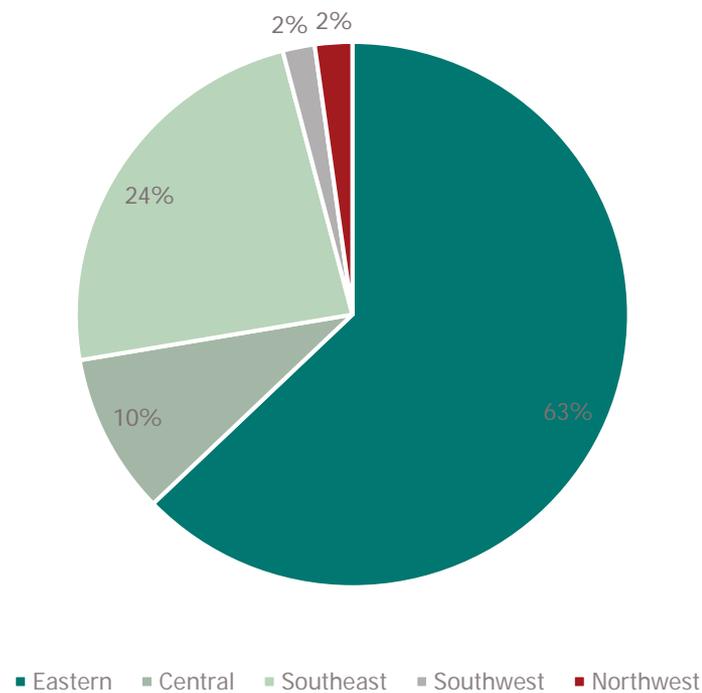


# STR Medication First Success



- 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

Total Consumers in Treatment by Region



# 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



# Missouri Peer-Based Recovery Community Centers

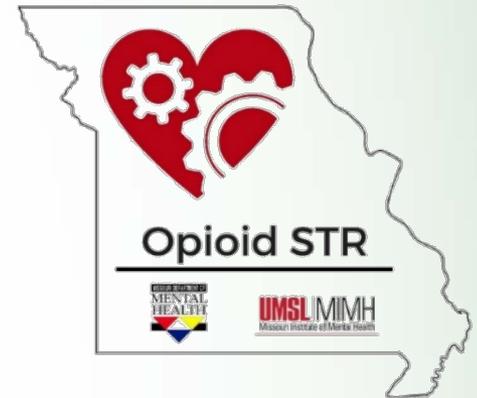


	Hours of Operations	Number of Recovery Activities	Number of Individuals Served
Eastern (St. Louis) <ul style="list-style-type: none"> <li>St. Louis Empowerment Center</li> <li>Missouri Network for Opiate Reform and Recovery</li> </ul>	387	52	2,064
Southwest (Springfield) <ul style="list-style-type: none"> <li>Springfield Recovery Community Center</li> </ul>	268	92	813
Western (Kansas City) <ul style="list-style-type: none"> <li>Healing House, Inc.</li> </ul>	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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