

## Opioid UnMeeting Washington University in St. Louis 11/15/2018; Breakout Session Notes

### Session 1: Defining areas of leakage in the cascade of care and making systems “stickier” (Facilitator: Bierut)

- Need for 24/7 access to care
  - Expanding hours of substance use treatment centers, as persons with OUD are often most amenable to treatment during hours when treatment centers do not typically admit
  - Possibility of utilizing pharmacists in a greater capacity, as some pharmacies are open 24/7
  - Utilizing peer support services to help navigate treatment system
- Relaxation of insurance stipulations dictating “appropriate” level of care
- Decreasing barriers to medication treatment
  - Removing requirement that psychosocial treatment must be a part of substance use disorder treatment
  - Realizing that often there is a psychosocial component to MD visits for medication therapy
  - Decreasing stigma surrounding need for treatment and addressing misconception opioid substitution therapy is “just substituting one drug for another”
- Need for increased standardization of medication treatment
- Encouraging a cognitive shift among health care system to treat opioid use disorder as a chronic medical condition
  - Decrease stigma
  - Change in reimbursement system for OUD
- Encouragement to integrate systems of health care and eliminate “silos”
  - Bridges between ERs, inpatient services, treatment centers, outpatient MD and counseling services

### Session 2: Strategies to optimize medication assisted therapies (Facilitators: Cavazos, Chen and Ramsey)

Some big take away(s):

- community barriers are clear, no one is confused about what is needed
- Most settings are primed, some work is being done but not nearly enough
- remedies will be costly; who will pay???

As we re-work our budget for our Heal grant, we need to be mindful of the costs. Are we budgeting enough for our community infrastructure changes/solutions?

Also, what happens if we don’t get funded? We are rallying folks and getting their buy-in. Do we need to specify a backup plan so that we don’t lose momentum or burn bridges.

I summarized key barriers that I heard. They are real and most of these will need serious money to fix.

Miscellaneous/outside of traditional settings	PCP barriers are primarily <b>workflow, capacity</b>	Justice barriers are primarily <b>structural (capacity not recognized but likely problem)</b>	ER settings <b>Protocols, capacity</b>	Addiction txt centers <b>capacity, attitudes</b>
Need to work hard in Black Community (stigmas, fear of getting arrested, etc. list goes on). We need to emphasize this more in our grant and figure out some concrete steps to make progress.	Need billing support, technical assistance	Policies and procedures need to facilitate MAT within systems (too rigid policies won’t allow a “controlled” substance in settings)	Protocols need to change to screen everyone to intervene aggressively, but we don’t want to penalize chronic pain patients who need their meds	Need to make txt more “attractive”; need to humanize the problem (is this a marketing, advertising to those in-need). Contingency management? Not clear here what the fix is.

Need more peer Recovery Specialists. These are heroes. We need to expand.	Need someone in office to help – “a scheduler”	Staff attitudes need to change; training on MAT is crucial	Predictive modeling; computer system that triggers alert of at-risk individuals	Need capacity in settings
Need to do outreach in at-risk neighborhoods; distribute naloxone and educate	Need computer systems to support this type of prescribing	Similar to ER’s in having a need to standardize protocols to identify at-risk individuals	Referral to places that have capacity to treat. ER staff/providers want access to data to know person didn’t “leak”	Need more docs waived
Need a 24 hour triage center		Need more docs waived	Need more docs waived	Too siloed from medicine; how to build these partnerships
Telehealth.				

**Session 3: Data, Data, Data: What we need and how to get it (Facilitators: Hays and Gruzca)**

Scherrer Epic Data

Notes lack of EHR data from FQHCs

Number of patients retained in care –

EPIC can be linked from system to system.

"Care Anywhere"

De-identified – STLCO Health Department can be honest broker.

They are doing the PDMP.

Can use to measure

**Emily Varner:** STLCO covers everybody except for a couple of counties and 84% of the states population. All counties and areas of interest in this grant except Pulaski and Washington.

SUD in pregnancy – child outcomes. Having child outcomes

Susan Depew with MIMH – Prevention Resource Centers across the state. Partnership for Success grant.

Letter of Support from DoC allowing changes to data structure.

Naloxone: Recovery Community Centers get naloxone

Field reports for Overdoses. Maintained by ER.

PDMP is a valuable source of waived / waived + prescribing physicians.

EHR-based networks involving sharing data across systems. De-identified patient-level data.

Missouri Health Network –

Jeff S – has student tracking treatment / release within STLCO Jail System.

Marissa – St Louis Co. Public Health.

Death Data – ME / corner

Behavioral health Network – EHR Data.

Larry Lewis – How many people approached / agree to treatment.

HIV/HCV

Alex Duello – CIMOR State Billing System (Lacking data on dose, days supply (PDMP has this info but may not be linkable).

University of Chicago – Opioid use tool . norc. Org Michael Renner MFH.

NIH Framework in terms of Implementation Research AJPH.

Starry –

Missouri State Licensing Board.

Missouri Medicine – series on OUD.

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Prescribing patterns

Specialty treatment programs.

# of individuals linked to tx following opioid od.

# of evidence based school and opioid prevention services.

SAMHSA prevention programs.  
Elliot – Literature on problems in identifying overdose.

# of formal  
Waiver training to number of  
Health Information Exchange – All healthcare data being fed in –

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*Amanda's Notes: Session 1*

**Existing Infrastructure:**

Understanding the ME process- St. Louis County PHD- community of practice  
Leverage the existing PDMP  
BHN-EPICC program data  
Generation Rx  
Step Up program  
Seymore data- Opioid STR  
Claims data- med tracking website  
NORC.org (opioid misuse tool)  
State licensing boards (use to identify number of providers with waivers, etc . .)

**Barriers:**

Death data captured by MEs (inconsistent)  
Timely data is almost impossible to find  
Adolescent and child data may not be included  
Complexity of pulling out intentional vs. non-intentional ODs  
Links to jail, other healthcare, behavioral health

**New Ideas:**

Track # of approached for MAT vs. # who accept vs. # who follow up vs. # in retention (6 month)  
2<sup>nd</sup> outcomes- New HIV/Hep C  
Use NIH framework for data  
OD post release tracking  
Use the “politics” to our benefit where interventions are happening vs. not  
Use DEA field agents to identify, seizure sources  
# of providers who get trained for waiver, vs. # who complete DEA vs. # who actually prescribe

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*Amanda's Notes: Session 2*

**Existing Infrastructure:**

MIMH- school programs/prevention, link to who has the number for this!  
Jail- SLU providers provide care in DPH for city  
HIE? Can we leverage this data for the grant in any way?  
MO-HOPE has naloxone numbers, 1<sup>st</sup> responders, other entities  
Greater plains network, healthcare data sharing?  
EPICC

**Barriers:**

FQHCS data- can we include outcome tracking  
Pulaski and Washington not in PDMP

**New Ideas:**

Data sharing agreement across large health systems (BJC, Mercy, SSM)= can we use “care anywhere?”  
Can we use STL CO PHD to be the “honest” brokers?  
Use PDMP to identify treatment and payment sources for MAT  
SUD in pregnancy- #NAS, outcomes

#### **Session 4: Optimizing targeted naloxone distribution and monitoring its use (Facilitators: Winograd and Green)**

- Prioritizing highest risk populations and times
- EMS vs. Police response times (and rural vs. urban)
- Lower cost options (intramuscular, rescue breathing)
- Racial disparities in access and receptivity
- Reaching family members/loved ones to educate them (ie. Likely witnesses)
- Getting naloxone access protocols “systematized”
  - Send ppl to pharmacies + Make sure pharmacies stock
- No one knows true number of nonfatal ODs
- Barriers
  - No state funding – how can this be sustainable?
  - Data collection gets in the way
  - Ppl have no contact with “the system”
  - False belief that naloxone = enabling

#### **Session 5: Workplace and employment issues (Facilitators: Dale and Evanoff)**

Overall summary:

- Two big barriers to recovery: stable housing and employment
- Past opioid use disorder, current MAT (buprenorphine, methadone) a barrier to employment
- Need training for employers to reduce stigma / fear of employing people in recovery – leads to difficult job placement
- Connect EAP programs to local treatment centers (to maintain employment)
- Create a directory of resources – job training, housing, employment programs. Break down silos to help people keep their jobs

#### **Additional notes**

Valerie Sparks – Dept corrections - state certified service providers (gateway, queen of peace, bridgeway). Training offered in prison for drivers, cooks. Being on methadone makes it tough to get a job (have to go to clinic daily). Re-entry specialists in corrections are engaged in trying to find employment for the recently incarcerated.

Preferred Family Health Care received a SAMSAH re-entry grant (for those with recent incarceration) Evidence-based practice around employment - “Show-Me Hope” project run by Mike Morrison from PFHC. They also have Macarthur grant.

Missouri Foundation for Health has provided technical assistance for seven rural providers who received a HRSA grant for providing services to opioid dependent clients.

RE-LINK Criminal justice – IHN has funding from the office of minority health – helping young people re-enter using social service network / community health providers / coordinated with mayor’s office, other city officials. Would it be useful to replicate in peer support space; peer support specialists could help recruit people into employment. Hiring people with lived experience (peer counselors) is a useful approach.

Constructing Futures – specifically employs people in recovery

Mission St. Louis – trains and helps with employment

Drug courts also deal with employment

Strive for “warm hand offs”

reduce “the fog of stigma”

How do you help people keep their jobs? There are barriers in current EAP - often provided by call centers out of town and don't know the local resources / treatment centers.

MO treatment network – in treatment centers, many clients are looking for work  
Those looking for work face stigmatizing attitudes toward buprenorphine, methadone.

Employers don't know current law and policy – for example, shield laws at federal and state level protect employers from legal liability if they hire folks on MAT

Work opportunity tax credits exist for hiring previously incarcerated

Look at Clark Fox foundation - they have done extensive mapping of workforce development

Washington University should hire 1000 people in recovery as part of our commitment to ending the opioid crisis

Subsidize job training

Civic Progress, Regional Business Councils, Heads of industries, Insurance companies are all leverage points to changing hiring and retention practices

Perception of OUD as an illness has been somewhat helpful in terms of perceptions of employers (everyone knows someone who's been affected)

Two big barriers to recovery: stable housing and employment

Past opioid use disorder, current MAT (buprenorphine, methadone) a barrier to employment

Need training for employers to reduce stigma / fear of employing people in recovery – leads to difficult job placement

Connect EAP programs to local treatment centers (to maintain employment)

Create a directory of resources – job training, housing, employment programs. Break down silos to help people keep their jobs

Look for clever solutions to barriers: Lack of transportation -> counseling over the internet

Need to track social determinants of health (like Arizona self-sufficiency matrix)

Common barrier for people coming out of incarceration

Lack of primary care physicians who are certified to prescribe MAT