CommStat 12/21/17

This disease comes
with a package:
shame. When any
other part of your
body gets sick, you
get sympathy.

-Ruby Wax

OLDQUOTES.COM

Opioid-Exposed Newborns and their families

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Associate Professor of Pediatrics
University of Vermont

December 21, 2017

CHILDREN AND RECOVERING MOTHERS (CHARM) COLLABORATION IN BURLINGTON, VERMONT

A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS

Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers

Table of Contents

Acknowledgments i
Introduction 1
Background 3
Scope of the Problem 5
Opioid Use Trends 5
Neonatal Abstinence Syndrome 6
Guidelines for Supporting Collaborative Policy and Practice 8
Existing Guidelines 8
Need for Collaboration Among Multiple Agencies 11
Comprehensive Framework for Intervention 16
Overview of Substance-Exposed Infants (SEI) Framework 16
A Guide for Collaborative Planning 18
Building the Collaborative Team 19
Concluding Thoughts 22
Appendix 1: Facilitator's Guide 25
Appendix 2: Citations 61
Appendix 3: Training Needs and Resources 67
Appendix 4: Key Features of Medications Approved for Treating Opioid Use Disorders 75
Appendix 5: Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont: A Case Study 81
Attachment A: CHARM Collaborative Memorandum of Understanding 103
Attachment B: CHARM Collaborative Release of Information 107
Attachment C: Hub and Spoke Initiative 111
Appendix 6: Additional Acknowledgments 115

LULU JONES (FICTITIOUS NAME)

- 23 year old woman, pregnant for the first time
- Although the pregnancy was not planned, Lulu and her partner Chad are looking forward to having a baby
- At 12 weeks of pregnancy, Lulu confides in her doctor that she has been using opioids, specifically Vicodin, for the past 3 years.
- She has tried to stop many times and keeps restarting the pills and then used heroin when she couldn't buy pills.
- She wants her baby to be healthy and is desperate to quit and feels ashamed that she cannot.

LULU JONES (CONT'D)

- Lulu experimented with drugs including marijuana, alcohol, cocaine (once) during her high-school years
- She really liked the feeling of opioids (Percocets) but they did not become a habit at that time
- 3 years ago, Lulu was in a car accident and had several limb fractures which required treatment with oxycodone
- She obtained several prescriptions for oxycodone in the months following, and then bought from the "street"
- Lulu began to suffer withdrawal and when she couldn't buy pills, she started using heroin
- She has repeatedly tried to stop using
- Lulu smokes cigarettes and has not used alcohol since she discovered she was pregnant

LULU JONES (CONT'D)

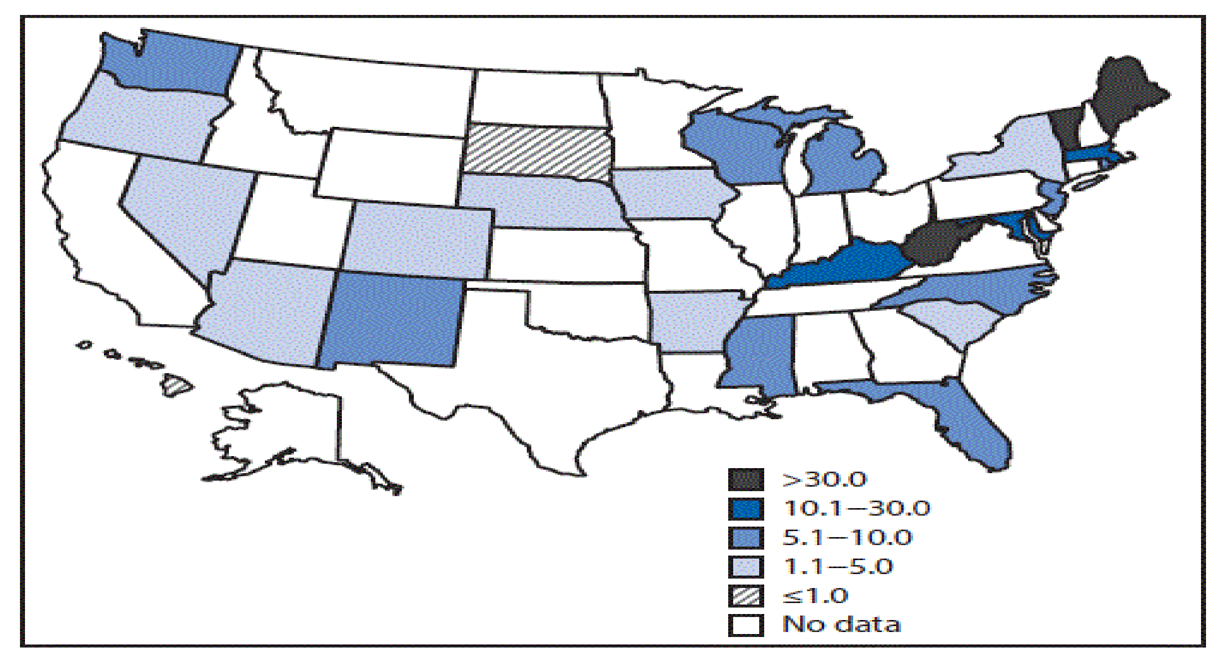
- Lulu reports that she grew up in a "good family", her mother is a nurse and her father has a successful business
- Lulu and Chad reside together in a rented apartment
- Lulu also related that she was sexually abused as a child by a distant male relative
- She has a history of anxiety and depression and is on anti-depressant therapy
- She has seen a therapist on occasion in the past, but never confided her drug use to her therapist

LULU JONES (CONT'D)

Vermont's CHARM approach:

- Lulu is assured that effective treatment is available and that part of her treatment will be to reduce the shame she feels
- Lulu was started on buprenorphine treatment with the goals of treating withdrawal, reducing cravings, and decreasing the effectiveness of any additional opioids she uses
- Immediately Lulu starts to feel better although she and Chad continue to worry about the effects of buprenorphine on their unborn baby
- Will our baby be "addicted"? What are the long-term effects?
- Will the state take our baby away?

Neonatal Abstinence Syndrome Incidence Rates – 25 States, 2012-2013



Maine	30.4
Vermont	33.3
W Virginia	33.4

Vermont had the highest annual rate increase of states surveyed

Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802

INCREASE IN NAS IN VERMONT

Represents:

- increased safe access to treatment
- increased identification

This is a good thing!

Myth #1: Opioids during pregnancy ➔ "damaged baby"

- There is no evidence that opioid exposure, in and of itself, results in developmental delay or any other lasting effects on the exposed child
- On the other hand, alcohol exposure can result in profound physical /developmental / behavioral effects

Myth #2: Every baby born to a mother on opioids is born "addicted"

- Opioid-exposed: exposure to opioids – either prescribed or illicit
- Opioid-dependent: infant exhibits signs of withdrawal severe enough to need medication
- Opioid-addicted: infants cannot be addicts, the disease of addiction requires obsession and compulsion, loss of control, "breaking the rules"
- Vermont data show that only 25% of opioid-exposed infants require treatment.

Myth #3: If a baby needs treatment for opioid withdrawal, it must be because the mother "used" opioids during pregnancy

- The severity of withdrawal is not associated with the dose of medication during pregnancy
- Exposure to tobacco can increase the severity of withdrawal
- Higher Neonatal Abstinence Scores (NAS) do not indicate that a mother has "used" during pregnancy

Myth #4: Opioid abuse + pregnancy = child abuse

- >1500 babies born to opioid-dependent women at UVMMC
- Over 90% of these babies were discharged in the care of their mother +/- father (2002 – 2014)
- The majority of parents we see are actively engaged in treatment and display good parenting, many need support in order to do so
- If a parent is not adhering to treatment, does not want to receive treatment **and** is actively using – they may NOT be ready to parent a child

Medication Assisted Treatment (MAT): Standard of Care for Opioid Dependency in Pregnancy

- WHO 2014: "Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment…rather than…attempt opioid detoxification."
- Facilitates retention of mothers/infants with decreased use of illicit substances when compared to no medication
- MAT results in NAS which needs Rx in 50-60% patients (Jones et al, 2010)
- The severity of NAS does not appear to differ according to the dose of methadone (or buprenorphine) maintenance therapy mothers received during pregnancy (Cleary et al, 2010; Jones et al., 2013)

Why is medication assisted treatment the best alternative?

- Decreases prematurity and low birth weight
- Improves the health of the pregnancy
- Lowers infant mortality
- Pregnant woman feels well (not "high") and has no cravings
- Successful engagement in treatment increases the probability of good parenting
- Detoxification during pregnancy is rarely successful and dangerous to the fetus

Concern: anything that drives pregnant opioid-dependent women from seeking treatment results in more prematurity, higher infant mortality, less probability of successful parenting

Opioid dependence : Treatment options

- Detoxification – generally not safe nor advisable in pregnancy
- Medication Assisted Treatment (MAT): the standard of care in pregnancy
  - Methadone
  - Buprenorphine

- Harm Reduction
  - Needle exchange

Issues facing substance-using pregnant women and their children

- Generational substance use
- Untreated mental health problems

- Legal involvement
- Unstable housing
- Unstable transportation

- Limited parenting skills and resources
- Exposure to trauma

- Lack of positive and supportive relationships

Slide courtesy of H Jones

Shame

POSAUDICHO
"I SWEAR TO TELL THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, FROM MY PERSPECTIVE."

Focus on the mother's health to have better outcomes

- Build trust
- Focus on respect and strengths
- Decrease fear and shame
- **Promote breastfeeding**

Neonatal Abstinence Syndrome (NAS): Description

- Neonatal Abstinence Syndrome is an expected consequence of a pregnant woman who
  - Uses opioids (e.g., heroin, oxycodone)
  - Is on prescribed opioids (e.g. for maternal pain)
  - Is on medication assisted treatment with methadone or buprenorphine
- Defined by alterations in the:
  - *Central nervous system*
    - high-pitched crying, irritability
    - exaggerated reflexes, tremors and tight muscles
    - sleep disturbances
  - *Autonomic nervous system*
    - sweating, fever, yawning, and sneezing
  - *Gastrointestinal distress*
    - poor feeding, vomiting and loose stools
  - *Signs of respiratory distress*
    - nasal stuffiness and rapid breathing

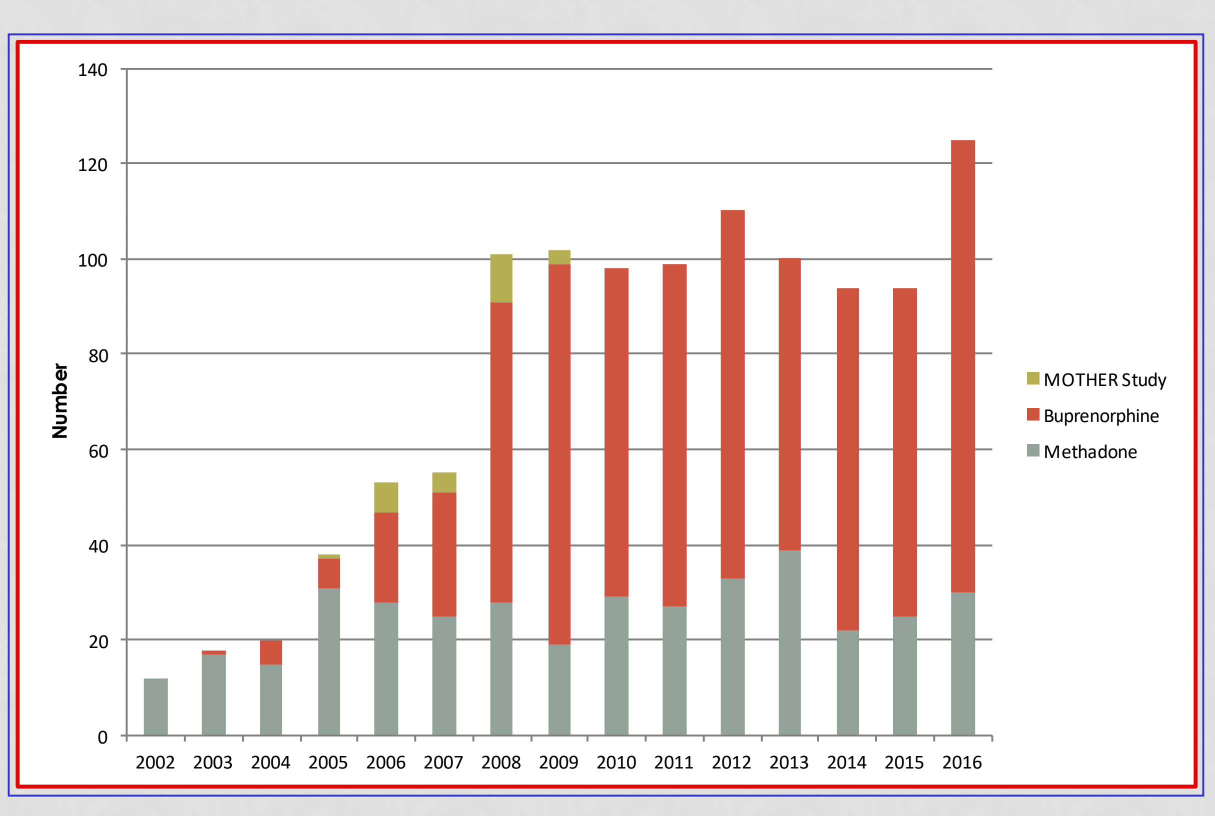
> - **NAS is *not* Fetal Alcohol Syndrome (FAS)**
> - **NAS is treatable and does not have any long-term consequences**

(Finnegan et al., *Addict Dis.* 1975; Desmond & Wilson, *Addict Dis.* 1975)

Slide adapted from H Jones

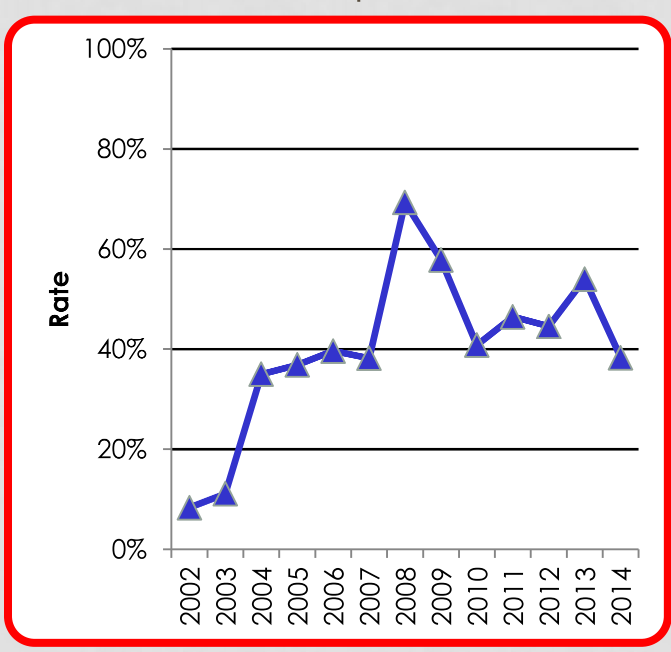
UVM Children's Hospital:

Infants born (at UVM) to opioid dependent women with substance use disorder on **methadone** or **buprenorphine** at delivery (N = 1119)

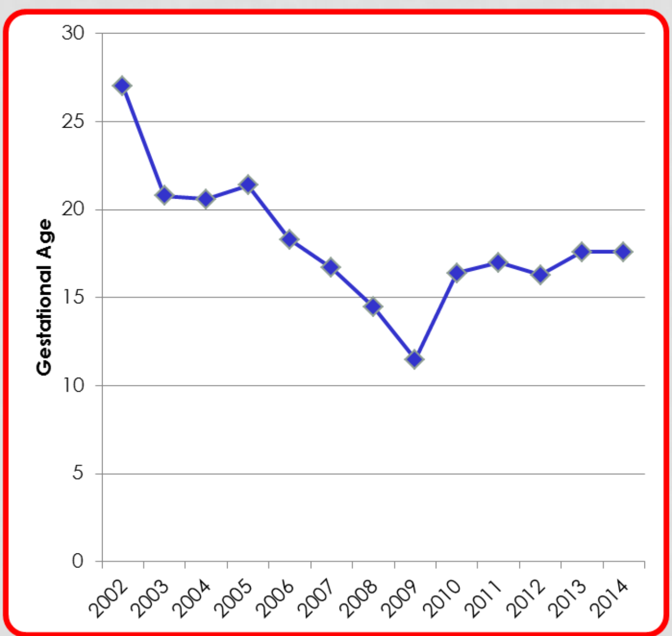


UVM CHILDREN'S HOSPITAL
TIMING OF INITIATION OF MEDICATION-ASSISTED TREATMENT(MAT)

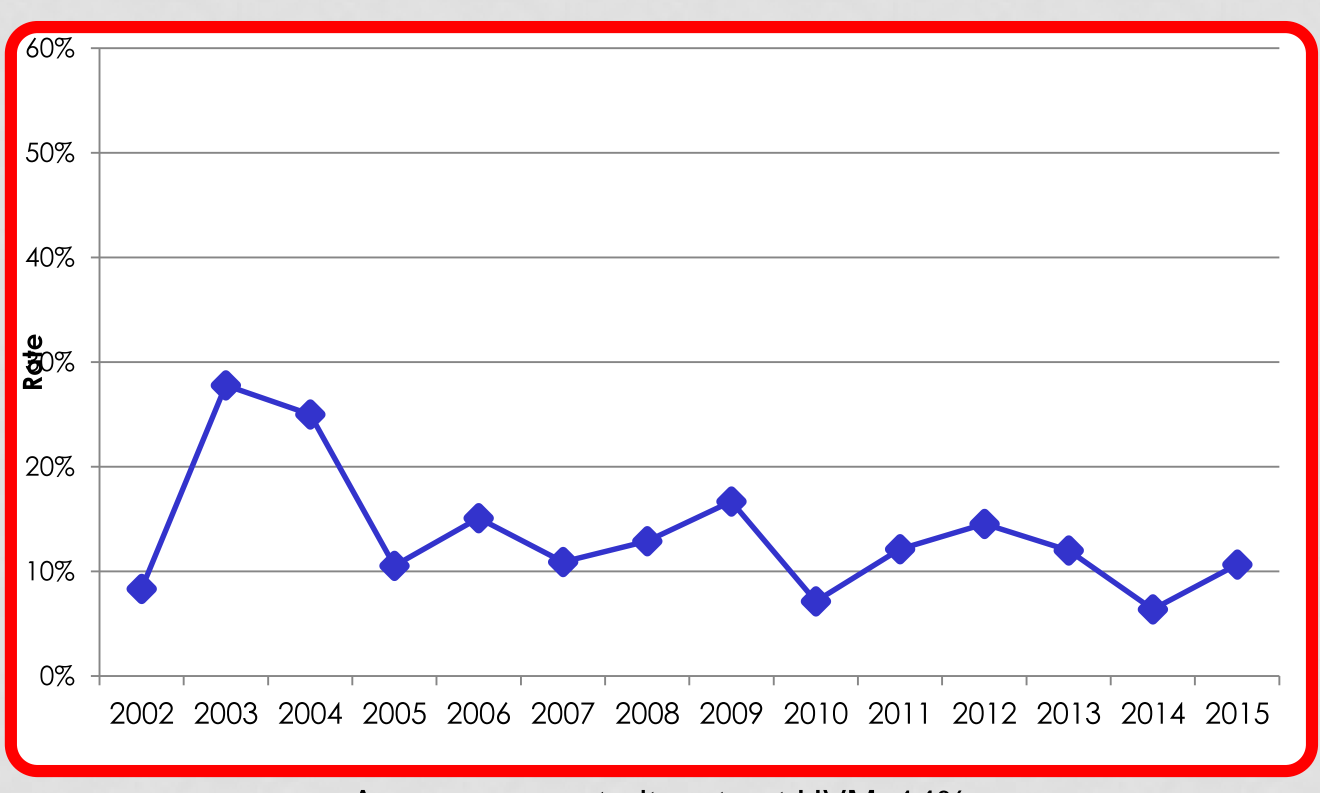
% Mothers on MAT prior to conception



Average GA started MAT if not prior to conception



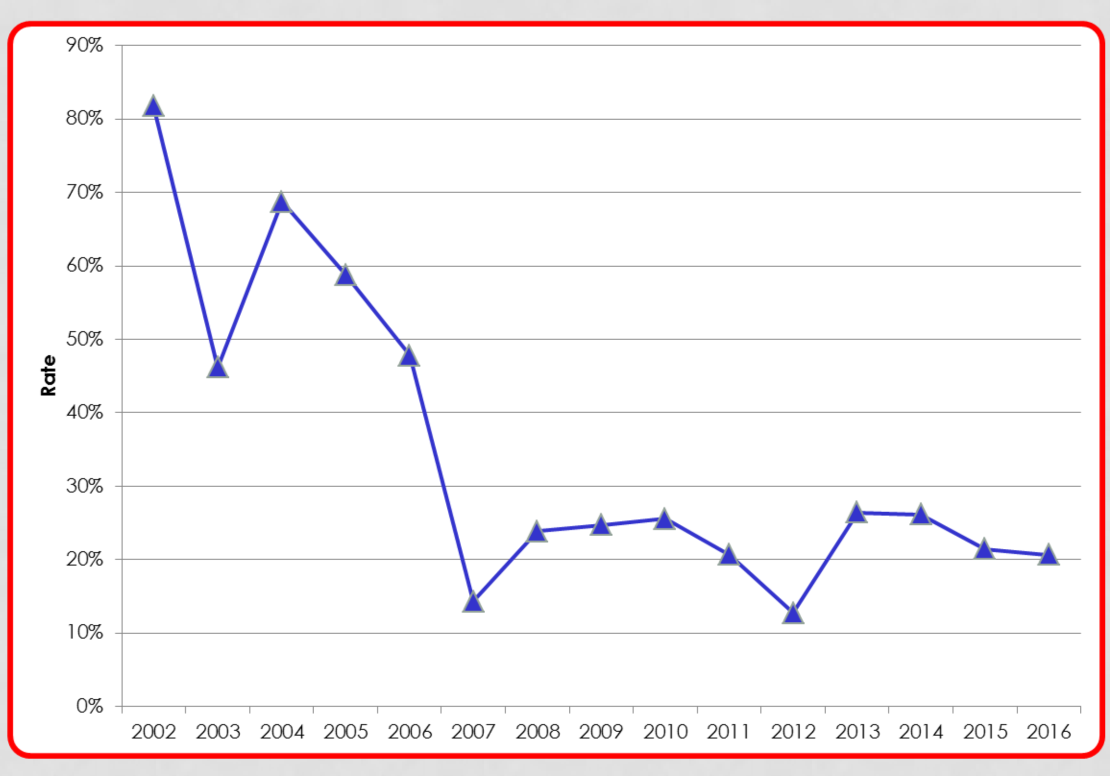
UVM CHILDREN'S HOSPITAL
% PREMATURE INFANTS BORN (AT UVM) TO WOMEN ON MAT



Average prematurity rate at UVM: 14%

UVM Children's Hospital

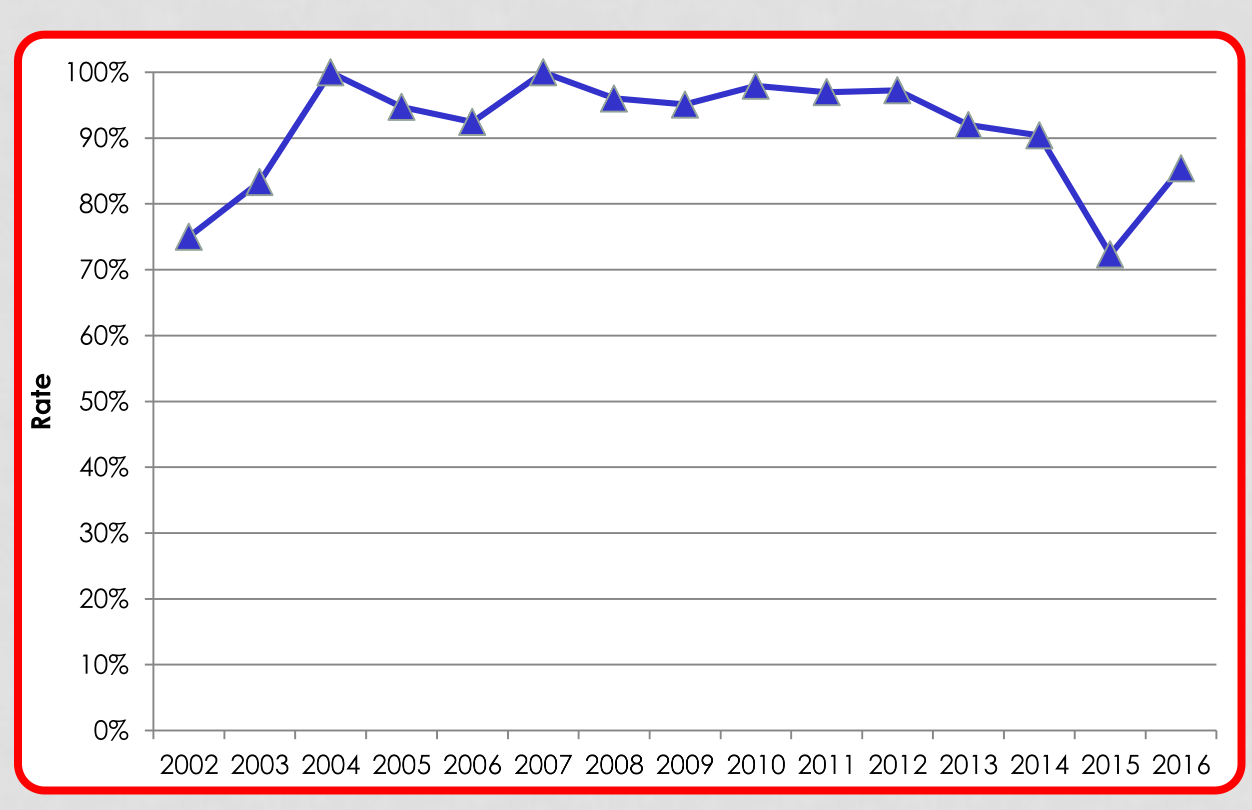
% Term newborns who received any pharmacologic therapy born to women on at UVM



National Average: 55%

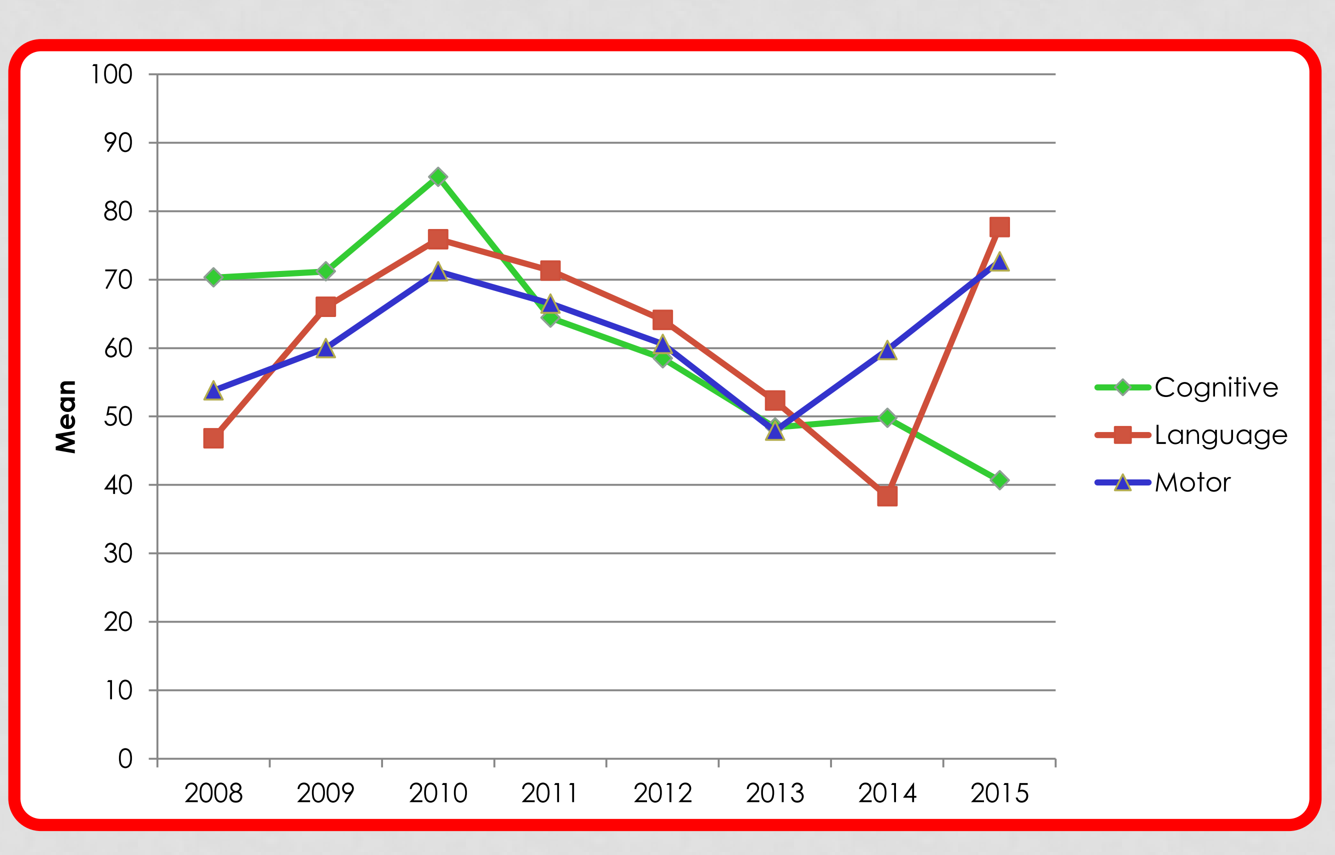
UVM Children's Hospital

% Discharged with one or both parents: newborns born at UVM to women on MAT



UVM CHILDREN'S HOSPITAL

BAYLEY III: MEAN PERCENTILE RANK (N=277) 7-14 MONTHS OF AGE



The baby’s health and safety depends upon the mother’s health, the family’s health

RiseVT Presentation

to Community STAT Group

December 21st, 2017

Jill Berry Bowen, CEO
Northwestern Medical Center &
RiseVT Board Chair

RiseVT is a *Movement!*

Our Frankin Grand Isle RiseVT Vision:
To Embrace Healthy Lifestyles.

Our Statewide RiseVT Vision:
Vermont will be recognized as the healthiest state in the nation with healthy living the norm.

We developed a "stairway speech" for consistent messaging:

RiseVT is a community collaborative to embrace healthier lifestyles, improve the quality of life, and lower healthcare costs where we live, work, play, and learn.

The RiseVT Roadmap to a Healthier Future

Getting Started:

- Develop relationships between local stakeholders;
- Initial assessment of interest in pursuing primary prevention;
- Convene a diverse community group of leaders/stakeholders.

Understanding the Data:

- Review the local Community Health Needs Assessment;
- Review the VDH data specific to the service area;
- Review the OneCare VT data specific to the service are;
- Review other relevant qualitative and quantitative data;

Deciding to Move Forward:

- What stands out in the data as pressing priorities?
- Is there a priority the group wants to tackle together?
- Will the group commit to working together on this issue?

Inventorying Existing Resources & Readiness:

- Are the right people at the table for this priority?
- What is currently being done in the community around the priority?
- What infrastructure exists that can help with the priority?
- Who can bring what resources to the effort to address the priority?

Conduct Results Based Accountability Process:

- Secure a facilitator trained in the RBA/Turn the Curve Process;
- Have diverse community group work through the RBA process;
- Identify desired outcomes, specific measures to be used, how progress will be measured, and long– mid– and short-term goals.

Drafting An Action Plan:

- What does best practice say will positively impact the priority to achieve the identified outcomes?
- What actions should be taken by who and by when?

Finalize the Action Plan:

- Organize RBA, draft action steps, and steps to align with EPODE methodology into a formal written action plan with specific timelines and point people for each action item;
- Create a dashboard of long-, mid-, and short-term indicators to track the progress.

Aligning with the EPODE Pillars:

- Plan how you will foster political support of your efforts;
- Identify how you will connect with the Scientific Advisory Council;
- Plan the development/expansion of public/private partnerships;
- Begin to plan a social marketing campaign (including social media) as a strategy to facilitate behavior change relating to priority;

Evolving the Structure:

- Reassess if the right people are engaged, changing as needed;
- Create an Executive Committee to steer local efforts;
- Create a Community Advisory Group to provide insight, advice, assistance, and connections across sectors within the community;

Pursuing the Resources:

- Revisit initial inventory of resources and engage partners in the effort to make use of existing staffing, funding, facilities, events, tools, communication vehicles, and other assets to create a shared approach to implementing the action plan;

Launch and Sustain the Movement!

- Refine action steps based on resources;
- Launch efforts, including communication blitz;
- Foster quick wins with individuals, schools, towns, & businesses;
- Work through action plan with ongoing monitoring and mid course correction for continuous improvement based on learnings

Evaluation:

- Collect and review participation and engagement measures;
- Monitor progress toward short–, mid-, and long-term goals;
- Re-assess and refine action plan based on progress to ensure outcomes;
- Arrange for an EPODE assessment of approach and progress.

RiseVT has helped establish primary prevention as a valued strategy within our Accountable Community for Health in northwestern Vermont.

Ongoing Measurement of Engagement

WHO'S ALREADY RISING?

18997

PEOPLE

VIEW ALL

46

BUSINESSES

VIEW ALL

16

SCHOOLS

VIEW ALL

9

COMMUNITIES

VIEW ALL

RiseVT is Part of Population Health

FY'16 Population Health Projects: Progress over 9 Months

Primary Care & Care Management	Year to Date	Goal
HCAHPS Care Transition from hospital to home, with continuing care support	61.88	61.63%
% change in avoidable visits with charge level of 1,2, or 3 (of 6 levels)	-21.02%	5% reduction in avoidable visits
Readmission to NMC for all-cause conditions	6.99%	≤ 9.2 %
Average length of stay for admitted patients, excluding swing beds and observation patients	2.91	≤ 3.23
Screening for Clinical Depression and Follow-up Plan	69.23%	61.39%
Adult Weight Screening & Follow-up	52%	73.54%
Falls: Screening for Fall Risk	43%	39.99%
Blood Pressure Screening	37%	59.58%
Lifestyle Medicine Clinic Pilots	**Year to Date**	**Goal**
Average weight-loss per at-risk cohort participant	9 pounds	8 pounds
Average waist circumference reduction per at-risk cohort participant	1.5 inches	1.5 inches
Average cholesterol reduction per at-risk cohort participant	12.0 point decrease	13.3 point decrease
Average systolic/diastolic blood pressure reduction per at-risk cohort participant	2.25 systolic 1.06 diastolic	12 systolic 6 diastolic

Wellness Specialist Embedded in School	Year to Date	Goal
Number of students walking or biking to/from school in targeted at-risk school	22% increase (32% up from 10%)	20% increase
Number of staff involved in wellness program in targeted at-risk school	Now at 100%	25% increase
Number of student and staff using school walking path in targeted at risk school	Now at 100%	30% increase
Healthy Roots Expansion	**Year to Date**	**Goal**
Food distribution sites providing gleaned healthy fresh local foods	10	5
Pounds of healthy food gleaned from local farms and consumed by vulnerable populations	2,853	1,500
Local counties served by online farmers' market with fresh local food	1 - had to rebuild Franklin County	2
Grand Isle residents served by online farmers' market	0	100
Grand Isle growers/producers participating in online farmers' market	0	8
Growers using the "season extending" cold storage site	7	6
Continued Reduction in Tobacco Use	**Year to Date**	**Goal**
Percent of F/GI adult non-smokers not exposed to second hand smoke	No new BRFS Data yet	55%
Percent of adult tobacco users in F/GI making a quit attempt in year	No new BRFS Data yet	62%
Municipalities addressing youth prevention through advertising, or other point of sale/retail options	Swanton, Enosburg future possibilites	1

NMC saw positive progress with population health indicators for an FY'16 project with GMCB.

Our Population Indicators

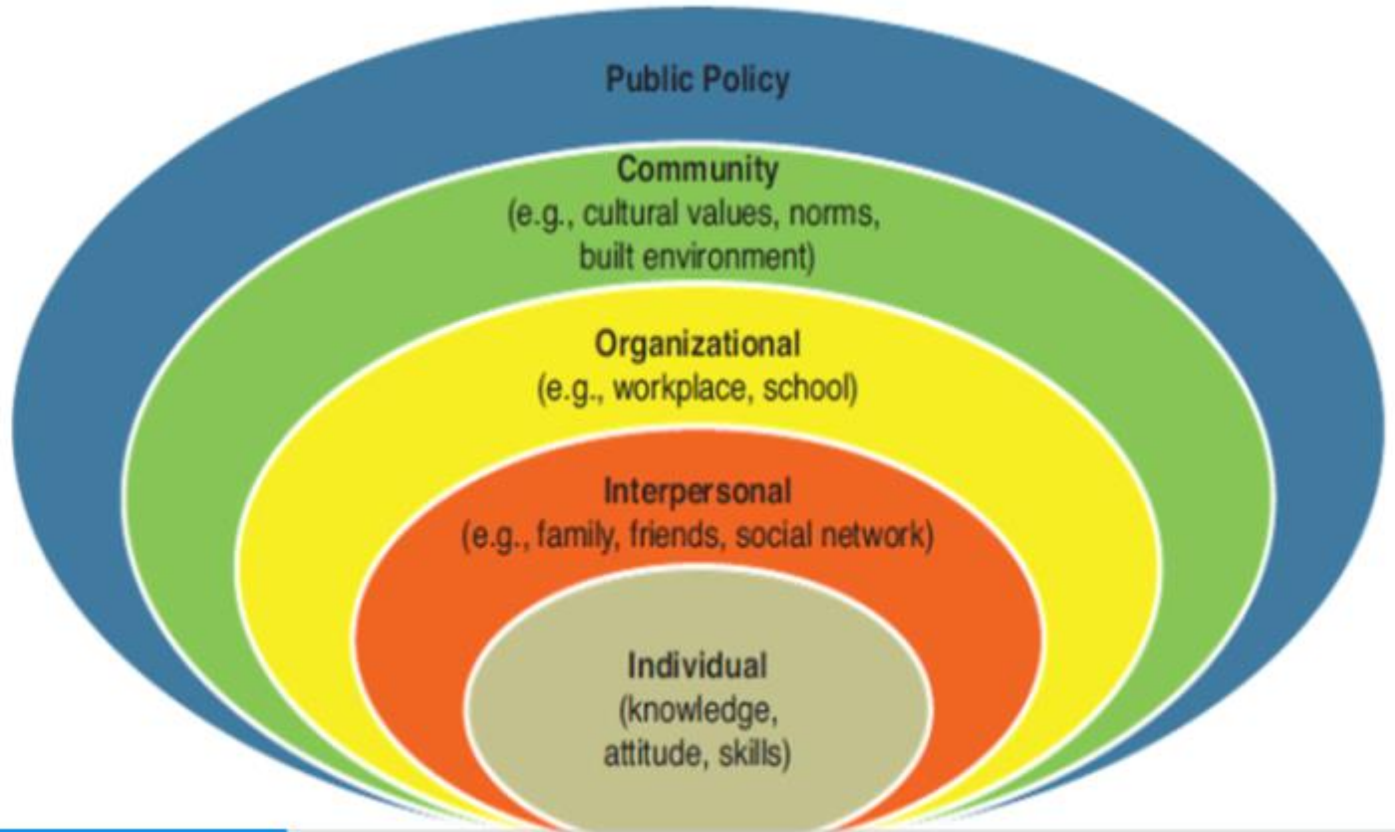
BRFSS (2014-15) or YRBS (2015)	FR (%)	GI (%)	VT Current (%)	US Current (%)	Vermont Target (%)	RiseVT Target (July 1, 2019)
% of adults (20+) who are obese	30	24	25	29	20	29%/23%
% of adolescents in grades 9-12 who are obese	16	19	12	14	8	15%/18%
% of adults eating fruit 2 or more times daily	33	26	32	29	45	35/28
% of adolescents in grades 9-12 eating fruit 2 or more times daily	31	28	34	32	40	33/30
% of adults eating vegetables 3 or more times daily	18	15	20	17	35	20/16
% of adolescents in grades 9-12 eating vegetables 3 or more times daily	13	16	18	15	20	15/16
% of adults meeting aerobic physical activity guidelines	49	60	59	51	65	50/61
% of adults with no leisure time aerobic physical activity	26	20	21	26	15	26/20
% of adolescents in grades 9-12 meeting physical activity guidelines	25	22	23	27	30	27/24
% of students who agree that in their community they feel like they matter to people. (protective factor)	FRCE 46 FRNE 48 FRNW 35 FRW 45	48	50	N/A	N/A	1% each school
% of adults exposed to second-hand smoke	50	N/A	46	37.8 (2005-08)	35	45
Increase number of eligible families enrolled in WIC (WIC data)	1,379 June 2017	N/A				1,480 (July 1, 2018)
Increase % of infants being breastfed (birth certificate data)	83% Quarter ending 12/2016		90% Quarter ending 12/12016			85%
Decrease % of women using tobacco during pregnancy (birth certificate data)	19% Quarter ending 12/2016		17% Quarter ending 12/2016			15%
Increase number of Breastfeeding Friendly employers	52	2	N/A	N/A	N/A	62/4

Program Evaluation

2018 Franklin Grand Isle RiseVT
Results Based Accountability – Metrics to evaluate our impact
IS ANYONE BETTER OFF?

	Numerical Target	**GOAL: % Increase/decrease**
Individuals	60 NEW PEOPLE	30% decreased their risk factors
		40% meet their 3 month goal
Schools	16 SCHOOLS	75% have active wellness committees (meet 4x/year)
		12.5% of schools increase their wellsat score (VDH tool to grade school wellness policies)
Classrooms	30	50% are at silver or above by end of school year
Worksites	55 WORKSITES (currently 46)	30% increase in scorecard level
	20 Policies @ worksites	50% NEW fully implemented wellness policies
		Each of our 55 worksites has 50% of employees engaged in worksite wellness. (defined as participation in at least one wellness initiative offered at work).
Municipalities	9 Municipalities	90% increase in scorecard level
		50% of the assessments performed moved forward to action

Socio-Ecological Model



CDC's Evidence-Based Approaches

Centers for Disease Control and Prevention
National Center for Health Statistics

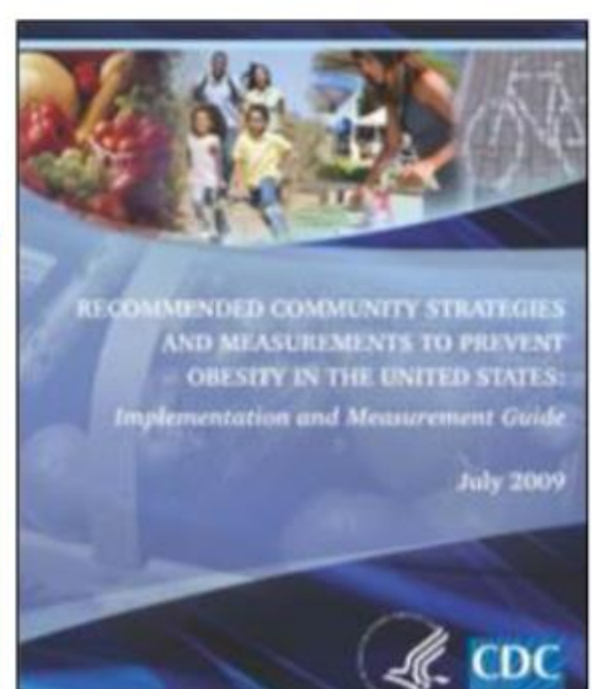
Increasing Physical Activity: Built Environment Approaches

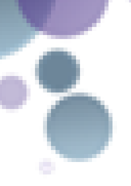
Community Preventive Services Task Force Recommendation

The Community Preventive Services Task Force recommends built environment strategies combining one or more intervention approaches to improve pedestrian or bicycle transportation systems with one or more land use and environmental design interventions based on sufficient evidence of effectiveness in increasing physical activity. Their recommendation is based on a systematic review of all available evidence.

Facts about Physical Activity

Despite the benefits, less than half of all adults, and 3 in 10 high school students in the United States, get the recommended daily amounts of physical activity.[1,2]





EPODE's impact on children overweight & obesity

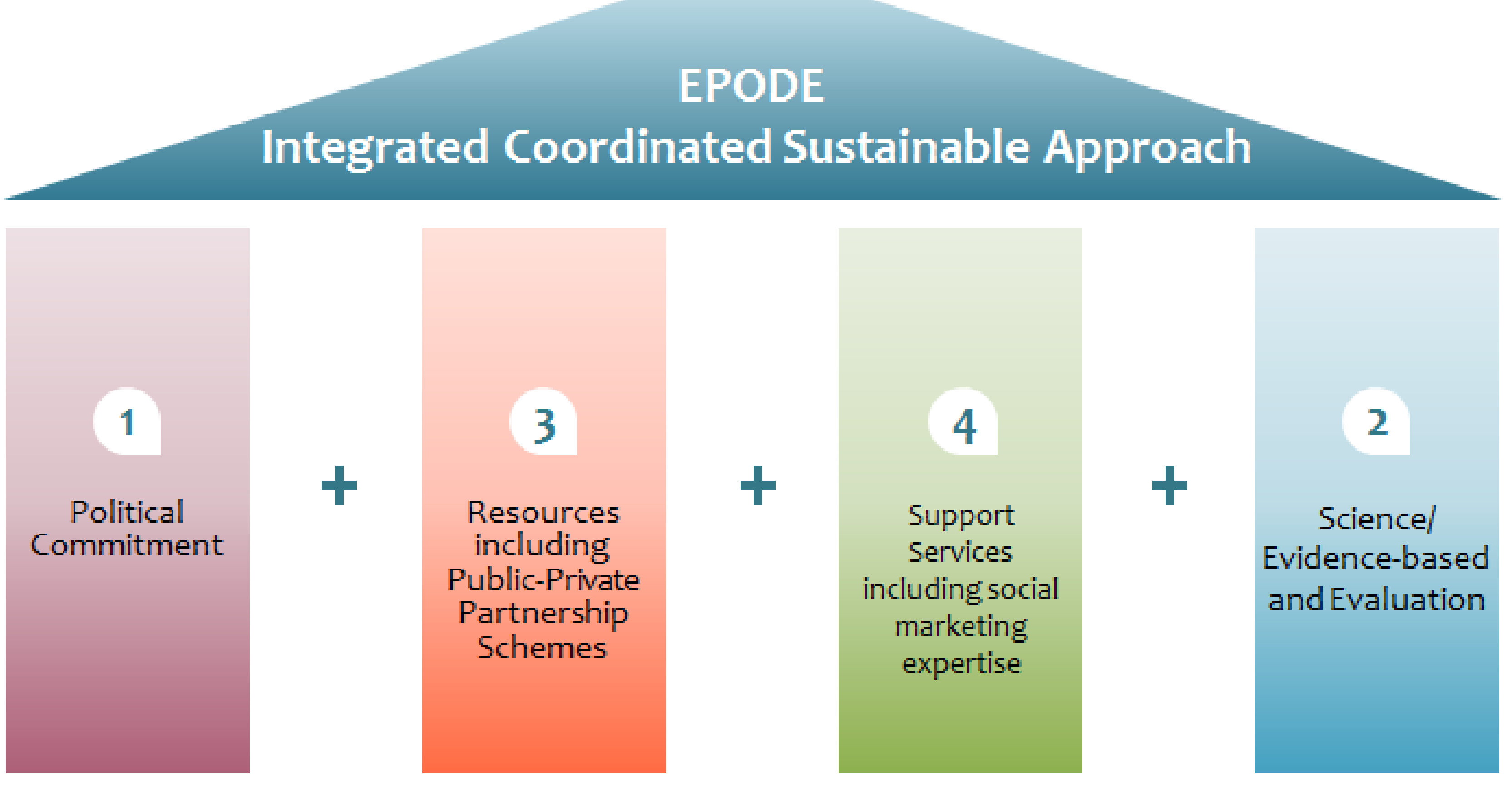
Results FLVS, 1992 – 2004

Prevalence of Overweight and Obesity

(1) Romon & Al., Public Health Nutrition, 2009; 12: 1735–1742

The EPODE Model

EPODE Pillars of Success



Building Resilient Communities to Address ACEs

"Community resilience is a measure of the sustained ability of a community to utilize available resources to respond to, withstand, and recover from adverse situations."

Why Invest in A Healthier Future?

Embracing healthier lifestyles can have a significant impact on healthcare costs and quality of life.

The Research-Based Reality:

"For every dollar we spend on prevention, we see a five-to-one return on investment in just five years. We simply can't fix our economy without it."

-- The Prevention Institute

Examples of Our Community Embracing Healthy Habits

2017 Heart Walk with NMC and Vermont Precision Tools employees

- RiseVT is actively working with 46 businesses, fostering employer-based **wellness initiatives for over 3700 employees**;
- RiseVT created the **Small Business Umbrella** (SBU) in St. Albans for micro businesses (less than 15 employees) in 2016 and it is being replicated in Enosburg and Swanton in 2017.
- The Mayor proclaimed St. Albans a "**breast feeding friendly city**" as a result of the SBU initiative which boosted the number of breast feeding friendly businesses from 4 to more than 50.

Examples of Our Community Embracing Healthy Habits

RiseVT assisting with healthy community design in Swanton.

- RiseVT's work with 9 municipalities has led to the **installation of signage** around community parks and paths, a **complete streets design in Swanton**, and the development of **the first sidewalks in Highgate**.
- This year RiseVT is working to assist in advancing **20 policies in municipalities**.

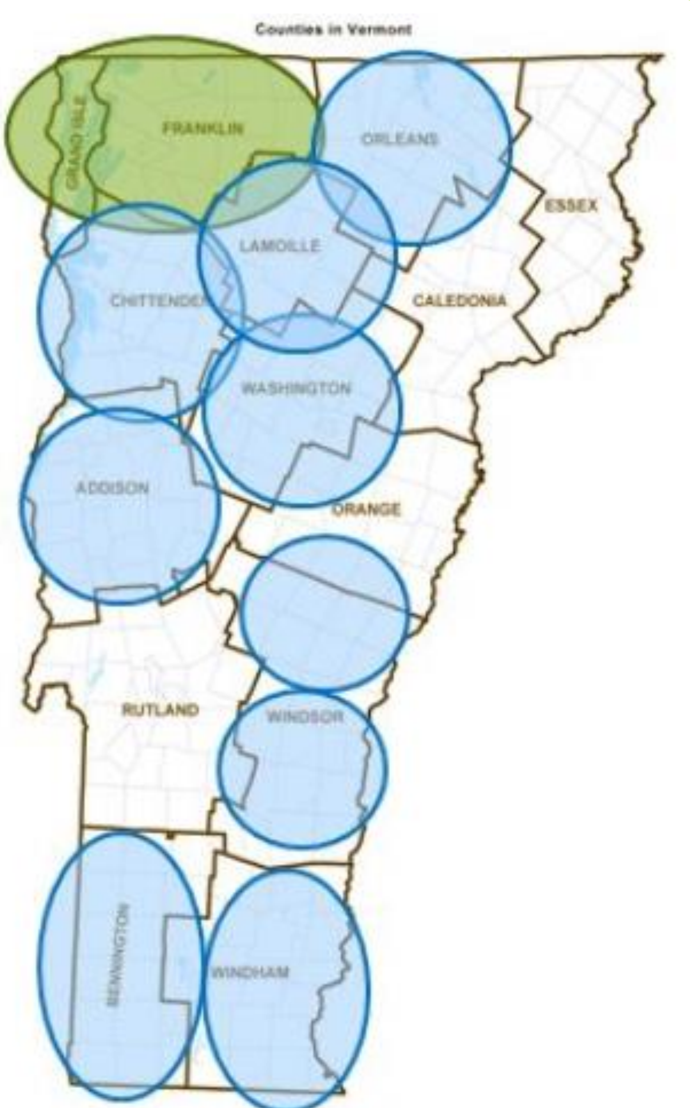
Examples of Our Community Embracing Healthy Habits

Local school children and parents on the walking school bus.

- RiseVT is partnering with 16 schools in our region which has led to a greater levels of engagement in **Safe Routes to School**.
- RiseVT has increased the capacity of Local Motion in our region, leading to over **2000 children trained in bike safety** and having acccess to helmets.
- RiseVT influenced **extended days in 2 schools** to provide children with more opportunities to move and play.
- RiseVT was awarded a Voices For Healthy Kids Grant to support grassroots support for **wellness policy creation and adoption by school boards**.

RiseVT – An Exciting Future

Moving Forward with



Statewide RiseVT Board of Directors

- **Jill Bowen**, CEO of Northwestern Medical Center;
- **Eileen Whalen**, COO of UVMMC;
- **Steve Gordon**, CEO of Brattleboro Memorial;
- **Don George**, CEO of BC/BS;
- **Dr. Mark Levine**, Commissioner of Health;
- **Todd Moore**, CEO of OneCareVT;
- **Chris Hickey**, NMC Chief Financial Officer
- **Winton Goodrich**, Superintendent of Schools, Franklin Northwest
- **Dr. Deanne Haag**, Pediatrician; and
- **Janet McCarthy**, Franklin County Home Health Agency, NMC Board, OneCareVT Board
- **Lisa Ventriss**, Executive Director of Vermont Business Roundtable
- **Beth Tanzman**, Executive Director, Vermont Blueprint for Health

Keeping Healthy People Healthy

Population Based Health Care Approach

- 44% of the population
- Focus: Maintain health through preventive care and community-based wellness activities
- Examples:
  - Rise VT primary prevention program
  - PCMH panel management
  - Wellness campaigns (e.g. 3-4*0*-50, health education and resources, wellness classes, parenting education)

- 40% of the population
- Focus: Optimize health and self-management of chronic disease
- Examples:
  - HTN Peer-to-Peer Learning Collaborative
  - QI Change Packages
  - CHT resources (e.g. tobacco cessation, nutrition & physical activity coaching, diabetes self management
  - Patient resource library in Care Navigator (in progress)

b/o psychosocial determinants

Category 1:
Healthy/Well
(includes unpredictable unavoidable events)
LOW RISK

Category 2:
Early Onset/
Stable Chronic
Illness
MED RISK

VERY HIGH RISK
Category 4:
Complex/High Cost
Acute Catastrophic

HIGH RISK
Category 3:
Full Onset Chronic
Illness & Rising Risk

- 6% of the population
- Focus: Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- Examples:
  - Complex care coordination: lead care coordinator, shared care plans, care conferences
  - Community QI projects on hospice utilization
  - Provider and patient education on palliative care (e.g. September OCV Grand Rounds)

16% Lives
40% Spending
89% Multiple Chronic
67% MH Condition

- 10% of the population
- Focus: Active skill-building for chronic condition management; identify & address co-occurring SDoH
- Examples:
  - Embedded mental health in primary care
  - SDoH screening (e.g. food insecurity in/out patient peds; VT Self Sufficiency Outcomes Matrix for patients with complex CC needs)
  - Care coordination: coordinate among care team members; shared care plans, transitions of care

Assembling an Exceptional Team

Elisabeth Fontaine, MD
Medical Director, RiseVT

Marissa Parisi
Executive Director, RiseVT Statewide

Emilia Wollenburg
Program Manager, RiseVT Statewide

Next Steps

Advancing the statewide expansion of RiseVT

- Onboarding the statewide staff in Dec & Jan
- Developing primary prevention population health indicators within the ACO
- Scaling up in 10 communities
- Hosting statewide education with EPODE

Summary

- RiseVT is a movement to amplify the great work and community assets that already exist and to further support a common methodology for primary prevention.
- RiseVT is an evidence based primary prevention strategy that is adaptable and transferable to meet the community's needs.
- RiseVT places the emphasis on children and community based intervention, in a collective impact framework of a community working together with a common purpose.
- RiseVT is creating the conditions in our communities to support making the healthy choice the easy choice.

RISE VT
Embracing Healthy Lifestyles

Integrating Behavioral Health and MAT into Medical Services

Naya Pyskacek, LICSW, LADC
Director of Integrated Behavioral Health Programs
Community Health Centers of Burlington

12/21/17

Community Health Centers of Burlington

Federally Qualified Health Center serving 29,0000 patients with medical, dental, and BH services

- Riverside Health Center
- Safe Harbor Health Center
- Pearl Street Clinic
- Champlain Island Health Center
- South End Health Center
- Good Health
- Winooski Family Health Center

Integration of Behavioral Health into Primary Care at CHCB

- 2000: Started hiring additional social workers for clinical work.
- 2001: Building renovation. Created **POD model**. Clinical Social Workers integrated into the POD structure.
- 2002: Received our first **HRSA Mental Health/Substance Abuse expansion grant** to integrate mental health and substance abuse into primary care. Able to hire more clinical staff – Behavioral Health Consultation Model.
- 2003: Started providing **Buprenorphine treatment**
- 2008: Received our second **MH/SA Expansion grant.**

  * Hired an additional clinical social worker at Safe Harbor site to staff SHHC Housing First Program. Added psychiatry staff.

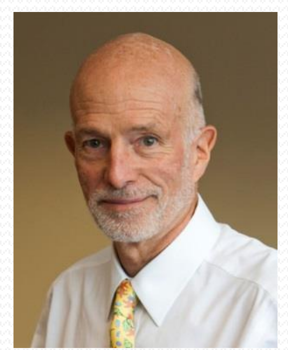
BH integration

- **2013:** Received a **SBIRT grant** to provide: screening, brief intervention, and referral to treatment
- 2014: Received our third MH/SA Expansion grant.
    - * Adding child therapy, case managers, psychiatric nurse practitioner

BH integration

- 2016: Received our fourth HRSA MH/SA Expansion grant – **SBIRT/MAT:**

- Expands universal screening to adolescents
- **Increases our buprenorphine physician prescribing time**
- With this grant, our Buprenorphine Panel increased from 130 to over 374 patients. Dr. Beach Conger had largest expansion.



- Creates a **Pain Team** fashioned after the MAT team to monitor and support patients with chronic pain Hired Gloria French, RN to monitor panels:
- Total patients on opioid analgesics at CHCB: 698
- Patients with 90 mg or over MMEs: 175

Current Behavioral Health Staff

Behavioral Health Clinicians/Therapists Embedded into our Clinics = 19

- 10 LICSWs at our Riverside site – dually certified or licensed with AAP or LADC
- 2 at SHHC
- 1 at Pearl Street Clinic
- 1 at Champlain Island Health Center
- 3 at South End
- 1 Good Health
- 1 at Winooski Family Health

Clinical Care Coordinators:

- **2.5 MAT Teams** for Spoke Services (OBOT) – Buprenorphine treatment, 2 Spoke RNs and 3 LADC Clinical Care Coordinators
- Pain Team RN

Case Managers:

- 2 social work case managers

Psychiatry: 6 psychiatric providers (5 FTEs)

Unique Model

Primary Care Behavioral Health Model:

- Universal screening for all patients for depression and substance use

- BH is integrated into the team in the medical clinic
- We work alongside nurses and medical providers
- Integrated electronic medical record
- We can refer to in-house specialty MH/SA services in-house

Embedded BH into primary care team: BH Consultation Model

- CHCB Delivery System Design in medical clinic: pods
- Integrated Team: Medical Providers, Nurses or MAs, and LICSW/LADCs
- *Allows for:*
  - Routine BH screening, brief intervention and referral as part of visit
  - BH integration at point of primary care visit
  - Curbside Consultation by BH to nurse and medical provider in real time

Incorporating BH into the Chronic Care Model

- Population Focused approach to treating chronic conditions
- Allows us to provide more behavioral health services to a greater number of people by providing BH interventions during the medical visit – “tending the flock”
- Not all patients need the traditional “45 minute hour” of traditional psychotherapy – and we could not serve all of our patients with MH concerns with traditional models

Increasing contacts

- If we provided traditional counseling only, we might help 200 – 300 people per year.
- With a stepped care model, we worked with over 2,500 BH patients last year
- 9,000 encounters

“Warm Hand Off”

- Once Nurses do initial screening and a score is positive,
- Nurses can provide a “warm hand off” to Behavioral Health

- **The beauty of universal screening protocols is that:**

- they are like standing orders
- There is already an “order” by the medical provider to refer to BH if there is a positive screen.

Primary Care BH: 20 – 30 mins BH Intervention by LICSW/LADCs

- Secondary Screenings
- Rapid Assessment: MH/SA
- Brief intervention
- Referral to Treatment/linkage to other resources
- Consultant to Patient and Medical Provider – provide "curbside consultation" in real time.

Brief Interventions for:

- Depression/Anxiety
- Addiction
- Smoking cessation
- Insomnia
- Stress Reduction
- Other medical conditions that would benefit from BH/Behavioral medicine interventions
- Motivational Enhancement
- Self Management Goal Setting
- **SBIRT Model** for MH, SA, and health and behavior

Primary Care BH Services for CHCB Patients

- Behavioral Health Consultation in medical clinic:
- Starting point for referral to specialty services

With referral to:

- ✓ Co-occurring brief treatment, longer term therapy for mental health and addiction, groups, and trauma infomed counseling including: EMDR, Seeking Safety group
- ✓ Case management
- ✓ Psychiatry
- ✓ MAT Services

Screening for MAT in medical clinic

- Nurses
- Initial Screening: PHQ-2, Audit-C and Drug use question
- Behavioral Health
- Secondary Screening: PHQ-9, Full Audit, DAST-10, PCL-5, GAD-7 and others
- If pt inquiring about MAT – Treatment Needs Questionnaire (TNQ), OCACC multiparty release

Screening for MAT

TNQ score of 10 or less: refer for further assessment by LICSW/LADC at CHCB.

- Psychosocial Assessment – ASAM risk assessment, level of care recommendation
- If OBOT appropriate – refer to MAT teams
- Stay at CHCB OBOT

TNQ score of 11 or more: refer to HUB

MAT at CHCB

- 15 prescribing physicians
- 1 PMHNP
- 2 APPs
- 2.5 MAT Teams
- 374 patients receiving buprenorphine treatment

- Patients can access our co-occurring counseling, psychiatry services, and other case management services in addition to MAT team support.

OCACC/Triage Team

- CHCB participates with Howard Center, UVMMC Family Practices, UVMMC Addiction Treatment Program, ADAP
- Collaborate on referrals and community response to treatment needs.

Increasing Access

- MAT Teams – panel management, protocols, and team based care increases physicians willingness to increase the number of people to whom they prescribe

- Since October, 2016, we increased from 130 – 374 patients

- Community Collaboration – increases willingness of providers to prescribe because they know we can refer to another level of care

References for Primary Care BH

- Blount, A., ED.D (1998). Integrated Primary Care: the Future of Medical and Mental Health Collaboration. New York: W.W. Norton and Company.
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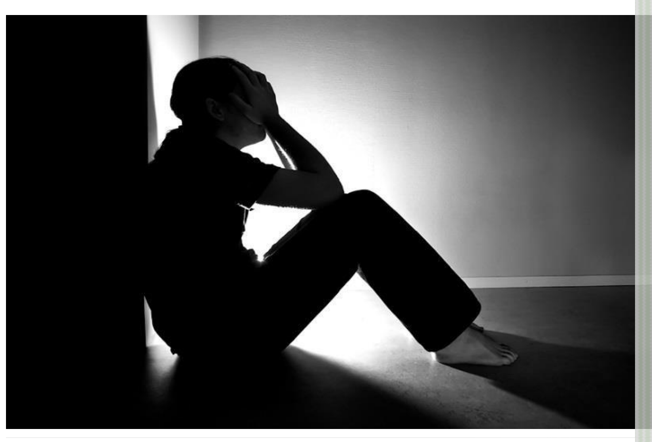
- Serrano, N., PsyD; Monden, K. Ph.D. (2011). The effect of behavioral health consultation on the care of depression by primary care clinicians. *Wisconsin Medical Journal*. 110 (3).
- Young, J., LICSW; Gilwee, J., MD; Holman, M. RHIA, CHDA; Messier, R. MT, MSA; Kelly, M., BA.; Kessler, R. Ph.D. (2012). Mental health, substance abuse, and health behavior intervention as part of the patient-centered medical home: a case study. *Translational Behavioral Medicine*. 2(3): 345-354.

FamilySTAT

An introduction…



High risk/high needs families who are struggling with addiction and are at risk of separation because of incarceration and/or death.

Immediate Response Team Identification (IRT)

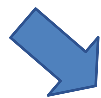
FSD (Family Services Division) Intake Social Worker identifies a client	ESD (Economic Services Division) Reach Up Worker identifies a client

Referral to:

Aime Baker Lund SA Case Manager at FSD	Kyla Boyce Howard Center Wellness Coach at ESD

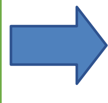
Assessment & Treatment {Parents}

Lund SA Clinician completes assessment if needed and/or coordinates with current preferred provider	Howard Center SA Clinician completes assessment and/or coordinates with current preferred provider



Parent(s) meet IRT criteria

Emergency Family Safety Planning (FSP) meeting to focus on the needs of the child(ren) while parent(s focus on treatment.



Parent(s) who meet IRT criteria will be referred to the FamilyStat Service Coordination Team (which will meet monthly to review case progress)

Referral Source:

- FSD (Family Services Division) clients are identified by the front end team (intake), with a focus on CF cases (CF = Child and Family; open support cases, non-court involved)
- ESD (Economic Services Division) Reach Up clients

Criteria to access FamilySTAT:

- Parent(s) with a substance use disorder
- Child(ren) have been or are at high risk of being removed from the home
- FSD and/or Reach Up clients
- Parent(s) qualifies for residential, IOP (Intensive outpatient), Outpatient, or PHP (partial hospitalization program)
- Willingness to engage in treatment

Service Coordination looks at
(using the CPFST- Child Protection and Family Support Team model)**:**

- Treatment
- Housing
- Child Care
- Employment
- Other

FamilySTAT Service Coordination Team:

Meets *monthly* to review cases and includes:

Sally Borden (KidSafe)	Liz Nault/Beth Maurer (FSD)	Peggy Heath/Jess Holmes/Leslie Stapleton (ESD)
Jackie Corbally	Jan Schamburger	Mitch Barron
Parent navigator (TBD)	Sarah Russell (BHA)	Jane Helmstetter
Ann Dillenbeck/Liz Mitchell	DOC (TBD)	Julie Coffey (STEPS)
Julie Ryley (DV Specialist, FSD)	Mark Ciociola (Voc Rehab)	Chittenden Clinic

How will the team track "Is anyone better off?":

- Outcomes oriented by reviewing progress via:
  a) Risk Assessment and Risk Re-Assessments (FSD)
  b) Self-Sufficiency Matrix (ESD)- includes housing, wellness, education, employment, community, etc.
  c) Did child(ren) come into custody?
  d) Time between removal from home and reunification
  e) Timely access to treatment (documenting days between assessment of need and entry into treatment)
  f) Was parent incarcerated?

- Gaps remain in our system of care.
- We do not have safe beds/homes.
- We do not have adequate sober housing options (short and long term) for families.
- This model will not meet the needs of every parent in our county.
- The system needs to identify other community agencies who will serve people not a part of FamilySTAT.
- We do not currently have a universal method to capture overdose data on FamilySTAT clients.

Chittenden Hub Average Treatment & Waitlist Volume 2014 - 2016

Treatment

Average # of individuals receiving Hub MAT

1000
950
900
850
800
750
700
650
600
550
500

725
957

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4* Q1†

2014 2015 2016 2017

Waitlist

Average # of individuals awaiting treatment

500
450
400
350
300
250
200
150
100
50
0

215
130

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4* Q1†

2014 2015 2016 2017

Data Source: Vermont Department of Health

* Data in Quarter 4, 2016 does not include data from December

† Data in Quarter 1, 2017 is preliminary and is subject to change

Individuals Treated in Chitt. Cty. Hub & Spokes

Individuals Receiving MAT in Chittenden Cty. Hub & Spokes, by Provider

1800
1600
1400
1200
1000
800
600
400
200
0

507

1004

Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

2016 2017

Total Spoke, Hub, CHCB, Community, Lund, Maple Leaf, Total UVM MC, Howard Spoke, COGS, ATP

Data Source: Vermont Department of Health and Opioid Care Alliance of Chittenden County

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Individuals Treated in Chitt. Cty. Hub & Spokes

Individuals Receiving MAT in Chittenden Cty. Hub & Spokes, by Provider

1800
1600
1400
1200
1000
800
600
400
200
0

Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

2016 2017

Total Spoke, Hub, CHCB, Community, Lund, Maple Leaf, Total UVM MC, Howard Spoke, COGS, ATP

Data Source: Vermont Department of Health and Opioid Care Alliance of Chittenden County

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Individuals Treated in Chittenden Cty. Spokes

Individuals Receiving MAT in Chittenden County Spokes, by Provider

800
700
600
500
400
300
200
100
0

474
663
507

Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

2016
2017

Total Spoke, CHCB, Community, Lund, Maple Leaf, Total UVM MC, Howard Spoke, COGS, ATP

Data Source: Vermont Department of Health and Opioid Care Alliance of Chittenden County

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Individuals Treated in Chittenden Cty. Hub

Individuals Receiving MAT in Chittenden County Hub, by Month

1200
1100
1000
900
800

899
1009
1004

Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

2016 2017

Data Source: Vermont Department of Health and Opioid Care Alliance of Chittenden County

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Chittenden Hub Waitlist Volume & Delay

Chittenden County Hub-Level Active Waitlist Volume & Average Wait Time

	# Individuals Waiting	Average Days Waiting	Median Days Waiting
1/9-2/18	138	80	67
2/19-3/18	130	84	75
3/19-4/18	93	71	67
4/19-5/18	87	58	44
5/19-6/18	62	58	47
Jun	53	41	
Jul	59	23	
Aug	23	24	
Sep	0	7	
Oct	0	11	
Nov	0	14.87	
Dec			

Data Source: Howard Center Triage Report

Chittenden Hub Admission Volume & Delay

Chittenden County Hub-Level Admission Volume & Average Wait Time

	1/19-2/18	2/19-3/18	3/19-4/18	4/19-5/18	5/19-6/18	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# Individuals Admitted	35	37	46	43	34	25	38	44	37	42	39	
Average Days Waiting	40	28	46	53	39	40	23	24	7	11	14.87	
Median Days Waiting	21	14	23	35	15							

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Burlington EMS Naloxone Administration Jan – Oct, 2016

Medication Administered Report

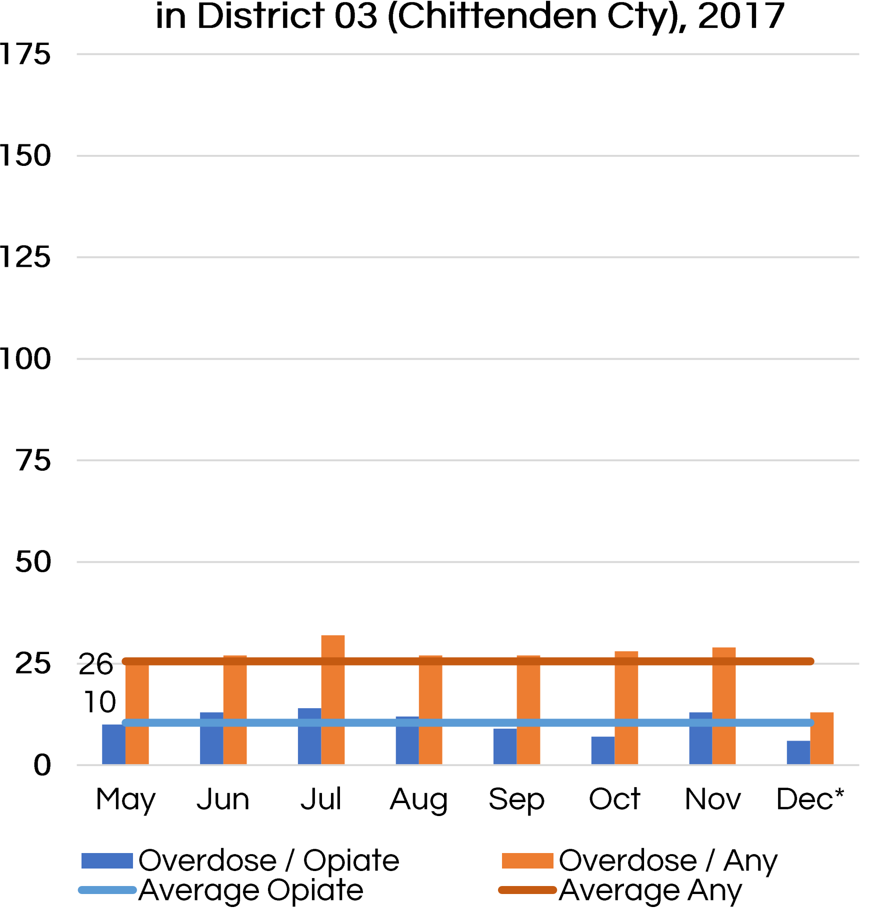
IMAGETREND
EMS SERVICE BRIDGE

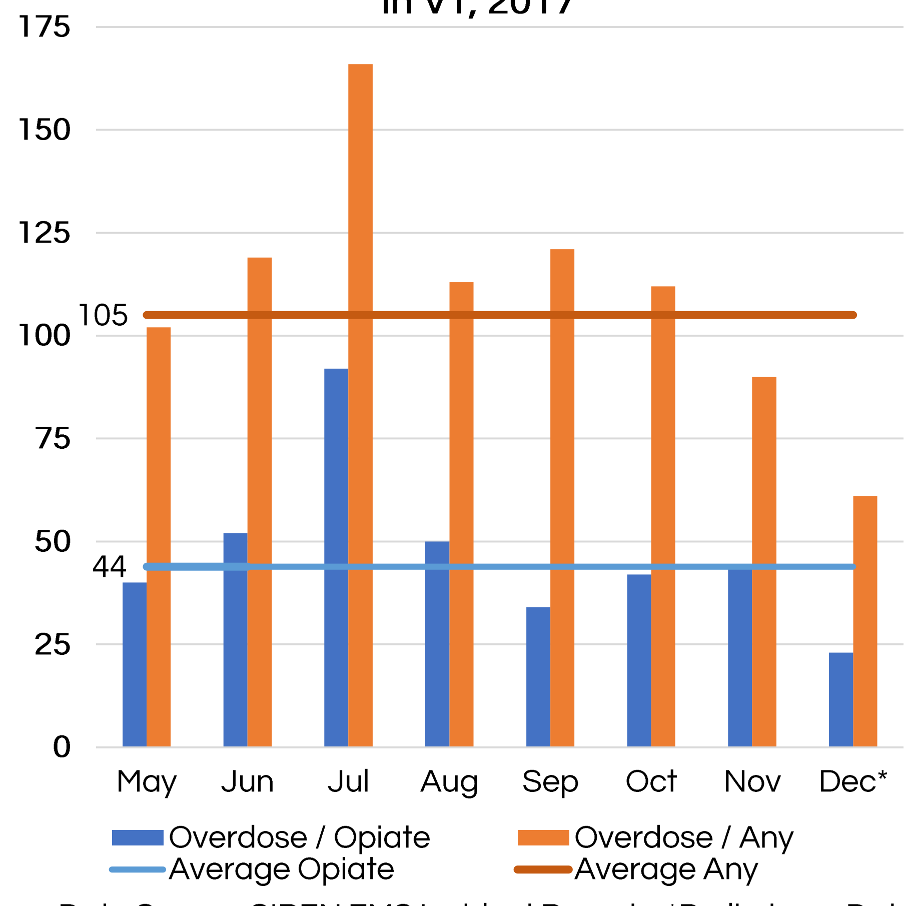
Medication Administered Report
From 01/01/16 To 10/25/16

Medication	# of Times Administered
Adenosine	6
Albuterol Sulfate	20
Amiodorone (Cordarone)	7
Aspirin (ASA)	86
Atropine Sulfate	3
Calcium Chloride	2
Dextrose 10% (D10)	14
Dextrose 50% (D50)	8
Diazepam (Valium)	4
Diltiazem (Cardizem)	3
Diphenhydramine (Benadryl)	1
Epi-Pen Adult	6
Epinephrine 1:10,000	96
Fentanyl	114
Glucagon	2
Glucose (Oral)	22
Ipratropium 0.5/Albuterol 2.5 (DuoNeb)	40
Ipratropium Bromide	9
Ketamine	6
Metoprolol (Lopressor)	1
Midazolam (Versed)	11
Morphine Sulfate	3
Naloxone (Narcan)	40
Nitroglycerin	48
Normal Saline	331
Ondansetron	61
Oxygen (non-rebreather mask)	112
Oxygen by Blow By	2
Oxygen by Mask	22
Oxygen by Nasal Cannula	243
Oxygen by Nebulizer	3
Oxygen by other means	4
Oxygen by Positive Pressure Device	22
Total	**1352**

Data Source: SIREN v1

VT EMS Responses to Overdose Incidents





Data Source: SIREN EMS Incident Reports, *Preliminary Data

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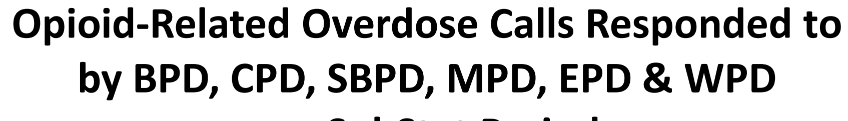
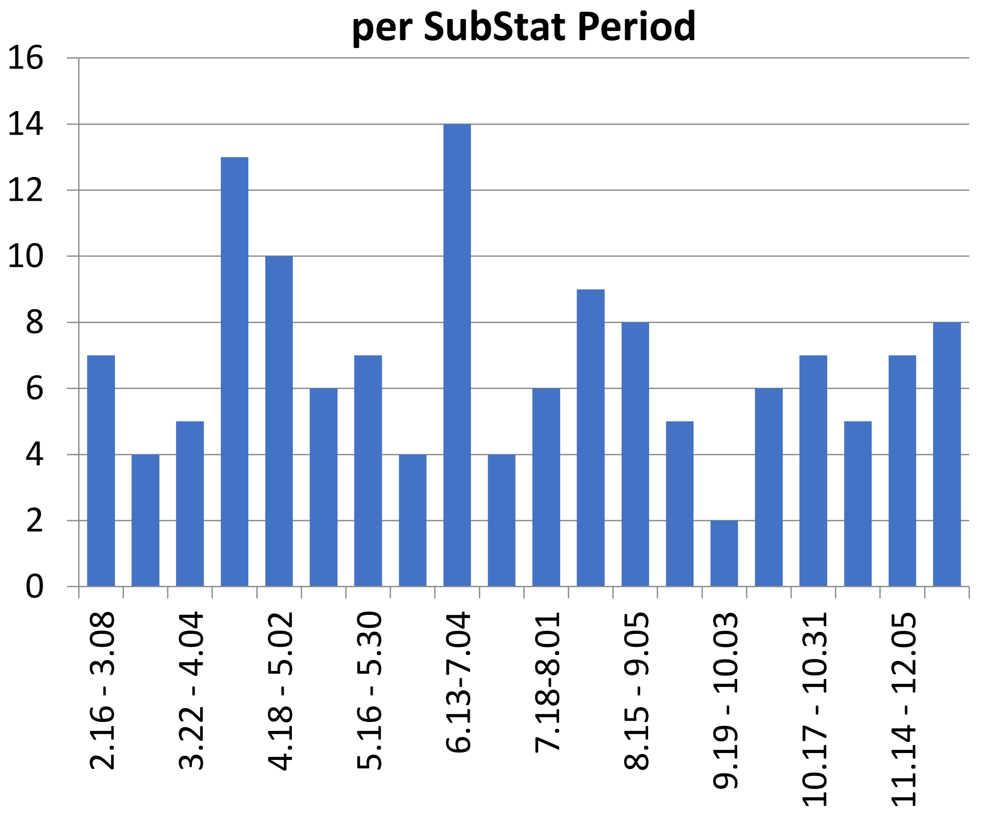
Burlington Police Department Heroin Violations 2012 – 2016

Data Source: Burlington Police Department

SubStat Opioid-Related Overdose Incidents





11

Non-Fatal Opioid-Related Overdose Incidents Among SubStat Partners Since Nov. 14th

3

Fatal Opioid-Related Overdose Incidents Among SubStat Partners Since November 14th

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SubStat Opioid-Related Overdose Incidents

Opioid-Related Overdose Calls Responded to
by BPD, CPD, SBPD, MPD, EPD & WPD per SubStat Period

16
14
12
10
8
6
4
2
0

8.01-8.15 | 8.15 - 9.05 | 9.05 - 9.19 | 9.19 - 10.03 | 10.03 - 10.17 | 10.17 - 10.31 | 10.31 - 11.14 | 11.14 - 12.05 | 12.05 - 12.19

■ Non-fatal Overdose Incidents ■ Fatal Overdose Incidents

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Chittenden County Opioid-Related Accidental Fatal Overdoses, ‘10 – ‘15

Accidental Fatal Overdoses Involving Opioids in Chittenden County by Opioid Type

Opioid Related Fatalities (#)

24
18
12
6
0

13
17
17
18
19
20
16
5

2010
2011
2012
2013
2014
2015

All Opioids
Rx Opioid (No Fentanyl)
Heroin & Fentanyl

Data Source: http://healthvermont.gov/research/documents/databrief_drug_related_fatalities.pdf

VT Opioid-Related Accidental Fatal OD

Number of Opioid-Related Accidental Fatal Overdoses in Vermont, by Opioid Type

120
110
100
90
80
70
60
50
40
30
20
10
0

41
61
50
69
61
75
106
102
72
38

2010
2011
2012
2013
2014
2015
2016
2017 (thru Sep)

All Opioids
Rx Opioid (No Fentanyl)
Heroin & Fentanyl

Data Source: Vermont Department of Health

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Monthly Opioid-Related Accidental Fatal OD, 2017

BURLINGTON POLICE VERMONT

Monthly Opioid-Related Accidental Fatal Overdoses by Region, 2017

Month	Vermont	Chittenden Cty.
Jan	7	3
Feb	10	1
Mar	12	4
Apr	8	4
May	5	2
Jun	8	2
Jul	12	4
Aug	6	3
Sep	4	2

Data Source: Vermont Department of Health

Monthly Opioid-Related Fatal/Non-Fatal ODs, '17

VT Opioid-Related Overdose Fatalities VS VT EMS Overdose Incidents,
January – November 2017

15
10
5
0

210
140
70
0

7
10
12
8
5
8
12
6
4

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

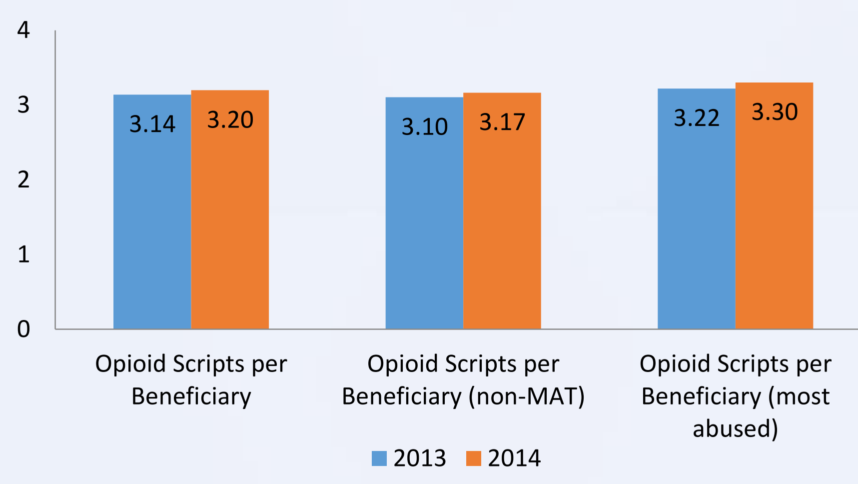
OD Fatalities
EMS "Overdose / Any"
EMS "Overdose / Opiate"

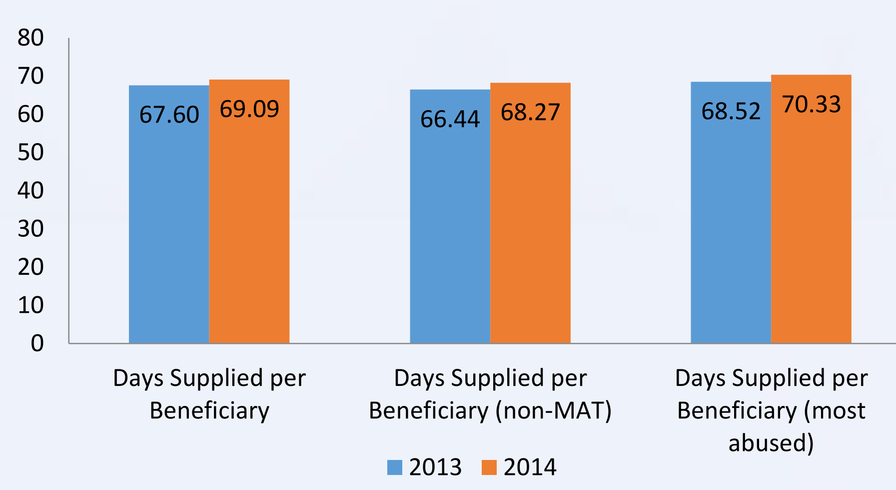
Data Source:

ecosproject.com/chittenden-county-opioid-alliance/

Medicare Data Analysis Findings: ‘13 to ‘14

From 2013 to 2014:
Doctors increase rate of opioids prescribed and number of days supplied



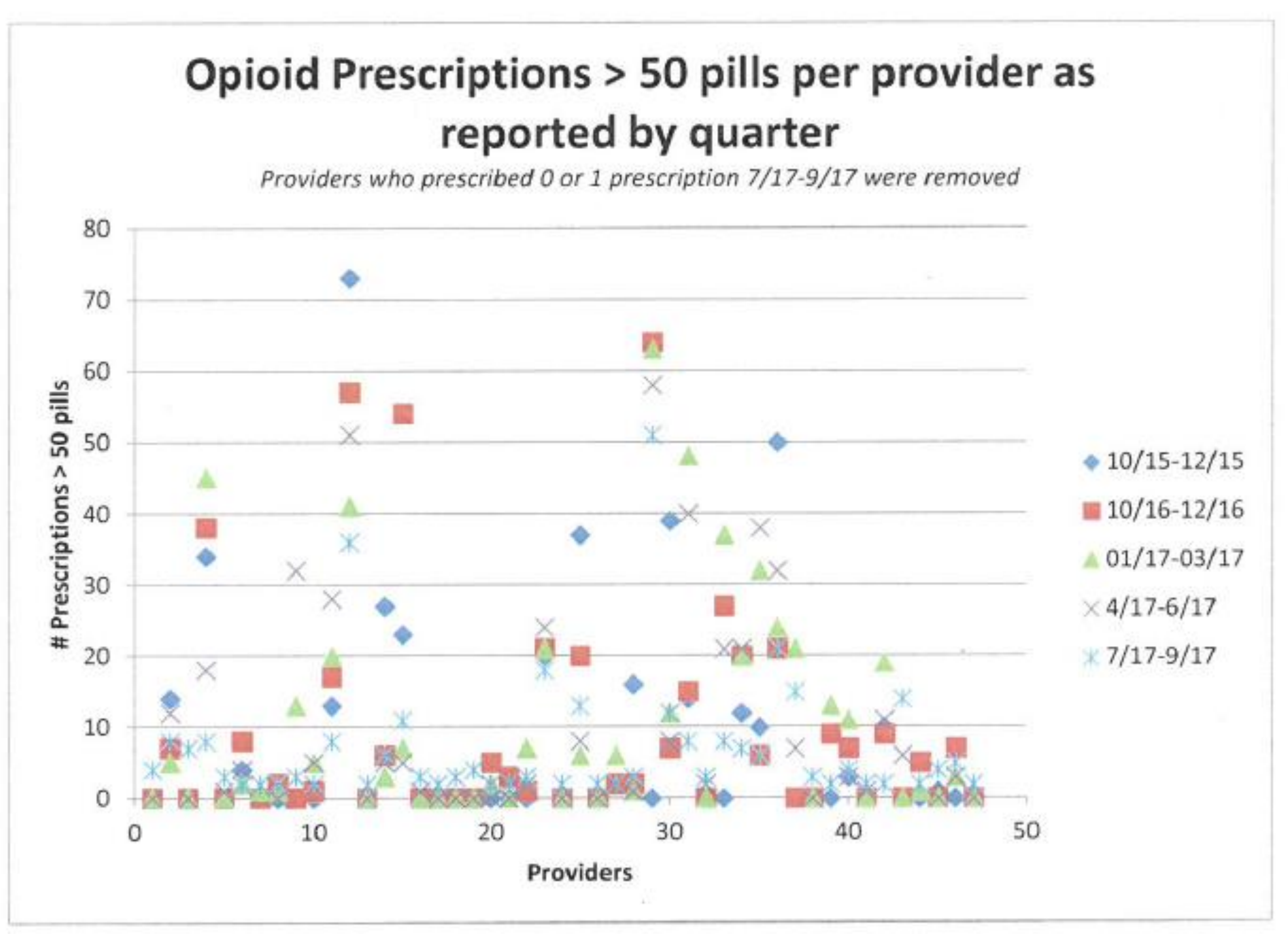


11,000 (9%) more opioid scripts in 2014

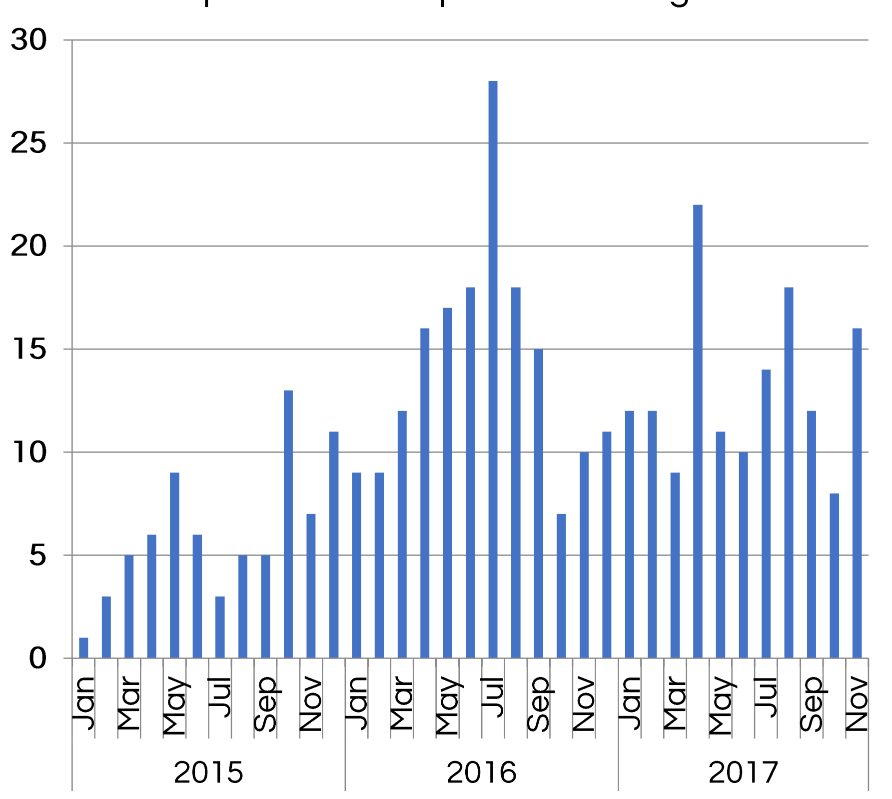
1.5 days longer supply periods in 2014

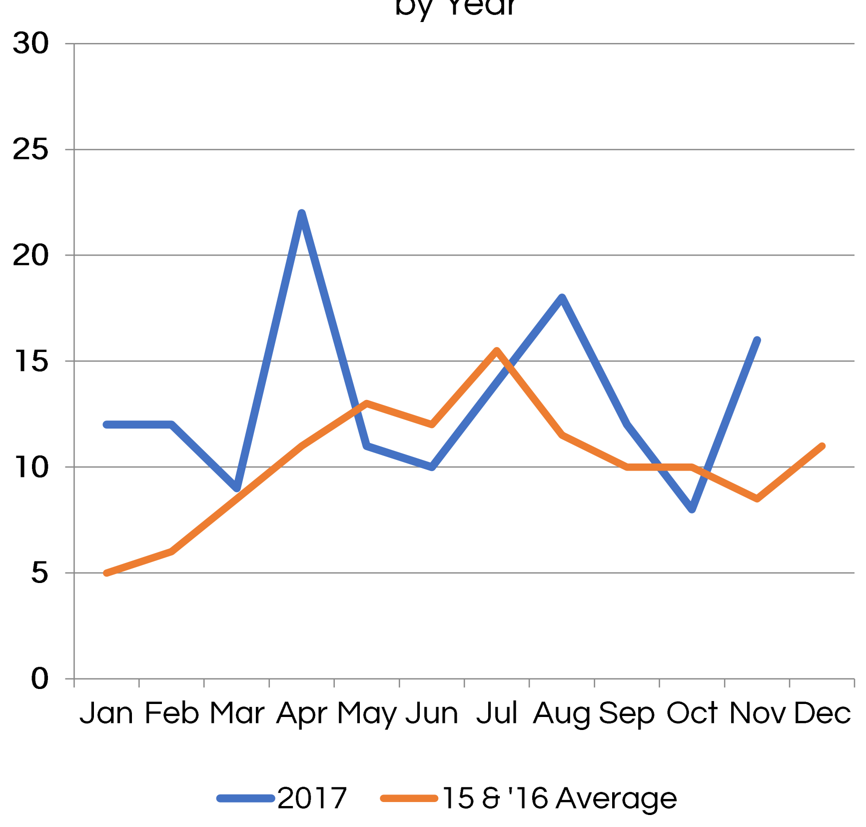
If we remove providers who prescribed 0 or 1 prescription in the most recent quarter (7/17-9/17) the graph demonstrates a reduction of the number of prescriptions over 50 pills per prescription per provider. For the purposes of graphically reporting the data, they have been omitted from the scatter chart below.

b. **Opioid Prescriptions > 50 pills per provider**



UVM Medical Center Opioid-Related ED Visits





Data Source: UVM MC ED

ecosproject.com/chittenden-county-opioid-alliance/

UVM Medical Center Opioid-Related ED Visits

Discharge Disposition of UVM MC ED Encounters
With Dx Code "Opioid OD/ Poisoning", by Year

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2015 2016 2017

- D/T COURT/LAW ENFORCEMENT
- D/T PSYCH HSP/PSYCH DIST PRT UNIT HSP w/PACHIPR
- TRANSFER OTH REHAB
- DISCH/TRAN TO SNF W/ MCR CERT
- DECEASED
- D/T DIFF TYPE HEALTHCARE FACILITY
- HOSPICE-HOME
- OTHER HOSPITAL
- AGAINST MEDICAL ADVICE
- PSY HOSP OR PSYCH DISTINCT UNIT
- HOME HEALTH CARE
- **HOME OR SELF CARE (ROUTINE)**

ecosproject.com/chittenden-county-opioid-alliance/

UVM Medical Center Opioid-Related ED Visits

2017 Discharge Disposition of UVM MC ED Encounters
With DX Code "Opioid OD/ Poisoning", by Month

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

- TRANSFER OTH REHAB
- HOME HEALTH CARE
- DISCH/TRAN TO SNF W/ MCR CERT
- DECEASED
- D/T DIFF TYPE HEALTHCARE FACILITY
- PSY HOSP OR PSYCH DISTINCT UNIT
- AGAINST MEDICAL ADVICE
- **HOME OR SELF CARE (ROUTINE)**

Data Source: UVM MC ED

ecosproject.com/chittenden-county-opioid-alliance/

UVM Cooccurring Endocarditis & Drug Abuse Diagnoses

Incidents of Endocarditis & Drug Abuse Diagnosis Code in Same Visit, by Fiscal Year (Oct-Sep)

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Visits	10	11	23	59	80
Unique Patients	9	10	18	50	59

Data Source: University of Vermont Medical Center

ecosproject.com/chittenden-county-opioid-alliance/

Spoke Provider Treatment Rates

Spoke Patients, Providers & Staffing: December 2016

Region	Total # MD prescribing to patients	# MD prescribing to ≥ 10 patients	Staff FTE Hired	Medicaid Beneficiaries	Beneficiaries / Prescribing MD	Rate of MDs w/ 10+ Patient
Bennington	9	4	5.6	229	25.4	44%
St. Albans	15	10	5.6	382	25.5	67%
Rutland	12	7	4.9	253	21.1	58%
Chittenden	70	16	13.9	596	8.5	23%
Brattleboro	10	5	2.57	145	14.5	50%
Springfield	4	1	1.5	53	13.3	25%
Windsor	6	3	4	161	26.8	50%
Randolph	7	5	2.1	145	20.7	71%
Barre	19	8	5.5	273	14.4	42%
Lamoille	9	3	3.2	151	16.8	33%
Newport & St Johnsbury	14	2	2	95	6.8	14%
Addison	5	2	2	74	14.8	40%
Upper Valley	4	0	1.5	13	3.3	0%
Total	180	63	54.37	2572	14.3	35%

Table Notes: Beneficiary count based on pharmacy claims October – December, 2016; an additional **167** Medicaid beneficiaries are served by **32** out-of- state providers. Staff hired based on Blueprint portal report 1/17/17. *4 providers prescribe in more than one region.

Spoke Provider Treatment Rates

Spoke Patients, Providers & Staffing: October 2017

Region	Total # MD prescribing to patients	# MD prescribing to ≥ 10 patients	Staff FTE Hired	Medicaid Beneficiaries	Beneficiaries / Prescribing MD	Rate of MDs w/ 10+ Patient
Bennington	11	4	5.2	230	20.9	36%
St. Albans	17	9	9.1	396	23.3	53%
Rutland	19	7	5.2	316	16.6	37%
Chittenden	82	12	14.8	508	6.2	15%
Brattleboro	10	6	3.7	133	13.3	60%
Springfield	5	2	1.55	53	10.6	40%
Windsor	10	4	4	198	19.8	40%
Randolph	7	4	3.1	100	14.3	57%
Barre	19	6	6.2	250	13.2	32%
Lamoille	15	5	4.8	242	16.1	33%
Newport & St Johnsbury	13	2	2	91	7.0	15%
Addison	7	2	2	84	12.0	29%
Upper Valley	4	0	1.5	17	4.3	0%
Total	212	59	63.15	2617	12.1	28%

Table Notes: Beneficiary count based on pharmacy claims August – October, 2017; an additional **287** Medicaid beneficiaries are served by **35** out-of- state providers. Staff hired based on Blueprint portal report 11/22/17. *6 providers prescribe in more than one region.

Data Source: Opioid Use Disorder Treatment Census and Wait List, Oct. '17

Next CommStat Meeting

- 1/25 (Thursday) 8:30-11:00 AM
- Contois Auditorium