Kathryn Santoro (00:00:01):
Good afternoon. I am Kathryn Santoro, Director of Programming at the National Institute for Healthcare Management Foundation. On behalf of NIHCM Foundation, we want to extend our sincerest thanks to the healthcare and essential workers on the front lines of the COVID-19 pandemic for keeping us safe. Our goal today is to share information and evidence-based strategies to address substance use disorders.

Kathryn Santoro (00:00:27):
Prior to COVID-19, the U.S. was faced with another public health crisis, the opioid epidemic. NIHCM released a series of interactive graphics last week highlighting a troubling new trend within that crisis, a more than doubling of drug deaths between 2015 and 2018 involving cocaine or methamphetamine. Also of concern is the dramatic increase in the number of inpatient admissions and emergency department visits associated with methamphetamines.

Kathryn Santoro (00:01:00):
At this time, when the healthcare system is overburdened responding to the COVID-19 pandemic, it is even more critical to explore strategies to address the opioid and stimulant crisis, especially since people with substance use disorder are at particular risk for the coronavirus due to the effects of these drugs on respiratory health. In addition, social distancing measures have created barriers to substance use disorder treatment for many Americans, while the severe economic consequences of the shutdown have raised the likelihood of substance use.

Kathryn Santoro (00:01:36):
To learn more about current trends in substance use and strategies to improve access to care, we're pleased to have a prestigious panel of experts with us today. Before we hear from them, I want to thank NIHCM’s President and CEO, Nancy Chockley, and the NIHCM team who helped to convene this event today. You can find biographical information for all of our speakers along with today’s agenda and copies of slides on our website. We also invite you to live tweet during the webinar today using the hashtag covid19sud.

Kathryn Santoro (00:02:12):
I am now pleased to introduce our first speaker, Dr. Carlos Blanco. Carlos currently serves as Division Director of Epidemiology Services and Prevention Research at the National Institute for Drug Abuse. We're so grateful he's here with us today.

Kathryn Santoro (00:02:29):
Carlos?

Carlos Blanco (00:02:32):
Yeah, thanks, Kathryn, for the very kind introduction and also for inviting me to this panel with Gary Mendell and with Bert. Both of them are fantastic, and I always learn from their talks.

Carlos Blanco (00:02:44):
The first thing we have to do is really acknowledge how hard this has been and continues to be on many levels, no? At the personal level, I think all of us have been touched in one way or another by relatives or
acquaintances or friends who have been infected by the virus and, in some cases, died. Also, that has been, I think, very hard for all of us. As you were mentioning also, very hard economic consequences for many people. It's still not clear what's going to happen.

Carlos Blanco (00:03:16):

And also from the health point of view, we are used, as professionals, to care for people and not to harm people; but in this particular circumstance, we have been sometimes unwillingly the agent of transmission and infection. We're also used to calm the anxiety of people who are sick and provide care; but again, in this case, we're also the victims of anxiety and, in a way, we've been at the same level than our patients now. So in a way, that has been an equalizer that we, as clinicians, are not on a different level as the patients, but because we are suffering the same consequences of our patients.

Carlos Blanco (00:04:02):

On the very positive side, though, I think that people have realized that science really saves lives. Even though the toll has been incredible, I have never seen so much support for science. Prior to COVID-19, some people thought that science was something that was done in the ivory tower, that was sort of entertaining and amusing, but you had no practical consequences. By now, everybody is aware that without science, the toll would have been much greater. And everybody is grateful for the contributions that science has made and how many lives have been saved and will continue to be saved, thanks to science. So we need to capitalize on these sort of real science or the appreciation for science to really move forward science and continue to build a better health system.

Carlos Blanco (00:05:01):

There are very diverse interactions that COVID has had drugs and with substance use disorders. At the very basic level, they are stress. So we had the physical stress of having the virus. So that the people who get infected get a biological, physiological stress on their systems. Then also, of course, the anxiety of getting infected, and as I was mentioning, potentially infecting loved ones. And then the social pressure of the shelter in place and confinement and isolation.

Carlos Blanco (00:05:35):

There are some structural factors that converge making this situation more difficult for individuals with substance use disorders. So access to treatment programs has been curtailed. It's much more difficult to access treatment, at least at the physical level. It's also more difficult to access peer support groups, at least, again, in a physical way. As I was mentioning, we are subject to isolation, and that is particularly hard for individuals who have anxiety or substance use disorders or other mental disorders. And then decreased access to community services.

Carlos Blanco (00:06:13):

Compounding these, there are social factors. So substance use disorders is traditionally a very stigmatized disease. And COVID-19, to a great extent, has become also stigmatizing because people who have been infected are sometimes not so well-received by their friends or acquaintances. Substance use disorders are also often associated with homelessness or housing stability, and there's also a degree of criminalization that also affects negatively the outcomes of substance use disorders.

Carlos Blanco (00:06:45):
Now, there have been multiple changes in the systems that does substance use disorder treatment. So there has been changes in access, as I was mentioning before, and it has forced us to really change the way we provide treatment. And it's been widespread except in the option of telemedicine, which has been good in particular for certain locations, like rural, that have traditionally more difficulty accessing treatment and also have become very creative and, of course, created virtual support groups. There have been also regulatory changes. So, as you know, SAMHSA has changed the regulations for take-home medication in methadone clinics, so that has facilitated access to medication and favored or facilitated the continuity of care for individuals in methadone clinics.

Carlos Blanco (00:07:37):
There have been also changes in methadone buprenorphine induction allowing for the use in telemedicine to facilitate induction. There have been also changes, interstate practice. So many states have allowed the use of either an emergency license or just practice across state lines, which again has facilitated access to care for many patients that would otherwise not have a physician or clinician to reach, they could reach out to.

Carlos Blanco (00:08:07):
There have also been, in addition, or related to the changes in access and regulatory changes, reimbursement changes facilitated by CMS and by insurance companies. And that has, again, facilitated the continuity of care for many... There have also been discussion and, in some cases, release of non-violent offenders with substance use disorders from jails and prisons, which might improve their long-term outcomes.

Carlos Blanco (00:08:35):
Sometime there have been also other still important challenges. One of them is that because of the unexpected nature and unprecedented nature of the situation, there are very limited data on evidence-based approaches on how to treat patients under these circumstances. So that behooves us to develop the research to take advantage of the current circumstance to develop an evidence base for future situations.

Carlos Blanco (00:09:04):
Also related to that, a lack of epidemiological and outcome data. So although we suspect that there have been increases in substance use and substance use disorders, we don't have currently the data to know this for sure. And also, there's a lack of outcome data regarding the treatment modifications that have been made. Also, in practicing telemedicine, certain situations are particularly difficult. For instance, the assessment of emergencies. If you have somebody who may have suicidal ideation or suicidal intent, it is much easier to do those assessments and to intervene when you do the treatment in person than doing it over the internet. And also, in the case of substance use and substance use disorders, for instance, direct observation of urine toxicology has become extremely difficult. So these are some of the challenges that we have.

Carlos Blanco (00:09:58):
Also, from the point of view of the treatment clinician, most of us are used to practicing in clinics or hospitals or private offices. Practicing from home office has particular challenges because sometimes you have to share your office with your spouse or with your kids. Sometimes the equipment is not optimal. So these are some of the challenges that we're working on solving, but certainly a lot of people
are struggling with them. And then, of course, as I was mentioning at the beginning of the talk, the uncertainty about how this pandemic is going to evolve, how long it's going to take, what is going to be the course of the pandemic, and also clinicians dealing with their own anxiety at the same time that we try to do the best that we can for our patients.

Carlos Blanco (00:10:45):
Now, compounding, of course, the issue of the pandemic, we have the issue that Kathryn was mention, at the beginning, of the stimulants were already on the rise. And so the stimulants complicate the opioid crisis and the COVID crisis in multiple ways. One of them is that, as Kathryn was mentioning, there's been a doubling of stimulants, and often individuals who have opioid use disorder also have increased prevalence of stimulant use and stimulant use disorders.

Carlos Blanco (00:11:19):
As you can see on the slides, since 2008 there's been a three-fold increase in methamphetamine among heroin treatment admissions. And also people or individuals who use stimulants, have stimulant use disorder, often have other mental disorders, such as depression or anxiety. And one other thing that has really come to the floor in thinking about the opioid crisis, how it converges with the stimulant crisis, is that many individuals have really polysubstance use and polysubstance use disorder. So instead of thinking in separate, sort of, boxes or separate sections about individuals who have one disorder or the other, we have to think about what are the commonalities because substance use disorders and how to develop interventions that can be effective across disorders.

Carlos Blanco (00:12:17):
One difficulty also that we have in treating stimulant use disorders is that in contrast with opioid use disorder, we don't have specific medications that can treat stimulant use disorder. So for opioid abuse disorder, we have buprenorphine, we have methadone, we have naltrexone. We don't have any analog medication for stimulant use disorder. So, in a way, it becomes much more difficult to treat.

Carlos Blanco (00:12:43):
We do have psychological interventions, such as contingency management, and continuously management is, in fact, quite effective for the treatment of the stimulant use disorder. Unfortunately, it is quite time consuming and very few people are trained to provide contingency management. So to the extent that it's not easily accessible by most patients, then it's going to be difficult to provide treatment. And also, an additional difficulty for contingency management is that many insurance companies at present do not provide reimbursement for that treatment.

Carlos Blanco (00:13:21):
So what are we doing to address the current situation? Well, we're doing a number of things, and the first thing that we have done is put out a notice of NIDA to provide emergency funding to provide research in these domains. Now, what kind of research do we want to fund? Well, the traditional monologue of our funding research is that researchers have ideas that they think are interesting, and they then can create their research. All these very interesting papers, but those findings don't necessarily get incorporated into the system. So besides that we want to fund now is really research, but there probably won't be top down, as it has been in the past. It's more of a dialogue between people who are engaged in clinical practice or direct public health departments who can generate research question and then we compare them with researchers that can help answer those questions.
So, for instance, if you look at the traditional model of definition of science, you can see again that it's very top down. Mostly you will get researchers generating their knowledge and then there will be early adopters, then other people will adopt it. I mean, these models, as you know, it takes about 17 years for findings to get adopted. We don't have 17 years to get the findings that we need in substance use disorders and COVID to get adopted. We need them today, if not yesterday. So that model is the model of the large healthcare system, which was developed for hospitals, for clinics. And this model is more, as I was saying, a dialogue or a circle in which clinicians, or in this case public health officials [inaudible 00:15:13] running large health systems, generate questions. Then we try something, we see how it works, we modify it, and we go back to the individuals who are running the systems and ask them whether that is working. And if not, how do we adjust it?

So what we need to do at this point is really hear from people who have the power and the ability to modify systems, like governors, state legislatures, or individuals who, as I was saying, run large health systems, to tell us what are the priorities? What kind of research, if NIDA funded it, would be adopted by those systems. And if we can find that research, it will have much greater impact than just writing papers for journals.

I want to conclude by saying that we are in a unprecedented crisis, as everybody knows. We are paying for this crisis really with our treasury, and more importantly, with our lives. At the same time, we really have a unique opportunity, an opportunity that only comes once in a generation to change the system and really create any world of science, of health, that could really save lives. So that world is within our reach, well within our reach, so I encourage you to work with NIDA and generate the research that can save lives in the future.

Thank you for your attention, and I'm going to yield the floor to my friend, Gary Mendell.

Thanks, Carlos. We'll turn it over to Gary in a second, but wanted to first thank you for sharing the changes and the challenges during COVID-19 and just really appreciate all of the great work that NIDA is doing.

Our next speaker, Gary Mendell, will discuss the stigma around opioid use disorder and how Shatterproof is addressing it. Gary is the CEO and Founder of Shatterproof and a nationally recognized expert on the opioid crisis, and we're so pleased to have him with us today.

Gary?
Kathryn, thank you, and also my thanks to Carlos. It's an honor to be on a panel with you, and also Dr. Price, as well, so thank you both. And thank all of you for listening to us today. We really appreciate your service and your work.

Gary Mendell (00:17:40):

Let me preface my remarks by saying I am going to talk about the stigma related to the opioid epidemic, but that's the place to start. And really, most of my remarks, although it's related to the opioid epidemic, the only place to start, it really relates to all drugs, all substances. It's really related to substance use disorders, not just opioid... And really what I want to say, the next slides coming up, that there's four things on this slide. First, many of you know about. I suspect all of you know about impact of the opioid epidemic. The number of lives it's taking, the cost to our society, which is really the first two sections there. But also, the third area is that how correlated opioid use disorder is with other infectious diseases. Homelessness, unemployment, there's such a crossover. And related to the current coronavirus situation, it's that much amplified.

Gary Mendell (00:18:52):

In a recent study that came out about two weeks ago, it was estimated that in addition to all the lives that are being lost to the opioid epidemic, there'll be an increase of somewhere approximately 85,000 lives additionally lost to the opioid epidemic because of the isolation and lack of access to healthcare because of the social... because of what's going on with the coronavirus. It was a range from approximately 30,000 to 150,000 with a midpoint of about 85,000 lost lives. So it's that much worse because of the coronavirus, and that really relates to that last bullet there. That's what I was referring to.

Gary Mendell (00:19:33):

As I move to the next slide... so I think you all know the issue, but I suspect what I'm about to show is as it relates to stigma. If you look at the drivers of the opioid epidemic, there's nine drivers that we have identified. The first two arguably have nothing to do with stigma, the overprescribing of dangerous opioids, the increase in the supply of heroin and fentanyl into this country. Those are clearly two drivers of the opioid epidemic, and I suspect all of us would agree that they're not driven by stigma.

Gary Mendell (00:20:24):

But the other seven, every single one of those, as we look through that list, is either partially or fully driven by stigma. And without reading the words, because you can all access the slides later, maybe if I can just bring to live those... Johnny, Johnny's 22 years old and he got hurt playing soccer in college, and he was prescribed opioids without being explained the risks, and became addicted. And then does Johnny seek treatment? Well, in a recent poll, half of Americans said those who can't control their substance use, it's their fault. They're not trying hard enough, poor character. Half said it's a chronic illness, not their fault. But 80% of the surveyed participants in the national... said I'm not comfortable associating with someone who's addicted to prescription opioids that's my friend, my co-worker, or my neighbor or marrying into my family. Because most of Americans, it doesn't really matter whether they think it's a chronic illness or it's someone's fault. They may be more empathetic if they think it's not someone's fault, but because most Americans don't believe it's a treatable disease, they don't want to associate with someone who's addicted.
And so Johnny, who's 22 years old, who becomes addicted to prescription opioids, it's very likely that he will not seek treatment. Why? Because he doesn't want anyone to know. The hard numbers, they're about 15% of those addicted are treated compared to 88% for diabetes and 75% for heart disease. Well, why is there such a difference? Some of it is because approximately 15% of those addicted have reported in the annual NSDUH study by SAMHSA that they did not seek treatment because they're afraid it will affect their relationship with their employer, their friends, or their family. So they may not seek treatment.

Gary Mendell (00:22:46):

Let's say Johnny can get through that barrier and he decides to seek treatment. Can he find a provider? Maybe not. In a recent poll, approximately 24% of primary care and internal medicine doctors said they don't want to... because it may attract undesirable people into their waiting room. 24%, one quarter of primary care doctors. That's stigma-driven. It's not taught in medical schools. Why? Because it hasn't been viewed as an illness. That's stigma-driven. And so because of that, Johnny might not be able to find a doctor or a provider, even if he's willing to seek one. 50% of the counties in the United States don't have a doctor license to prescribe the medication that is the gold standard for treating addiction. One [inaudible 00:23:45] patients, 50% of the counties.

Gary Mendell (00:23:48):

Let's say Johnny gets through that hurdle and he can find a provider. Will the health insurance cover him, provide health benefits to him, comparable to another physical disease? They are required to, health plans are. Many do, but some don't. Let's say Johnny gets through that hurdle, can he find evidence-based... chances are no. This is a data point, 60% of the providers in the United States don't even offer one of the three medications that are recommended by all of science. 60% don't offer any, and only 3% of the providers offer all three.

Gary Mendell (00:24:39):

And let's just talk about the biggest killer. Let's say Johnny gets through all that, but through this process, Johnny has internalized what the public is basically saying, that he's got bad character and it's not a treatable disease. And Johnny... so even if he gets through all those hurdles and he went to the best treatment program in the United States, all based on science, he enters a society where 80% of Americans don't want anything to do with him, and he now believes it. He believes. He's internalized it. He believes that he is not worthy of treatment. He believes he's not worthy of a job. He believes that he shouldn't date his neighbor's daughter because he's not worth it.

Gary Mendell (00:25:35):

I would submit to you that stigma is one of the most important things that we need to break down if we want to save lives and reduce the care of healthcare cost related to this disease. If we go to the next slide, what's our nation's response? A lot of wonderful things related to the opioid epidemic. You can read the list here. You can look at the slides later, but in short, our country is doing a wonderful job in a lot of areas responding to the opioid epidemic. Pouring more money into treatment, doing more research, increasing the access to naloxone, on and on and on. You can read the list here, a lot of wonderful things, but guess what's missing? The driver from the previous page that touches seven of the nine drivers of the opioid epidemic. And not one dollar in any line item of our federal response related to stigma. It's the missing piece.
So moving on, knowing this, Shatterproof worked with McKinsey & Company for nine months and we looked at all the research, social movements that have had success. We looked at how did our country change its views on HIV/AIDS? What things worked and what things didn't work? How did our country change its views on marriage equality? 15 years ago, you could not even join the Boy Scouts if you were gay, and now you can run for president. Well, what things worked and what things didn't work?

Just to move on to the next slide, we studied 11 social movements to determine what things worked, what things didn't work, can this be done for addiction? And if it can't, let's cross it off our list and we will have to deal with it. But if it can, we have a plan to do so. And as we did our research, we then identified the different types of stigma. I mentioned all three in my story with Johnny. How the public feels, public stigma. That then turns into structural stigma, stigma within systems, insurance not covering things the same way, the stigma against medication, not being offered in treatment programs, people being put into the criminal justice system versus the healthcare system, people not being employed, not being able to get a job because they checked on their application that they have a substance use disorder, on and on and on. Systems within our society.

And then, as I mentioned, probably the biggest killer is what someone internalizes, what they feel, which limits their ability to life because they lose hope. So that will have been the types of stigma we uncovered in our research, and then we built a plan around it. And our research, by the way, absolutely determined this can be done for addiction. There's no if. It can be done.

So six key success factors. We looked at about a dozen and we narrowed it down to six that we believe was useful in reducing the stigma of addiction. Number one, one well-funded, central actor to coordinate the behavior of everyone around the country because this is not about Shatterproof or NIDA or any one of you listening to this call doing a lot. It's about all of us doing a little and coordinating... key actions were in three categories: Educating, altering language, and changing policies. It's really important it's done in a very specific way. I found out, when I studied all this research with McKinsey, that Shatterproof was doing the wrong thing last year. We had a campaign in the first quarter of 2019 that was educating the public that addiction was a disease. That is counterproductive. It's stigma-producing. Yes, it may increase the number of people who don't think it's Johnny's fault, but it makes it even more so that, if they believe it's a disease, they still don't want to be Johnny's friend because it's not treatable. The message has to be it's a treatable disease, not that it's a disease, which it is, by the way. The research shows that properly treated, based on treatment that's based on science, this disease has a recurrence rate that's no different than diabetes or heart disease, no different, but that's what the education has to be. And it also has to be contact-based. It has to be a short video or in person or a picture, but in person is less scalable, obviously, so it's humanized and giving the message that a treatment is effective.
Number four, movements have to be sequential. Obviously, if Shatterproof wants to get the entire country changing their language, no more junky, no more addict, no more clean and dirty drug tests, it's positive and negative drug tests. We can't get the entire country to do it. We have to sequence it very smartly and deliberately with the largest organizations in the country that are influencers and cascade it down.

Gary Mendell (00:31:46):
And just to go backward for a second on language, there is research that definitively shows, without any doubt, that if we use the language of addict, the exact same story about Johnny and he's an addict, the public will respond by thinking that Johnny is going to the criminal justice system. If we describe the same story with Johnny, who has a substance use disorder, then the public is more likely to say, "Let's get him into healthcare system," by changing our language. Five and six, positive, negative incentives. And, obviously, it's just not from the top down in terms of grassroots up.

Gary Mendell (00:32:41):
Moving on to the next slide. So what's our plan, based on those key success factors in previous movements? We identified six systems in our society that we believe will have outside impact in reducing the stigma of addiction, of doing simple-to-implement action items. Our employers, our care system, local communities, criminal justice system, government, and media entertainment. In reality, we have 13 systems embedded in those 6. For example, healthcare there's two. There's payers and providers. Local communities includes those in recovery, high schools and middle schools, universities, community organizations, et cetera. So there's really 13 systems. So those are the systems that we want to activate to do very simple, easy-to-implement action items.

Gary Mendell (00:33:42):
Educate and employers, for example. Educating their constituents about what this disease is and bring simple, user-friendly, highly-curated information that doesn't... and giving stories shared, short videos, or a picture with a paragraph that addiction is a treatable disease and it's humanized with a person who has done well with treatment, and get these stories shared. For employers, put it in your monthly newsletter. For the healthcare system, maybe we're going to meet with providers and get their advice on how to get these stories shared more widely, et cetera, on and on.

Gary Mendell (00:34:26):
But there's also, in this ecosystem, five other groups. There's Shatterproof as the coordinating body, but that's it, the coordinating body. We can't do this on our own. There's partners, which are organizations that want to be a true partner with Shatterproof and help fund us to get this where it needs to go, to be thought leaders, advisory board members, and build this out. There's also principals, which are simply funders. There's allies, which are organizations that simply don't want to take a leading role as either a funder or a fault leader, but they and their organization want to implement the action items. And then there's coalition leaders that just want to help spread it, like the National Academy of Medicine, like the National Safety Council, and others who are teaming up with us to do this. So that's the ecosystem we plan to build.

Gary Mendell (00:35:28):
I will also say, while I'm on this slide, imagine this ecosystem built, and three years from now we're working with 10,000 employers and we're working with thousands of hospital systems and providers
and payers, and 10,000 community organizations, and different players within the criminal justice system, and 20 states, et cetera. How hard would it be to migrate this to all substances, not just that related to opioids? We heard Carlos speak about what's going on with stimulants. How hard would this be to broaden this to all substances and stimulants... to all of behavioral health, pretty easy.

Gary Mendell (00:36:13):
Next slide. Just checking my time. Actually, I'm out of time, so yes. So I'm going to finish it up really quickly. The action items are fairly simple. It's educate, it's language, and it's policy change. I already mentioned the roles of different stakeholders or the roles that organizations can play. And lastly, this needs to be sequenced very carefully and very strategically to get mass adoption. And my last slide is if anyone wants to learn more, just email us at endstigma@Shatterproof.org and we'd be happy to respond and give you all the information that we have as we roll out this plan in the next six months. Thank you.

Kathryn Santoro (00:37:03):
Thank you so much, Gary, for being with us today and sharing this important work to change the conversation around substance use. And we look forward to continuing to learn more as you launch your plan.

Kathryn Santoro (00:37:17):
Under the leadership of Curtis Barnett, Arkansas Blue Cross Blue Shield's President and CEO, Arkansas Blue Cross is leading a comprehensive approach to address the opioid epidemic and respond to the COVID-19 pandemic and the needs of their members and their communities. Through the Together Arkansas Opioid Response Initiative, Arkansas Blue Cross is partnering with other state leaders to provide employers with resources to help them prepare, prevent, and respond to the opioid crisis. Arkansas Blue Cross has also expanded access to behavioral health and substance use treatment during COVID-19.

Kathryn Santoro (00:37:58):
To hear more about these efforts, we're now joined by Dr. Herbert Price, Arkansas Blue Cross Blue Shield's Corporate Medical Director. Bert?

Herbert H Price III (00:38:07):
Thank you, Kathryn, and thanks to Gary and Carlos. I'm going to be talking addressing opioid use disorder treatment in Arkansas during COVID-19.

Herbert H Price III (00:38:19):
Arkansas is a rural, agricultural state with some areas of high poverty along the Delta counties along the Mississippi River and with some booming areas. Population is a little over three million people, and we have a high rate of opioid use disorder in the state. In fact, in 2016, we were number two in the country in terms of prescribed opiates. We had a rate of 93.5 per 100 compared to the U.S. rate of 51.4. The state is number one in rice production, we're number one in duck hunting licenses, and we're number two in per capita gun ownership, after Alaska.

Herbert H Price III (00:38:57):
Now, in a state like that, it's remarkable that we're one of the few southern states that expanded Medicaid. And for people that were up to 120% over the federal poverty level, we got a waiver from CMS and we bought them commercial medical policies. Initially, it was called the Private Option and now it's called Arkansas Works. So our increase in members all had commercial insurance. In terms of the number of overdose deaths in Arkansas, it's been trending upward. We haven't quite had the fentanyl crisis that some other states have had, although it is in the state. So we had, in 2018, 208 opioid overdoses compared to 400 of other drug overdoses.

Herbert H Price III (00:39:50):

Now, our governor, Governor Asa Hutchinson, he is a former DEA administrator in the first Bush administration. And when he was running the DEA, he called attention to the emerging methamphetamine threat in rural America, and he lobbied for prevention and treatment and drug courts when he was in that position. And he's doing really well as a governor. He respects science and medical experts, and he's done a good job during the COVID-19 crisis with his daily briefings.

Herbert H Price III (00:40:25):

Other state efforts, he created a position for an Arkansas drug director and it's like our drugs czar. And Director Kirk Lane came from a law enforcement background. He was a 35-year veteran of law enforcement, and he oversees, in his position, both enforcement efforts and treatment efforts in the states. And he has a strong emphasis on reducing stigma and on enabling and training peer counselors. In fact, his director, Mr. Jimmy McGill, is the Department of Human Services Recovery Coordinator, and he's in personal recovery himself. And, in fact, back in the day, Director Lane had repeatedly arrested him for drug offenses prior to him getting into recovery. So there's a nice emphasis here in the state with the state government on working with the recovering community and respecting people who are in recovery.

Herbert H Price III (00:41:32):

Other efforts by the state, we've increased our Prescription Drug Monitoring Program and we expanded a Drug Take Back Day. And, in fact, last year we took back 26,000 pounds of pills compared to 7,000 pounds in neighboring states. We also passed a Good Samaritan Law, which if you're in the presence of someone who's overdosing and you call 911 or you give them naloxone or you take them in to seek medical attention, you have immunity from arrest or prosecution for controlled substance possession and paraphernalia offenses. And the motto for this is, "Don't run. Call 911." So if you call 911 or contact authorities if someone is overdosing, you will not be charged. We've also had an increased use of naloxone in the state by police and first responders. Many police and first responders carry naloxone kits. And in the last 15 months, we've had 471 lives saved by naloxone.

Herbert H Price III (00:42:53):

Kathryn mentioned that Together Arkansas, which is a state-wide collaboration working opiates in the workplace, and it's a collaboration between the State Chamber of Commerce, the Associated Industries of Arkansas, the Arkansas Foundation for Medical Care, and Arkansas Blue Cross Blue Shield, with the goal of creating a drug-free workforce and reducing opiate dependence.

Herbert H Price III (00:43:19):

And Kathryn also mentioned our CEO, Curtis Barnett. He's really been focused on addressing the opioid epidemic and having the plan help with those efforts. He said, "The opioid epidemic is one of the biggest
threats to the foundation of business and our economy today. Providing Arkansas employees tools to address a problem as pervasive as opioid use disorder is critical. Helping employees break the bonds of addiction and get and stay healthy keeps them creative, innovative, and productive. And that makes Arkansas strong."

Herbert H Price III (00:43:52):
Now, some of the initiatives we've had prior to the COVID-19 epidemic, in terms of our Quality of Care programs, we have a plan substance abuse prevention coordinator and we do outreach to prescribers identifying our members that have multiple prescribers and multiple pharmacy use. We also do outreach to providers if our members are on combinations that are likely to produce overdose, and we have Care Management Outreach to members who meet certain thresholds.

Herbert H Price III (00:44:28):
In the realm of communication, we provide opioid utilization reporting to Collaborative Health Initiative Partners, which are some hospital systems and hospitals in the state that we partner with, and other physician group partners. And we have educational efforts on the risks of opioid misuse and treatment options through employee, member, and provider publications.

Herbert H Price III (00:44:52):
And we've instituted quantity limits on opiates. We allow a limited amount of opiates prescribed at one time. We limit them to seven-day fill for acute pain patients, with a daily limit of 90 morphine milligram equivalents, and any quantities over that per day requires prior approval. The maximum dose we allow is 200 morphine milligram equivalents, and we require patients to use immediate-release opioids first before moving on to extended-release. We took away the prior approval from Suboxone, and there's no cost share for the member for naloxone or Narcan.

Herbert H Price III (00:45:38):
In terms of the opioid trend reports, this is our commercial population. You see there's been a steady decrease for the commercial population in the amount per member per month prescribed. That's the commercial population, and this shows the exchange, which is the expanded Medicaid population. We've also shown a similar trend line in reducing the amounts per member per month.

Herbert H Price III (00:46:04):
And looking at medication-assisted treatment, in our commercial population, we have an improving trend in terms of people being prescribed buprenorphine, and it's more impressive with the exchange population. We've definitely tried to encourage medication-assisted treatment for opioid use disorder and tried to increase prescribing for that within the state.

Herbert H Price III (00:46:34):
Now, the other things we've done, we've done grants for education. We gave a grant to the Psychiatric Research Institute at the University of Arkansas for Medical Sciences for prescriber education on opioid management and dependency reduction. And then we gave 1390 Naloxone kits to the state for first responders. We also support community organizations and the National Alliance on Mental Illness and recovery organizations that have foundations.

Herbert H Price III (00:47:09):
Now, when the COVID-19 pandemic hit, we responded by... we stopped prior approval requirements. So for our inpatient, for substance use treatment and behavioral health, for residential treatment, for partial hospitalization, and intensive outpatient. We got rid of prior approval. We stopped concurrent review. We request them to give us a pre-note notification so we can help with the member with case management after discharge, but there's no cost sharing for behavior health or substance use disorder treatment. There are no co-pays, there are no deductibles, and no co-insurance. And for the inpatient and partial and residential, we've had about a 12% decrease during the COVID-19 for people being admitted to behavioral health facilities and substance use disorder treatment facilities.

Herbert H Price III (00:48:08):

We expanded outpatient substance use disorder treatment. Again, for that, we waived co-pays, co-insurance, and deductibles. We opened up some telephone codes that we had never covered before as a plan. In Arkansas, there was a restriction in that the state law was passed where provider state boards had to meet the level of stringency of the requirements of the state medical board. And a couple of the other provider boards had not done that quite yet, so our first move was to try to open up the telephone codes to allow providers just to use the telephone. And then later, the telemedicine codes were declared. A provider could use a telemedicine code by using a telephone, so we got rid of the audiovisual requirement with the telemedicine technology. So we opened up telemedicine to substance use treatment disorder providers, MDs, DOs, APRNs, psychologists, licensed psychological examiners, clinical social workers, and licensed professional counselors.

Herbert H Price III (00:49:30):

The telemedicine codes that were opened up had always been in existence, but we removed a lot of the requirements. So these are for the psychiatric diagnostic codes and psychotherapy codes, with and without evaluation and management. There was also a family psychotherapy code with the patient present or without the patient present that was covered by telemedicine. And for partial hospitalization and intensive outpatient programs, we cover the individual psychotherapy and family psychotherapy components of the program by telemedicine.

Herbert H Price III (00:50:09):

Now, this slide shows the office visits versus telehealth. So you see this is for both medical and for behavioral health treatments, including substance use disorder. You see there's been a decrease starting in March and April as the COVID-19 crisis kicks in, and then you see a decrease in office visits and an increase in telemedicine visits. This is for all services. This is looking at the same number in terms of total encounters. There's been a decrease in encounters, but there's been a marked increase in telemedicine services for both medical and for behavioral health treatment. These are the telephone codes that we opened up, and we haven't seen much uptake for the telephone codes. This is... primarily because once telemedicine codes were declared to be you could use a telephone to do them and they pay better, people went to use the telemedicine instead of the telephone. And this shows the dramatic increase in telehealth visits for behavioral health and substance use disorder as the crisis kicks in, February, March, and April.

Herbert H Price III (00:51:35):

This is looking at behavioral health services and what was telehealth and what was office visits. And you see it's now pretty much all done by telehealth here in the state. And this looks at opioid and stimulant use disorder by place of service. And notice there's an increase, as we went to telemedicine, in services
provided to opioid and stimulant use disorder that was not there when it was primarily office-based visits. So this has increased access to this population during the COVID-19 crisis. This slide compares office visits to telehealth visits for opioid and stimulant disorder and you see that, again, the increase in telehealth is pretty dramatic.

Herbert H Price III (00:52:34):
Looking at opioid and stimulant disorder use by diagnosis class, the blue is opioid-related disorders and the orange is other stimulant-related disorders. And there are more treatment encounters now with the telemedicine and with the COVID-19 than there were previously. Looking at total services, percentage of total services, again, this shows the number of people that are opioid-related disorders in blue and then an increasing number of people percentage-wise are seeking treatment for stimulant disorders.

Herbert H Price III (00:53:20):
The final thing I want to talk about is that there's been an explosion in virtual 12-step meetings in the recovering community. Alcoholics Anonymous, Narcotics Anonymous, ALANON, and Adult Children of Alcoholic meetings have moved to Zoom. And people can go to multiple meetings, multiple times of the day, in multiple states. In fact, in the AA community, there's a program where people try to do 50 states in 50 days. So you'll get people visiting from other states that are coming to Arkansas to get the A knocked off their list.

Herbert H Price III (00:53:55):
Initially, there was a concern about Zoom bombing where people would get into an AA meeting or a recovery meeting and disrupt it. That seems to have been controlled pretty well by passwords and by better management by the meeting chair. And for a meeting format where the chair calls on participants, it works really well. If you have a really large meeting, everyone needs to be on mute, and then the chair will call on people, and they'll unmute themselves and have a chance to share. This has really been well-received in the recovering community.

Herbert H Price III (00:54:33):
How to find online meetings, basically just go to AA.org and click on your state and look for AA groups near you, and click on their website. And that will give you Zoom meeting number and the password, both for open meetings and for closed meetings. And this works for both Alcoholics Anonymous and Narcotics Anonymous.

Herbert H Price III (00:54:55):
So, in conclusion, Arkansas Blue Cross Blue Shield efforts during the COVID-19 pandemic increased access to treatment for opioid use disorder and stimulant use disorder. The use of telemedicine for opiate use disorder and substance use disorder treatment has increased exponentially. This will probably continue after the pandemic. And recovery groups have successfully went online during the pandemic, and virtual AA and NA meetings will continue after the pandemic period ends.

Herbert H Price III (00:55:31):
Thank you.

Kathryn Santoro (00:55:35):
Thanks so much, Bert, for sharing Arkansas Blue Cross Blue Shield's leadership and commitment to addressing substance use disorder and ensuring access to treatment during these challenging times. I'd now like to invite all of our speakers to come off of mute and we'll take a few quick questions.

Kathryn Santoro (00:55:53):
I wanted to start with Bert and just open the question up to anyone, but you mentioned a key point about how first responders are trained to help with opioid overdoses and how we're providing resources. Could any of our speakers talk about how first responders are adapting to the increasing use of stimulants and what additional evidence or resources we really need to be able to address this emerging crisis?

Kathryn Santoro (00:56:29):
Bert or Carlos, could you speak to that?

Carlos Blanco (00:56:35):
This is Carlos Blanco. As I mentioned before, this is one of the tragic situations [inaudible 00:56:43] for opioid users, currently we have naloxone, which is very effective, or quite effective at reversing overdoses, but we don't have anything similar for methamphetamines. So one thing to take into account is that stimulants are often not used alone. So to the extent that we can treat the comorbid conditions like, let's say, benzodiazepines or opioids, we can't reverse those overdoses. The only other thing that can be done is really be taken to the hospital. And let's say if they have hypertension or any kind of condition, treat those conditions. The other thing we're doing at NIDA is really trying to develop medications both for the reversal of the overdoses and for ongoing treatment similar analog to what we have for methadone or naltrexone or epinephrine for methamphetamine, but that's going to take some time. So actually that's one of the difficulties of the methamphetamine and stimulant crisis in general.

Carlos Blanco (00:57:42):
Bert, tell them if you want to add anything to what I'm saying.

Herbert H Price III (00:57:45):
Yeah, for the methamphetamine, I don't think... it's not common to see people just with methamphetamine. Most of them, they're using polysubstances to include alcohol and opioids and other drugs, cannabis. So it's not a pure methamphetamine culture.

Kathryn Santoro (00:58:10):
Great, thank you. Thank you for that. Another question, Bert, you mentioned this a little bit in your concluding slide, but for any of the speakers, what long-term impact do you see regarding the relaxation of rules regarding in-person patient visits and the allowance of longer term prescriptions for substance use disorder?

Herbert H Price III (00:58:36):
Well, I think that as so many providers have become more comfortable with using telemedicine, I think people that might have been reluctant to do it before, they're now discovering that they're able to do it and they're more comfortable. And I think that the fact that they're more willing to do that, that's going to persist after the pandemic ends.
Herbert H Price III (00:59:02):
Our increase in telemedicine provided, we kept the requirement to have an Arkansas license to treat patients in Arkansas, and we saw this... this is an explosion of people that weren't doing telemedicine before that had Arkansas licenses. Now they're doing it.

Carlos Blanco (00:59:20):
Yeah, I agree with Bert on that. I think that not only from department providers, but really patients are going to push to keep telemedicine because it's so much... it really increases access and convenience. It takes away, you don't have to drive to the place, to the clinic, you have to wait. You can do it at any moment. So I think that there is going to be a big push for that.

Carlos Blanco (00:59:42):
One of the things that we really need is the outcome data to really make sure that telemedicine is as effective as in-person medicine. My expectation is that it will be, but it's important to get the data and make sure that when we establish a new practice, we have the evidence tool to back it up.

Kathryn Santoro (01:00:02):
Thanks. And now we’re almost running out of time, so I just want to ask our speakers one final question. And for our audience, we’ll try to follow up off-line with some of these other specific questions. But just following up on this conversation, is there one thing you'd like to share with the audience that you've learned during this COVID-19 pandemic that you think will impact how we address substance use treatment and prevention going forward.

Kathryn Santoro (01:00:30):
Do you want to start, Carlos?

Carlos Blanco (01:00:34):
Yes. So I think that the speed at which we have to generate new science and deploy science, I think that impact is not only how do we re-put together research and practice in a very, very fast way to really serve the patients in the best way.

Kathryn Santoro (01:00:55):
Gary?

Gary Mendell (01:00:55):
I think the thing that has been most obvious to me is that when this country sees an issue, it can react to it and get things done. There's a lot happening here now, obviously, with the coronavirus, and a lot of good change is happening. And the opioid epidemic... there'll be 80,000 overdoses this year. 70 or 80,000 overdoses this year. 400,000 people lost their life in the last several years. 400,000. And a lot of this is preventable, and I think I'm very focused on making sure that we improve how we communicate that to those who can influence how we can do things better.

Kathryn Santoro (01:01:53):
Thank you. Bert?
Herbert H Price III (01:01:55):

Yeah, I think the... a result of this COVID-19 is this impact of virtual meetings in the recovering community. I think that's going to increase the number of different types of meetings people can go to, different subtypes of meetings, LGBT meetings or AA meetings, all men's meetings, all women's meetings. I think that that's going to increase the opportunity for people to engage with the recovering community through online participation.

Kathryn Santoro (01:02:36):

Great. Well, thank you all, and thank you. You just have been an excellent panel of speakers. Thanks for taking the time to be with us today. And to our audience, thank you for joining us. Please take a moment to share feedback from this event, and also please check out our other resources on our website. We'll be posting a recording of this event. The slides are up there, and you can also view our latest infographic on the rapid rise in stimulant use.

Kathryn Santoro (01:03:03):

Thank you again for joining us today, and we hope everyone stays safe. Thanks again.