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INSIDE

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Case Management's Role in Curbing Opioid Epidemic Increases

Key component is education

Opioid addiction resulted in more than 33,000 U.S. overdose deaths in 2015, making drug overdose the No. 1 cause of accidental death in the nation. The overdose death rate has quadrupled since the 1990s, as have sales of prescription painkillers, according to the American Society of Addiction Medicine (ASAM).

"The U.S. population equals 5% of the world population, but we use 80% of opioids in the entire world," says **Kathleen Fraser**, MSN, MHA, RN-BC, CCM, CRRN, executive director of the Case Management Society of America (CMSA) in Little Rock, AR.

"There are more overdose opioid deaths than suicides and motor vehicle crashes," Fraser adds.

> "THE U.S. POPULATION EQUALS 5% OF THE WORLD POPULATION, BUT WE USE 80% OF OPIOIDS IN THE ENTIRE WORLD."

Everyone in healthcare has a role to play in stopping the epidemic, but the case management role is especially important: "The case manager knows what to look for and can speak with doctors about alternatives for pain and speak with patients, warning about the addictive nature of opioids," Fraser says.

Primary care physicians may not realize how long patients have been on their prescribed opioids, or where else they are getting prescriptions. Case managers can help by following up with general practitioners, or working with doctors who overprescribe, Fraser suggests.

"That's something the case manager brings to the table — being able to educate," she says. They can educate patients about opioid addiction,

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EDITORIAL E-MAIL ADDRESS:
melindagyoung@att.net.

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AUTHOR: Melinda Young
EDITOR: Jill Drachenberg
EDITOR: Dana Spector
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

and educate physicians about overprescribing and monitoring patients for opioid dependence, she adds.

In workers' compensation cases involving pain management, case managers are an important part of treating injured workers, helping them recover and helping them avoid opioid dependence and other problems. *(See related story about chronic pain and opioid use, page 99.)*

"Because of their clinical backgrounds, nurse case managers play an invaluable role working with physicians," says **Patricia Brookey**, MS, CRC, CCM, LRC, senior vice president of managed care services at PMA Companies in Blue Bell, PA.

"They help create optimum outcomes for injured workers with chronic pain by encouraging physicians to consider treatment options other than opioids," Brookey says.

Case managers also raise awareness of opioid abuse and work with physicians in developing treatment plans.

"We intervene at the outset, and our clinical teams work with physicians to develop a pain management plan customized for the injured worker," Brookey explains. "If opioids are prescribed by the treating physician, goals and benchmarks for opioid use are established, including an exit strategy."

Setting goals and an exit strategy are important prior to surgery to help set realistic expectations about postoperative pain management for the injured worker, she adds.

Slowing the nation's opioid crisis takes a concerted effort by the entire healthcare industry. This is something the Centers for Medicare & Medicaid Services (CMS) recognized with its mandate that Medicare plan sponsors have in place an opioid overutilization program.

Indianapolis-based Anthem launched its Opioid Overutilization Management Program in 2013, following the CMS mandate, says **Devanshi Sheri**, PharmD, BCGP, a clinical pharmacist who leads the Anthem program.

The program has evolved in the last four years and has successfully reduced opioid claims among at-risk members by 50%.

Sophisticated data-mining to identify at-risk members, combined with a pharmacist-driven case management program, are the key components to the program's success, Sheri says. *(See related story on Anthem's opioid program, page 100.)*

EXECUTIVE SUMMARY

More people die from drug overdoses than die from car crashes, according to data from the American Society of Addiction Medicine. Opioid dependency has become an epidemic nationwide, leading to a crisis.

- One problem is that primary care physicians may not realize how long patients have been on their prescribed opioids, or who else is prescribing them.
- Case managers can assist through education and following up with general practitioners who overprescribe.
- In workers' compensation cases involving pain management, case managers can help injured workers recover and avoid opioid dependency.

Workers' compensation insurers' pharmaceutical oversight for patients on opioids is a huge assistance to claims adjusters and case management, Fraser notes. Some of the red flags they can identify include opioid prescriptions with higher than typical milligrams, long-acting opioids, and patients who have been on opioids, post-surgery or post diagnosis, longer than necessary, she says.

"You need a partnership with physicians, case managers, pharmacists, and patients to look for the best line of care for patients," she says.

Opioids might be necessary medication for some patients with acute pain after an injury, surgery, or where there is severe back strain, but patients often need short-acting medication.

In cases of patients with injuries that cause chronic pain, case managers can assist in getting them treatment to alleviate their pain to a tolerable level — without opioids, Fraser says.

In some states, pain relief might involve cannabis. Chronic pain patients also could benefit from massage, acupuncture, TENS units, and heat therapy.

"These are all viable alternatives," Fraser says. "The goal is not to eliminate opioids completely, but to decrease the amount of opioids taken."

Case managers can help patients reduce opioid use by working closely with physicians and pharmacists to monitor patients' prescriptions from all prescribers. For instance, a patient might receive an opioid prescription from a surgeon, and psychotropic medications from another physician. Some combinations could lead to an overdose, and neither doctor knows about the other's prescriptions, she explains.

"Case management can do medication reconciliation, to make sure everybody is on the same page," Fraser says.

While electronic medical records are helping prevent this problem, they're still not integrated across many hospitals, pharmacies, and different systems. "It's still a huge problem," she says.

Case managers also can take the lead in educating patients about the dangers of opioids. They can find patient and opioid use information online at the National Institute on Drug Abuse website: http://bit.ly/2uHqU4N.

Also, CMSA provides some education about case management and the opioid epidemic.

"We're trying to support the effort to stop or reverse the effects of this widespread, out-of-control aspect of the opioid epidemic," Fraser says. ■

Pain Management in Workers' Comp Has Evolved to a Holistic Approach

Industry's aware of limitations of opioids

Psychosocial aspects of chronic pain are much better understood today than a generation ago. What healthcare organizations now know is that each person's pain after an injury or surgery is different.

This understanding has helped the workers' compensation industry improve its approach to working with injured workers, says **Patricia Brookey**, MS, CRC, CCM, LRC, senior vice president of managed care services at PMA Companies in Blue Bell, PA.

"We now have a much greater understanding of how an injured worker's medical history and the psychosocial aspects of their personality impact chronic pain," she says. "These factors can influence the depth and duration of the corresponding treatment plan."

For example, a new study of people with chronic back pain found that critical life events were a strong predictor of future pain, as was physically demanding work. Another new study found that for many patients, severe pain in any body site was associated with anxiety/depression, lack of social support, unemployment, and low educational status.[1,2]

Patients with chronic pain are assessed more holistically now than they were in the past. The focus no longer is solely on the injury, Brookey says.

"The workers' compensation industry's understanding of the factors impacting chronic pain has resulted in greater acceptance of using alternative therapies to treat chronic pain," she says. "These may include cognitive therapy, yoga, mindfulness-based stress reduction, biofeedback, acupuncture, and psychological treatments for anxiety."

The medical industry also is more

aware now of the contraindications of using opioids to treat chronic pain, Brookey notes.

"Current scientific research is questioning whether narcotics are effective for those with chronic pain," she says. "In fact, the CDC 2016 Guidelines on chronic pain and opioids raised the red flag, stating that opioids are not the first line, nor should they be routine therapy for chronic pain patients, and — in all cases — those who are prescribed opioids require close monitoring."

For this reason, PMA is much more aggressive in developing strategies and tools to manage opioid use and prevent dependency among injured workers, Brookey says.

"These strategies are very comprehensive, involving data analytics to identify injured workers at risk for chronic pain, early intervention strategies, and ongoing monitoring and management of opioid use," she says.

Some pharmacy tools and strategies that can assist with monitoring and management include customized formularies for chronic pain, peer interventions, programs to combat fraud, and morphine equivalent dose programs.

"Case managers work in tandem with the pharmacy benefit managers and pharmacy intervention specialists to maximize the use of these tools in order to prevent and alleviate opioid addiction," Brookey says.

Case management is helpful in pain management and opioid dependence cases as part of a team of experts. "Nurse case managers are key members of this team, which may also include a pharmacy nurse, claims adjuster, and pharmacy benefit management company," Brookey says.

"The case management role has become much more specialized, requiring increased knowledge of pharmaceuticals, an understanding of the short- and long-term effects of opioids, and an awareness of the psychosocial factors impacting injured workers with chronic pain," she adds. ■

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Opioid Overutilization Management Program Paves Way for Success

Pharmacy case management is one strategy

Healthcare organizations could learn a great deal about developing an opioid management program by following some of the best practices created as a result of the federal Medicare mandate for health plan sponsors.

For example, Anthem's Opioid Overutilization Management Program has state-of-the-art data mining and targeted case management to address opioid dependency. As a result, it has successfully reduced opioid claims, and expects also to reduce ED visits by opioid-dependent plan members.

"While we have seen a reduction in opioid claims in our case management population, we are still evaluating the impact of case management on overdose and ED visits," says **Devanshi Sheri**, PharmD, BCGP, a clinical pharmacist who leads the Anthem program.

"We feel that we have seen such a positive success rate due to two main reasons: We are always trying to understand our members better by incorporating as much information as we can, and our case management is completed by trained pharmacists who interact with the prescribers, members, and pharmacies to facilitate the member's pain management," Sheri says. "The most important goal is to facilitate appropriate care coordination."

The following is how Anthem's opioid management program works:

• **Collect good data.** Intricate data mining is the key component to why the program has been successful and remains adaptable, Sheri says.

"We have a good analysis for identifying our members," she explains. "We use pharmacy claims to extract information about members who meet preset criteria for what we define as overutilization."

The program mines data from pharmacy and medical claims, looking for members who have had

an opioid overdose diagnosis within the last 24 months. Another red flag is repeated ED visits.

"It's picture-building," Sheri says. "The more we know about the member, the better we can understand the member's pain needs and take the appropriate course of action." Data about health plan members who are identified as having an opioid dependency issue go to the case management program.

• **Refer members to case management**. "We have a responsibility to our patients and are taking these steps to keep them safe," Sheri says. "We give their providers as much information as we can."

The case management program is pharmacist-driven. Pharmacists contact ER doctors, orthopedists, pain specialists, dentists, and other prescribers.

"We identify the decision-maker who is making pain management decisions for this patient," Sheri says. "We want to understand if there's been diversion or abuse or mismanagement. We inform prescribers of all other opioid claims the member has in a given time frame that the prescriber might not be aware of."

For example, the plan member's pain specialist might not be aware that the person is going to the ED once a month to supplement medicine the pain specialist prescribed.

The program's pharmacists call physician offices until they receive a return call. Their phone script typically is, "Hi, I'm a pharmacist and I've been working with your patient. We've done a utilization review, and we see that the member has seen a number of doctors and pharmacists and had these ER visits," Sheri says.

"We give doctors information about whether the patient is taking non-narcotics as well, and we answer their questions," she adds. "We find out if there is a diagnosis that needs to be treated with pain medication, and we let them know that these are some courses of action we can take."

Pharmacists ask physicians what course of action they would like to take, including the option of monitoring patients or placing a medication restriction if patients pose a threat to themselves.

Once confronted with data about their patients, physicians usually change the prescription to one with more limited quantity and renewals. They're more aggressive and aware than they were before they were contacted through the program, Sheri says.

The case management program works closely with behavioral health experts, nurses, clinicians, and others at Anthem.

"We've had compassionate interview training, and we also work closely with behavioral health case managers who listen in on calls," Sheri says. "We use their experience and guidance."

• **Limit at-risk members' access to opioid prescriptions.** Each opioid dependence case is unique, Sheri notes.

"We have a standard operating procedure, letters, and protocols, and it all builds into our making a final decision about that member," she says. "Should we limit the member at point of sale?"

A member could be fully restricted from opioid prescriptions, meaning the member is cut off from the prescriptions and referred to opioid addiction therapy. This is only done to stop opioid use for the patient's safety, she says.

The program sends members a decision letter, stating what is happening — whether monitoring or restricted access to opioids — and, sometimes, referring them to a behavioral health program.

"The pharmacist will call the member, saying, 'You have this medical benefit through your health plan for substance use disorder treatment," Sheri says. "Our pharmacists are trained to be very sensitive, with the goal of opening members' minds to the possibility of enrolling in a medication-assisted treatment program."

The case management program pharmacist opens the communication channel by introducing the behavioral health program, and then it's up to members to decide whether to enroll.

"CMS has included this point-of-sale drug-level restriction as a key tool in the Opioid DUR [drug utilization review] mandate," Sheri explains. "We can stop the purchase of the opioid at the time of sale, denying payment for

EXECUTIVE SUMMARY

An Opioid Overutilization Management Program uses state-of-the-art data mining and targeted case management to reduce opioid claims.

- The program works by having trained pharmacists interact with prescribers, plan members, and pharmacies to facilitate members' pain management.
- The overarching goal is to facilitate appropriate care coordination.
- The program mines data from pharmacy and medical claims, looking for members who have had repeated ED visits and who had an opioid overdose diagnosis within the last 24 months.

the prescription. The pharmacy gets a point of sale rejection, informing them that the member's access to the opioid medication is restricted and will not be paid for through the plan benefit."

But this step is limited in its effectiveness because members might access opioids on a cash basis — meaning their prescription is not picked up in the health plan sponsor's claims data. Or, the person could be using illegally obtained opioids.

"That's one of the largest roadblocks, as an industry, in managing this epidemic," Sheri says.

Often, the plan is to educate members about opioid dependence and to continue to monitor them to see if they have cut back on their opioid use.

"We give the member an opportunity for behavioral change for six months," she says. "On the seventh month, we re-review the case against the same criteria. If the member doesn't meet the threshold criteria, we know that the overuse is resolving."

So far, the plan is working well, she says.

"We have seen over the course of the past few years that members are inclined to change their behavior when their pain management needs are better coordinated," Sheri says. ■

Look to Social Determinants of Health When Building Post-acute Ties in ACOs

Keep 'eyes' on patients through care continuum

Accountable care organizations (ACOs) that involve case management in the entire care continuum often build post-acute care relationships to help their teams find solutions to patients' social determinants of health issues.

For instance, one organization has RN transitional care managers and social workers embedded in primary care practices.

"We provide care and have eyes and influence on our patients, all the way through the continuum of care," says **Peggy Tyndall**, RN, MBA, director of the care management program at Innovation Care Partners in Scottsdale, AZ.

Innovation Care Partners has two ACOs, five hospitals, and acute and post-acute services. "Essentially, we have an integrated physician network with 1,700 physicians, and about 300 of them are primary care providers," Tyndall says. "We have about 75,000 or more patients in our network."

With the focus on the care continuum and transitional case management, the organization has had significant healthcare cost savings, sharing the savings with CMS through its Medicare Shared Savings Program. It also has dramatically decreased its readmission rate, Tyndall says.

"In 2014, when it started, the readmission rate was 11%," she says. "In 2016, it was 5%."

The organization's backbone is its health information exchange, which collects data on all patients through their primary care to their hospital medical record. Through a state health information exchange, Innovation Care Partners also can obtain information about patients who visit hospitals out of its network.

"The bottom line is we're able with our core technologies to know where our patients are, and our staff knows where they are, and can outreach to them and make sure we manage our patients through the care continuum," Tyndall says. "We work collaboratively with the case manager, making sure our patients have what they need when they're discharged," she says.

Another strategy has embedded care coordinators focus on the moderate-to-high-risk patient population, Tyndall notes. "We have a software tool that can identify those patients by primary care practice, and we share

EXECUTIVE SUMMARY

A program with embedded care managers in primary care practices has lowered readmission rates.

- At-risk patients are followed throughout the continuum of care.
- The program also has resulted in healthcare cost savings.
- It's involved with a Medicare Shared Savings Plan.

that information with our care coordinators, who are embedded in the practices."

This permits proactive outreach to patients. Care coordinators can make sure patients have everything they need to stay safe and secure. Patients who sign up for the care coordination program receive intakes and patient activation testing, which is a way to find out how involved patients are in their own healthcare. They also are screened for depression and quality of life, she says.

Data show that patients in the program show improvement at the six-month follow-up test. "We've seen that after six months, there's a significant decrease in the percentage of patients that were severely depressed when tested, and we see a 15% increase in their mental quality of life," Tyndall says. "We also see a significantly higher engagement in their own care."

This reflects the success of patient activation in which the program helps patients set goals, identify what they need, and become more involved in their own healthcare.

The program addresses patients' social determinants of health, partly by utilizing a community resource network.

"We can connect people through their insurance or Medicare for [equipment and other] things that are covered and that, frequently, they didn't realize they could get," Tyndall says. "Sometimes, we've had the ability to get things like walkers and shower benches that are donated or reasonably priced, and we tap into community resources, including one grant that allowed us to purchase some equipment."

The program's embedded care managers follow a care coordination model and do not provide any clinical services. Also, there are guardrails established for how often care coordinators call and reach out to patients, Tyndall explains.

"Most of the help is around social community resource support," she says. "We also communicate back to the primary care provider about what's going on with the patient."

Care coordinators help physicians identify home health service needs, for instance.

Typically, a care coordinator's caseload is between 90 and 110 patients. Their follow-up can last six months to a year.

Social workers follow patients in post-acute settings, including skilled nursing facilities and rehabilitation services. "Post-acute social workers go to the skilled facilities to see patients there, and they go to care conferences," Tyndall says.

The RN transitional care managers see all new admissions to the hospital and work with inpatient case management discharge staff.

"Their goal for all groups of staff is to make sure coordination of care is appropriate and patients are getting what they need," Tyndall says. ■

Initiating Medication-assisted Treatment for Patients Presenting With Opioid Withdrawal

With a new report showing dramatic surges in both ED visits and hospital admissions because of problems related to opioid misuse, it's clear that current approaches to the problem are not sufficient.

The report, published by the Agency for Healthcare Research and Quality, indicates that in 2014, ED visits prompted by problems related to opioid use were double what they were a decade earlier, and opioid-related inpatient stays were up by 64%.[1]

While many emergency providers have long resisted getting involved with addiction treatment, the scope of the problem has prompted some EDs to re-examine their role in potentially connecting patients with treatment at a time when they are highly motivated to make a change. For instance, following a two-month research period last summer, the ED at Providence Sacred Heart Medical Center in Spokane, WA, began initiating medication-assisted treatment (MAT) to presenting patients with opioid use disorders, and then immediately connecting them to a MAT provider for continuing care.

There were initial concerns about potential provider resistance as well as spikes in volume, but these issues did not materialize. In fact, while these are still early days with the new approach, providers report that the program is working well, and that they are taking calls from colleagues who are interested in spearheading similar approaches.

The decision to consider initiating MAT in the ED was driven, in part, by a sense of frustration with the available treatment options for patients who present with symptoms of opioid withdrawal.

"There is a perception that there is

a lot of medicine that is really effective at combating withdrawal symptoms, which are diarrhea, abdominal pain, sweatiness, agitation, and anxiety, but there is not a lot that we can do," explains **Darin Neven**, MD, an emergency physician at Providence Sacred Heart Medical Center. "There are some addictive substances we can use to treat symptoms, but obviously that is not what we want to do in someone we are treating with addiction, so a lot of times we would give them over-the-counter medicines, and they would have to tough it out."

For example, patients would be given antihistamines, acetaminophen, or ibuprofen, Neven explains. "We tried to stay away from benzodiazepines, but generally it wasn't a rewarding experience," he says. "Patients would often stay in a sobering center where they were often sent for just a short period of time, and then they would relapse."

Neven knew that unless patients were given treatment that could alleviate their physiologic cravings, the prospects for recovery were dim, so he took part as the principal investigator on a two-month study, testing an approach whereby appropriate patients would be given their first dose of Suboxone (a combination of buprenorphine and naloxone) in the ED, and then immediately would be connected with a MAT provider who would pick up their care from that point.

"This was actually a medicine that completely removed [the patient's] withdrawal symptoms, took away all of their physiologic cravings, and then set them up for long-term stability if they could follow through the next day and subsequent days with the Suboxone treatment," Neven says.

Ariana Kamaliazad, a medical student at the University of Washington School of Medicine in Seattle who served as an investigator on the study, concurs that the Suboxone essentially enabled patients to make it to their follow-up appointments with a MAT provider.

"Before, if you saw someone in the ED who was interested in a MAT program ... you could give them the information on how to do that, but it would be difficult for them to follow up because they would be feeling these withdrawal symptoms so much," she explains. "Usually, these people would just be enticed to just use [opiate drugs] when they got out of the hospital, rather than follow up with a treatment program."

During the two-month study period in the summer of 2016, Kamaliazad would be contacted by phone or text message by the emergency provider whenever a patient presented to the ED with symptoms of acute withdrawal and he or she was interested in treatment for their addiction.

"I would respond to the ED in person and go in and meet the patient to determine their eligibility for the program," she explains.

For instance, the patients would need to be able to get to the Spokane Regional Health District every day for daily dosing of Suboxone, and they couldn't have other addictions or comorbidities.

Kamaliazad notes that another critical piece of information involved determining when the patient last used opiate medications because if they were still feeling the effects of the opioids, Suboxone actually could send them into withdrawal rather than ease their symptoms. Also, Kamaliazad would use a clinical opiate withdrawal scale (COWS) to assess the severity of withdrawal that the patient was experiencing.

"Then, I would give the emergency provider the information that I had gathered, and we would both come up with an assessment of whether or not we thought it was appropriate for this patient to receive Suboxone," she says. "If it was appropriate, we would administer [the pill], watch the patient take it, and I would set the patient up with an appointment the following morning at the MAT program where they would go in and enroll."

Kamaliazad would keep tabs on whether the patient kept the follow-up appointment the next day. "As the patient is feeling better, he or she is more likely to make it to that appointment rather than go out and find more drugs," she says.

After 30 days, 71.4% of the patients who received a dose of Suboxone in the ED were still enrolled in MAT at the Spokane Regional Health District, and 28.6% were no longer participating, according to data provided by Kamaliazad. Among the 25 patients still in treatment, six patients had switched from taking daily doses of Suboxone to daily doses of methadone.

At 60 days, 51.4% of the patients were still in treatment at the health district, and three additional patients left to seek MAT at a program that offered weekly rather than daily dosing, although these patients were lost to follow-up by investigators at this point.

Ensure Prompt Follow-up Care

There were some limitations during the two-month study period. For example, with the available funding for the project, the health district could accommodate only two patient enrollments in MAT per day. "During the research, when we had a third person who wanted to be enrolled for that day and we couldn't fit him in,

we had to turn that person down," Kamaliazad notes.

Also, under the Drug Addiction Treatment Act of 2000, providers who have not received a Drug Enforcement Administration (DEA) waiver to prescribe Suboxone can administer only one dose, and only if the patient is connected to a MAT provider who can continue with the treatment. "Under that law, we couldn't give people treatment if they weren't going to be able to follow up the next day in a clinic," Kamaliazad notes. Because the health district was open to provide MAT services only from Monday through Thursday, emergency providers were limited to enrolling patients in the program from Sunday through Wednesday. "The law says [providers without DEA waivers] can't prescribe Suboxone; we have to physically administer it, so we can't give patients three days of the drug," Neven says. "We were only treating patients in the ED when we knew we could get them into a clinic the next day, which was Sunday through Wednesday."

Despite these limitations, the results of the study convinced the hospital to continue offering the approach, although there have been some logistical changes. For instance, now nurses from ED case management fulfill the role that Kamaliazad handled during the study. This involves determining when patients qualify for MAT, working with emergency physicians to initiate the Suboxone treatment, and arranging for follow-up. Also, instead of working with the health district to connect patients with ongoing MAT, the ED has partnered with a large Suboxone provider.

Although the program still is limited to patients who present to the ED from Sunday through Wednesday, Neven notes that it is nonetheless a big plus for the ED to have a referral resource for patients in need of MAT. "That is a major barrier [for many EDs]," he says. "There is a shortage of clinics that will take these patients, and [the approach] definitely requires a cooperative clinic to provide MAT."

Rely on Evidence

There is often a concern among emergency providers that if they begin inducting patients into MAT, the ED will be overwhelmed with patients wanting this service, potentially leading to crowding, boarding, and other volume-related issues. Neven acknowledges that he had concerns along these lines as well, but, in fact, demand for MAT has been modest and manageable.

"We estimated that, at most, we would refer five patients per day to the Suboxone provider, and we haven't hit that yet," Neven reports. "We are treating what feels like about four patients per week in an ED that sees 60,000 adults and 30,000 pediatric patients a year."

Kamaliazad acknowledges that the study conducted last summer had a bigger impact on ED volume. "It did attract more people to the ED because they had heard about [the MAT] program and wanted to get into treatment," she says. "We were referring patients to the health district, and that was the only program at that time that was accepting Suboxone patients or any type of MAT patients."

However, Kamaliazad notes that now patients don't need to come to the ED to access MAT treatment; they can go straight to the MAT treatment provider.

Still, Neven acknowledges that he was worried that the program could cause volume to spike. "There are so many patients who come to the ED with an agenda to get prescription opioids," he says. "I have been really surprised that we have not been overrun with people who want to get Suboxone." While Neven is supportive of offering Suboxone in the ED, he used the study period to determine whether the rest of the emergency providers would buy into the concept as well. "That was one of the major things we were testing," he says. "There were vocal physicians that I knew of who felt that methadone programs are misplaced and misguided ... and that they are a waste of money."

However, all the physicians ultimately agreed to participate in the program and offer Suboxone to the patients they determined were appropriate for the treatment, Neven explains.

Although many emergency providers have been hesitant to get involved in the treatment of addiction, the opioid crisis has gotten so severe that more physicians are willing to engage on this issue, Neven observes. He also has a ready comeback for physicians who question whether MAT is the right approach. "My main answer to that is to look at the data on what is most effective for treating opioid addiction. It is not abstinence-based therapy. It is not tough love. And it is not a 12-step program," he says. "These things do not work for opioid addiction, and it is very clear in the literature that they do not work."

People relapse at rates topping 90% when those approaches are used, and outcomes are much better when opioid substitution therapy or MAT is used, Neven adds.

"We are slowly educating physicians that this is the best, evidence-based approach, and it is also a harm reduction method," he says. "Every dose of Suboxone is one less dose of heroin, which is one less dose of harm, so we should do everything we can to reduce harm. We shouldn't

go for a lifetime of sobriety because that is not realistic.

Kamaliazad adds that the ED may offer the best opportunity to connect with patients who have opioid addictions. "A lot of these patients have other social factors that are going to predispose them to not make regular appointments with doctors, so whether or not people in the ED want to treat people with addictions, it might be that the healthcare system is only able to capture these patients when they are in an acute setting because they tend not to follow up with regular physicians," she says.

How might emergency medicine clinicians move forward with a similar program to what Neven and colleagues are doing in Spokane? One easy first step is to take the Suboxone course that will enable providers to obtain a DEA waiver to prescribe the drug, Neven advises. "It is four hours of a webinar online and then four hours in front of a computer doing online learning," he says. "You will learn a comprehensive approach for giving Suboxone ... and obtain your DEA number."

While the approach offered at Providence Sacred Heart does not require providers to prescribe Suboxone or to obtain a DEA number, it does give physician leaders added flexibility, Neven explains. He also advises providers who are interested in initiating MAT in the ED to spend a day or two in a Suboxone clinic.

"You will get an idea of how a clinic works and how you get someone inducted," he says. "I worked in a Suboxone clinic for several months, and that is how I learned [the approach]."

Kamaliazad adds that when implementing the program it is helpful to employ a community health worker or some type of healthcare professional who has taken the Suboxone course, can consult on some of the more difficult cases, and facilitate the transition of patients to a MAT program.

"It is difficult for every physician in the ED to learn about all the options people have for MAT, so if one person knows about all the available programs, and he or she can be called and consulted, it makes it a lot easier," she says.

Other emergency providers are taking an interest in developing MAT programs similar to the approach used at Providence Sacred Heart. Neven has fielded calls from colleagues on the subject, and he is looking at opportunities to expand the approach to other EDs.

Meanwhile, **Lauren Whiteside**, MD, MS, an emergency physician at Harborview Medical Center in Seattle, says she is one of the principal investigators for a large, multisite trial that will be evaluating the effectiveness and implementation of ED-initiated buprenorphine/naloxone for patients with opioid use disorder. The study includes sites in New York City, Cincinnati, and Baltimore, in addition to Seattle, and researchers anticipate recruiting 2,000 patients to participate in the investigation. *(For more information about this trial, please visit: http://bit.ly/2ueJrnq.)*

Investigators will be looking to see if outcomes confirm earlier findings from a randomized, controlled trial conducted by the Yale School of Medicine from 2009-2013. In that study, researchers found that providing patients with Suboxone and a referral to treatment in the ED made them more likely to remain in treatment for an opioid use disorder for at least 30 days than patients who only received a referral to treatment. The findings showed that 78% of the patients given Suboxone were still in treatment at 30 days, while just 37% of the patients who only received referrals to treatment were still engaged in treatment.[2] ■

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Changes to Readmissions Rule Will Help, But No Panacea

A significant number of hospitals are set to benefit from changes in how CMS calculates penalties under the value-based Hospital Readmissions Reduction Program (HRRP), but the proposed rule won't solve all their problems related to readmissions, says **Bill Bithoney**, MD, formerly CEO, CCO, and

CMO at Sisters of Providence Health System in Springfield, MA, and now a managing director at BDO International consulting in New York City.

CMS has proposed a change that would have it consider a hospital's proportion of dual-eligibles when determining penalties under Medicare's Hospital Readmission Reduction Program (HRRP), a change welcomed by hospitals that have long argued dual-eligible patients are more expensive for hospitals and skewing readmissions figures for safety-net hospitals.

The proposed rule has a good chance of moving forward because it is budget neutral, Bithoney says. However, accounting for dual eligibles may not solve all the problems that safety net hospitals face with readmission penalties, Bithoney says.

"There are many other reasons that readmissions may be higher in hospitals caring for poorer people," Bithoney says. "Some have suggested adjustments based on linguistic minorities that hospitals and health systems care for in disproportionate numbers, as well as other census data. It has been said that when it comes to your health, your ZIP code may be more important than your genetic code, and you can see that in increased mortality and increased readmissions."

As defined by the proposed rule, a dual-eligible patient has full-benefit dual status in the State Medicare Modernization Act during the month he/she was discharged from the hospital. "The State MMA file is considered the most current and most accurate source of data for identifying dual-eligible beneficiaries since it is also used for operational purposes related to the administration of Part D benefits," the rule explains.

The rule offers two ways to calculate a hospital's proportion of dual-eligible patients. The first defines the proportion of full-benefit dual-eligible beneficiaries as the proportion of dual-eligible patients among all Medicare fee-for-service (FFS) and Medicare Advantage inpatient visits, which CMS calls the best comparison of social risk factors among hospitals. That method "represents the proportion of dual-eligible patients served by the hospital, particularly for hospitals in states with high managed care penetration rates," the rule says.

The other option defines the proportion of full-benefit dual-eligibles as Medicare FFS hospital episodes of care, which CMS says it included because the HRRP payment adjustment applies only to Medicare FFS payments and is based on excess readmissions among only those cases.

CMS suggests using data from the Medicare Provider and Analysis Review (MedPAR) to identify total hospital stays, but says it also will consider using data from the CMS integrated data repository. CMS then proposes stratifying hospitals into five peer groups, broken down by their proportion of dual-eligible patients because quintiles create "peer groups that accurately reflect the relationship between the proportion of dual-eligibles in the hospital's population without the disadvantage of establishing a larger number of peer groups."

CMS also could correct for behavioral health diagnoses and patients with minimal social support, Bithoney says. He recalls being informed about a recent case in which a patient was discharged after having both legs amputated and had to climb four sets of stairs to his apartment.

"He was just learning to get around after his hospitalization, and he had little to no social support in the way of family and friends, or social services. You can easily predict that that patient is going to be readmitted soon," Bithoney says. "The social aspects of recovery, and the effects of social isolation, are never taken into account."

The cumulative effect of certain diseases also could be considered, Bithoney says. It is well known that some conditions combine to affect the situation far more than might be suggested by simply tallying up the effects of each disease, he says.

"With the triad of heart disease, diabetes mellitus, and renal failure, those diseases interact with each other in a way that predicts readmission much more frequently than you might expect from the summative score of having each of those diagnoses separately," Bithoney says. "CMS could adjust for that patient population in considering readmissions, but currently that effect is not factored in to the evaluation."

Hospitals that serve a higher proportion of dual-eligibles might need to rethink their financial risk management plans in light of the rule, he says. It may no longer be necessary to include CMS readmission penalties as a given, or at least not at the same level, he says.

Some hospital leaders would not be happy with the proposed rule leveling the playing field with regard to dual-eligibles, Bithoney says. Wealthier hospitals may have some trepidation about the change because it narrows the performance gap between them and safety net hospitals, he says.

"Hospitals that have fewer dual-eligibles might find themselves with penalties from CMS, whereas they did not have penalties previously," Bithoney says. ■

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **Which of the following is the No. 1 cause of accidental death in the United States, according to 2015 data?**

   a. Suicide
   b. Gunshot accidents
   c. Opioid/drug overdoses
   d. Motor vehicle crashes

2. **Which of the following is a possible strategy a health plan could employ when a plan member is jeopardizing his or her health through inappropriate opioid use?**

   a. Notify local law enforcement.
   b. Cut off the member from opioid prescriptions being covered by the health plan.
   c. Have the plan member involuntarily committed to a mental health facility.
   d. None of the above

3. **The CDC 2016 Guidelines on chronic pain and opioids states that opioids as pain management treatment should be prescribed in which of the following ways?**

   a. Opioids should not be the first-line treatment.
   b. Closely monitor all patients who are prescribed opioids.
   c. Opioids should not be routine therapy for chronic pain patients.
   d. All of the above

4. **A case management program with embedded RN transitional care managers and social workers in primary care practices has seen its readmission rate change in what way over the first two years of the program?**

   a. It went from 15% to 5%.
   b. It went from 11% to 5%.
   c. It went from 8% to 10%.
   d. It went from 18% to 12%.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.