NJ Rural Health Advisory Committee:
Addressing the Effects of Opioid Use and Diabetes
November 16, 2017

Mitzi Vince: Good afternoon! Welcome to today's webinar, Addressing the Effects of Opioid Use and Diabetes. My name is Mitzi Vince and I am a communication specialist for Quality Insights and we'll be hosting today's session. We will get started with today's program in just a few minutes but first, a few housekeeping items. First, most of you are probably listening to today's webinar through your computer speakers. If you have any questions during today's presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen. If you've dialed in, we will unmute the phone lines at the end of the webinar for questions.

We will get to as many questions at the end of the presentation as time allows. Next, please note that this webinar is being recorded. The presentation, recording and slides will be available to you in the coming days. Also, at the end of today's webinar, you will be directed to take a short evaluation through SurveyMonkey. Your responses will help us, tell us how we did and it will also help us shape future programming. We thank you in advance for your help with this. Your moderator for today's webinar is Ms. Linda Johnson. Linda is a consultant and a New Jersey Role Health Advisory Committee member.

She continually work to help develop new approaches for reaching populations that have sometimes been overlooked and she has always believed that education is a key component to help communities understand the importance of maintaining a healthy lifestyle. At this time, I'll go ahead and turn the presentation over to Ms. Linda Johnson. Linda?

Linda Johnson: Thank you. Good afternoon everyone. Once again, your webinar today is Addressing the Effects of Opioid Use and Diabetes. I'd like to welcome you all. Before we began, I'm going to outline the webinar goals. Today, one of the goals is to increase awareness and linkage to appropriate care in rural and urban communities including chronic pain secondary to diabetes, communicate different modalities for the treatment of pain to prevent opioid dependence or addiction, assist and connect two treatments or recovery and resource support services, promote, improve prevention, recovery, wellness and healthy lifestyle and finally, to improve health behaviors, clinical outcomes and the quality of life.

Before we begin, I'm going to give a list of all of the presenters today. Our first presenter is Deborah Burt. Deborah is our patient representative and she resides in East Orange, New Jersey and will share her story focusing on diabetes, pain and self-management and her own issue with using opioid medication. She will also discuss other alternatives that helped her in dealing with her pain. Ms. Burt is trained in diabetes self-management as a peer leader through the united

way of Essex and West Hudson. Our second presenter is Dr. Lynda M. Bascelli. Dr. Bascelli is a practicing family practitioner in Camden, New Jersey.

Dr. Bascelli graduated from Albany Medical College in 1997 and has been in practice for 20 years. She completes the residency at Yakima Valley Memorial Hospital. She currently practices at Project H.O.P.E.and is affiliated at Memorial Hospital of Salem County and Virtua West Jersey Hospital in Berlin. Dr. Bascelli accepts multiple insurance clients including Aetna, Medicare, and Cigna. Dr. Bascelli is also a board certified in family medicine. In addition to English, the practice supports and accepts Spanish speaking patients. Our third presenter is Adam Bucon. He's with the State Opioid Treatment Authority Division of Mental Health and Addiction Services.

Adam is the State Opioid Treatment Authority for the state of New Jersey. He oversees the day to day monitoring and oversight activities necessary to implement the Substance Abuse and Mental Health Services Administration and the regulations regarding the use of medication-assisted treatment for the treatment of opioid use disorders. These activities include providing technical assistance to support the certification and accreditation requirements for all licensed opioid treatment programs throughout the state. In addition, Adam have taken an active role in implementing the Opioid Overdose Prevention Program and Opioid Overdose Recovery Program, both having the goal to prevent opioid overdose death and link those individuals who are reversed from an opioid overdose into some form of substance use disorder treatment.

Our fourth presenter is Diana Haniak. Diana is a practiced integration advisor for Healthcare Quality Strategies Incorporated, part of Quality Insights, Quality Innovation Network in East Brunswick, New Jersey. She received her BA from Ohio University and has been working with physician practices in various capacities for over 10 years. Diana joined HQSI in 2014 and has been devoted to physician practice quality improvement initiative for the centers for Medicare and Medicaid services in New Jersey. Diana works with providers and stakeholders to improve quality of care in the areas of antibiotic stewardship, cardiovascular health for million hearts, adult immunizations, opioid misuse and diversion and annual wellness visit utilization.

She also supports clinicians in quality payment programs. Diana has been a frequent contributor to essential QIN and QIO educational resources including the recently developed opioid practice change package and continues to work with providers, stakeholders and partners throughout the state of New Jersey. Our fifth presenter is Janet Knoth. Janet is currently being a quality improvement specialist at Quality Insights, Quality Innovation Network. She is also a master trainer with the Self-Management Resource Program created by Stanford University for diabetes. She's also a lead trainer for the Diabetes Empowerment Education Program created by the University of Illinois at Chicago.

Part of her responsibility is to train new peer leaders as well as lead workshops for Medicare beneficiaries. Janet has been involved in the peer leader as well as lead workshops for Medicare. Janet has been involved in the Everyone with Diabetes Counts Initiative since it began in August 2014. The team works together to identify areas in need, locate a community site and promote this free six-week workshop through stakeholders to many programs as well as physician involvement for referrals. Quality Insights diabetes team has participated in recruitment and workshops throughout all 21 counties in the state of New Jersey.

Now, once again, I'm going to remind everyone, we will be taking questions at the end of the webinar. If you have questions, if you would jot them down, we'll be sure to try to get to them at the end. At this time, we're going to begin with our patient representative, Ms. Deborah Burt.

Deborah Burt: Hi, good afternoon everyone. My name is Deborah Burt. The issues I have with my diabetes were that they were out of control. My A1c was 12.9 and higher. My sugar count was 1,000 and higher. I wasn't not here until medications, wasn't taking my insulin and pills as I suppose to. I have diabetic neuropathy at both my hands, feet and legs. How do I manage my diabetes now? I took the diabetes self-management class with [inaudible 00:09:36] By taking that class, it taught me how to self-manage my diabetes first by changing the way that I eat, not what I eat but how much of it did I ate and how to plan my meals, read labels and channeled my pain into other areas.

After taking the diabetes self-management class, it really helped me because my A1c did go down, it's at 6.6 now. I am still on insulin but I don't take as much as I used to. I was three shots three times a day plus on metformin, 1000 metformin twice a day. Now, I take 10 units once a day and I'm only on 500 of metformin. I've lost weight. I was at 296 pounds, now I'm down to 202 pounds. The tools that I use is I still read my Juicing Healthy Living book. I do the body scan. I do the meditation. As far as my pain goes, I was on Tramadol and Percocet for the pain. Now, I don't take any opiates at all for my diabetic pain.

I learned how with meditation and the body scan and the simple exercises that I do helped me to manage my pain more better. That's how I handled my diabetes. I became a peer leader. I'm teaching diabetes self-management, also chronic disease self-management. Thank you.

Linda Johnson: Thank you, Deborah. We're going to go on to our next presenter, Dr. Lynda Bascelli.

Lynda Bascelli: Good afternoon everyone. I'm Lynda Bascelli. I'm a family doctor and the chief medical officer at Project H.O.P.E. Camden Federally Qualified Health Center for the Homeless. In 2015, I became board certified in addiction medicine as well because there weren't enough resources from my patients who were struggling with chronic illness and with addiction particularly opioid use disorder, which is what we're going to talk about today. In the next 15 minutes, we're going to

touch on a few things. We will talk about opioids, what they are, how they work and why they are used.

We will talk about how diabetes and opioid use disorder intersect clinically, why people with diabetes might be prescribed opioids, what risks are associated with using opioid medications for chronic pain and patients with diabetes, and how we can minimize those risks. We'll talk about how limited access to appropriate resources for both rural and urban underserved populations has helped to create the burden of disease that we are seeing today. Finally, briefly on how Project H.O.P.E. has worked to improve access to medication as the treatment for opioid use disorder in the primary care setting for our underserved population including patients with chronic disease like diabetes.

What are opioids? Opioids are a type of medication used to treat pain. Opioids bind to specific receptors in the brain causing both the pain relieving analgesic effects and the rewarding effects or the high for some people who take them. This high can be a euphoria, a tranquility or a sedation. Some patients described it as the feeling of motivation, not everyone who takes an opioid feels those rewarding effects. Opioids have important clinical uses particularly in the acute setting following an injury or surgery when tissue injury is present. Opioids are appropriate to use for short defined time period to relieve pain.

Using opioid medication is also appropriate to manage the pain associated with cancer which can be a longer term or more chronic treatment duration. Pain is considered to be chronic when it last from more than 12 weeks and when there is no obvious continuing tissue damage. Here you see some examples of opioid medications. You'll also often hear the terms opioid and opiate used interchangeably. Opiate generally refers to natural opioids which are directly derived from the resin of the opium poppy. Morphine and heroin fall under this category. There are semi-synthetic opioids which are partially derived from opiates.

Oxycodone and hydrocodone are examples and synthetic opioids which are fully synthesized in the lab. Methadone and fentanyl are synthetic opioids. One medication left of this list which really should have been on there is buprenorphine which is the active ingredient in Suboxone which is prescribed like methadone is to treat opioid use disorder. At Project H.O.P.E., we prescribe buprenorphine to treat opioid use disorder. I'll touch on that in a few minutes. Opioids, like I mentioned, are indicated to treat pain from a surgery on an injury. Many patients are prescribed opioids for chronic noncancer-related pain.

How did this happen? In a patient with diabetes, for example, well, people with diabetes are at risk for peripheral neuropathy, osteoarthritis, and other conditions related to obesity like back pain, all conditions that can cause chronic pain. Patients with diabetes may have nephropathy or kidney problems making medications like anti-inflammatories, NSAIDs unsafe to use for pain. When a patient with diabetes and chronic painful neuropathy presents to a medical

provider's office, a well intention medical provider may look to help this patient to suffer less and maybe to sleep better.

After exhausting other treatment options, may turn to an opioid medication as a last resort or as a temporizing measure until a better treatment option, perhaps one with fewer associated risks comes along. A provider may reason that this painful condition is contributing to the patient's elevated blood sugar because of chronic stress. In order to get the patient's diabetes under better control, his or her pain needs to be controlled. A patient with diabetes may choose to accept the risks of taking opioid medication, either is a temporary measure or perhaps longer reasoning that, I really can't exercise of pain and exercise is necessary for me to control my diabetes.

If pain becomes the essential focus of the medical visit, that limits the time that a provider and the patient can spend developing a treatment plan to achieve improved outcomes related to diabetes. Yet, those still need to be addressed. There are consequences associated with chronic pain beyond diabetic control including limitations and activities, lost work productivity and reduced quality of life. A provider trying to provide compassionate patient care may turn to opioid as a part of a treatment plan. Can this patient safely use an opioid medication?

Treatment planning for patients who are taking opioid medications is important and appropriate and can contribute to the safety of a plan that includes opioids. The CDC released the guideline in 2016 to help medical providers better care for their patients who have chronic pain and who use opioids to manage that pain, improving the way opioids are prescribed through clinical practice guidelines like these can help patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse or overdose from these medications.

Some components of a safe prescribing approach include utilizing non-pharmacologic and non-opioid treatments, perhaps along with opioids including but not limited to behavioral health referral and/or treatment. A focus on maintaining and improving function is crucial. The goal in treating chronic pain is not to eliminate pain but rather to reduce the impact of the pain on a person's life. Can this person leave the house and do the things that are meaningful to him or her? That's the goal. Evaluate the treatment regimen and agreement regularly. Are we using the lowest effective dose? Do we have a plan in place to taper the medication if functional goals are not being met?

Does the patient know and understand that this is the plan? Review the New Jersey prescription monitoring program. Is my patient using controlled medications from another prescriber? Maybe a benzodiazepine which will increase the risk of sedation and overdose. Urine drug testing can be a valuable tool to monitor both of the presence of the medication in the patient's urine, to monitor for diversion of the medication or to ensure the absence of illicit substances. Finally, any patient on any opioid medication should also have a

prescription for Narcan or naloxone as well. Overdose has happened and having the remedy nearby at all times can save a life.

Let's turn back again to diabetes specifically and the risk that exist for patients with diabetes who use chronic opioids. Opioid use is associated with significant health risk like weight gain and difficulty controlling blood sugar. If opioid medications alter one's perception of pain, they may also affect the perception of one's glycemic state. Are you able to pick up on your body's signals that your blood sugar is too low or too high? If your opioid medication causes an altered mental state, will you remember to take your medication or take your medication correctly?

Just like any other person exposed to opioids either in the acute treatment of pain or chronic treatment of pain, patients with diabetes are at risk for the development of opioid use disorder overdose and death. The term opioid use disorder includes both addictive behaviors marked by craving and an inability to stop using opioids resulting in biopsychosocial consequences as well as physical dependence on those opioids. Brain abnormality is resulting from chronic use of opioids or underlying causes of opioid dependence which is the need to keep taking in opioid to avoid a withdrawal syndrome and addiction, which is marked by intense opioid craving and compulsive use.

In the 2013 DSM-5 of the American Psychiatric Association, DSM stands for Diagnostic and Statistical Manual of Mental Disorders. Opioid use disorder is defined as the repeated occurrence within a 12-month period of two or more of 11 problems including withdrawal, giving up important life events in order to use opioids and excessive time spent using opioids. A cluster of six or more items indicates a severe condition. The DSM criteria include the physiologic issues of tolerance and dependence. Tolerance being the need for more medication to achieve the same effects as your body gets used to the medication and withdrawal which is marked by really uncomfortable physical symptoms including chills and sweats, nausea and diarrhea, pain and muscle cramps and insomnia.

It's important to note here that any patient who takes an opioid chronically, even exactly as prescribed will develop tolerance and physical dependence. Even if physician and a patient working together to safely prescribe and take an opioid medication will not prevent the development of tolerance and the physical dependence that will result in withdrawal if the medication is abruptly stopped. If the medication is taken only as prescribed, then these criteria of tolerance and withdrawal do not count towards the diagnosis of opioid use disorder.

Not every patient presenting needing a higher dose of his or her opioid to achieve the same level of pain control is addicted or misusing the medication. Let's go back to the patient I talked about a few minutes ago, who now is physically dependent on the prescribed opioid medication. Let's say they lose their insurance and they can no longer see the doctor that was prescribing the

opioid medication. Now, the patient is going through withdrawal and feels horrible, sicker than he or she has ever felt and is desperate to feel better, perhaps that patient is now using someone else's prescribed opioid illicitly while here she tries to find a new doctor to prescribe the opioids.

Finding a new doctor has been impossible because of transportation issues or other access issues. A friend might suggest that it is cheaper and easier to get heroin than it is to buy pills on the street. Before you know it, this patient is using heroin. Here, she may be able to function for quite a while until life becomes focused only on looking for their next bag of heroin, not to get high but simply just to avoid withdrawal. It sounds dramatic I know, but it happens regularly. This is a fairly typical story told to me by my patients. Nobody wants this, not patients, not medical providers. Nobody intents to become dependent on opioids but it happens a lot as we all know.

Trying to change the slide. There we go. Fortunately, effective evidence-based treatment for opioid dependence success including medication-assisted treatments like buprenorphine and methadone. Problem is, for a rural and urban underserved patients, the lack of access to these treatments. How can they access this care? They have transportation issues, limited medication-assisted treatment providers. As an aside here, I never expected to see the influx of suburban privately insured individuals, people who have transportation and money to access treatment coming to see me in Camden because they cannot get the care they need anywhere else.

If there's a lack of access to treatment across the board, well, our rural and urban underserved populations are then … they're suffering disproportionately. When I started working at Project H.O.P.E. in 2011, one thing I learned about pretty quickly was that there was a big and growing problem with opioid dependence. One that I had not necessarily appreciated in my prior work, I had never seen a patient in my office under the influence of heroin before. Literally, nodding off in the chair in front of me, asking me for refills of diabetes medicine.

I learned that no matter how earnest I was and my desire to help my patients achieve better health outcomes for chronic disease like diabetes, there was no way that I was going to help them make any progress towards those goals unless we address the opioid dependence first and alongside the diabetes and other chronic disease. Long story short, we began providing medication-assisted treatment with buprenorphine for our primary care patients in 2013. We've been blown away by what our patients have been able to accomplish once they stabilize. They've gotten housing, employment. They've repaired relationships.

Yes, many of them have achieved better control of their diabetes. Opioid dependence is a chronic disease just like diabetes that needs to be managed as such. The clinical course of opioid use disorders involved periods of relapse and recovery but the underlying vulnerability is always there. In this way, opioid dependence is no different than diabetes, a chronic illness which can be managed with a mutually agreed upon treatment plan that probably will not be

adhered to completely but we trust the patients are doing the best that they can. I'll end here with the shameless plug for any providers out there who might be listening.

If you are on the fence or nervous about starting to offer this treatment for opioid use disorders to your patients, just do it. It is the most clinically satisfying part of my practice as a family doctor. These patients are already in your office and they need the treatment. They don't have access, otherwise, and you can provide it. Thank you.

Linda Johnson: Thank you, Dr. Bascelli. Our next presenter is Adam Bucon.

Adam Bucon: Good afternoon everybody. Thank you. As I was announced, I am the State Opioid Treatment Authority for the state of New Jersey and I work for the Division of Mental Health and Addiction Services. For years, we are with the Department of Human Services and we just switched over to the Department of Health as of October 1st which really is a positive move when you think about it especially when you talk about diabetes and when you talk about addiction. They are very similar and that they're both diseases. With any disease, really utilizing medication-assisted treatment for these diseases is important.

I think it's really a good move that we can collaborate more on health issues as well as behavioral health issues, so physical health and behavioral health, so that we can really treat the person as a whole person and not just parts of them. What I'm going to do today is I'm really going to go over some of the statistics that are reported in New Jersey, how to access treatment in New Jersey, and then what new services or initiatives are in New Jersey to address the opioid epidemic. As you see from this first slide, the drug related deaths in New Jersey have really increased from 2010 until 2015.

There were reported 843 in 2010 and you'll see the increase to 2015 at 1,587. We did get some information, some preliminary information for 2016 for the first six months of the year. That's from January 1st 2016 to June 30th 2016. It's reported that there's 1,022 drug-related deaths. If you look at that number, if you multiply that times two, for the second half of the year, we're going to be possibly over 2,000 drug-related deaths for the year. This is obviously a concern as that really totals that there is more than five-and-a-half people a day dying of a drug-related death for drug overdose.

The second part of the slide shows our 2016 total treatment admissions to be 76,509. This number is taken from all licensed substance use disorder agencies which are required to implement data into our New Jersey substance abuse monitoring system. From this, you'll see that 50%, 43% heroin as primary drug admission and 7% as other opioids as primary drug addiction. 50% of our individual seeking or getting treatment in New Jersey are actually those with an opioid use disorder. As Dr. Bascelli had mentioned, heroin as an illicit substance but then there's also people that are using medications that are prescribed to them and that's what counts for 7% of the total treatment admissions.

The next slide really just gives you some more treatment statistics. According to our 2012 treatment episode data set which is collected at the federal level, New Jersey was fourth in the nation for primary heroin admissions ages 12 and older. The rate of these admissions per 100,000 age 12 and older was 336 for heroin and 111 for non-heroin opioids or synthetics. The state of New Jersey was only behind three other states and those states are New York, Massachusetts and California. Obviously, the opioid epidemic is really strong and powerful in our state.

Here's some more information on statistics. As you can see, 5.5 hours in the year of 2015, someone died from a drug-related death in New Jersey. Every 9.1 hours, someone died from a heroin-related death. Again, that's more than four people a day dying from a drug-related death. In 2016, we're thinking those numbers are going to increase to over five people a day that had died from a drug-related death. In 2015, as I said, there were 1,587 illicit and prescription drug overdose that's in New Jersey. Of these, 961 were heroin-related. The number of heroin-related deaths increased each year from 2010 to 2015 in New Jersey, rising 196% from 325 deaths in 2010 to 961 in 2015.

The number of heroin-related deaths spike sharply from 2014 to 2015, rising from 776 to 961 and that's a 24% increase in just one year. The next slide shows you some more staggering numbers. It really just shows that heroin-related deaths in New Jersey outnumbered the deaths by homicide, firearm, motor vehicle crashes, and suicide in 2015. 4.3 times as many lives were taken as opposed to homicides, 3.4 times as many from firearm deaths, 2.8 times as many as motor vehicle crashes, and then 2.1 times as many lives as suicide has taken in the year of 2015.

If the rate of drug-related deaths for the second half of 2016 are consistent with the first half, we are going to see over 2,000 drug-related deaths in 2016. As for accessing substance use disorder treatment services in New Jersey, there's been a lot that's been done in the last couple of years and those of you who are from the state of New Jersey have probably seen governor Chris Christie on commercials for ReachNJ. This is one of the numbers that it's being utilized as really getting information out to people that call in and trying to assist them connecting to services. With this, there are some other services that ReachNJ works with.

They work with PerformCare. PerformCare, with the Children's System of Care and the phone number is listed there, that helps adolescents and children access treatment services. There's also New Jersey connects for recovery that is a service call line developed for two purposes. One, it's for those concerned with their own opioid abuse and use. Two, family and friends concerned about loved on and their use. Then, adults without insurance can be referred to the IME Addictions Access Center. The number is there. That number is through Rutgers University UBHC. Individuals with private insurances are helped by ReachNJ.

Usually, they're told to call the back of their insurance cards to access treatment. Really, there's no wrong door approach so you can really call any of these lines. What ReachNJ really does is try to titrate the calls to where they need to be. That's why we're providing you this information. For adults again, with health private insurance, the IME Addiction Center takes calls from ReachNJ and what they do is they make targeted referrals using a database of treatment providers with the level of care that's appropriate and eligible funding sources. They'd screen for addictive disorders for emergency levels of care. They try to assist somebody with the eligibility for access in public funds.

It also provides care coordination. If somebody can't get immediately into treatment, there's a care coordinator from the IME that helps assist them and almost like care manages them through the process. Also, we have the IME patient placement which uses the addiction severity which determines client eligibility for services. Now, I'm just going to talk about some of the resources to address the opioid crisis. Enlisted here are most new resources that are here to address the opioid crisis from the past two to three years. Since I only had 15 minutes, I'm only going to discuss really the first few. My contact information is listed at the end of the slides.

If there are any questions about the programs, one is that there was … earlier this year in September, there was Governor's Initiatives that were announced that were currently the Division of Mental Health and Addiction Services is working on. We have the 21st Century Cures Act which I will discuss a little bit. We also have a Substance Abuse Block Grant which funds many of the services in the State Treatment and Prevention Services. There is a strategic prevention framework for prescription drugs, a grant that the division had received a couple of years ago. There's also a Prevent Prescription Drug/Opioid Overdose Related Deaths grant that we also received.

Then, another grant for really Medication-Assisted Treatment Program but it's done through outreach so that we try to increase the number of people accessing Medication-Assisted Treatment Services. Again, I'm just going to discuss the first couple today. In our Governor's 2017 Initiatives, as you'll see, that was announced in September. There is $200 million, a new funding being committed to enhance programs and services that are national models to address the opioid and substance use disorder emergency.

Listed below are some of the programs that are being implemented or expanded just by the Division of Mental Health and Addiction Services which accounts for about $100 million of the $200 million that was made available. There is a new request for proposal that was sent out to the community for Incentive-Based Opioid Recovery Program, which will really focus on case management to support an individual with an opioid use disorder so that they can stay into the community. I think on the mental health side, there's a lot of different services that are available that exist for really care managing and case managing someone but there hasn't really been much done with addiction.

This is something that is going to be done differently and something that we're excited about and that we'll be able to tell you more details in the near future. One of the other things that we have is the Recovery Coach Program. This is an Opioid Overdose Recovery Program which I will discuss in a little bit more detail. Then, we have supportive housing that will be increasing in the state of New Jersey. Right now, there is a lot of supportive housing for the mental health individuals with mental health disorders. We are going to be increasing a lot for supportive housing for someone with the substance use disorder.

Also, we're going to have On-Campus Recovery Programs and then also a consumer helpline which will be there to assist somebody with a substance use disorder. Basically, there was a 21st Century Cure Act which was passed in December of 2016. This designated $1 billion in grants for states over a two-year period. What we have, basically, the state of New Jersey itself received $13 million annually for two years. We were one of the higher states that receive funding. California was actually had the highest and they receive $60 million.

The program really aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, really reducing opioid overdose-related deaths. That's one of the main things that the federal government wants to try to address at this point because we keep seeing more and more deaths each year really in all of the states. Grants were awarded to states based on a formula for unmet need of people living with an opioid use disorder and also people that had died from a drug-related death. One thing that we, I guess what the state of New Jersey did with this funding is we call our program the state targeted opioid response initiative or the story initiative.

Really, the goals are to address the opioid crisis confronting the state using a variety of strategies, increase access to treatment, reduce unmet treatment need, and reduce opioid-related deaths. A couple of the focuses that I'll go over what we're doing with the $13 million. We're really increasing primary prevention. We're focusing a lot on older adults with the goal to reduce demand for and misuse of opioid prescriptions. We're also doing a lot of trainings on the naloxone. We're already doing community trainings. This funding actually is allowing us to go into schools, jails, and prisons and also provide a community training and distribute free naloxone kits.

We're also trying to do a lot of training for primary health and behavioral healthcare practitioners, really on the best practices for prescribing opioids because I think a lot of that may have been missed and a lot of the blame ended up on physicians which really wasn't correct. We just want to continue to do training that supports physicians and in the community. We're also going to do some more peer training for volunteers. There's Law Enforcement Addiction Assisted Recovery and Referral Program, so we're doing training for them.

We're also doing something with Project ECHO which is a collaborative model of medical education and care management that empowers clinician to provide better care to more people. We're continuing to work that. We're going to work

with Rutgers University on this Pilot Program. In 2016, most of our services, the fee-for-service, so one thing that we did with this new funding is we developed a new fee-for-service initiative that only services people living with an opioid use disorder. We are trying to expand some services that weren't provided before such as buprenorphine and Vivitrol.

Through this, also smoking cessation services and peer services which are really important and really we're trying to focus on more peer to peer services that assist somebody in the recovery process as they go through it because that's really the best practice. The other thing I mentioned before, we are increasing funds for our Opioid Overdose Recovery Program. Prior to this funding, we were operational in 11 counties. Now that we got this new funding, we're actually operating in all 21 counties in the state of New Jersey. Our Opioid Overdose Recovery Program utilized recovery specialist and patient navigators who go to engage an individual who is reversed from an opioid overdose.

They really provide non-clinical assistance to them and they follow up with them for a minimum of eight weeks. In a future side, I'll give you some reports on the outcomes of that. Also, we created some support teams for addiction recovery which really wrap around the individual and they're in our really high-risk counties. They're providing more care management services to them. Telephone Recovery Services, this is another thing. We're developing a program that provides weekly phone calls to people in recovery. Family support centers, that's another thing. Obviously, as you know, addiction doesn't only affect an individual, it affects the whole family.

These support centers will help family members as they go through the disease of addiction with their loved one. Some of the anticipated outcomes, we do want to reduce the drugs and alcohol, increase employment, reduce criminal justice, also increase stable housing. We have a lot of different things that we're looking for and this slide shows that. Some of the observed outcomes before, I just wanted to touch real quickly on this was, from our Opioid Overdose Recovery Programs thus far, we have 56% of the people that this program has operated since January 1st 2015.

56% of the people that have been in an Emergency Room and we've brought in recovery specialist to talk to have gotten into either treatment or recovery so far with this program. Before this data, really there wasn't that much done. We're doing a lot and my contact information is here. I know I couldn't base on everything we're doing a lot. Thank you very much.

Linda Johnson: Thank you, Adam. Next, our presenter, Diana Haniak.

Diana Haniak: Thank you, Linda, excuse me. I'd like to begin with just a quick introduction to who we are and what we do. Quality Insights is a QIN or Quality Innovation Network, Quality Improvement Organization, we are quality improvement specialists funded by the Centers for Medicare and Medicaid Services to work with providers and in some case, beneficiaries across the continuum of care to

help meet healthcare quality goals. The QIN-QIO, Quality Improvement Approach is aligned with CMS triple aim of providing better care, lower cost, and improved health.

Quality Insights support strategies that promote best practices, effective communication, and engaging patients and families and prevention and treatment in order to make care safer and more affordable. Our QIN Quality Insights covers Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. I'm going to share two examples of high priority initiatives that we are focusing on starting with everyone with diabetes counts. Through this initiative, Quality Insights is working to improve the health of people with diabetes by providing and facilitating diabetes self-management education training classes through partnership with providers and community organizations throughout our network.

Our collective goals include improving health outcomes for Medicare beneficiaries with diabetes such as hemoglobin A1c, lipid, blood pressure, and weight control, decreasing the number of people who require lower extremity amputations due to complications resulting from poorly controlled diabetes, improving the health literacy of people with diabetes, and increasing providers' adherence to clinical guidelines related to hemoglobin A1c, lipids and eye exams. We are also working on medication safety which entails working with various care coordination communities across the state to reduce preventable adverse drug events with the focus on three groups of high-risk medication, anticoagulants, diabetes drugs and opioids.

For today's purpose, I'll be focusing on Quality Insights opioid misuse and divergence Special Innovation Project or SIP. Opioid overdoses affect our entire population including Medicare beneficiaries. The overarching goal of the opioid special innovation project is to reduce overall opioid use and promote safer care. Quality Insights is working to achieve this goal by developing and providing education, resources and tools to both providers and patients that support opioid prescribing guidelines and share best practices for safe opioid use.

We are promoting the utilization of safe prescription and drug monitoring programs as well as convening state level stakeholders for collaboration as we're all after the same common goal. The following information is detailed resources that have been developed by our team at Quality Insights. These resources are completely free and area available in print as well as on our website. In order to introduce our project, the team created fact sheets that explain in detail the project goals, efforts, anticipated outcomes and data that support these goals.

The team also created a real life mail-mail postcard that are sent to providers in areas identified with a high prescribing rate in order to get the word out and promote our efforts and available resources. The QPP alignment document was designed to support providers in order to highlight examples related to the opioid misuse and divergence Special Innovation Project and two performance

categories of the quality payment program, quality measures and quality improve activities. The document details examples from each of these categories that can be reported for 2017 to avoid a penalty and possibly earn a positive payment adjustment in 2019.

Our next resource was developed with the support of the Centers of Medicare and Medicaid Services Quality Improvement Organization Program. They have made brief recordings available that detail the functionality of individual state prescription drug monitoring programs in order to help promote use and increase understanding of the PDMP. For New Jersey, Dr. Sindy Paul, the medical director of the New Jersey Board of Medical Examiners recorded a brief overview of the New Jersey prescription monitoring programs that addresses key points such as approved users, obligations as users, exemptions, exclusion and information on which state shares databases.

We've included a link to the state specific recordings that can be accessed at any time. Teach-back is a communication method used by healthcare providers to confirm whether a patient or their caretaker understands what being explained to them. If a patient understands, they're able to teach-back this information. These medication teach-back cards developed by Quality Insights contain a section on opioids that can be used as a guide for providers on what to discuss with their patients regarding opioid and want to seek medical attention. They also provide a comprehensive list of many marketed opioid brand and generic name.

The practice change package is a multifaceted tool that is available in both hard copy and online as an E-version for easy access information at your fingertips. This comprehensive and extensive tool was developed using a big picture approach to combine evidence-based tools and resources for multiple accredited sources to help practices and providers feel more confident about safely prescribing opioid to help detect abuse or emerging addiction and tips to help address these issues with patient. It also includes information about state-specific medication storage and disposal programs.

New guidelines best practices and resources are constantly being developed so we view this as a living, breathing document and work to keep this up-to-date as possible. We've also identified patient friendly resources from a well-known nonprofit safety organization, the ISMP short for the Institute for Safe Medication Practices. They have developed a series of colorful and informative piece in education flyers on fentanyl, hydrocodone and oxycodone that may be downloaded for free. With the understanding that the education and engagement of our patients in their own care is vital to positive outcomes, Quality Insights has created patient education flyers to help support providers.

The Not Just a Pill flyer addresses the seriousness of taking prescription opioids and suggests questions for patients to ask their doctors. The Fast Facts flyer is specific to New Jersey and give the patient a better understanding of the new law that went into effect May 15th of 2017 and how does legislation may

change their provider's prescribing practices. My contact information is displayed as well as our website where the resources discussed can be found. I thank you for your time and commitment to reducing overall opioid use. It really does take a village.

Linda Johnson: Thank you very much, Diana. Our next presenter is Janet Knoth.

Janet Knoth: Hi, good afternoon. Today, I want to share some details about the diabetes initiatives in New Jersey. I'll start with CMS cast called Everyone with Diabetes Counts. Here are five of our task calls. First is to reduce the number of beneficiaries that require lower leg amputation due to poor blood sugar management and to get diabetes education to people earlier by offering free education and conversation right in their town. Sometimes a nonclinical setting is left intimidating. Second, we offer the underserved beneficiaries and opportunity to attend a six-week workshop in our community.

We have partnered with library senior center and churches to provide a form of learning and sharing for beneficiaries trying to manage their diabetes. We also strive to increase adherence, the clinical guidelines by providers. Next, we want to increase the number of educators, educate providers, and increase referral for diabetes education and self-management. Last but not least, one of our goals is to support organization that want to become AADE, ADA certified. Quality Insights works with providers, community partners and stakeholders to support these important efforts to help them build and support infrastructures that provide access to interactive evidence-based diabetes self-management education.

The overall objective of DSME are to support and form decision making, self-care behaviors, problem solving and active collaboration with their healthcare team to improve clinical outcomes, health status and quality of life. The book shown here is Living a Healthy Life with Chronic Conditions. It was written by Stanford University faculty but they realize that a book alone would not increase self-management. That is when they developed the interactive workshop scripts to encourage participants to create action plans and move forward with healthy lifestyle changes. The participants quickly bond over their common concerns.

They are transparent in sharing their own problem which might be challenging in another setting but they know they are in a safe non-judgmental group. When they join in with questions and suggestion, they realized they are not alone. Each week, they create an action plan for the next seven days. They pick one thing that they really want to add more consistently to their life. It can be anything they choose and those that select walking or portion control, things become the motivators of the group. They come back the next week and share their progress.

The best part is, when they report to the group that their blood sugar went down, they all listen because they all want that to be part of their success as well. As of last month, Quality Insights in New Jersey has educated over 1200

people with 900 being Medicare beneficiaries with diabetes or pre-diabetes. We've trained peer leaders from various partners throughout the state including United Way, County Department of Health, Meals on Wheels, YMCA, and Jewish Family Services, to name a few. Here we ask participants several questions during the first class and then again at the last class to evaluate the change in self-management. Here is an example.

We ask them, do you know healthy ways to handle the stress related to your diabetes? As you can see from the graph, the comments in blue are the very first day response and they were not feeling very confident. We look at the responses on the last day in gold and we see the improvement. As only 34% felt confident prior to the workshop, you see that 87% of the respondents report feeling confident in managing stress by the end of the workshop. This is a relative improvement of over 150%. This mirrors most of our workshop success. Quality Insights works closely with the Diabetes Prevention and Control Program within the New Jersey Department of Health.

Let's look at some of these resources. The New Jersey Department of Health Diabetes Prevention and Control Program, DPCP, approach to addressing diabetes in New Jersey is driven by population-based and evidence-based strategies. The plan is to increase community clinical linkages and clinical innovations to support the prevention and management of diabetes. The overall goal of DPCP is to reduce the burden of diabetes on New Jersey residence by implementing interventions that increase awareness of the disease, control disease related complication and increase quality improvement processes.

One of the models that New Jersey employs to accomplish these goals is called the Diabetes Resources Coordination Centers, the DRCCs. New Jersey currently funds two nonprofit organizations, the New Jersey Academy of Family Physicians and the New Jersey Hospital Association to serve as DRCCs. By partnering with this organization, New Jersey is able to leverage the relationship that each of this DRCCs have what their constituents. New Jersey promotes specific diabetes programs according to federal funder guidelines that include the ADA, AADE and the Stanford model as well as the national diabetes prevention program. We work closely with these DRCCs.

There are currently 20 diabetes prevention programs operating throughout the state. Each of these programs unfortunately is not represented in each county but a program information can be accessed by contacting NJ211 and as you can see, the diabetes self-management programs are well under way and offered by some of the organizations that I previously mentioned, the diabetes prevention and control partners with NJ211 to promote ADA, AADE, and Stanford education. New Jersey also provides funding to federally qualified health centers to adapt evidence-based strategies and specifically the goal is the adaption of diabetes [inaudible 00:58:14] and referral policies for patients.

Thank you for your time.

Linda Johnson: Thank you very much, Janet. At this time, I'm going to turn the session back over to Mitzi who'll be working with you regarding questions.

Mitzi Vince: Okay. Thank you very much, Linda. Right now, we'll go ahead and begin the question and answer portion of the webinar. If you have any questions regarding today's presentation, you may type them into the chat box which is located on the right of your screen. If you've already submitted a question through the chat feature, we will address that in just a moment. First, I'm going to start with unmuting the phone line to see if there's anyone on the phone that has a question at this point. Phone lines are now unmuted. If you have a question and you're on the phone, go ahead and ask that now.

Okay, I will go ahead and mute the phone lines and we do have a few questions in the chat and Q&A box. First question asked, how do you obtain the AAD and AADE certifications?

Janet Knoth: I'm going to answer that. It's a very expensive program and I think that we could work with anyone that's interested. It's really too much information to share on a call right now. We would certainly be happy to help you.

Mitzi Vince: Okay. Next question we have, do you see much discrepancy issues with tapentadol, might be mispronouncing that, T-A-P-E-N-T-A-D-O-L.

Lynda Bascelli: This is Dr. Bascelli, can you please repeat the question?

Mitzi Vince: Sure. It says, do you see much discrepancy issues with tapentadol? Again, I might be mispronouncing that. That is spelled T-A-P-E-N-T-A-D-O-L.

Lynda Bascelli: I'm not sure I actually understand the question. I'm wondering if the person meant do you see much diversion, I'm not sure I understand what the question is. I'm sorry.

Mitzi Vince: No problem. Ken, if you could clarify, we will get back to your question as soon as we can. Moving on, we have another question. This is, what's being done with the patients that are immuned to methadone? There are a lot of patients in Campen city that say the methadone does not work.

Lynda Bascelli: Well, not every treatment is going to work for every individual. We have patients who do really well on methadone and do poorly on Suboxone and vice versa. It's not a one size fits all treatment. If one treatment doesn't work or if a patient is resistant to a treatment, it's always best to move to something new. We do have patients who transitioned back and forth to different treatment modalities, depending on what's going on in their life. Again, with the goal of reducing harm for these individuals, paying attention what their concerns are is really important.

Adam Bucon: Dr. Bascelli, I wanted to add to that. The other thing I'm thinking is that with our opioid treatment programs that prescribe and dispense methadone on site, we're also really working with them to have them at other medications to their toolkit, so really be able to also provide buprenorphine and Vivitrol. If methodone doesn't work, they could also try buprenorphine or Vivitrol for that person.

Mitzi Vince: Okay. We have a follow up to the previous question. The question was about dependency issues or addiction issues with tapentadol which is described as an opiate that you don't hear much about.

Lynda Bascelli: You're right, we don't hear much about it. Currently, I have one patient who is taking this medication prescribed by a pain management physician. I don't have a whole lot of clinical experience with it. My patients who present for treatment for opioid dependence issues don't talk about this medication at all so I don't have a sense for what's going on at least in Camden. I wish I had a better answer for you. I don't know.

Mitzi Vince: We have another question asking where can patients access self-care tools for diabetes.

Janet Knoth: As trainers, we have access to information. I'm just used to training, I'm not used to giving the material directly to people without self-management education. We can get back to you if you can give us information, [inaudible 01:04:04]

Deborah Burt: Hello? Hello, this is Deborah. They can get that information from Stanford University patient information education.

Mitzi Vince: We have another question asking where the teach-back cards can be accessed. This was the teach-back cards that were referenced in Diana's presentation earlier.

Diana Haniak: Excuse me, there's a link to the Quality Insights website where all the resources I had discussed are available, teach-back cards, the practice change package. It's a platter of resources that we've developed are out there.

Mitzi Vince: We've had several questions asked whether people will have access to today's presentation, the slides and we will make the recording, a transcript of the webinar and the slides available in the coming days. We do have another question, if someone has diabetes and it's constantly opioid medications that are not helping alleviate pain, what's the risk of being addicted and what can be done to help the person?

Lynda Bascelli: That's a great question. If a meditation is not working for somebody, the goal is would be to take the patient off the medication and that should be a part of any treatment agreement between a patient and a physician regarding opioid. If this

mediation does not work, I agree that the medication will be tapered with an appropriate taper plan in place. Now, as far as addiction goes, addiction implies certain behaviors around the medication. Patients who continue to use the medication despite harm or they're seeing problems develop in their lives because of use of the medication, problems in relationships or with work.

Patients who take opioids chronically may not be addicted but they likely will have some degree of dependence on the medication. If this patient is not getting pain control anymore from their opioids, and if they decided to stop the medication or if the physician stops the medication abruptly, that person will go through withdrawal. That's very painful. That doesn't mean that someone is addicted to the medication. That just means that they are dependent on it. Again, that doesn't really … according to the DSM criteria, if a patient is prescribed the medication and they're using it exactly as prescribed, that criteria of the dependence doesn't necessarily imply that the patient has an opioid use disorder, just the natural consequences being on the medication for an extended period of time.

Mitzi Vince: Okay. Thank you, Lynda. We have a couple more questions. This question is directed to Adam. It says, in terms of the data presented, what further perspective can you share on opioid misuse or hospitalization stratified by New Jersey local, educational status, income and/or race, ethnicity.

Adam Bucon: To answer that question, some of the data that I presented on regarding what is entered into our New Jersey substance abuse monitoring system, that information can actually be found on our website. You could actually just Google New Jersey substance abuse overview and then you can in the date 2016 so that you can actually see the information as who was in our treatment slots and then you could find out their educational status, income, race, ethnicity. We also work very closely with our Medicaid office on finding out some more information about hospitalizations. We're trying to pull that data together. There'll probably be a lot more forth coming especially as we've now joined with the Department of Health.

Mitzi Vince: We have a comment that was mentioned and there might be some follow up discussion from that. It says, I think it's important to mention that New Jersey has been working very hard to decriminalize the use of opioids with people being able to present to many municipal police facilities and the referred for detox and rehab rather than serving jail time. Does anyone a follow up to that? That was the comment we received.

Adam Bucon: Well, actually, it was a year ago that a law was put out to implement law enforcement referral agencies. We work with law enforcement to really execute these plans of being able to have somebody show up inside the law enforcement agency and be referred to treatment. A lot of these agencies are currently getting volunteers to work there that will help refer somebody into treatment. A lot of the people that have reached out to us are recovery specialists that are actually working in the law enforcement agencies. They're

making that connection, so either treatment or recovery supports. Instead of going to jail, they can actually turn themselves in. They can turn their drugs or medication into that law enforcement agency as well.

Mitzi Vince: Okay. We have this, a few more minutes for question. One other question asked, what are other modalities for the treatment of pain in order to prevent opioid dependence or addiction?

Lynda Bascelli: That's a huge question. Obviously, to prevent opioid dependence or addiction, you'd want to avoid opioids. There are plenty of treatment options out there for patients, let's say , who have a diabetic peripheral neuropathy. Gabapentin, Cymbalta, there are options before a provider and patient decide to turn to an opioid to treat pain. The other important thing is that the treatment of chronic pain is not just west medication. The treatment of chronic pain should be a multidisciplinary approach, difficult to access a multidisciplinary team in an underserved area. Ideally, the team would include behavior health.

Patients who are dealing with chronic pain will often have accompanying depression or anxiety. It's important to address those issues along with the chronic pain, physical therapy, mild exercise, massage, acupuncture. There are lots of different things. It's just the matter of whether you're able to pull together the right individuals, the right treatment team for your patient. One thing that we did with our patients recently which was completely surprising to us is we started offering patients because we became fortunate with a small grant. We were able to work with an individual who taught mindfulness, meditation and mindfulness based stress reduction.

She brought together a group of our patients with chronic pain and the results were astonishing. These are patients who have very few resources who were able to complete this program and saw great improvements and their pain and their functioning level. Now, we've got this and we know that this works to our patient population. It's a multidisciplinary approach.

Mitzi Vince: Okay. I have one more question and then I'm going to open up the phone lines one last time to see if anyone on the phone has a question. This person ask, can you please comment on resources for smoking cessation, which is sometimes difficult when one is also using opioid and then we also had one who was asking for a little bit more information about the diabetes self-management classes and how to get involve with that.

Lynda Bascelli: Smoking cessation is one of those things that when we see patients with opioid dependence, opioid use disorder, and they're coming in for treatment, it's one of those things that we often say, okay, we'll handle that, once we've gotten the opioids under control. Patients often comment that's the hardest thing for them, that it's harder to quit smoking than anything else even the opioids. As far as resources go, they do exist. There's a quit line and quit net, the patients can access. We prescribe patches for them. We invite them to come in for medical visits specifically to address the smoking.

It can't just be an add-on to a visit where you're dealing with 17 other clinical problems and yeah, hey, you need to quit smoking too. It's a significant enough problem that deserves its own time and space. Once patients have made progress with their opioid use disorder, it gives them some confidence in their own ability to move through hard things. Quitting smoking is a hard thing. You've already quit opioids, you can do hard things and again, a multidisciplinary approach. We have one medical assistant who loves talking quitting smoking and if we have someone who has a few minutes and she's available, we'll hook the two of them up so that they can develop a relationship and talk about these issues.

Adam Bucon: I also wanted to comment that as for tobacco cessation, a lot of our programs are now were utilizing some of our funding to support people that want to also have tobacco cessation products. That's something that our licensed agencies are going to be able to do in the near future, use some of their funding for that speaker service. Also, were connected with Dr. Jill Williams. She actually does a lot of trainings regarding tobacco cessation from Rutgers University. If whoever ask that question once to send me an email, I could forward you her contact information since I don't have it on me today.

Mitzi Vince: Okay. One last question, someone was asking how they can get information about the diabetes self-management classes and if they are free.

Deborah Burt: Hi, this is Deborah.

Linda Johnson: Go on Deborah.

Deborah Burt: Hi, you can find it on the New Jersey Department of Health. Take control of the website. Take control of your health. Scroll down to find the workshop in your area. Yes, it is free.

Mitzi Vince: Okay. I'm going to open up the phone lines one last time to see if anyone has any questions. The phone lines are now unmuted. If anybody on the phone has a question, please feel free to ask that right now.

Okay. I just want to thank everyone for joining us for today's webinar Addressing the Effects of Opioid Use and Diabetes. As a reminder, you will receive a link for the recording of this webinar and the presentation slides in the coming days. Also, please fill out the evaluation that you see when you exit this webinar. This input is going to help us plan future program. Again, thank you so much for joining us. I hope you have a great day and the webinar will now conclude.