Addressing The Opioid Epidemic: An Evidence-Based Approach

Translating Research And Policy Into Practice

2018 Missouri Rural Health Conference
August 22, 2018 1-2pm
Distribution of Drug-Induced Deaths by Type in the U.S.

- Opioids: 70%
  - Heroin: 22%
  - Fentanyl: 28%
- Rx Opioids: 20%
- Meth: 11%
- Cocaine: 15%
- Methadone: 5%

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

Nine counties and St. Louis City 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.
Figure 5: Opioid Dependence Risk in Missouri 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)

Missouri NAS Rate Identified with Conventional Hospital Discharge Coding Surveillance: 2008-2017

Number of NAS Diagnoses per 1,000 Births

NAS Rate per 1,000 Births
NAS Rate % Change from 2008

MISSOURI HOSPITAL ASSOCIATION

DATA AND ANALYTICS
POWERED BY
Incidence of NAS in Missouri by County During 2016 and 2017: Rate per 1,000 Births Identified with Diagnosis Codes for the Infant vs. Linking New and Expectant Mothers to Hospitalizations for Opioid Misuse

Rate of NAS Detected by Diagnosis on Hospital Discharge Record, 2016-2017

Rate of New and Expectant Mothers with an Opioid-Related Inpatient or ED Visit: Rate per 1,000 Births by County, 2016-2017
Survey to Missouri Hospital Obstetric Departments on Perceived Severity of NAS, Screening Protocol, Accuracy of Coding and Barriers to Reducing the Incidence of NAS

- Survey administered to 70 birthing hospitals during April 2018:
  - 41 responses received from 38 hospitals (54% response rate)

- Responding hospitals accounted for 33,785 total and 257 NAS births for Missouri newborns during 2017:
  - 45% of all births and 50% of all NAS births in Missouri

- Key Findings:
  - Perceived severity of NAS in respondents’ hospitals featured agreement with actual NAS rates identified through claims data
  - Large differences observed between the estimated frequency of NAS births at respondent hospitals and actual NAS births identified with claims data
    - 2,369 survey-estimated vs. 257 NAS births identified with claims data at responding hospitals during 2017
    - Claims-based NAS rate per 1,000 births = 7.6
    - Survey-estimated NAS rate per 1,000 births = 70.1
  - Perceived accuracy of claims-based NAS coding in respondents’ hospitals featured disagreement with differences between survey-estimated and claims-identified NAS births
NAS Summary Findings

- Cases of NAS are growing more rapidly than the broader opioid epidemic
  - In Missouri, rates of hospital inpatient and emergency department utilization for opioid misuse across all age groups has increased by roughly 140% over the past 10 years, while the rate of NAS, as detected by claims data, has increased by 270%.
- Anecdotal evidence suggests the true scope of the NAS crisis could be under-detected using traditional diagnostic code surveillance of hospital claims data
- A mixed methods evaluation of NAS in Missouri using alternative identification techniques linked to new and expectant mothers in hospital claims data and survey-generated data support the possibility of significant under-coding of NAS ICD-10 codes P961 and P962
  - The range of NAS births in Missouri during 2017 varied widely by detection method:

<table>
<thead>
<tr>
<th>Competing Estimates of the Incidence of NAS Among Missouri Newborns</th>
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</thead>
<tbody>
<tr>
<td>Surveillance method</td>
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<td>---------------------</td>
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<tr>
<td>Claims-based by identifying neonates with ICD-10 codes P961 or P962 on discharge record (2017)</td>
</tr>
<tr>
<td>Claims-based by linking new and expectant mothers to hospital utilization for opioid misuse (2016-2017)</td>
</tr>
</tbody>
</table>
Policy Changes
Medication Management System
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.
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
Missouri Government Action

- July 1 — DHSS “shocking” report
- Medicaid initiative on opioid prescribing practices
  - Prescribers contacted to change or justify prescribing violating state expectations
  - Practitioners are referred to the Bureau of Narcotic and Dangerous Drugs for review after second notice
  - State mailings sent to as many as 8,000 prescribers
Opioid Prescriber-Accountability Initiative

On March 1, DSS, DMH and DHSS began enforcing national standards for prescribing opioids to chronic pain patients.

- **DSS Opioid Prescription Intervention Letter**
- **DSS First Letter to MO HealthNet Prescribers**
- **DSS Second Letter to MO HealthNet Prescribers**
- **DSS Third Letter to MO HealthNet Prescribers**
<table>
<thead>
<tr>
<th>MO OPI Quality Indicator™ Number</th>
<th>MO OPI Quality Indicator™ Description</th>
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<tbody>
<tr>
<td>850</td>
<td>Use of Buprenorphine with another Opioid (Prescribed by another Physician)</td>
</tr>
<tr>
<td>852</td>
<td>Use of Buprenorphine with a Benzodiazepine (Prescribed by another Physician)</td>
</tr>
<tr>
<td>853</td>
<td>Patient’s Use of Four or More Pharmacies for Opioid Prescriptions</td>
</tr>
<tr>
<td>856</td>
<td>Patient’s Use of Five or More Prescribers for Opioid Prescriptions</td>
</tr>
<tr>
<td>859</td>
<td>Patient’s Use of Four or More Pharmacies for Opioid Prescriptions (Under 18 Years)</td>
</tr>
<tr>
<td>860</td>
<td>Patient’s Use of Four or More Prescribers for Opioid Prescriptions (Under 18 Years)</td>
</tr>
<tr>
<td>883</td>
<td>Use of Opioids for 60 or More Days with a Diagnosis Suggesting Opioid, Alcohol, or Other Substance Abuse in the Last Year</td>
</tr>
<tr>
<td>884</td>
<td>Use of Opioids at a High Dose without a Malignant Cancer Diagnosis</td>
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<tr>
<td>885</td>
<td>Use of Opioids at a High Dose without a Malignant Cancer Diagnosis or Other Supporting Diagnosis (65 Years and Older)</td>
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<tr>
<td>889</td>
<td>Use of Opioids for 60 or More Days with Two or More Diagnoses of Malingering, Somatization, or Factitious Disorder</td>
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<tr>
<td>890</td>
<td>Use of Opioids for 60 or More Days in Absence of a Diagnosis Supporting Chronic Use</td>
</tr>
<tr>
<td>891</td>
<td>Use of Opioids for 60 or More Days in Absence of a Diagnosis Supporting Chronic Use (Under 18 Years)</td>
</tr>
</tbody>
</table>
Koon v. Walden and SLU (Mo. App. 2017)

- Male with acute and persistent low back pain
- Treated with increasing doses of opioids — 2008-2012
  - 2008 — average daily dose was 49.67 MMEs (six pills daily)
  - 2009 — average daily dose increased to 208 MMEs
  - 2010 — average daily dose doubled to 545.59 MMEs
  - 2011 — average daily dose reached 1,173.37 MMEs
  - 2012 — average daily dose was 1,555.94 when the patient and wife demanded help (40 pills daily)
Jury Award

- Standard of care based on 2016 CDC guidelines for care delivered from 2008-2012
- Judgement for plaintiffs — Brian Koon and Michelle Koon. Jury awarded:
  - Brian Koon — $1.4 million
  - Michelle Koon — $1.2 million
  - Punitive damages — $15 million from Dr. Walden and SLU
- Total award — $17.6 million to plaintiffs
- SLU was vicariously liable for everything Dr. Walden did to cause Koon’s injury.
Standard of Care

1. Conduct a **risk assessment** with the patient before prescribing.
2. Risks and benefits should be **re-assessed** each time the opioid dose is increased.
3. Patient should be regularly **monitored** while on opioids.
4. **Track** the number of pills and dose the patient is taking.
5. All health care providers must have a **medication management** system.
6. Check for side effects and behaviors that suggest **dependency or addiction**.
7. If a doctor suspects the patient is **addicted**, he should cease the opioids and wean the patient.
8. The risk assessment and monitoring results should be **documented** in the medical records.

Used with Permission. Opioid Prescribing, Healthcare Services Group, presented by Arvids Petersons, JD, MA, CMPE, CPHRM, January 2018
Evidence-Based Care

Guidance 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. Nonpharmacological 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.

**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 consideration of switching to an alternative regimen that can reduce the risk of opioid overdose, such as history of overdose, history of substance use disorder, higher opioid doses (>150 MME/day), or concurrent benzodiazepine use, or both.

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 doses 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 substance 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.

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

**OPPION SELECTIO, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION**

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/opioid (ER/LL) or OTC use.

5. When opioids are started, clinicians should prescribe the lowest effective dose. Clinicians should use caution when prescribing opioids at any dose, should carefully weigh the benefits and risks when considering increasing dosages to >150 MME/day or when assessing risk and benefit for the intended duration of pain management to ensure opioids. These or less will often be sufficient, more than seven days will rarely be needed.

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 or six months, whichever is shorter.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or at more frequent intervals. Clinicians should evaluate the benefits and harms of continued opioid therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimally other therapies and work with patients to taper opioids to lower doses or to taper and discontinue opioids.

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

Voluntary ED Opioid Prescribing Guidelines

• Launched December 1, 2015
  ➢ Consistent with national and other state guidelines
  ➢ Engaged providers and associations
  ➢ Reviewed for risk and liability
  ➢ Board approval from all associations
Emergency Department: Suggested Recommendations

- Focused pain assessment
- Evidence-based diagnosis
- Non-narcotic treatment of non-traumatic tooth pain
- Communication between emergency room and primary care physicians
- Prescriptions limited to 72 hours
- New acute conditions for shortest duration*

- Refuse requests to provide prescriptions for refills “lost” or “destroyed”
- Avoid prescribing long-acting or controlled-release opioids; consider abuse-deterrent forms of opioids
- Counsel about handling*
- Encourage policies allowing Naloxone dispensing

*New recommendation added December 1, 2015.
# Practice Change: Adoption of ED Prescribing Guidelines for Opioids

## ADOPTION OF ED PRESCRIBING GUIDELINES (N-95)

<table>
<thead>
<tr>
<th>Prescribing Guidelines</th>
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<td>Avoid Long-Acting</td>
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<td>Shortest Duration</td>
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<td>4</td>
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<tr>
<td>Refuse &quot;Lost&quot;</td>
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<tr>
<td>72 Hour Limit</td>
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<tr>
<td>Tooth Pain</td>
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<td>9</td>
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<tr>
<td>Counsel Handling</td>
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<td>26</td>
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<tr>
<td>ED Policy</td>
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<td>38</td>
</tr>
<tr>
<td>Encourage Naloxone</td>
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<td>3</td>
</tr>
</tbody>
</table>

Data: MHA Member Survey, June 2017
Practice Changes
Addiction Medicine for Opioid Use Disorder
Chronic Care Model

The partnering of the health care system with substance abuse treatment programs could dramatically expand the benefits of prevention and treatment of SUD. Expanding roles of health information technology and nonphysician workforces, such as social workers, are essential to the success of a chronic care model.
MISSOURI’S OPIOID CRISIS ROADMAP

**NEED:** To transform the system of care for OUD in Missouri

**IN WHAT:** Prevention, Treatment, & Recovery Support

**DELIVERED HOW:** Training, Consultation, & Direct Service with a Medication First treatment model

**TO:** SAVE LIVES.
“Medication First” Model

- Address withdrawal symptoms
- Reduce cravings
- Enable the patient to focus and engage in counseling and social support groups
- Increase treatment retention

<table>
<thead>
<tr>
<th>Medication</th>
<th>Action</th>
<th>Dispensing</th>
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</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Full Agonist — Full agonists (like heroin, morphine, hydrocodone, and oxycodone) bind to opioid receptors and create a response proportional to the dose.</td>
<td>Opioid Treatment Program</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Partial Agonist — Partial agonists bind to opioid receptors, cause a limited reaction, and prevent the euphoric effect.</td>
<td>Any prescriber with waiver</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Antagonist — Antagonists bind to opioid receptors and block the receptors from being activated.</td>
<td>Any prescriber</td>
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</table>

Source:
https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/59bab107f09ca461180d6429/1505407240927/Opioid+STR+Implementation+Guide_nonDMH.pdf
MISSOURI STR - Medication First Model

1) Patients with OUD receive timely pharmacotherapy treatment – prior to lengthy assessments or treatment plan development;

2) Maintenance pharmacotherapy is delivered without contraindicated tapering or time limits;

3) Individualized psychosocial services are offered and encouraged but not required as a condition of pharmacotherapy.

4) Medication is only discontinued if it is clearly worsening the patient’s condition.
The take-aways

Individuals enrolled in STR are more likely to...

1. receive medication
2. get medication sooner
3. receive fewer psychosocial services
4. be engaged in treatment at 1 and 3 months
STR Year 1 Outcomes: Pharmacotherapy Access

1,783 individuals have received evidence-based medical treatment for opioid use disorder (OUD)
STR Year 1 Outcomes:
Overdose Education & Naloxone Distribution

• **4,318 naloxone kits** have been distributed to at-risk individuals and their loved ones, and clinicians who work with at-risk populations

• **4,061 individuals** have received training on what to do in the event of an opioid overdose
If you suspect an overdose is occurring, CALL 911.

Administer rescue breathing and naloxone (Narcan)

OVERDOSES DON’T HAVE TO BE FATAL.

For information about treatment, naloxone, or other resources visit mohopeproject.org
STR Year 1 Outcomes: Recovery Support Services

- Over 1,100 individuals have received recovery services at the four Recovery Community Centers (RCCs) across the state.
- Over 1,000 individuals have received peer-based post-overdose outreach in emergency rooms through the Engaging Patients in Care Coordination (EPICC) Project.
- 98 individuals received training to obtain their Certified Peer Specialist (CPS) credential.
STR Year 1 Outcomes: Generation Rx Programming

4,633 youth have been engaged through the Generation Rx program, which increases public awareness about prescription medication misuse.
STR Year 1 Outcomes: Evidenced-Based Professional Development

• Over **10,000 individuals** have received training at **62 agencies** through **85 trainings and consultations** on topics across the spectrum of treatment, prevention and recovery. Trainings took place at a variety of settings including DMH facilities, state-funded agencies, hospitals, schools and universities, pharmacies, recovery houses, conferences, and more

• **29 total Chronic Pain Management and Opioid Use Disorder ECHO sessions** were held, reaching **208 unique participants**
Research Medical Treatment

Boston University
• Compared to inpatient detox protocol, hospital-based buprenorphine induction and follow-up with office-based buprenorphine treatment is effective in engaging OUD patients in treatment and reducing illicit opioid use at six months.
• Challenge — maintain engagement in treatment

Yale
• ED induction of buprenorphine was compared to brief intervention and referral.
• ED induction of buprenorphine increased engagement in treatment, reduced self-reported illicit opioid use, and decreased inpatient addiction treatment use.

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.
EPICC Project Results

ED Referral Volume by Month $n=1,052$

# EPICC Demographic Profile

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Refused</th>
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<td>Gender</td>
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<td>18-25</td>
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<td>46-64</td>
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<td>&gt;65</td>
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<td>Narcan Provided through Recovery Coach</td>
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<td>5%</td>
<td>95%</td>
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Source: Data obtained from Efforts to Outcomes (ETO) database

Obstacles to Medical Treatment

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

• Funding

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

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 region: five homes
  - Southwest region: one home
  - Western region: eight homes

Source: [https://missouriopioidstr.org/recovery/](https://missouriopioidstr.org/recovery/)
Missouri Recovery Community Centers

- Peer-based community centers
  - St. Louis Empowerment Center, St. Louis
  - Missouri Network for Opiate Reform and Recovery, St. Louis
  - Healing House, Inc., Kansas City
  - Springfield Recovery Community Center, Springfield

Source: https://opioids.mo.gov/node/56
Peer Support in Recovery

- March 2018 — DMH began recognizing a single peer certification.
- Certified Peer Specialists will be qualified to support individuals in recovery from substance use, mental health or co-occurring disorders.
- The Missouri Credentialing Board will oversee the credentialing process.

Source: www.missouricb.com
What Do Peer Recovery Coaches Do?

Recovery coaches provide many different types of support, including:

• **Emotional** (empathy and concern)
• **Informational** (connections to information and referrals to community resources that support health and wellness)
• **Instrumental** (concrete supports such as housing or employment)
• **Affiliational support** (connections to recovery community supports, activities, and events)

MHA’s Current Efforts in Support of the “Medication First” Model

- The production and dissemination of guidance documents to promote statewide alignment with evidence-based treatment of opioid use disorder
- Collaboration with Missouri College of Emergency Physicians to raise awareness of the need for additional physicians waived to prescribe buprenorphine
- Convening key stakeholders in Columbia and Springfield to establish ED-initiated programming that links patients to medical treatment, recovery support services and behavioral therapy post-discharge (EPICC/NAS Programming)
- Advocacy for statewide adoption of the PDMP to promote safer prescribing practices
Contact Information

Shawn Billings, MS, CCM
Opioid Project Manager
Missouri Hospital Association
sbillings@mhanet.com
573/893-3700, ext. 1409