Maine Medicine

a quarterly publication of the Maine Medical Association

JULY/AUGUST/SEPTEMBER 2018

Maine Medical Association Mission: **SUPPORT** Maine physicians, **ADVANCE** the quality of medicine in Maine, **PROMOTE** the health of all Maine citizens.

MMA CONFRONTS MAINE'S PUBLIC HEALTH CRISIS

EDITOR'S NOTE:

In the many years that *Maine Medicine* has been published, this issue is the first dedicated solely to a single topic. Each article is focused on the opioid crisis, which more accurately should be known today as the opioid/heroin/fentanyl crisis. So long as hundreds of Mainers continue to die impacting thousands of families, the Maine Medical Association will continue to devote resources to address this public health crisis.

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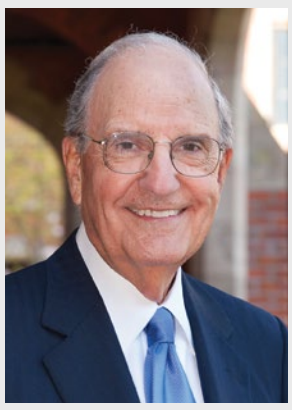
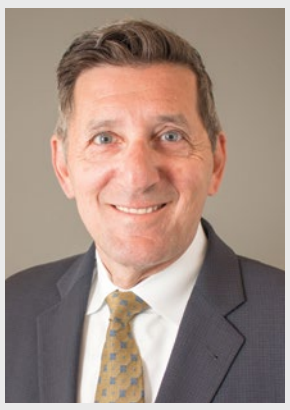




165TH ANNUAL SESSION TO FOCUS ON OPIOIDS

Honorable George Mitchell and Michael Botticelli to Present Keynote Talks

The Maine Medical Association will hold its 165th Annual Meeting September 7-9, 2018 at the Harborside Hotel and Marina in Bar Harbor. Former Majority Leader of the U.S. Senate George Mitchell will open the Session with a Keynote presentation at 6:00pm Friday night, September 7. Michael Botticelli, former Director of the White House Office of Drug Control Policy will Keynote Saturday's session and will speak at 10:00am. The title of the talk is, "Opioid Epidemic, How We Got Here, How We End It." Following the Director's talk, two panels will focus on different aspects of the issue. At 11:00am; a panel entitled, "418 Deaths: What's Needed to Strengthen Maine's Response to the Opioid Crisis?" will offer some solutions. Moderated by Lisa Letourneau, M.D., MPH, the panelists include Ranjiv Advani, M.D. with Bluewater Emergency Partners, Noah Nesin, M.D., Penobscot Community Health Care, and Michael Murnik, M.D., Chief Medical Officer, Blue Hill Memorial Hospital. The second panel at noon will feature "Alternatives to Opioids for Treatment of Chronic Pain" and will be moderated by Judiann Smith, J.D., Executive Director of the Daniel Hanley Center for Health Leadership. Panelists include State Representative Patricia Hymanson, M.D., Ursula Schmidt, LAC, MSCM, Karen Simone, Pharm D, Pharmacy Director at the Northern New England Poison Control Center and Susan Woods, M.D.

See the enclosure for registration materials and a complete schedule beyond the opioid presentations.

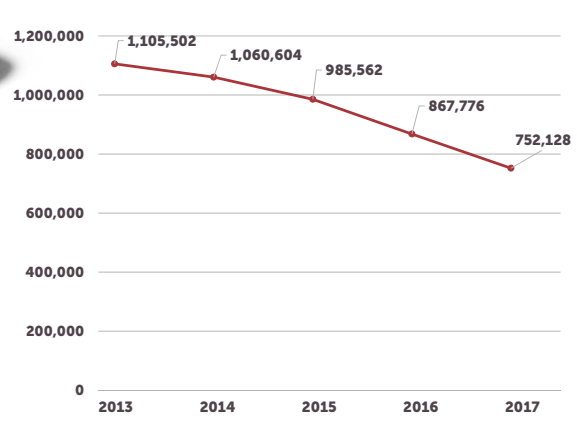
OPIOID PRESCRIPTIONS DROP IN MAINE

Two recent studies have shown a significant decrease in both the amount and dosage of opioid prescriptions.

The data from QuintilesIMS reported that over the five-year period 2013-2017, Maine practitioners decreased opioid prescribing for pain by 32%, the 5th largest drop in the country. All fifty states saw some decline. When looking at the dose of opioid medication, the firm Avelere found that Maine experienced the largest decrease in the nation from 2016 to 2017. Maine's drop was 25% while the average drop nationally was 11%.

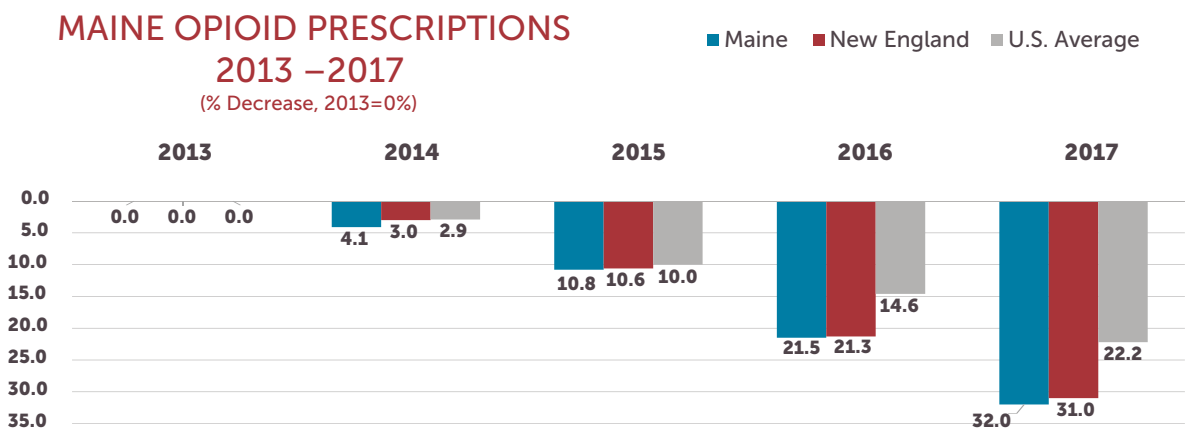
MAINE OPIOID PRESCRIPTIONS 2013 – 2017

(Retail filled prescriptions)



MAINE OPIOID PRESCRIPTIONS 2013 –2017

(% Decrease, 2013=0%)



MMA STEPS UP TO ADDRESS STATE'S OPIOID/HEROIN PROBLEM

As directed by members in a Resolution passed at the Annual Meeting in September 2015, the Maine Medical Association is engaged in a number of activities intended to address the state's serious drug abuse epidemic, particularly the growing use of heroin. In 2016, MMA supported L.D. 1537 which was signed into law on January 20. The $3.7 million package included $1.2 million to help fund new positions within the Maine Drug Enforcement Agency and an additional $2.5 million for various treatment options, including $900,000 to establish and operate a new drug detoxification center in northern or eastern Maine. Some of the treatment money also funded projects run by jails or local police departments to help individuals with substance use disorders with treatment resources.

MMA was instrumental in 2015 in the creation of the Task Forces in the state which focused on the opioid/heroin issue. Called the Maine Opiate Collaborative, the effort was led by former U.S. Attorney Thomas Delahanty, Attorney General Janet Mills and Commissioner of Public Safety John Morris. There were a dozen physicians spread across the three Task Forces which were organized around the topics of Treatment, Prevention/Harm Reduction and Law Enforcement. The Task Forces made recommendations to policy makers after conducting many Community Forums across the state. Physicians on the Task Forces include Rebecca Chagrasulis, M.D., Lani Graham, M.D., MPH, Chris Pezzullo, D.O., Matt Sholl, M.D., David Moltz, M.D., Meredith Norris, D.O., Mary Dowd, M.D., and Steve Diaz, M.D.

Since 2003, MMA has presented over one hundred (100) CME programs on the topic of prescribing for pain and preventing diversion and addiction. These programs will continue indefinitely. In addition, MMA's academic detailing program is presenting currently a module on prescribing for pain.

MEHAF, MMA, QUALITY COUNTS AND PIVOT POINT PRESENT AT GRANTMAKERS IN HEALTH ANNUAL CONFERENCE

The breakout session at the conference, held in Chicago in late June, was entitled, "Orienting towards Action: Strategies to Address the Opioid Crisis." Panelists included Gordon Smith, Esq., from MMA, Lisa Letourneau, M.D., MPH, from Quality Counts, Carol Kelly from Pivot Point, Inc and Kathryn Rouillard from Maine Health Access Foundation. Panel members highlighted different types of philanthropic tools that can be used, independently or in sequence, to support a variety of activities to help address the opioid epidemic.

Mr. Smith provided context for the discussion by describing the landscape in Maine today. Beginning with the establishment of the Maine Opiate Collaborative in 2015, he described the recommendations of the three task forces organized as part of the Collaborative and the progress to date on these recommendations. All four panel members emphasized the importance of engaging communities in this important work. All panelists agreed that private philanthropy could play an important role in filling some of the gaps in funding created when public sources of funding are withheld or otherwise are not forthcoming.

Continued on page 7

Check out our inserts with this issue including MMA Annual Session, MICIS Opioid Educational Offerings, Doctor of the Day, and more.

THE EVIDENCE

By Merideth C. Norris, DO, FACOFP, FASAM

(The opinion expressed is that of the author and does not necessarily represent the opinion or policy of the Maine Medical Association.)

I am an osteopathic family physician with many treatment tools within my repertoire. However, every Tuesday morning I arrive at the job where I treat many stories with the same medicine: methadone.

I always feel a little bit defensive when discussing medication assisted recovery, because of the eternal harping that "methadone is just replacing one drug with another drug!" This phrase is almost never uttered by anyone with actual education but is almost universally delivered with the air of someone imparting a great truth nonetheless.

Opinion has no place in medicine: only evidence. And the evidence is that medication assisted recovery using methadone is extremely cost effective and is associated with significantly reduced rates of overdose. In any other setting, for example, if I worked at a dialysis center or a cancer treatment site, I would be committing malpractice if I failed to offer a medication with such good outcomes. Yet because I am treating substance use disorder instead of kidney failure, the whole world feels entitled to weigh in, and worse, to make policy.

The first time I heard of the legislature's belief that the road to reduction of substance use disorder was to place great restriction on the prescribing of opioids, I immediately sent up alarms to every representative I could find, in every district where I worked. I explained that restricting the supply of opioids to certain populations would not result in sudden sobriety.

This is for several reasons: one, fewer than 10% of people with an opioid dependence maintain recovery simply by withholding the drug. Outcomes for abstinence alone, even in the presence of counseling or peer support, are abysmal. And the people who relapse are at higher risk for overdose. There needs to be access to medication assisted recovery. Which in virtually every area of Maine is either limited or impossible, particularly for those without insurance.

Another is that opioids do not "cause" substance use disorder. Although about 30% of people who actually have the disorder had their first exposure to opioids via a medical setting, the reality is that out of everyone who is exposed to opioid pain management, less than 5% will develop a disorder.

What is also true is that some people with chronic pain are dependent on opioids in order to manage their lives, their jobs, and their day to day functioning. For a person who is uninsured and works doing physical labor, opioids may be the one thing that allows them to put food on the table. To those who would tell these people should instead do yoga, learn biofeedback, or get another job, you are speaking from a position of great privilege. These are not choices everyone has.

For both the pain patients who are suddenly without a prescribing physician, and for the person with SUD whose supply is suddenly cut off, neither have the option of "just stopping." So, they find the next best thing. And on the streets of Maine, the next best thing is fentanyl, or whatever other injectable opioid is around. And unlike oxycodone, the FDA does not regulate heroin.

I predicted what would happen: if you cut off pain meds but do not provide increased access to comprehensive pain management OR to medication assisted recovery, you will not see more sobriety, but you will see more overdoses.

In 2015, there were 272 fatal overdoses in Maine. In 2017, the year we rolled out the new rules which were going to "fix the crisis," there were 418.

I love to say, "I told you so." But in this case, I wish I had been wrong.

PRESIDENT'S CORNER

By Robert Schlager, M.D., President, Maine Medical Association

The Opioid Crisis - When Will We Have Done Enough?

Maine has a lot to be proud of when it comes to managing opioids. We are a leader in reducing the percent of prescription opioid use in the United States; we have a law and regulations that are among the best in the country-written in conjunction with input from practicing physicians and physician associations-including the Maine Medical Association; the MMA was and is regarded as a standard bearer both in opioid education and policy formation; we have gotten much better at recognizing and acutely treating opioid overdoses in the emergency room and newborns and children at risk from the consequences of maternal or parental opioid abuse; and last but not least, we have a physician workforce that is very hard working and dedicated to providing excellent care to our patients. Well done colleagues! But we can't rest on our laurels. There is still much to be done. It troubles me when I hear that it is time to move onto other issues. "Why should I do a urine drug screen or a pill count on my 80-year old patient whom I have known for many years" or "I have all the trust in the world in my neighbor, friend and patient for 15 years and am wasting money on following the regulations regarding monitoring." An understandable reaction from overworked providers, but the question we should be asking ourselves is, "Why are there so many prescription opioid pills for sale and so easy to obtain?" Are all of them coming from out of state or from our relatively new patient with a history of low back pain who cannot take anything other than opioids? Could the medical community possibly have many innate biases that keep us from spotting all but the obvious people who divert prescription drugs? I personally believe that we are only beginning the journey of recognizing the critical role we play in keeping prescription drug diversion alive.

We all intellectually "know" but might not fully embrace that opioid addiction is a disease, just like alcoholism. It is not a character flaw. Once recognized, if we merely "wash our hands" and refer patients to an addictionologist or discharge them from our care, we are shifting the problem to someone else, not tackling the problem head on for what it is - a disease.

From my perspective, we have more to do as physicians. We can't just get patients down to the legal maximum limit and assume the job is done. We must recognize that in some cases after reaching the limit they just move on to illegal substances such as heroin and manufactured fentanyl.

I hope that these single focused articles on opioids will be a stimulus for further study and challenge us to improve our own knowledge base in this ever-growing epidemic. You can reach me at president@mainemed.com.

MMA MEDICAL STUDENT SECTION PRESENTS "COMBATTING THE OPIOID EPIDEMIC" EVENT

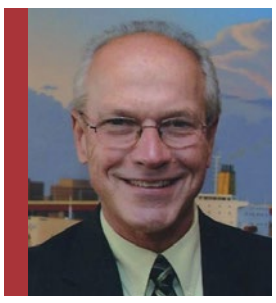
The American Medical Association Medical Student Section chooses a National Service Project theme to focus on community service initiatives. This year's theme is combatting and reversing the opioid epidemic and on April 23, the Maine Medical Association Medical Student Section (MMA MSS) presented their first public event which focused on the opioid crisis. Thirty-five attendees heard from Maine medical students about how to recognize and respond to an overdose, how to access and administer different antidotes for opioid overdose, what legal protections exist for individuals/families experiencing opioid addiction/overdose, and local resources for combatting the opioid epidemic.

"Attendees included medical students from both osteopathic and allopathic schools, a naturopath, family and friends of people who have suffered from opioid abuse, and locals who simply wanted to learn more about this epidemic and what they could be doing," said Kimberly Dao, TUSM '18 who coordinated the Portland event. The student organizers received very positive feedback from the public, and they are excited for next year's project. For more information about the MMA MSS, visit www.mainemed.com/MSS.

L-R: Emily Follo (TUSM M'18), Ryan Lena (TUSM M'18), Cam Bubar (UNECOM M'20), Kim Dao (TUSM M'18), Abhijit Srungavarapu (TUSM M'18), Cecily Swinburne (TUSM M'18), Archana Anandakrishnan (UNECOM M›21), Annie Sprogell (TUSM M'18).

NOTES FROM THE EVP

By Gordon H. Smith, Esq., Executive Vice President, Maine Medical Association



By the time most members and other readers have an opportunity to read this issue of *Maine Medicine*, summer will decline and the Association will be a few weeks from its 165th Annual Session. I hope many of you will join us in Bar Harbor where we will be joined by former Senator George Mitchell, former White House drug chief Michael Botticelli and the four gubernatorial candidates. It promises to be a very special meeting as we approach the mid-term election.

This issue of *Maine Medicine* is the first "theme" issue ever produced. All the content except for advertising is focused on Maine's opioid/heroin/fentanyl epidemic. Despite a significant decrease in opioid prescribing in the state (see related article in this issue), overdose deaths continue at a rate of more than one a day in the state and an average of three babies a day are born impacted by maternal drug use. Treatment resources are scarce and too many Mainers remain uninsured. Articles in this issue are intended to highlight gaps in care and advocate for actions that will improve access to treatment, reduce the risk for existing patients with substance use disorders and prevent patients from developing a substance use disorder.

There are many actions that each and every one of us can take to assist. Attend a community forum organized to reduce stigma, mentor an at-risk youth or take the 8-hour course required to receive the x-waiver to prescribe buprenorphine (suboxone). We must all do our part to halt this latest public health crisis. And a special shout out to some of the MMA members fighting on the front lines in our state such as Mary Dowd, M.D., Noah Nesin, M.D., Steve Hull, M.D., Lisa Miller, M.D., Peter Leighton, M.D., Lisa Letourneau, M.D., MPH, and Elizabeth Fowle-Mock, M.D. to name just a few.

I hope to see you in Bar Harbor, where the CME presentations focus directly on this critical issue.

PROVIDERS HAVE TROUBLE ACCESSING PATIENT DATA

By Liz Dears, Sr. Director for Strategy and Regulatory Programs, DrFirst

Even in today's highly connected world, physicians are still facing immense challenges in accessing patient data, specifically data from health insurers and Pharmacy Benefit Managers (PBMs). Of course, the more data a physician has about a patient, the more effectively they can treat them.

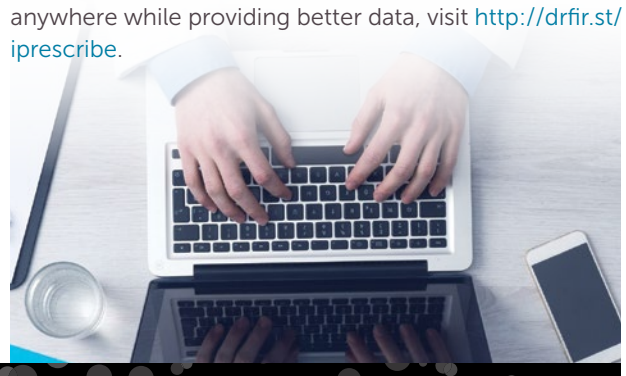
This is incredibly important for physicians in Maine as the opioid crisis continues to affect our state. By having more information about patients and the medications they may be taking, a provider can more efficiently and effectively prevent diversion and abuse.

A recent study from SureScripts and ORC International interviewed 300 primary care physicians on this topic and we have summarized some important takeaways below.

1) Only 50% of doctors are satisfied with the amount and quality of patient intelligence information they get.
2) 83% of respondents see patients' adherence information as a priority but only 17% of them get such information electronically.
3) While 56% of surveyed doctors assign high priority to having electronic access to out-of-pocket medication costs, only 11% actually have such access.
4) 59% want to be able to compare the price of therapeutic alternatives before prescribing.
5) 88% of doctors find it important to get access to information on other venues where patients have received treatment, while just 30% say they have easy access to it.

A physician's first goal is to treat their patients to the best of their ability. Like nearly every other industry, data is crucial to healthcare. Despite that maxim, physicians are still woefully underinformed when it comes to patient data. Having the latest research study, pharmaceutical technology or state-of-the-art medical equipment is of course a major part of modern healthcare. However, without accurate, reliable patient information, physicians are still being held back in providing the absolute best care for their patients.

DrFirst can help physicians overcome this challenge with our state-of-the app, iPrescribe. To learn more about how iPrescribe allows you to prescribe anything from anywhere while providing better data, visit http://drfir.st/iprescribe.



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MMA WELCOMES OUR NEWEST CORPORATE AFFILIATE:

Groups: Recover Together

We appreciate their support!

By Lisa Letourneau, MD, MPH

Building a Stronger System for Substance Use Disorder Treatment to Decrease Drug Overdose Deaths in Maine: What Will it Take?

To better understand our system of care for opioids and Substance Use Disorder (OUD/SUD), I recently undertook a six-month project in partnership with the Co-Occurring Collaborative Serving Maine (CCSME) to learn more about how care is provided for people with this too-often-deadly condition. During that time, I met with over 120 people receiving care, providing care, and/or otherwise supporting care and recovery of people with OUD/SUD. The journey took me to all corners of Maine, and offered many valuable insights into ways to strengthen our current system of care. I learned about many good efforts around the state to address various aspects of the current epidemic; at the same time, the fact that we have seen a 135% increase in overdose deaths in the past five years—with 418 overdose deaths in 2017—makes it clear that everything we're doing is still not enough. The emergence of synthetic opioids, particularly fentanyl, can cause severe respiratory depression and rapid death, and now poses a whole new level of threat. While traditional approaches to promoting prevention and offering treatment are important, they are inadequate to counter this dangerous new challenge.

Data from other states suggests that new strategies can help decrease drug overdose deaths, particularly when community leaders and clinicians come together to coordinate efforts and work in partnership to find solutions. Lessons from these efforts suggest that focusing on the following strategies could help stem this tide:

- Collect and monitor data on overdose deaths, ideally identifying key variables such as specific location of the overdose; patient characteristics (e.g. homelessness, previous participation in OUD treatment); and criminal justice history (e.g. recent release from jail)
- Provide rapid access to low-barrier OUD treatment, particularly access to evidence-based medications for OUD (e.g. buprenorphine) through new models of care and to high-risk populations
- Promote widespread availability of naloxone in the community, particularly to individuals at high risk of overdose
- Promote ready access to recovery supports, including linking individuals with OUD/SUD with peer recovery supports when they are ready to seek treatment

Some of the newer models for providing more rapid, widespread access to OUD treatment include the "Hub & Spoke" model, and initiating buprenorphine in the Emergency Department (ED). The Hub & Spoke model consists of addiction specialty "Hubs" that offer initial treatment and stabilization for OUD, linked with maintenance care from primary care "Spokes." This model, initially developed statewide in Vermont, offers a powerful strategy for expanding treatment, especially when Hubs offer low-barrier, rapid access to treatment. This year, the Maine Legislature passed L.D. 1430, a bill promoting development of a Hub & Spoke model in Maine, including $6.6M to provide funding for treating uninsured patients.

Clinician Leadership members work on OUD issues, April 4th.

Additionally, a recent study from Yale researchers suggests that initiating buprenorphine in the ED provides another model for offering potentially life-saving treatment for patients with OUD. While there admittedly are many challenges to setting up such programs, at least two EDs in Maine (MidCoast & Mercy) now offer life-saving MAT services to patients willing to engage in treatment.

To support these efforts, QC continues to work collaboratively with the MMA to host the "Caring for ME" initiative, an effort to engage clinicians in a compassionate response to Maine's opioid epidemic. We encourage providers interested in becoming involved in the Caring for ME to visit the QC website at https://mainequalitycounts.org/initiatives-resources/opioid-epidemic-caring-for-me-2/, which contains a wealth of opioid-related news and resources.

USDA ROUND TABLE

By Bailey Carter, MMA Intern

On Monday, July 9th, Husson University hosted the USDA for its 5th and final national roundtable discussion, *Opioid Misuse in Rural America.* This discussion was moderated by Anne Hazlett, Assistant to the Secretary for Rural Development and included sixteen panelists. Amongst these panelists were Senator Angus King and Congressman Bruce Poliquin, both of whom informed the audience of their work in Washington to help with the epidemic. This roundtable discussion had three major themes tying each speaker to the next: prevention, treatment, and recovery. While there are many conferences that emphasize at least one of these aspects, this was the rare case in which an abundance of expertise was available on each section. This allowed for in-depth analysis, the ability to connect each topic together and allow each speaker to build upon the last.

Prevention was at the forefront of every speakers' mind, as the root problem must be resolved or more people will succumb to Substance Use Disorder. Christine Theriault, Maine CDC, noted that each Maine community has specific needs that need to be catered to. One point, however, that all communities could improve upon, is youth prevention. By using programs such as *Prime For Life*, and targeted efforts in schools, adolescents would be less likely to start using controlled substances. Many others also spoke of the need for care and counseling with those individuals who have experienced adverse childhood events. Troy Morton and Barbara Ford, Penobscot County Sheriff and Director of Shepherd's Godparent Home respectively, said they found that childhood trauma had been a recurring theme for people with SUD. Another common point for preventing the use of opioids, is the realization that for many, illicit opioids were not the first substance they used. While not everybody who uses marijuana will end up using harder drugs, a large percentage of people who are currently using opioids started on marijuana and/or alcohol. Barbara Ford said that the recent legalization of marijuana has led to a dramatic increase in use during her patients' pregnancies because it is seen as a "benign" substance. While the use of prescription painkillers was agreed upon to be a segway to illicit drugs, the dramatic reduction in prescribing has lessened their impact.

The largest focal point for the speakers was the treatment of substance use disorder, or the lack thereof. Bruce Poliquin highlighted a major reason for this problem: the federal formula that grants funding to fight the opioid epidemic is based on population, not total area. With Maine being spread over such a vast area, with so few people, the resources must be spread very thinly as well. Lack of access to quality treatment centers was a recurring theme amongst the table, with almost all citing funding as the largest barrier. With limited access to treatment and funding, the jails have become the largest detox centers in the state. With so many patients losing Medicaid coverage while in jail, and the jails' responsibility to care for its inmates, the correctional facilities have been put into a very difficult economic situation. Once these people have left the jails and have been started on a treatment plan, there is very little help to transition them back into normal life. This pivotal point in the path to recovery is often hindered by the inability to continue treatment.

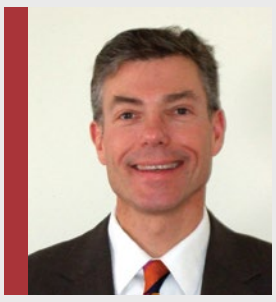
Maine Supreme Judicial Court Chief Justice, Leigh Saufley, proposed a 'Wrap Around Drug Court' system that combined treatment and a smooth transition into recovery. This two year, two-million-dollar project would start treatment with detox, give broad access to health care, and easily move the patients into the recovery process. The recovery plan would give them safe housing, education, and employment assistance. The time lost by someone who was suffering from Substance Use Disorder can be compensated by quickly furthering their education and job training. This project would not only give treatment but also help patients reintegrate back into society. A panelist, who is currently in recovery, noted that safe family housing and additional detox beds would be a tremendous help to those who are ready to begin their path to recovery.

Although this lack of funding and Maine's rural nature make the opioid epidemic daunting, there is hope for its future. This hope stems from newly graduating medical providers, such as the pharmacy students at Husson and medical students at Tufts. These students are currently receiving special teaching and training on the opioid epidemic. Maine currently has twenty community health centers with seventy access sites that give help to the neediest, regardless of their ability to pay. Recently passed legislation has allocated additional funding for Maine jails that could be used to help fund Substance Use Disorder treatment for its inmates. The USDA believes that it can be part of the solution, as Anne Hazlett announced that the USDA recently launched an opioid web page (www.usda.gov/topics/opioids) for local communities. Their website is constantly being updated and aims to connect rural individuals with local resources. Linking resources to the people and groups who need it most will assist. Maine must keep pushing forward and continue fighting on behalf of the Mainer who dies every day from an overdose.

Senator King, Rep. Poliquin, and Panelists.

LEGISLATIVE UPDATE

By Andrew MacLean, Esq., Deputy Executive Vice President, Maine Medical Association



Legislative Update: 128th Maine Legislature Continues Rocky 2018 Regular and Special Sessions Into July

The 128th Maine Legislature began its Second Regular Session on January 3rd and adjourned on April 18th amidst partisan disagreement about several issues. But, legislators returned to continue deliberations on many important bills, including several addressing the opioid abuse crisis, requiring funding from the Appropriations "table" during their First Special Session from June 19-22, 2018. After the July 4th holiday, they returned to the State House for a "veto" day on July 9th and as this issue goes to press, they are expected to return again in July to consider additional vetoes from Governor LePage.

With the June primary election narrowing the field of candidates, attention now turns to the general election on November 6, 2018 with Maine's junior U.S. Senator Angus S. King, Jr. on the ballot along with incumbents Chellie Pingree (D – 1st Congressional District) and Bruce Poliquin (R – 2nd Congressional District); at least four candidates for Governor (Shawn Moody – R, Janet Mills – D, Terry Hayes – I, and Alan Caron – I); and contestants for all 186 seats in the 129th Maine Legislature. The general election also will include a referendum question with substantial implications for the health care system – a ballot question proposing a new surtax on high income individuals to fund "universal home care."

The MMA staff welcomes your ideas for our legislative agenda for the 129th Maine Legislature. MMA's Legislative Committee will hold its organizational meeting in late November or early December, so watch MMA's weekly e-newsletter, **Maine Medicine Weekly Update***, for meeting details. The MMA staff is assisting members with compliance with the new laws enacted during the 128th Maine Legislature by providing a 1-hour legislative update (accredited for CME) for hospital medical staffs, medical specialty societies, physician practices, and federally-qualified health centers. We are available to assist your physician group, too!*

MMA has devoted this issue of *Maine Medicine* to the clinical and public policy response to the state's continuing opioid drug abuse crisis and this public health issue has remained a focus of legislators during the 2018 sessions. The recommendations of an *Opioid Task Force* created by Joint Order during the 2017 session have informed legislators' discussions about the crisis. You can find the Task Force's Final Report on the web here: http://legislature.maine.gov/uploads/originals/opioidtffinalrpt-3.pdf. Two important bills addressing the opioid crisis that became law despite the Governor's objections during this session are L.D. 1871, *An Act To Implement the Recommendations of the Task Force To Address the Opioid Crisis in the State Regarding Respectful Language* (P.L. 2017, Chapter 407) [replacing dated terminology with the term "substance use disorder"] and L.D. 925, *An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government* (P.L. 2017, Chapter 460), a budget bill that includes several provisions addressing the opioid abuse crisis. Part E of the bill provides a 15% increase in reimbursement rates for medication management under MaineCare Benefits Manual, Chapter III, Section 65, *Behavioral Health Services*. Part G of the bill requires DHHS to support a "hub-and-spoke" system for the treatment and recovery of individuals with substance use disorder. Part J of the bill provides additional funding to support the State's drug court system.

Along with allied advocacy groups, the MMA continues its work with the legislature and the public in pursuit of ACA Medicaid expansion. During the recent special session, Governor LePage vetoed a Medicaid expansion bill for the seventh time and his veto was sustained in the House by an 85-58 vote. The Medicaid expansion issue also remains in litigation now before the Maine Supreme Judicial Court.

Since January, the MMA has been at the State House presenting physicians' views on a variety of bills dealing with aspects of health insurance, public health, mental health and substance abuse, children's issues, medical and recreational marijuana, professional regulation, and other health policy before the legislature.

You can find the complete list of all bills before the 128th Maine Legislature being tracked by the MMA on the web at: https://www.mainemed.com/sites/default/files/content/testimony/128th_LD_Tracker_032018.pdf.

MMA members are demonstrating a strong interest in current political and public policy matters and this interest has prompted seven physician candidates for the 129th Maine Legislature. The seven physician candidates include incumbents Sen. Geoffrey Gratwick, M.D. (D-Penobscot, Senate District 9); Rep. Patricia Hymanson, M.D. (D-Ogunquit and parts of York, Wells, and Sanford, House District 4); and Rep. Heidi Brooks, M.D. (D-part of Lewiston, House District 61). The list also includes former House member Linda Sanborn, M.D. (D) challenging Sen. Amy Volk (R) in Senate District 30, part of Cumberland County. The physician candidates finally include a returning challenger, Richard Evans, M.D. (D) in House District 120, Dover-Foxcroft, Atkinson, Brownville, Medford, Milo, Lakeview Plantation, and the unorganized territory of Orneville Township; Ned Claxton, M.D. (D) in Senate District 20, part of Androscoggin County and Cumberland County; and Patricia Nobel, M.D. in House District 142, Enfield, Howland, Lincoln, Maxfield, Woodville, and the Plantation of Sebois, plus part of the unorganized territory of North Penobscot. You can find lists of candidates for the November 6, 2018 General Election on the web here: https://www.maine.gov/sos/cec/elec/upcoming/index.html.

The MMA welcomes your participation in our legislative advocacy activities. For more information, please contact Andrew MacLean, Deputy EVP & General Counsel, at amaclean@mainemed.com.

MICIS: MMA ATTACKS THE OPIOID PROBLEM

By Peter P. Michaud, J.D., R.N. and Susan Kring, Maine Medical Association

MICIS, the Maine Independent Clinical Information Service, has been providing evidence-based prescribing education in Maine since 2008. A program of the Maine Medical Association, the MICIS academic detailing program provides information free of commercial bias on a variety of disease processes and pharmacologic approaches to them. MICIS is funded through a contract with the Maine Department of Health and Human Services which receives the fund from a statutory tax on pharmaceutical manufacturers.

In 2016 MICIS presented a module on opioid prescribing and the treatment of chronic pain. In 2017 the DHHS asked MICIS to focus exclusively on the opioid issue and to expand its approach to offer larger-scale educational presentations. This was partially in response to the new opioid law's (Chapter 488) requirement of three hours of mandatory continuing medical education for prescribers every two years. Recent changes to the Board of Licensure in Medicine rules require all licensees of that board to take this opioid education, regardless of whether they prescribe opioids.

MICIS currently offers 1- to 3-hour presentations on opioid prescribing on both clinical and legal topics, a change from the academic detailing one-to-one or one-to-few model to add a larger scale, one-to-many delivery system. The framework for these larger programs is "Educational Outreach," formatted after Academic Detailing where evidence-based prescribing information is delivered to prescribers at or near their practice sites by specially-trained, trusted colleagues with the goals of improving best practices, clinical service delivery, and quality of care.

Clinical modules and presentations on opioid prescribing were researched and developed by MICIS Academic Detailers Elisabeth Fowlie Mock, MD, MPH and Erica Pierce, MMSc., PA-C. Presentations on Chapter 488 and Chapter 21 are created, presented and updated regularly by the attorneys at the Maine Medical Association.

Presentations take place at hospitals, medical practices, meetings and conferences, and feature one hour on the opioid prescribing laws, one hour on clinical modules, one legal hour with two hours on clinical modules, or three hours on clinical modules. MICIS also provides large-scale 3-hour regional presentations in various parts of the state and presents webinars through Maine Quality Counts on both legal and clinical topics.

In 2017 there were 62 presentations of *Improving Opioid Prescribing and Patient Safety* as well as three 1-hour webinars. The following 30-minute clinical modules were combined for 1, 2 or 3-hour presentations in 2017, and most 3-hour MICIS presentations included two hours of clinical content and one hour on the law.

- The Genesis of the Opioid Crisis: "How We Got Here"
- Opioid Basics: MMEs & Tapering
- Practice Transformation & QI for Opioids/ Chronic Pain
- Harm Reduction: Naloxone & MAT
- Communication Skills & Difficult Conversations/ Behavioral Health Integration
- Non-opioid/Non-pharm Treatments for Acute & Chronic Pain

In 2017, 2204 people attended MICIS presentations and 267 people attended webinars presented by MICIS. The Maine Medical Education Trust has approved these MICIS presentations, including the webinars, for 1 to 3 hours of continuing medical education, depending on the length of each program.

In 2018 MICIS has extended its opioid education program with *Next Steps in Addressing Maine's Opioid Crisis*. There are three new 1-hour clinical modules:

- Opioid Use Disorder and Medication Assisted Recovery: Caring for Our Communities;
- Alternative Treatments for Chronic Pain;
- Co-prescribing Benzodiazepines and Opioids: The Black Box of Increased Overdose Risk

An updated presentation on opioid prescribing laws and rules includes the licensing boards' new rules regarding opioid prescribing contained in Chapter 21, as well as a look forward to the Chapter 10 rules currently being developed on Medication Assisted Recovery.

In 2018 MICIS will schedule 5 regional presentations that cover the topics included in the 2017 program *Improving Opioid Prescribing and Patient Safety*.

The MMA is pleased to do its part to enhance the education of Maine physicians and other prescribers and, in doing so, to do something concrete and constructive about the opioid crisis facing our state.

MAINE QUALITY COUNTS

By Amy Belisle, MD, MBA and Lisa Letourneau, MD, MPH

The Opioid Epidemic in Maine: What's a Physician to Do?

As a physician in Maine, it can be both daunting and challenging to know how best to take a role in addressing the epidemic of opioid misuse and opioid-related overdose deaths the state has been facing for the past several years. But while the headlines can often feel overwhelming, the good news is there are many opportunities for clinicians to take action to help reverse this terrible tide.

Just over two years ago, Maine Quality Counts (QC) and the MMA partnered to launch "Caring for ME" (C4ME), a statewide effort to engage clinicians in maintaining a compassionate approach to addressing the opioid epidemic. Together, we support a range of education, advocacy, and leadership opportunities for clinicians across the state and, as part of this effort, QC offers several opportunities to get involved:

- QC shares information and promotes advocacy for best practices through the C4ME Leadership Group. Meetings are held monthly via web-based video calls and are open to anyone interested in finding ways to address this epidemic. Meetings and related communications highlight opportunities, new developments, and innovative efforts from organizations around the state. To join, please contact Amy at amiller@mainequalitycounts.org.
- QC makes a range of educational tools, policies, and other resources available on the C4ME webpage (https://mainequalitycounts.org/initiatives-resources/opioid-epidemic-caring-for-me-2/), and hosts monthly educational webinars, typically on the 2nd Tuesday of each month (12N-1P). Since 2016, 33 webinars have been held with over 5800 attendees. Recent topics have included initiating buprenorphine in the Emergency Department, care for pregnant moms and babies affected by Opioid Use Disorder, and increasing the use of naloxone to reduce overdose deaths. More info on this webinar series can be found under the "Learning Opportunities" tab on the C4ME webpage.
- With support from the ME Board of Licensure in Medicine (BOLIM), QC has developed eight on-demand online Learning Modules https://qclearninglab.org/course-cat/caring-for-me/ to help clinicians build their knowledge about a range of opioid-related topics, including improving chronic pain management, a review of Maine's new prescribing limits under Chapter 488, safe and compassionate approaches for tapering opioids, and ways to appropriately diagnose addiction. Since August 2017, 1700 clinicians have accessed the modules and earned credit that counts for their BOLIM CME requirement.
- Additionally, QC is currently running an 18-month "C4ME Clinician Leaders" program. With funding from the Physicians Foundation, this program brings together 35 clinicians from across the state, helping them build critical leadership skills to address public health issues, with a focus on the opioid epidemic.
- QC has also hosted several learning opportunities through the ECHO (Extension for Community Health Outcomes) model—an innovative, web-enabled, case-based learning program developed by researchers at the University of New Mexico. Over the past year, QC has hosted ECHO programs focused on compassionate tapering of opioids and care for substance use during the perinatal period. With support from Harvard Pilgrim Health Care, QC will be launching a 9-month ECHO session focused on improving skills for offering Medications for Addiction Treatment (MAT). QC is currently accepting applications for primary care clinicians and practice teams interested in participating in this MAT ECHO. If so interested, please contact Lise at LTancrede@mainequalitycounts.org.

QC encourages providers interested in becoming involved in the Caring for ME work to email us at CaringforME@mainequalitycounts.org or to visit our website at https://mainequalitycounts.org/initiatives-resources/opioid-epidemic-caring-for-me-2/ which contains a wealth of opioid-related news and resources.

MEDICAL PROFESSIONALS HEALTH PROGRAM

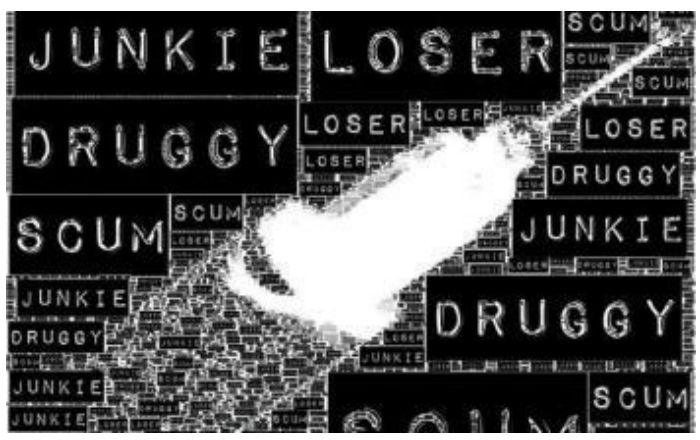
By Guy R. Cousins, LCSW, LADC, CCS, Director, Medical Professionals Health Program and the Staff at MPHP

The Stigma with Substance Use Disorders

The daily reporting from the media regarding our state and national opioid epidemic is inescapable.

Individuals with substance use disorders (SUD) (especially those with opioid use disorders) are routinely judged by members of society. Although the public is touched by this epidemic, not everyone understands substance use disorders (SUD) as they really are, but only from their own experience and point of view.

Stigma is defined as a set of negative beliefs that individuals or society holds against a specific topic or group. Individuals with SUD are often referred to as alcoholics, addicts, junkies, dope heads, etc. What needs to be understood is that they are people first and foremost. They are individuals who are suffering from a chronic brain disorder.



The first thing someone who doesn't understand this medical condition will say: "they decided to drink, smoke, pop it, or shoot it; it's self-inflicted." I've worked in the behavioral health field since 1983 and I have never encountered anyone who has said to themselves when they first used, "I want to become an alcoholic or drug addict." People start using for a variety of reasons; boredom, stress, fun, fitting in, coping with relationships/families, excitement, dealing with current or past traumatic events, etc. Over time, their use pattern progresses to the point that it begins creating problems for them and others.

Individuals with a SUD experience significant negative emotions as well as physical consequences as a result of their use. They often engage in behaviors that compromise their own beliefs and values, all the while their body physically requires them to take in more substances to relieve withdrawal symptoms. This pattern perpetuates guilt and shame they experience.

Shame is common for those who suffer with SUD. The individual has engaged in behaviors to support their SUD and not only do they feel badly about what they've **done**, but now see it as who they **are**.

Not only do the individuals with a SUD have a negative belief about themselves, it is reinforced by others and they get treated differently because of those negative beliefs. Dr. Kim Johnson, former Director of the federal Center for Substance Abuse Treatment once said, "let's call stigma what it really is...discrimination."

There is hierarchical structure with SUD as it relates to stigma, depending on what the drug of choice is: alcohol, cocaine, pills (benzos/narcotics/opioids), or heroin. The individual shooting heroin is the most stigmatized of all. Healthcare providers wonder why more people don't come forward looking for help. Imagine feeling the worst you could about something that you're doing; you cannot manage or control, coming clean about your use, only to get judged, shamed, or discriminated against. Let's take it a step further, imagine you are female and pregnant and the added stigma/discrimination that gets projected onto you. Should we really be surprised when people do not come forward asking for help?

It's clear, the opioid/drug epidemic we are facing today is directly related to the level of access to effective, evidence-based treatment and recovery services. As a society, we have not fully embraced the idea that this is a chronic medical condition that is treatable, with heroic stories of how individuals with support, recover from this powerful and debilitating disease.

We must ask ourselves, **are we part of the problem** (perpetuating stigma & discrimination) **or are we part of the solution** (challenging the stigma/discrimination)? Neither of these positions are passive, you are either one or the other. Which do you want to be remembered by?

We must challenge discrimination/stigma when we hear it and see it. If we choose not to do anything, then we have taken a stance. As we see all too clearly in Maine and across the nation, that stance could be the difference between life and death.

Opioids and Chronic Pain Control: Avoiding Risks When Prescribing Medication Therapy in the Primary Care Practice

In an effort to address the growing opioid epidemic, state and federal guidelines have been created to assist clinicians in safely prescribing opioids.

The following risk management recommendations have been developed to assist in providing patients with appropriate pain control/relief, in a manner consistent with legal requirements and accepted medical practice.

Provider Recommendations:

- Keep current with and follow state and federal regulations for prescribing controlled substances. A failure to follow prescribing guidelines can lead to physician investigations and actions against physicians' licenses.
- Develop and annually review and revise as appropriate, a policy regarding the management of patients with chronic pain.
    a. Assessment, treatment and follow-up protocols developed in accordance with currently acceptable guidelines should be outlined in the policy. Preprinted/trigger forms or checklists to assure documentation meets the requirement of physician licensing board regulations and current medical practice standards may also be included as a component of policy.
- Maintain current, comprehensive medical records in accordance with controlled substance laws and regulations.
- Complete a comprehensive patient evaluation.
- Obtain the patient's past medical records and thoroughly review information received.
- Conduct and document a risk assessment, to evaluate the patient's risk of misuse, abuse, diversion, addiction or overdose.
- Query your state prescription drug monitoring program (PMP) to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing initial opioids and periodically thereafter.
- Develop and document a treatment plan.
- Obtain written informed consent for opioid treatment.
- Agree to a written controlled substance treatment agreement with the patient which includes the following elements.
    a. The provider's policy when prescribing controlled substances for chronic pain management.
        - The patient's consent to random drug screens.
        - The requirement for random pill counts at the discretion of the provider.
        - The clinician as the single source of controlled substances.
        - Agreement to use one pharmacy.
        - The patient's written informed consent to release the contract to local emergency departments and pharmacies and for those clinicians to report contract violations to the treating provider.
    b. The reasons for discontinuance of opioid therapy and that the patient understands why therapy may be discontinued.
        - Treatment goals not met.
        - Contract violation.
        - Illegal activity and notification of proper authorities.
- Adopt proactive strategies to assess the risk of abuse.
- Develop strategies to address patients who misuse or abuse their opioids or violate their treatment agreement. Determine how your office will address requests for early refills or reports of lost or stolen medications.
- Reflect in the medical record, the thoughtful reassessment of the patient receiving chronic pain control therapy.
- Complete regular chart audits.
- Consult with or refer patient to a pain management specialist when indicated.

Medical Mutual Insurance Company of Maine's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

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PERCEIVED BARRIERS TO SOLVING THE OPIOID CRISIS

By Gordon Smith, Esq./ Maine Medical Association

Critical to the understanding of the barriers is an understanding of the crisis itself and how we got here, both in Maine and nationally. While there are many articles and books that cover pieces of this history, none is better in getting to the root causes than *Dreamland* by west coast journalist Sam Quiones. Mr. Quiones does an exquisite job of explaining the intersection of prescription opioid medication and illegal drugs such as heroin and its profound impact on our communities and our citizens in the last twenty years. The opioid crisis is not new. It has been with us a long time and it will take a long time to recover from it. With this in mind, what follows are the major barriers that I have found as MMA has focused on this issue.

1. **Lack of treatment resources**. Despite the profound need, neither the public nor private sectors have allocated the resources necessary to provide comprehensive treatment options for individuals struggling with substance use disorders (or specifically opioid use disorders). Statistics are available from several sources, but my recollection is that Maine has sufficient capacity to treatment only between 10 and 20% of individuals needing treatment. And by treatment I am referring to whatever option is appropriate for the individual patient. This could include a detox bed and medication assisted therapy (MAT) with methadone or suboxone accompanied by appropriate counseling. Abstinence based programs should be considered as well. And it is estimated that less than 10% of eligible prescribers are certified to offer MAT. The shortage of treatment professionals and facilities is, in part, caused by the lack of insurance coverage (public or private). Individuals who are ill and in need of treatment find it more difficult to get treatment when there is no payment source. And when our health professionals and facilities are able to treat such individuals, the cost associated with that care (which may last a lifetime) is paid for in taxes and insurance premiums by those individuals fortunate enough to have employment, assets and insurance.
2. **Lack of investment**. Lack of investment in prevention programs and in educational and economic development programs that could address the underlying causes of substance abuse, including adverse childhood events (ACEs), poverty, unemployment and feelings of hopelessness, particularly in Maine's rural counties.
3. **Stigma**. Stigma amongst the public and even in professional circles is a major barrier toward finding the political will to tackle the problem of opioid abuse in a comprehensive way, with substantial resources being put to treatment and prevention. Until the public and policy makers understand that abuse of substances is a chronic disease and not a moral failing, Maine will continue to see increasing rates of substance use disorders with the accompanying crime, overdose deaths, babies born with neonatal abstinence syndrome and communities and our society torn apart by this insidious disease. We have seen firsthand the difficulty of getting Narcan into the hands of family members, first responders and others in the face of opposition by individuals and policy makers who do not believe that SUD is a chronic disease.

Despite these barriers, there are many dedicated health care professionals and volunteers in Maine who work hard every day to treat individuals struggling with addiction. They deserve our help and our thanks for all they do.

Continued from page 1...MeHAF, MMA, Quality Counts and Pivot Point Present at Grantmakers in Health Annual Conference

Other points made during the presentation and Q & A:

- Importance of breaking down silos
- Critical role of the recovery community
- Opportunities for multi-sector approaches
- Significant role that stigma plays in creating a barrier to treatment and harm reduction

Mr. Smith emphasized that there are positive steps that each and every individual can take to help solve this crisis which took several years to reach its apex and which will not be quickly eradicated. A few examples: mentor a child, become a recovery coach, volunteer at a health facility, donate to a treatment center, attend or organize a community forum in your town or city or work in your work place or community to decrease the stigma attached to substance use disorders.

From left: Kathryn Rouillard, Gordon Smith, Carol Kelly, Lisa Letourneau, MD, and Barbara Leonard.

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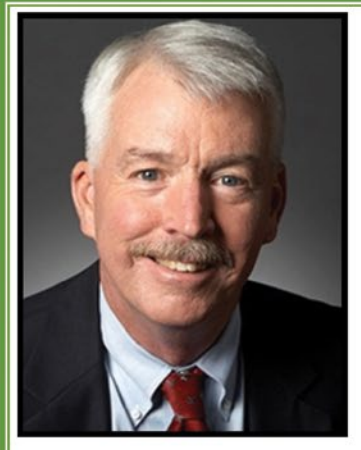
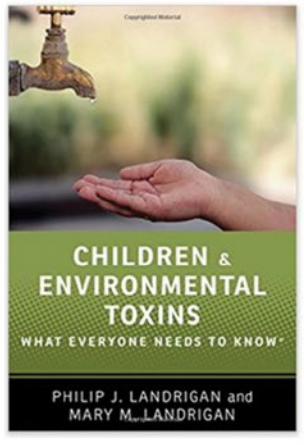


Children & Environmental Toxins: What Everyone Needs to Know

An evening with internationally recognized pediatrician and epidemiologist, Dr. Philip Landrigan

Friday, October 19, 2018
UNE, Portland Campus, Innovation Hall
5:30PM reception, 6:30PM talk



Join hosts Maine Chapter of the American Academy of Pediatrics and Physicians for Social Responsibility Maine Chapter and **Premiere Sponsor, the University of New England,** for this important event. Thanks to the generosity of our funder & other sponsors, this event is free and the first 100 pre-registered will receive a copy of his book.

To sponsor or register: http://bit.ly/LandriganEvent or contact karen@psrmaine.org

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