Welcome to the 2017 Indiana Health Workforce Collaborative!

Thank You to Our Sponsors:
Attacking the Drug Epidemic

KEVIN MOORE
Director, Division of Mental Health and Addiction
The following speaker for this program has disclosed no actual or potential conflict of interest in regard to this program:

Kevin Moore
The Opioid Epidemic: What is Public Health’s Role?

Joan M. Duwve, MD, MPH

Associate Dean for Public Health Practice
Indiana University Richard M. Fairbanks School of Public Health

Chief Medical Officer
Indiana State Department of Public Health
The following speaker for this program has disclosed no actual or potential conflict of interest in regard to this program:

Joan M Duwve, MD, MPH
How the Epidemic of Drug Overdose Deaths Ripples Across America
By HAEYOUN PARK and MATTHEW BLOCH JAN. 19, 2016

Drug Poisoning Death Rates by Year, Indiana and US, 2003-2015

*Age-adjusted rates

Source: CDC WISQARS, Prepared by ISDH Division of Trauma and Injury Prevention
Drug Overdose Deaths, Indiana
2010 – 2016*
Health care providers in different states prescribe at different levels.

State Abbreviation — GA — Number of painkiller prescriptions per 100 people

Source: IMS, National Prescription Audit (NPA™), 2012.
### Drug Overdose Death Percent Increases, Indiana, 2010-2015

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Drug Poisoning</td>
<td>34%</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>36%</td>
</tr>
<tr>
<td>Opioid</td>
<td>87%</td>
</tr>
<tr>
<td>Heroin</td>
<td>343%</td>
</tr>
</tbody>
</table>

Data Source: Indiana State Department of Health (ISDH), Vital Records
Mortality data set: ISDH Epidemiology Resource Center, Data Analysis Team
Prepared by: ISDH, Division of Trauma and Injury Prevention
Drug Poisoning Deaths, 2012 to 2015

Overdose deaths identified through underlying cause of death coded on death certificate as drug overdose fatality or "acute drug overdose" (ICD-10 codes X40-X44, X60-X64, X85, Y10-Y14.9). Counts less than 5 are suppressed. Rates based on counts less than 20 are considered unstable (\( \hat{u} \)) and should be interpreted with caution.

Crude Rate per 100,000

- 3.8 - 11.5
- 11.6 - 17.2
- 17.3 - 23.8
- 23.9 - 39.0
- Suppressed

Online copies available at: http://www.in.gov/isdh/26689.htm
Defining Public Health’s Role
Public Health System

www.cdc.gov/nphpsp
The Essential Public Health Services

- Evaluation and continuous quality improvement
- Public health workforce and leadership
- Access to care, link with primary care
- Enforcement, review of laws
- Identifying and sharing best practices; participation in research
- Community health assessment; registries
- Investigate infectious water-, food-, and vector-borne disease outbreaks
- Health education and health promotion
- Partnerships with private sector, civic groups, NGOs, faith community, etc.
- Strategic planning; community health improvement planning
- System Management
Monitoring and Surveillance

- ESSENCE
- Death Records
- Hospital/ED discharge data
- EMS database
- INVDRS Opioid Module
- Prescription Drug Monitoring Program – INSPECT
- NEDSS Based System (NBS)
- SEP data
Diagnose & Investigate
Indiana HIV Outbreak

• Dec. 2014: 3 individuals from Austin, IN diagnosed with HIV
  • 2 had a common needle-sharing partner
  • Contact tracing → 8 additional infections by January 23
  • Only 5 HIV infections had been reported 2004-2013

• June 20, 2017: 217 individuals diagnosed with HIV
  • Linked to Austin, IN
  • Most are from a single strain of HIV
  • 95% co-infected with Hepatitis C

• Source of HIV transmission: injection of the prescription opioid, oxymorphone (OPANA® ER)
Disease Intervention Specialist (DIS) Investigation

- Identify risk factors for HIV infection
  - Sexual
  - IDU
  - Other

- Explore risk behaviors
  - MSM
  - Syringe sharing
  - Commercial sex work

- Elicit information about partners in the past 12 months
  - Injection partners
  - Sexual
  - Social contacts (who could benefit from an HIV test)
Inform, Educate, Empower

- Inform parents, youth and patients
  - risks of opioid use, misuse, and diversion
  - safe storage and disposal options

- Educate Providers
  - Management of chronic, non-terminal pain (Provider Toolkit)
  - Annual symposium
  - Public speaking at Grand Rounds, Professional Association meetings

- Empower lay and first responders
  - Overdose reversal with Naloxone (Optin.in.gov)
Mobilize Community Partnerships

- Attend Community Events (County Council Meetings, coalition meetings, training sessions)
- Provide support to LHDs
  - Syringe Exchange Programs
  - Education
- Strengthen Community Capacity to Respond
  - Coalition building
  - Technical Assistance
- Identify and Engage Community Assets
  - Faith based communities
  - Employers
  - Schools
Develop Policies

• Strategic Planning
  • State, county, community levels
  • Critical to assess the problem and include stakeholders

• Rules for evidence-based prescribing for acute and chronic

• Harm Reduction Programs:
  • Policies to support distribution and administration of Naloxone
  • Syringe Exchange Programs
OPTIN: Entities Registered to Dispense Naloxone

Map as of 6/16/17
Indiana Syringe Exchange Programming (SEP) Progress and Approvals (December 15, 2016)
Enforce Laws

1. Required reporting of reportable infectious disease (HIV, Hep B, Hep C)
2. Infection control practices
3. Opioid prescribing practices
Link to Care

1. INCREASED TESTING for HIV and Hep C, especially in high risk communities - field testing, ERs, jails, provider offices, health departments

2. Referrals for treatment

3. Immunizations, STI testing and treatment, TB testing,

4. Link to Treatment for Substance Use Disorder
Assure Competent Workforce

1. Project ECHO: Web-based assistance to rural docs with treatment for Substance Use Disorder (SUD), Hep C, and HIV
2. Provide training to HIV testers/counselors
3. Training PH workforce in CQI/evaluation
Evaluation:
Continuum of HIV care in Austin, Indiana, April 13, 2017

Total diagnosed=215 (confirmed).
*Persons were ineligible if deceased (n=6) or outside of the jurisdiction (n=3); estimates are based on the number of eligible persons (n=206);
** Patients engaged in care with at least one VL or CD4
*** Percent virally suppressed increases to 70% when denominator changed to number engaged in care. Clinical services were initiated 3/31/15.
Major Progress in Scott County

- Total number of persons who have enrolled in addiction treatment at the SSP location
- Average number of syringes needed by clients each day
- Number of new HIV infections diagnosed

- Syringe needs are stable
- More persons getting addiction treatment
- New HIV infections remain low
- No evidence of increased drug use

Source: Indiana State Department of Health, Indiana Family and Social Services Administration, and IU Fairbanks School of Public Health
Gaps in Treatment Capacity, 2012
(2012 rates per 1,000 people ≥12 years of age)

QUESTIONS?

Joan M. Duwve, MD, MPH

Associate Dean for Public Health Practice
Indiana University Richard M. Fairbanks
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Chief Medical Officer
Indiana State Department of Health
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Primary Care Behavioral Health Integration and Workforce

DEBBIE HERRMANN, LCSW
Deputy Director, Adult Mental Health and Medicaid Behavioral Health Initiatives
Division of Mental Health Addiction, Family & Social Services Administration
The following speaker for this program has disclosed no actual or potential conflict of interest in regard to this program:

Debbie Herrmann, LCSW
Indiana Division of Mental Health and Addiction (DMHA) identified PCBHI in the 2012 combined mental health and addiction Block Grant application as one of 4 priority areas.

2. Formed partnership with Indiana State Department of Health along with DMHA sister agency Indiana Office of Medicaid Policy and Planning—Agency heads and executive leadership buy-in

3. ISDH and FSSA created a PCBHI Stakeholder work group

4. Goal - Define, Design and Implement a best practice Primary Care Behavioral Health Integration (PCBHI) service delivery system model across Indiana

5. Needs/Gaps assessment – WORKFORCE Shortage

6. Care and training in silos
PCBHI Purpose and Goals:

1. Improved access to primary care and behavioral health services;

2. Improved prevention, early identification, and intervention to reduce the incidence of serious mental illness/addiction and physical illnesses, including chronic disease;

3. Increased availability of best practice integrated, holistic care for physical and behavioral disorders; and

4. Improved overall health status of individuals.
Role of PCBHI with Substance Use Disorders

1. 27 million Americans use illicit drugs (including non-medical use of prescriptions)

2. 7 million meet criteria for substance use disorders (SUD)

3. 1.9 million have disorders related to non-medical use of prescription pain relievres

**Center for Health Economics of Treatment Interventions for SUD, HCV, and HIV - Published August 2016**
PCBHI-Screening, Early Identification and Intervention

1. Rate of overdose deaths involving opioids have tripled, and
2. Fatal overdosed involving sedatives have quintupled since 1999.
3. Only 10%-20% of individuals receive any treatment
4. Significant barrier/challenge is fragmented siloed care (separation between SUD treatment and rest of health system)

**Center for Health Economics of Treatment Interventions for SUD, HCV, and HIV Published August 2016**
Medical Conditions-Substance Use Disorders

National Institute of Health/Nat Institute Drug Abuse (NIDA)

**https://archives.drugabuse.gov/about/welcome/aboutdrugabuse/chronicdisease/**

1. Addiction is a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease.

2. No one chooses to be a drug addict or to develop heart disease.
PCBHI-Screening, Early Identification and Intervention

1. Treatment of chronic pain – 50% of all prescription opioids come from primary care settings

2. Estimated 3%-26% of patients seen in primary care setting use illicit drugs

3. Study by Alford, German, Samet, et al. (2016) - 87% primary care patients who screened positive for illicit drug use reported chronic pain

4. Study by Bernstein, Cheng, Samet, et.al. (2015)- 50%+ of primary care patients reporting weekend use, escalated to weekday use within 6 months

5. Routine and on-going screening for SUD important for identification and early intervention

6. PCBHI requires real-time "Warm hand-off" for more in-depth evaluation and treatment (strike while the iron is hot)
PCBHI-Screening, Early Identification and Intervention

1. Demand exceeds capacity for specialty settings (workforce shortage)

Individual preference (stigma):

1. Survey says: 37.2% would be willing to enter SUD treatment in a primary care setting

2. Survey says: 24.5% willing to enter SUD treatment in a specialty setting


Improve Access and Capacity (meet people where they are):

1. Expand capacity and workforce through increasing primary care physician expertise in SUD screening, identification and treatment, and

2. Implement a primary care behavioral health integrated care delivery system (create a bi-direction delivery system)
PCBHI - Co-Occurring Conditions

1. Depression is the **third most common** reason for a visit to a health center after diabetes and hypertension

2. If depression and diabetes coexist, total healthcare cost has been shown to be **86% higher** than diabetes existing alone

3. People with Serious Mental Illness are dying **25** years earlier than the general population

4. **68%** of individuals with a mental illness have one or more chronic physical health conditions

5. More than one in five adults with a mental illness have a co-occurring substance use disorder
PCBHI Opportunity to Impact Workforce
Work Smarter Not Harder – Collaboration Creates Synergy By Enhancing Existing Workforce

1. 2013 – PCBHI Federal Grant – Develop Strategic Plan and build workforce/capacity

2. Workforce – 2 prongs

   • Hosted series of national presenters- train/cross-train existing workforce
   • Use existing framework for Certified Recovery Specialists (CRS) training and certification to build and expand the underutilized workforce

3. In partnership with ISDH assessed existing CRS and CHW curriculum

   • excellent training opportunities for CHW
   • none included mental health and/or addiction issues
   • CRS training excellent but did not included physical health

4. Community Health Workers /Certified Recovery Specialist training and certification process developed and implemented (2013)
Community Health Worker Specialized Training and Certification

1. Contract vendor facilitated collaboration and resource review

2. Wide array of CHW training opportunities, but none that incorporated behavioral health conditions…nor did Certified Recovery Specialist training incorporate physical health conditions

3. Train and Certify - Incorporate core competencies of Certified Recovery Specialists (CRS) and Community Health Workers (CHW)

4. Options for Training for Certification –
   - CHW/CRS (5 day) or
   - CHW (3 day)

5. Train the Trainer model to extend training capacity across the state

6. Must receive a passing score on competency test to become certified as a trainer and/or CHW/CRS or CHW

7. Currently working on increasing funding/reimbursement opportunities
# Overview of CHW and CHW/CRS Training

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4 (CRS)</th>
<th>Day 5 (CRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Communication Skills</td>
<td>Motivational Interviewing</td>
<td>Role of Peer Support</td>
<td>Mental Disorders</td>
</tr>
<tr>
<td>Core CHW and CHW/CRS Skills</td>
<td>Practices That Promote Health and Wellness</td>
<td>Coaching Consumers for Positive Health Outcomes</td>
<td>Personal Safety</td>
<td>Addiction Overview</td>
</tr>
<tr>
<td>Ethics</td>
<td>Physical Health/Chronic Disease Overview</td>
<td>Tobacco Treatment</td>
<td>Home Visits</td>
<td>Co-occurring Disorders and Recovery</td>
</tr>
<tr>
<td>Diversity/Cultural Competency</td>
<td>Behavioral Health Overview</td>
<td>Group Facilitation Skills</td>
<td>Securing Employment as a CHW/CRS</td>
<td>Wellness Recovery Action Plan</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>Substance Use Disorders</td>
<td>Advocacy, Collaboration and Teamwork</td>
<td>Personal Supports: Medical Appointments and PAD</td>
<td>Telling Your Recovery Story</td>
</tr>
<tr>
<td>Technology</td>
<td>Integrated Care Model</td>
<td>Wrap-Up Test Preparation (CHW)/Building Your Recovery Story (CRS)</td>
<td>Managing Finances</td>
<td>Wrap-Up/Test Preparation</td>
</tr>
</tbody>
</table>
Community Health Worker (CHW) Role Includes:

1. Activities to ensure compliance with health regimens and healthcare provider recommendations

2. Coaching to assist the member in interacting more effectively with behavioral and primary healthcare providers

3. Support member-driven goals for healthcare or lifestyle changes, and identify the health activities and assistance needed to accomplish the member’s objectives.
Growing Demand

1. 2015-2016 – Certified Community Behavioral Health Centers (CCBHC) Federal planning grant - Required Peer Advisory Board

2. CCBHC State Peer Advisory Board feedback, CCBHC site consumer surveys, and providers all reported and recommended inclusion and importance of peers

3. NEW Requirements for becoming a state (ISDH/FSSA) approved PCBHI Integrated Care Entity (ICE) – Must establish a peer advisory board and include certified peers on Integrated Care Teams.
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ATTACKING THE DRUG EPIDEMIC

KEVIN MOORE

Director, Division of Mental Health and Addiction
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Kevin Moore
Attacking the Drug Epidemic

The Drug Epidemic: Next Steps for Indiana

JIM MCCLELLAND, MBA

Executive Director for Drug Prevention, Treatment and Enforcement
The following speaker for this program has disclosed no actual or potential conflict of interest in regard to this program:

Jim McClelland
A Strategic Approach
One of Governor Holcomb’s top priorities

• New position created by Executive Order

• Coordinate, align, and focus the resources of state government and leverage the state’s resources with those of other public sector entities and other sectors

• Strategic approach that recognizes SUD as a chronic disease

• Complementary public health and public safety strategies

• Focus on prevention, early intervention, treatment, recovery, and enforcement
High priorities

1. Help keep people alive
2. Greatly expand access to treatment services and recovery supports
3. Greatly increase use of evidence-based prevention programs
4. Use various media to educate, inform, increase public awareness, and reduce stigma
Overall Goal

Reduce the prevalence of substance use disorder in Indiana

and

Help those with SUD achieve recovery and become or return to being productive, contributing members of their communities
Partial list of actions relevant to today’s topic

1. New OTPs
2. Pilot programs approved by Indiana Commission to Combat Drug Abuse
3. Training of MAT providers through ECHO webinars
4. Placement of trained peer recovery support specialists in emergency rooms
5. Mobile addiction treatment teams
Workforce Issues

1. Indiana has one of highest rates of opioid abuse, but ranks only 44th in capacity to meet the need for medication-assisted treatment (PEW Charitable Trusts).

2. Increasing treatment capacity is hampered by shortage of addiction treatment professionals.

3. Postponing treatment is often life-threatening.
Workforce Issues

1. Treatment staffing ratios
2. Rules revisions
3. Community Health Worker licensing
4. Other?
Conclusion

1. Massive problem – we need to be creative
2. Must have strong sense of urgency
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Healthcare Delivery Perspective

UKAMAKA M. ORUCHE, PHD, RN, PMHCNS-BC
Associate Professor of Psychiatric/Mental Health Nursing
Indiana University School of Nursing, Indianapolis
Healthcare Delivery Perspective

Dr. Oruche has clinical privileges at Eskenazi Health; she serves on the Board of Directors for Fairbanks Hope Academy Recovery High School

Ukamaka M. Oruche, PHD, RN, PMHCNS-BC| Associate Professor
Acknowledgements

Dean Babcock
Rachel Beeler
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Ryan Martin
Marissa Manlove
Blayne Miley
Ashley Overly
Robin Parsons
ATTACKING THE DRUG EPIDEMIC: HEALTHCARE DELIVERY PERSPECTIVE

Scope of the Problem
Rachel is 4 years sober! and a college graduate!
Scope of the Problem

“In 2015, more Americans died of drug overdoses than any other year on record — more than 52,000 deaths in just one year. That's higher than the more than 38,000 who died in car crashes, the more than 36,000 who died from gun violence, and the more than 43,000 who died due to HIV/AIDS during that epidemic's peak in 1995” (Garmez Lopez)

(Data source: CDC Report authored by Rudd et al, 2016)
144 drug overdose deaths daily

Source: Addiction Policy Forum
Who Is Affected?

1. Increased risks for persons with mental illness
2. Patients – loss of self-control
3. Family members & communities (National Academies of Medicine, 2016)
4. Effects on unborn infants (neonatal abstinence syndrome) and children (entry into child welfare system; Sausser, 2017)
5. Provider burden
9 out of 10 people who need treatment do not get it!

Surgeon General’s Report on Alcohol, Drugs, and Health, 2016; Rudd et al, 2016
Challenges and Proposed Solutions
Challenges & Contributing Factors

1. Lack of public awareness and knowledge of risks and consequences
2. Unabating stigma
3. Inadequate investment in prevention strategies
4. Barriers to access
Challenges & Contributing Factors

5. Shortage of trained behavioral care workforce
6. Limited uptake of evidence-based practice
7. Inadequate recovery support
Increase Public Awareness & Knowledge

1. Educate American public

2. Youths need to know that “first” drug misuse leads to life-long consequences

3. Parents must take drug or alcohol use serious
Target Stigma!

8 million American have co-occurring substance use disorder and mental illness (Center for Behavioral Health Statistics and Quality, 2015)

90% respondents in a national survey were unwilling to have a person with drug addiction marry into their family and 78% were unwilling to work with them (Barry et al., 2014)
Invest in Prevention Strategies

1. Preventative education is the key to future success (Surgeon General’s Report, 2016)

2. Optimize opportunities for education and screening in primary care clinics; Substance and alcohol use; Adverse childhood experiences

3. Mainstream early intervention and treatment into primary care settings (Chou et al., 2016)

4. Pay for prevention services (e.g., Screening Brief Intervention & Referral to Treatment)
Enhance Access

1. Remove current restrictions on behavioral health workforce; Scope of practice; Licensure; Certification
2. Address reimbursement issues with private and public health plans
3. Expand use of telehealth to health professions shortage areas
4. Promote use of Electronic Health Record
5. Restructure regulations around release of information

Develop & Train an Integrated Health Workforce

1. Develop and train an integrated health care workforce that can promote family-focused behavioral health care for all persons including children and their families (The National Academies of Medicine, 2016)

2. Provide internship/residency programs and continuing education

3. Adopt federal, state, and health system guidelines such as CDC Guidelines on Prescribing Opioids for Chronic Pain (2016); and Indiana State Best Practice Guidelines for the Treatment of Opioid Use Disorder (2016)
Increase Uptake of Evidence-based practice

1. Accept that treatment is effective! (Surgeon General Report, 2016)
2. Use collaborative, comprehensive, multi-prong approach
3. Increase use of evidence-based behavioral therapies with fidelity
4. Identify and address barriers to uptake of evidence-based practice
5. Include entire family in care continuum!
Recovery support cannot be overstated!

- Increase community based or psychosocial supports
- Assess and address social and environmental determinants of health
  - e.g., provide recovery high schools; recovery coaches
Summary

Addiction is a chronic and recurring brain disease. Despite the associated conning, powerful, and baffling behaviors, prevention works, treatment is effective, and recovery is possible for everyone!

Together we can attack drug epidemic using a public health framework of integrated, multipronged, and comprehensive strategy appropriate to each person’s need!
Thank you!!
References


3. 144 a Day: Understanding the Numbers http://www.144aday.org/


References


11. The National Academies of Medicine


12. Indiana State Best Practice Guidelines for the Treatment of Opioid Use Disorder (December 30, 2016). Indiana DMHA