ISSUE BRIEF

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WELL BEING TRUST

Pain in the Nation: Healthcare Systems Brief

HOW HEALTHCARE SYSTEMS CAN HELP ADDRESS THE DRUG, ALCOHOL AND SUICIDE CRISES

Hospitals and health systems are on the front line addressing alcohol and drug misuse, providing or linking patients to health services and integrating behavioral health services across systems. As such, it's critical healthcare system efforts are supported so they can optimize prevention and build a "whole health" approach.

This approach requires a careful, encompassing systems method—creating new programs without intentionally integrating them with and connecting them to other parts of the same system continuum cannot bring about as robust a change as necessary. Additionally, in some cases, without taking this comprehensive method, a solution could increase fragmentation and create more problems.

This brief focuses on how to support this approach by focusing on prevention and collaborations and partnerships that will result in enhanced behavioral health services.

Systems can and should be advocates for patients and ensure the resources commensurate with the challenge are quickly identified—and accessed.

MAY 2018

The Rising Problem of Deaths of Despair

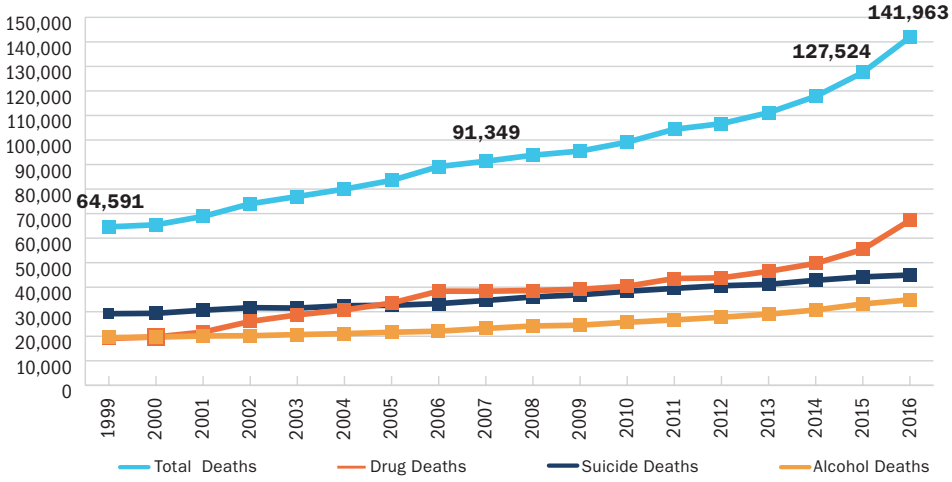
In 2016, 142,000 Americans died from alcohol-induced fatalities, drug overdoses and suicide—one every four minutes.[1] These "diseases of despair" have become a full-blown public health crisis and contributed to the unprecedented fall in life expectancy in the United States in 2015 and 2016.[2,3]

Unfortunately, the problem is not getting better. Alcohol, drug and suicide deaths increased 11 percent between 2015 and 2016, and the nation is now on a trajectory to lose more than two million people to these causes by 2025.[4]

And the data indicates alarming trends: while drug overdoses were still highest among Whites in 2016, there were disproportionately large increases in drug deaths among racial/ethnic minority groups, particularly among Black Americans. In the previous decade, Blacks had relatively low drug overdose rates — averaging 35 percent lower than Whites between 2006 and 2015. However, between 2015 and 2016, Blacks experienced an alarming increase — of 39 percent — in drug-related deaths.[5]

The United States has also seen a steady rise in alcohol-related and suicide deaths over the past few decades — with increases in death rates of 55 and 54 percent between 1999 and 2016, respectively.[6,7]

Annual Deaths from Alcohol, Drugs and Suicide, 1999-2016



Source: CDC WONDER

Deaths of Despair & the Healthcare Sector

The deaths of despair dramatically impact our nation's healthcare system. Overdose patients are inundating hospitals and overwhelming first responders. One-third of adult hospital stays and one-fourth of teenage hospital stays in 2012 included a mental or substance use diagnosis.[8,9]

In fact, hospital stays for mental health/substance use was the only category of hospitalizations that increased from 2005 to 2014 and, between 2009 and 2014, opioid-related inpatient stays increased 64 percent and emergency department visits doubled.[10,11]

During a similar period, drug-use related hospital stays for mothers and newborns also rose, including a 135 percent increase in maternal hospital stays for opioids.[12] These increases are reflected in community health needs assessments, with communities consistently ranking behavioral health and substance use as two of their top three health concerns.[13,14,15,16,17]

The increases in these expensive conditions are also driving up our nation's healthcare costs. Healthcare spending on patients with substance use disorders or at risk for suicide in 2014 were 2.5 times higher than average at $20,113 per patient per year.[18] Accordingly, these patients account for a disproportionate share of total healthcare spending, with roughly 9.5 percent of total health costs spent on the 3.8 percent of the population with drug, alcohol or suicide-related diagnoses.[19]

For the purposes of this brief, behavioral health involves substance use, mental health and other psychological conditions.

How Healthcare Systems Can Help

Recognizing that deaths of despair are caused by a confluence of factors that contribute to adverse health and underlying pain, the Trust for America's Health (TFAH) and Well Being Trust (WBT) have called for a national strategy to improve resilience.[20]

As hospitals and health systems work with patients, providers and communities to address alcohol, drug and behavioral health conditions, it is critical to support healthcare system efforts to prioritize prevention and adopt a "whole health" approach. Organizations that provide healthcare—including hospitals, outpatient and long-term care facilities, community health centers, and other healthcare providers (referred to in this brief collectively as "healthcare systems")—have efforts underway to modernize behavioral health services, improve pain treatment and management practices, limit the supply of opioids, raise awareness of the risk of addiction, reduce stigma, and partner with the broader community on improving the health and well-being of Americans.

Prioritizing Prevention

Investing in efforts to prevent patients from misusing substances or attempting suicide can be cost-effective and save lives.[21,22,23] Healthcare systems that more fully integrate prevention efforts into their organizations can help stem the increase in despair deaths. Promising practices include: screening for mental health or substance misuse risks, counseling patients and families to safely store lethal means, implementing take back days, and expanding the availability and use of naloxone.

1. Screening for substance misuse, suicide and mental health issues

Regularly screening patients for substance use disorders and mental health issues is a critical step healthcare systems are taking. Routine screening for substance misuse is one of the National Principles of Care for Substance Use Disorder Treatment issued by the Substance Use Treatment Task Force (see box on page 13). The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, which involves:

- **Screening** patients on a regular basis using an age-appropriate questionnaire;
- **Briefly intervening** with patients who present risk factors by providing feedback about unhealthy behaviors and educating them about the risks involved with substance misuse; and
- **Referring for treatment** those patients who need further assessment and services.[24]

AMERICAN HOSPITAL ASSOCIATION'S (AHA) *STEM THE TIDE* TOOLKIT

Health care systems can help to reduce the stigma associated with alcohol, drug and behavioral health conditions, both within healthcare systems and the broader community. This will help foster an environment in which individuals are willing to seek treatment. AHA's *Stem the Tide* opioid toolkit includes resources to help providers better understand and address stigma in patients with opioid use disorders and describes how many hospitals and health systems implement programs like Mental Health First Aid to combat stigma.[25]

Studies show that even a single instance of SBIRT or another brief discussion about a patient's behavioral health can help lower healthcare costs, lessen rates of drug and alcohol misuse and reduce the risk of trauma.[26,27,28,29,30] For example, suicide screening is a central aspect of the successful Zero Suicide initiative discussed below (see box on page 6).

Additionally, healthcare systems are coordinating with schools and other community partners to implement screening and provide access to treatment for individuals identified as at risk for substance misuse, suicide or other mental health concerns. Systems also play a role in supporting evidence-based primary prevention efforts in their community—including social-emotional learning programs. People, particularly students, who are socially and emotionally healthy are less likely to engage in substance misuse and have higher academic outcomes.[31]

To support these programs, systems can use a mix of funding sources. For instance, nonprofit hospitals can use their community benefit dollars: Nationwide Children's Hospital uses community benefit dollars to place licensed behavioral health clinicians into first and second grade classrooms in Columbus, Ohio schools to help teachers administer the evidence-based PAX Good Behavior Game and Signs of Suicide SOS program with their students.[32] Using another strategy, through a $1.33 member per month investment, Trillium Community Health Plan Coordinated Care Organization supports teacher training and implementation of the PAX Good Behavior Game in Lane County, Oregon schools.[33]

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THE ZERO SUICIDE MODEL

The Zero Suicide Model is a comprehensive suicide prevention approach that rests on the foundational belief that all suicides are preventable.[34] Launched by the National Action Alliance for Suicide Prevention and supported by SAMHSA, the model uses a framework of screening, treatment and support to integrate suicide prevention into primary and behavioral healthcare. The Zero Suicide initiative was modeled on practices utilized by several healthcare systems that showed significant reductions in suicides for patients in their care, including the Henry Ford Health System in Detroit.[35,36]

At Henry Ford, primary care doctors screen every patient during every visit with two questions:

1. How often have you felt down in the past two weeks?
2. How often have you felt little pleasure in doing things?

Patients with high scores are asked additional questions about sleep disturbances, changes in appetite and thoughts of hurting oneself. Patients who indicate a problem are assigned to appropriate care, which may include cognitive behavioral therapy, medication, group counseling or, if necessary, hospitalization.[37] The Zero Suicide protocol includes other practices, such as:

- Testing new behavioral health models, such as drop-in group therapy and same-day psychiatric visits;
- Developing firearm removal policies with patients and their families to help reduce access to means of suicide; and
- Assuming every patient with a history of behavioral health needs is a suicide risk.[38]

The program has achieved dramatic results—an 80 percent reduction in suicides among Henry Ford's HMO members. This reduction has been maintained for over a decade, even as the overall U.S. suicide rate has increased.[39]

Implementation of this approach has had no negative impact on the division's financial health. In fact, the Zero Suicide approach can even save health systems money. Nashville-based Centerstone, a behavioral healthcare organization that implemented the model, has reaped annual cost savings of more than $400,000 from the program.[40]

SAMHSA is now providing federal funding to organizations—including community-based primary care and behavioral health organizations and emergency rooms—to implement the Zero Suicide model in health systems.[41]

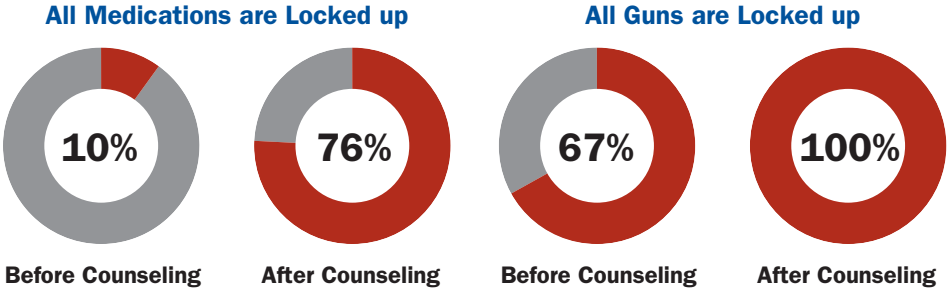
2. Reduce access to lethal suicide means

As a suicide prevention measure, healthcare systems can also encourage their providers to counsel patients to safely store both firearms and medications. A proven successful method is the Counseling on Access to Lethal Means (CALM) approach. One study of this intervention at Children's Hospital Colorado found that parents of children being treated for suicide risk who were educated about safe storage of medications and guns made significant changes in their behavior. In follow-up interviews, 76 percent of parents who had been counseled about safe storage reported that all medications were now locked up (compared to 10 percent before counseling) and 100 percent of those with guns reported their guns were now locked up (an increase from 67 percent).[42]

In recent years, there have been efforts in a number of states to pass legislation prohibiting doctors from counseling their patients about safe gun storage, and Florida became the first state to pass such a law in 2011.[43] However, a federal court in 2017 struck down the bulk of the Florida law as a violation of the First Amendment.[44] While three other states—Minnesota, Missouri and Montana—have legal restrictions related to health providers collecting firearm information, none of them explicitly prevent clinicians from counseling patients about safe gun storage.[45]

Medication "take back" programs can help prevent drug misuse by reducing the number of unused medications available in homes and institutions. Given that a majority (53 percent) of people who misuse prescription drugs get them from friends and family,[46] these can serve as important prevention efforts. Some healthcare systems have installed drop boxes in hospitals and pharmacies where patients can deposit medication. Another strategy is to supply patients with safety bags along with their medications where they can seal unused medicines and dispose of them in the regular garbage.[47]

Reported effectiveness of counseling regarding the safe storage of medications and guns on parents.



Community Partnerships

Prevention efforts are most effective when all sectors in a community—healthcare systems, schools, law enforcement, government agencies, businesses, community organizations and faith-based groups—work together to invest in upstream prevention and identify at-risk community members to ensure they receive the support and services they need.

The Institute for Healthcare Improvement has identified a community-wide, system-level approach as a meaningful strategy to combat the opioid epidemic.[48,49] Healthcare systems have an important role in spearheading and participating in such community-wide efforts.

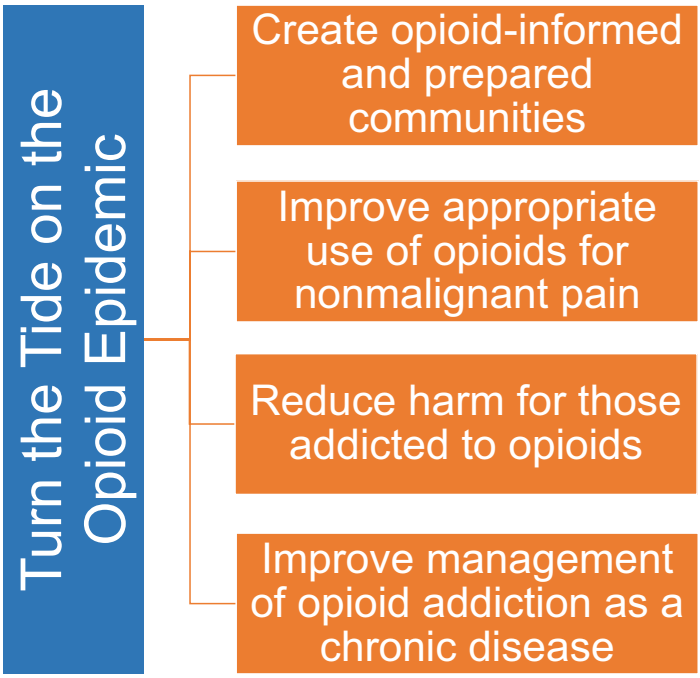
Many healthcare systems are participating in and providing support for community coalitions to prevent substance misuse, prevent suicide and improve mental health. Hospitals can be key leaders in such community coalitions.

Healthcare systems can also work to educate their communities about pain, anxiety, addiction and trauma, including the potential dangers of opioids and viability of alternative pain management methods. For example, hospitals are providing training for first responders, law enforcement officers and other community workers about overdoses and use of the drug naloxone.[50]

And another way healthcare systems are partnering with the community is through take back programs and expanding availability and use of naloxone, a medication that rapidly reverses opioid overdose. A recent advisory from the Surgeon General calls on physicians and other prescribers, substance use disorder treatment providers and pharmacists to prescribe or dispense naloxone to those at elevated risk for opioid overdose and to their friends and family.[51]

One example of this type of successful community effort was spearheaded by the Massachusetts General Hospital (MGH) Center for Community Health Improvement. The Center created four coalitions focused on preventing substance use disorders, including take back programs, naloxone distribution, emphasizing connections to treatment through recovery coaches, and screening all patients for substance misuse.[52]

Specifically, the MGH Coalition in the Charlestown neighborhood partnered with community residents who teach science at elementary and middle schools, utilized a community health worker model, and worked with the Charlestown Drug Court to help individuals on probation who are suffering from chronic substance use disorders.



Source: 100 Million Healthier Lives

The Charlestown Coalition, formed in 2004, has had some notable successes:

- Emergency Medical Services responses for heroin overdoses decreased 62 percent from 2003 to 2010;
- Drug-related deaths decreased 78 percent between 2003 and 2008; and
- A preliminary evaluation suggests youth are more likely to think through the consequences before deciding about substance use and more likely to say no to tobacco, alcohol, or another drug.[53]

Improving Behavioral Health Services

1. Better training and care integration and coordination

Health systems are educating their clinicians about both substance misuse and suicide prevention. Unfortunately, many healthcare providers have never been trained in suicide prevention and lack the confidence to effectively deal with a suicidal patient.[54] The National Action Alliance for Suicide Prevention has proposed suicide training guidelines for clinicians and suggested they be required by state licensing entities, educational institutions and accreditation programs.[55] Healthcare systems can use these recommendations to develop their own training requirements or programs for their providers.

In addition, while behavioral health services have long operated in their own silo and have not traditionally been part of the medical care systems, systems and providers are increasingly employing strategies to shift towards a "whole health" mentality to ensure coordinated medical and behavioral healthcare services and systems, including:

- Co-locating and integrating physical and behavioral healthcare services;
- Assigning patients case managers to help them navigate the healthcare system;
- Implementing Accountable Communities for Health (ACH) models, a cross-sector approach to improving health and health equity by enhancing the clinical-community link;[56, 57] and
- Supporting a "no wrong door" approach, which allows patients to quickly access an entire range of healthcare and social service benefits regardless of where they enter a health system. This philosophy requires coordination among multiple sectors, so that healthcare providers can refer patients to other entities for services needed to improve their health and well-being, such as for housing or nutritional assistance.[58, 59, 60, 61, 62]

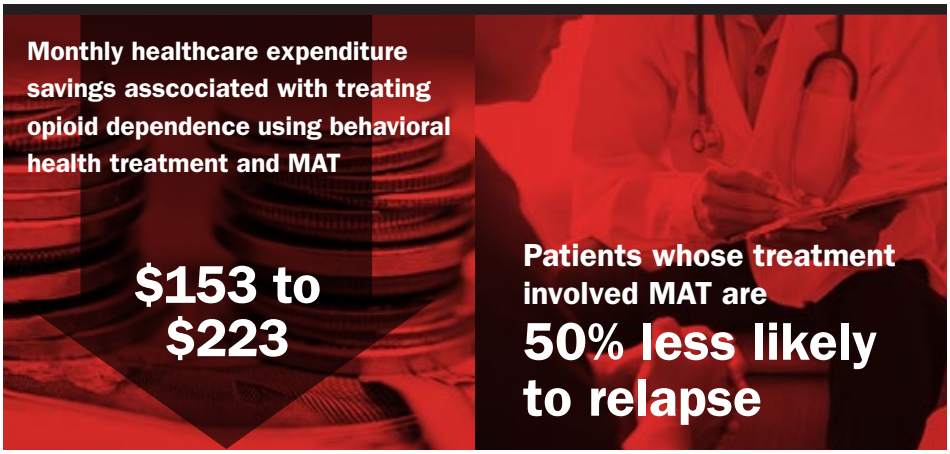
2. Boosting medication-assisted treatment

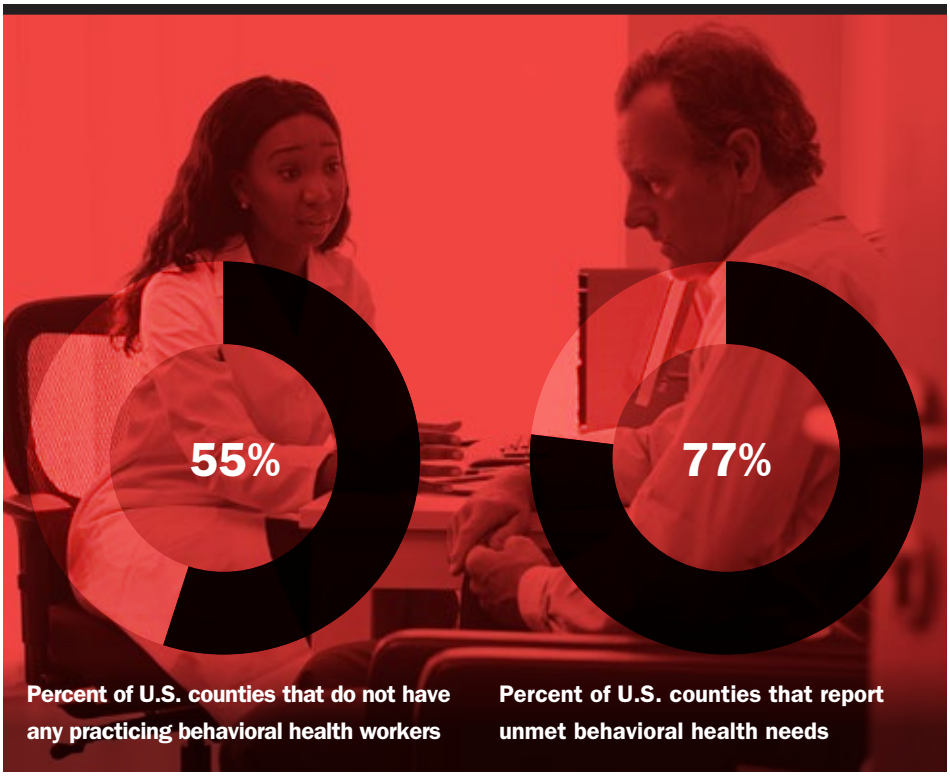
These medications are clinically effective; reduce or prevent withdrawal symptoms; relieve cravings; block the reward sensations from substance use; and sustain recovery.

Enhancing behavioral health services requires ensuring providers are employing up-to-date treatments that have been proven clinically effective, notably medication-assisted treatment (MAT)—the use of FDA-approved medications in combination with therapy to treat substance use disorders. The FDA has approved three medications to help treat opioid disorder: methadone, buprenorphine and naltrexone. The FDA has also approved naltrexone, acamprosate and disulfiram to treat alcohol use disorders. These drugs are clinically effective; reduce or prevent withdrawal symptoms; relieve cravings; block the reward sensations from substance use; and sustain recovery.[63,64]

MAT is one of the National Principles of Care for Substance Abuse and endorsed by all major government health agencies and experts in the field. Nevertheless, SAMHSA has found that MAT is underused.[65] Indeed, a Blue Cross Blue Shield study of its member plans found that the number of patients diagnosed with an opioid use disorder between 2010 and 2016 exceeded the increase in those receiving MAT by eight-fold.[66] They attributed this discrepancy to the misperception that MAT simply replaces one illicit substance with another, discrimination against MAT patients, lack of physician training, and negative views about MAT in the healthcare field.[67] Another complicating factor is the fact that both methadone and buprenorphine are controlled substances that are subject to additional restrictions when used to treat an opioid use disorder, including limits on the number of patients that one practitioner can treat.[68]

In addition to being clinically effective, MAT also makes fiscal sense. A 2015 study found that treatment of opioid dependence with methadone and buprenorphine was associated with $153 to $223 lower total healthcare expenditures per month than behavioral health treatment without MAT, and that patients were 50 percent less likely to relapse when treatment involved MAT.[69] A systematic review of the literature has found that pharmacotherapy treatment of alcohol dependence produced marked economic benefits.[70] Unfortunately, despite research to the contrary, many physicians do not believe that MAT is more effective than abstinence-based treatment, according to a 2016 GAO review.[71] Healthcare systems are working to educate their clinicians about the effectiveness of MAT.[72]





3. Increasing the number of behavioral health providers

A successful behavioral healthcare system also requires sufficient providers to care for the growing number of patients who need treatment. Currently, there are not enough: 55 percent of U.S. counties do not have any practicing behavioral health workers and 77 percent report unmet behavioral health needs.[73] In 2011, 43 percent of counties in the United States did not have a doctor licensed to prescribe buprenorphine.[74] Reasons for these shortages include high turnover rates, an aging workforce, stigma and low pay.[75]

Increasing the workforce intentionally is incredibly important.

Healthcare systems are working to address these shortages by:

- Offering recruitment incentives to behavioral health providers;
- Training other providers—such as peer counselors, community health workers and paramedics—to serve as behavioral health workers;
- Shifting towards providing care in teams that include physicians, counselors and recovery specialists to maximize the use of providers' time and expertise;[76]
- Implementing innovative approaches such as telehealth that ease geographic and logistically difficulties; and
- Encouraging nurse practitioners and physician assistants to train and obtain certification to prescribe buprenorphine in office settings, which is permitted under the Comprehensive Addiction and Recovery Act (CARA) through October 1, 2021.[77,78]

The *Journal of the American Medical Association* published new research in March 2017 that found that ibuprofen, acetaminophen and other nonsteroidal anti-inflammatory drugs reduced pain more than opioids in patients with chronic back, knee and hip pain.[80]

Pain Treatment & Management Practices

Patients should not suffer in pain. At the same time, healthcare providers have a responsibility to ensure they are relieving their patients' pain in ways that do not leave their patients vulnerable to substance addiction and misuse. Healthcare systems must develop pain treatment and management practices that require their physicians to treat pain responsibly, including clear guidelines on opioid prescribing, educating patients and prescribers on opioid risks; training healthcare providers to identify early signs of an opioid use disorder; and expanding prescription drug monitoring programs (PDMP) and other tools to detect misuse and diversion.

The U.S. Centers for Disease Control and Prevention's (CDC) Guideline for Prescribing Opioids for Chronic Pain can serve as a resource in this process. The Guideline recommends that, when not treating active cancer, palliative or end-of-life care, healthcare providers:

1. Not use opioids as a first-line treatment;
2. Establish goals for pain reduction and function and continue opioid use only if the benefits of opioids towards meeting these goals outweigh the risk;
3. Inform patients of the benefits and risks of opioid use;
4. Begin opioid treatment with immediate-release versions;
5. Use the lowest effective dose when prescribing opioids;
6. Prescribe opioids in short duration for acute pain;
7. Frequently reevaluate the harms and benefits of continued use of opioids;
8. Use risk reduction strategies, such as naloxone;
9. Review PDMP data;
10. Drug test patients prior to starting opioid therapy and at least annually;
11. Avoid prescribing opioid and benzodiazepine concurrently; and
12. Offer treatment, including MAT, for patients with opioid use disorder.[79]

Alternative therapies to opioids include physical therapy, cognitive behavioral therapy, localized nerve blocking and non-opioid medications, such as acetaminophen or ibuprofen. Many of these treatments can be as or more effective than opioids. In fact, the Journal of the American Medical Association published new research in March 2018 that found that ibuprofen, acetaminophen and other nonsteroidal anti-inflammatory drugs reduced pain more than opioids in patients with chronic back, knee and hip pain.[80]

PDMPs, recommended in CDC's Guideline, are an important tool for healthcare systems working to establish responsible opioid prescribing practices. These electronic databases allow healthcare professionals to access information about the dispensing of controlled substances statewide and the data can help physicians avoid dangerous drug interactions and identify "doctor shopping" patients seeking multiple opioid prescriptions. PDMPs also allow healthcare systems to identify possible provider overprescribing, both intentional and unintentional.

The Partnership for Drug-Free Kids' prescriber education initiative, Search

and Rescue,[81] is a tool that can assist healthcare systems with opioid misuse prevention. Search and Rescue provides a one-minute opioid risk assessment, continuing education courses on opioid prescribing and helps providers find local opioid treatment programs where they can refer patients. Other resources include the AHA, Catholic Health Association and America's Essential Hospitals, which have all issued guidance to help hospitals and emergency departments respond to the opioid crisis and integrate and support mental health.[82,83,84] CDC and AHA have also developed a prescription opioid handout to facilitate communication between providers and patients about the risks and side effects of opioids, and what patients should do when prescribed opioids.[85]

Healthcare systems are also implementing risk-reduction practices such as requiring patients to show identification prior to dispensing opioids, prohibiting dispensing of certain medication in the office setting (i.e., requiring pick up at a separate pharmacy), and requiring patients with high patterns of receiving prescriptions from multiple providers to be "locked-in" to using a single pharmacy to monitor and coordinate the safety of their prescriptions. To prevent the diversion of opioids for illicit use, healthcare systems are also working to ensure that onsite or partner pharmacies have appropriate control processes in place to ensure all medications are secure.[86]

NATIONAL PRINCIPLES OF CARE FOR SUBSTANCE USE

In 2017, the public-private Substance Use Treatment Task Force, which was created by the organization Shatterproof to ensure all Americans with a substance use disorder have access to treatment based on proven research, issued National Principles of Care for Substance Use.[87] Based on core concepts from the Surgeon General's Report on Alcohol, Drugs, and Health, the task force advocates for:

1. Routine screening in every medical setting
2. A personal plan for every patient
3. Fast access to treatment
4. Disease management that includes long-term outpatient care
5. Coordinated care for every illness
6. Behavioral health care from legitimate providers
7. Medication-assisted treatment
8. Support for recovery outside the doctor's office[88]

These principles have been endorsed by more than 300 experts in the field, as well as by the federal agencies with primary responsibility for addiction policy: SAMHSA, the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), CDC, FDA, and the Centers for Medicare and Medicaid Services (CMS).[89]

Conclusion

Unless action is taken, the country will continue to be on the worst possible case scenario track for alcohol, drug and suicide deaths. TFAH and WBT strongly recommend that the resources and expertise needed to prevent more deaths be provided as soon as possible—and the nation come together to support a National Resilience Strategy.

Prioritizing prevention, working together, improving behavioral health services and engaging in responsible pain treatment and management practices, healthcare systems can help mitigate the devastating epidemic of drug overdoses, alcohol-related fatalities and suicides among the next generation of Americans.

When implementing these action steps, it is essential that healthcare systems take a careful, system-wide approach to maximize impact and minimize fragmentation. The integration of new and existing programs alike can boost community capabilities and ensure community members have access to all available resources (i.e. connecting a patient across the healthcare system, the private sector and safety net programs). Simply creating new programs in communities, hospitals or schools without connecting them to other systems pieces will not bring about as robust a change as possible.

Additionally, healthcare systems can and should advocate for the policies and resources necessary—both within and beyond the clinical setting—to reduce alcohol, drug and suicide deaths among their patients.

Endnotes

1 Unless otherwise noted, all of the despair death data is from the CDC WONDER database. United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10.html.

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