



# Netsmart

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## 6 ways to tackle the opioid crisis:

A combination of healthcare  
technology, policy, integrated care  
and data sharing

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## Opioid epidemic by the numbers



While these staggering statistics spark awareness and discussion, the opioid crisis extends far beyond the numbers. Its human impact is tremendous, and without a significant commitment from providers, government, healthcare IT companies and individuals, it will continue to further devastate the country. We believe that a combination of healthcare technology, policy, integrated care and data sharing can contain, and eventually decimate, the opioid crisis in the U.S.

### 1 Achieving true integrated care through interoperability

So how do we contain the opioid crisis? Contractors cannot build a house with only half of the blueprint, yet we expect medical care to happen with access to only a portion of the information needed. Simply put, healthcare data is not universally or easily shared amongst care teams. The Healthcare Information and Management Systems Society (HIMSS), a strong advocate for interoperability in healthcare, defines interoperability as the ability of different information technology systems and software applications to communicate, exchange data and use the information that has been exchanged.<sup>6</sup> To achieve true integrated care, interoperability must go beyond just the exchange of information and extend to how that information is being used once it is received.

1 National Institute on Drug Abuse. (2018, March 6). Opioid Overdose Crisis, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>

2 *ibid.*

3 LaMagna, M. (2018, August 16). More evidence that the opioid epidemic is only getting worse, <https://www.marketwatch.com/story/how-much-the-opioid-epidemic-costs-the-us-2017-10-27>

4 *ibid.*

5 Stein, P., & Bever, L. (2017, July 1). The opioid crisis is straining the nation's foster-care systems, [https://www.washingtonpost.com/national/the-opioid-crisis-is-straining-the-nations-foster-care-systems/2017/06/30/97759fb2-52a1-11e7-91eb-9611861a988f\\_story.html?utm\\_term=.eccbf475aafb](https://www.washingtonpost.com/national/the-opioid-crisis-is-straining-the-nations-foster-care-systems/2017/06/30/97759fb2-52a1-11e7-91eb-9611861a988f_story.html?utm_term=.eccbf475aafb)

6 What is Interoperability? (2018, October 8), <https://www.himss.org/library/interoperability-standards/what-is>

Its human impact is tremendous, and without a significant commitment from providers, government, healthcare IT companies and individuals, it will continue to further devastate the country.

Imagine if a provider didn't know an individual was allergic to penicillin. This person presents in the emergency department (ED) and because the physician doesn't have access to this person's health history or medication reconciliation, the physician prescribes penicillin. Without access to all relevant information, it can potentially cause more harm than good to the individual and increase cost of treatment to the provider organization. When it comes to managing the opioid epidemic, if a provider does not know a person has a history of substance use, they may unknowingly perpetuate the addiction cycle.

One way to access this kind of data is by integrating electronic health record (EHR) platforms with Prescription Drug Monitoring Programs (PDMPs)<sup>7</sup>. The concept of a PDMP is simple: reduce drug abuse by giving prescribers full access to what medications an individual is using. Initially, PDMPs were used by law enforcement to curtail diversion, and only Schedule II drugs were collected 30 days at a time. Now PDMPs are intended to give providers real-time access to a person's prescription and fill history.

The challenge with PDMPs is that each state has a different validation process, which means every state requires different information and documentation, making compliance difficult. It is critical that a standardized, national PDMP database be created to compile information from all 50 states and allow providers to access that data from anywhere. Only through integrated care and turning information into knowledge can we begin to control the costs of the opioid epidemic and influence outcomes.

In order to achieve a level of truly connected care, Recovery Resources<sup>8</sup> in Ohio needed a way to reduce the prescriber burden of having to go outside of the prescribing workflow to check PDMP data. The organization serves one of the hardest hit states of the opioid epidemic, where more than 5,200 people died<sup>9</sup> from an opioid-related overdose from June 2016 through June 2017, which was an increase of 39 percent.

Recovery Resources partnered with the Ohio Board of Pharmacy and Appriss Health to integrate the state PDMP with their Netsmart EHR. Now, prescribers can check the Ohio PDMP directly from their prescribing workflow in the EHR, saving countless hours and eliminating the possibility of transcription and medication reconciliation errors.

## 2 A network of networks

PDMPs aren't the only answer when it comes to healthcare data exchange. Many states and regions have their own health information exchange (HIE), but like PDMPs, a universal HIE does not exist. This creates a need to connect networks to networks, regardless of the EHR platform. A higher standard of care and scalability can be achieved through building secure, robust referral networks that utilize interoperability to link individuals to community mental health or substance use disorder (SUD) treatment providers. Instead of just connecting to other organizations, providers would have access to a network of networks.

<sup>7</sup> Prescription Drug Monitoring Frequently Asked Questions (FAQ) | The PDMP Training and Technical Assistance Center. (n.d.), <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>

<sup>8</sup> Recovery Resources. (n.d.). Substance, addiction, alcoholism, mental illness treatment | Cleveland, Ohio | Recovery Resources, <http://www.recres.org/WhoWeAre>

<sup>9</sup> Ludlow, R. (2018, February 12). Ohio drug overdose deaths up 39% -- nearly triple US average, <https://www.dispatch.com/news/20180212/ohio-drug-overdose-deaths-up-39----nearly-triple-us-average>

Unless these providers have access to technology that allows them to exchange healthcare information with other providers, we cannot achieve true integrated care.

The Carequality<sup>10</sup> interoperability framework is a great example of how more than half of all healthcare providers are connected to each other and share authorized health data on a national scale. In September 2018, 14 million documents were exchanged through the Carequality interoperability framework by more than 1,250 hospitals, 35,000 clinics and 600,000 providers.

The ability to gain a longitudinal view of where a person has been, along with their physical, mental and social determinants history, has supplemented the traditional single Continuity of Care Document (CCD)<sup>11</sup> as part of the electronic referral process. Imagine how powerful a network of networks could be if they all included physical and mental health history and social determinants. This is how we can accomplish a truly integrated care network, stem the opioid crisis and reduce costs.

The opioid epidemic isn't a standalone issue. There are many contributing factors that created and sustained the crisis. Integrated care can help not only contain the crisis, but empower providers to look for and treat the underlying causes of addiction through whole-person care.

### 3 Eliminating regulatory burdens and creating parity

One of the impediments to the adoption of data sharing initiatives in healthcare is not only the financial viability of implementing an EHR system, but the ability to accept and share protected health information (PHI), which requires uniform rules to accept and share.

Since 1996, all healthcare providers have been governed under the Health Insurance Portability Accountability Act (HIPAA)<sup>12</sup>, which initially improved the portability of insurance. In 2000, a patient privacy component was enacted, which defined PHI and set up protections for the sharing of that information.

But there is an older law passed in 1970, before EHRs were mainstream, that requires greater restrictions on healthcare information regarding the treatment of SUD. Going a step further to protect individuals with a history of SUD, 42 CFR Part 2<sup>13</sup> was created as an additional layer of protection for the confidentiality of drug and alcohol treatment and prevention records and their use against an individual in criminal or law enforcement actions, in a court of law or custody disputes. Addiction treatment providers are subject to Part 2 requirements. However, Part 2 is so stringent that it siloes vital health information and places restrictions on whether or not an individual can share their own health data.

New models of integrated care and care management involving multiple providers and care specialties, like health homes and HIEs, require clinicians to have complete access to an individual's health information prior to administering care. Due to the complexity of consent processes and data segmentation requirements for SUD treatment information, some HIEs refuse to accept SUD patients altogether. These limitations bring the issue of equity and parity to the forefront of the opioid crisis. By comparison, an individual with diabetes, HIV/AIDS or a mental illness would not be excluded from sharing information with their care team, but a person with a history of SUD is subjected to these restrictions.

<sup>10</sup>Home - Carequality. (n.d.), <https://carequality.org/>

<sup>11</sup>McNickle, M. (2015, May 4). 5 things to know about CCD, <https://www.healthcareitnews.com/news/5-things-know-about-ccd>

<sup>12</sup>HHS. (2015, December 18). Health Information Privacy, <https://www.hhs.gov/hipaa/index.html>

<sup>13</sup>Laws, Regulations, and Guidelines | SAMHSA - Substance Abuse and Mental Health Services Administration. (2018, October 12), <https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines>

Consider this example where Part 2 significantly hinders patient safety. An individual with a SUD is undergoing outpatient surgery at a local surgery center and upon arrival, signs a consent form disclosing information about their opioid addiction and subsequent SUD treatment program. The surgery center makes a note in the health record, but the surgeon, who is employed by a different clinic, is not permitted to see that part of the health record. This creates a gap in integrated information that could negatively impact the patient's outcome and significantly contribute to cost of care.

Another example impacts the ability to provide proactive care. When a provider has access to a person's past history of successfully treated heart disease because that information is shared, they can give a little extra attention and provide early intervention to any signs of illness relapse, such as shortness of breath or getting tired going upstairs. Part 2 prohibits the individual from receiving that extra care and attention for SUD. If a healthcare provider knows a person was successfully treated for SUD several years ago, because that information is accessible through an HIE, then the provider can be extra alert for some of the subtler symptoms of an addiction relapse, such as depression, diarrhea or itchy skin. Not knowing which of your patients is at higher risk makes it hard to be proactive and intervene early.

To create more parity when it comes to information sharing, a bill<sup>14</sup> currently making its way through Congress proposes to amend Part 2 to align more closely with HIPAA, and add stronger protections related to the use of or reference to SUD patient records in criminal, civil and administrative proceedings and law enforcement activities. In addition, the bill adds anti-discrimination protections against the use of SUD patient records to discriminate against a patient for admission or treatment for healthcare; hiring or terms of employment; sale or rental of housing; access to federal, state or local courts; or by the recipient of federal funds. These additional protections do not exist under the current statute or Part 2 regulation.

If a bill isn't passed in the session of Congress ending December 2018, another potential option to address the issue is a new 42 CFR Part 2 rulemaking process by the Substance Abuse and Mental Health Services Administration (SAMHSA).

## **4** **Creating financial incentives for behavioral health providers to digitize**

Another barrier to the adoption of EHRs and the ability to integrate behavioral health and primary care comes from the lack of financial incentives for behavioral health and addiction treatment providers. As part of the American Reinvestment and Recovery Act of 2009, the Health Information Technology for Economic and Clinical Health (HITECH)<sup>15</sup> Act was created to incentivize acute care and primary care providers to invest in technology to digitize their operations.

Behavioral health and SUD providers were not included for full eligibility for these funds in parity with hospitals, physicians and other acute care providers. Recently, President Trump signed into law a major opioid bill that includes authorization for

14 H.R.6082 - 115th Congress (2017-2018): Overdose Prevention and Patient Safety Act. (2018, June 21), <https://www.congress.gov/bill/115th-congress/house-bill/6082>

15 Introduction | Meaningful Use | CDC. (2017, January 18), <https://www.cdc.gov/ehrmeaningfuluse/introduction.html>

a Center for Medicare and Medicaid Innovation (CMMI)<sup>16</sup> demonstration project<sup>17</sup> that would incentivize behavioral health and SUD treatment providers to adopt EHR technology and utilize it to improve quality of care and for care coordination. CMMI will develop the framework for the program and is expected to release program details in early 2019. Unless these providers have access to technology that allows them to exchange healthcare information with other providers, we cannot achieve true integrated care.

## 5 Clinical decision support tools

We can accelerate the path to integrated, whole-person care by incentivizing all healthcare providers to digitize and adopt standards. With access to an individual's complete health history, actionable analytics can be used to influence treatment plans. Previously ineffective treatments can be avoided, past imaging and lab results can be referenced and evidence-based practices can be introduced to the providers when determining the best treatment approach. In other words, it puts all of the essential information at the provider's fingertips and allows them to make the best care decisions possible. This can all be achieved by embedding clinical decision support tools into an EHR system.

Having as much information about a person as possible is critical to the success of clinical decision support. Integrated care makes this possible by taking the data that is exchanged through interoperability and clinical reconciliation, and bringing it into the EHR as discrete data elements that can be used as part of the clinical decision support process.

In order to influence outcomes, clinical decision support tools shouldn't just be task reminders. It should be embedded into the workflow of a provider so that it automatically becomes part of the process. For example, if a physician is seeing a patient that has a history of depression, the physician will receive an alert to give the patient a depression screening assessment. The EHR system will continue to remind the doctor to conduct the assessment until it is marked complete. However, a true clinical decision support system measures progress, not process.

In the example listed above, the clinical decision support EHR will not only alert the doctor that a depression screening assessment needs to be conducted, but it will also prompt other reminders along the journey to measure the outcomes of that individual. A person's physical and mental health as well as social determinants influence behaviors and outcomes; by giving providers access to this full picture, they are better equipped to treat the underlying issue, not just the symptom being presented.

As we move toward a completely automated healthcare system, data shouldn't just sit in an EHR. It should work for providers and the people they serve.

<sup>16</sup> Home | Center for Medicare & Medicaid Innovation. (n.d.), <https://innovation.cms.gov/>

<sup>17</sup> House Bill Would Create Behavioral Health EHR Demonstration Program - Capitol Connector. (n.d.), <https://www.thenationalcouncil.org/capitol-connector/2017/07/house-bill-create-behavioral-health-ehr-demonstration-program/>

## 6 The power of telehealth: Improving immediate access to behavioral health and addiction treatment services

One of the primary objectives of the 21st Century Cures Act<sup>18</sup> was to eliminate barriers to access quality healthcare, particularly in rural areas. One of the ways to accomplish this is through telehealth. With telehealth, individuals can immediately access healthcare resources, versus waiting weeks for treatment. Immediate access to care for someone who is experiencing a mental health or addiction crisis can mean the difference between reaching recovery and facing a costly hospital stay.

The cost<sup>19</sup> of treating an opioid overdose victim in intensive care jumped 58 percent between 2009 and 2015, with an average cost of \$92,400 per patient. By using telehealth capabilities, providers can go directly to members of the community who cannot access adequate healthcare resources on their own, potentially avoiding catastrophic and costly outcomes caused by delay in care.

According to a recent white paper entitled, “Anticipating Economic Returns on Rural Telehealth<sup>20</sup>,” telehealth could save \$5,718 per medical facility annually in transportation costs alone. Hospitals could save \$20,841 annually and hospitals in rural communities could potentially save more than \$81,000 a year by employing telehealth capabilities rather than paying a full-time on-staff specialist.

To better support individuals affected by SUD who are homeless or living in rural counties, a mobile health program in New York provides outreach and transportation services to thousands struggling with addictions to heroin and other opioids.

A part of the program includes a team of counselors, certified peer advocates and physicians who travel to underserved and rural communities to connect people needing treatment with appropriate services. By using a mobile van equipped with a TV, tablets and Netsmart technology, individuals can receive telehealth counseling, undergo assessment and get on-demand treatment right where they are.

### Measurement is the path to success: Containing the opioid crisis

If we integrate PDMPs, create interoperability framework standards, utilize clinical decision support tools, enact health information sharing policy, incent behavioral health providers to digitize and adopt standards and develop ubiquitous telehealth capabilities, how will we know if we've been successful in containing the opioid crisis?

Measurements and data are the essential ingredients when it comes to proving outcomes and providing a level of accountability. We must benchmark ourselves across the board when it comes to integrating behavioral and physical health information and share lessons learned across organizations, cities, counties and states. As we move toward a completely automated healthcare system,

<sup>18</sup>The Office of the National Coordinator for Health Information Technology, [https://www.healthit.gov/sites/default/files/curesactlearningession\\_1\\_v6\\_10818.pdf](https://www.healthit.gov/sites/default/files/curesactlearningession_1_v6_10818.pdf)

<sup>19</sup>LaMagna, M. (2018, August 16). More evidence that the opioid epidemic is only getting worse, <https://www.marketwatch.com/story/how-much-the-opioid-epidemic-costs-the-us-2017-10-27>

<sup>20</sup>Healthcare Informatics. (n.d.). Report: Adoption of Telehealth Can Generate Cost Savings for Rural Communities, Hospitals, <https://www.healthcare-informatics.com/news-item/telemedicine/report-adoption-telehealth-can-generate-cost-savings-rural-communities>

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data shouldn't just sit in an EHR. It should work for providers and the people they serve. It should provide the knowledge necessary to make the best clinical decisions available.

There are many programs and initiatives taking place now that are collecting and analyzing outcomes data to drive quality improvement and drive down costs. The Certified Community Behavioral Health Clinic (CCBHC)<sup>21</sup> pilot program for example, was designed to provide a comprehensive range of mental health and SUD treatment services to vulnerable individuals. Eight pilot states are already proving outcomes, including Missouri. In July 2018, the program was extended to 16 more states.

Over the last decade, Missouri has served as a model for other states by creating and testing innovative programs in the six areas described above that improve health outcomes and reduce costs. In 2012, Missouri became the first state in the country to implement a health home model with community behavioral health organizations (CBHOs) and was supported in part by the Missouri Coalition for Community Behavioral Healthcare<sup>22</sup>, a consortium of 33 community-based provider organizations across the state. The health home program is an innovative, care coordination model for the delivery of healthcare services. The program is customized to meet the specific needs of high health risk Missourians with chronic health conditions, serious mental illness and SUD.

Nearly 70 percent of Missourians with mental illness have one or more chronic physical conditions. The health homes model focuses on personalized and comprehensive care plans that are quality driven and cost effective. Providers use evidence-based practices, along with a multidisciplinary care team, to encourage participants to proactively manage their physical and mental health. Missouri uses this initiative to reduce inpatient hospitalization and ED visits, enhance the amount of primary care nurse liaison staffing available at community mental health centers, add primary care physician consultation and enhance Missouri's ability to provide transitional care between institutions in the community.

In just one year, the Missouri health home saved the state an estimated \$31 million by helping individuals manage chronic health conditions like mental illness, substance use, obesity, metabolic syndrome, hypertension and diabetes. Over the first five years, the behavioral health homes have saved the state \$127.7 million.

By addressing both the physical and behavioral health needs of a person's health, from February 2012 to April 2016, participants in the program saw their good cholesterol increase by 54 percent, while 71 percent of participants reported blood pressure in the normal range and 62 percent had normal blood sugar. Participants with cardiovascular disease from February 2012 to April 2016 experienced a 57 percent increase in good cholesterol and 67 percent had normal blood pressure. In three years, the Missouri home health program reduced hospitalizations by 38 percent and emergency room visits by 34 percent.

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21 Certified Community Behavioral Health Clinics « National Council. (n.d.), <https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/>

22 Missouri Coalition for Community Behavioral Healthcare. (5989), <https://www.mocoalition.org/>



With evidence-based treatment and measured outcomes, all healthcare providers can drive quality and allow for best practices to be established across the industry. In the ever-evolving payments world, behavioral health and physical health providers must prove outcomes in order to be paid. We must work together to improve outcomes and reduce costs. Technology is the bridge that will connect and integrate us all. It should easily and intuitively be embedded into the workflow of all roles on an individual's care team so whole-person care becomes not just a reality, but an expectation.

## About Netsmart

Netsmart designs, builds and delivers electronic health records (EHRs), solutions and services that are powerful, intuitive and easy-to-use. Our platform provides accurate, up-to-date information that is easily accessible to care team members in behavioral health, care at home, senior living and social services. We make the complex simple and personalized so our clients can concentrate on what they do best: provide services and treatment that support whole-person care.

By leveraging the powerful Netsmart network, care providers can seamlessly and securely integrate information across communities, collaborate on the most effective treatments and improve outcomes for those in their care. Our streamlined systems and personalized workflows put relevant information at the fingertips of users when and where they need it.

For 50 years, Netsmart has been committed to providing a common platform to integrate care. SIMPLE. PERSONAL. POWERFUL.

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