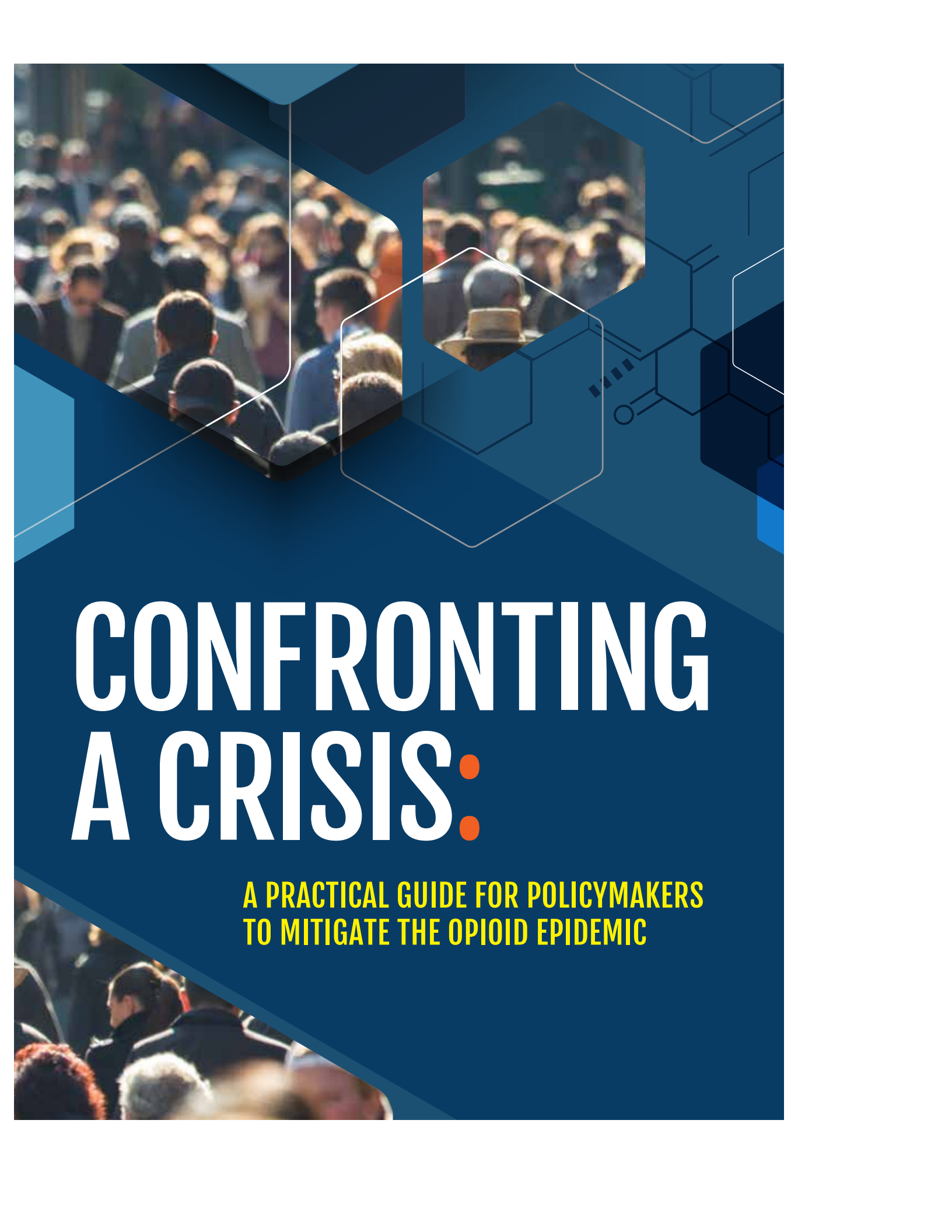




CONFRONTING A CRISIS:

**A PRACTICAL GUIDE FOR POLICYMAKERS
TO MITIGATE THE OPIOID EPIDEMIC**

TABLE OF CONTENTS

04 THE OPIOID EPIDEMIC:
A PUBLIC HEALTH CRISIS

06 HOW WE GOT HERE

08 STRATEGIES TO PREVENT
OPIOID USE DISORDER

16 STRATEGIES TO TREAT
OPIOID USE DISORDER

22 A TOOLKIT FOR STATE AND
LOCAL GOVERNMENT LEADERS

26 CONCLUSION

**THE OPIOID
EPIDEMIC:
A PUBLIC HEALTH
CRISIS**

Ninety-one Americans die every day from opioid overdoses.¹ Victims come from all walks of life: a 19-year-old mother of two from Panama City, Fla.,² a 28-year-old Army sergeant from upstate New York,³ a 49-year-old juvenile court mediator from Arizona.⁴ For some, addiction started in their youth. For others, it began after an injury or surgery when a doctor prescribed opioids for pain.⁵

Opioids, a class of drugs that includes everything from prescription medications, like oxycodone, morphine, tramadol and fentanyl, to illegal drugs like heroin, have led to a public health crisis. The addictive nature of opioids and overprescribing are fueling the epidemic. In the last 15 years, the number of opioids prescribed and sold in the U.S. has quadrupled, even though the amount of pain Americans report is the same.⁶

Opioids were involved in more than 33,000 deaths in 2015, but the crisis continues to grow. Drug overdose deaths have significantly increased in Massachusetts, Florida, New York, North Carolina, West Virginia and more than a dozen other states.⁷

The opioid epidemic is a public health crisis that is tearing families apart and ruining lives. It also puts an incredible burden on government, including law enforcement agencies, justice departments and the foster care system, as children are orphaned or removed from parents and caretakers struggling with addiction. Though some states are taking significant steps to address the problem, they face continuing challenges in preventing future overdoses and addictions. Some experts contend there isn't nearly enough state or federal funding to combat the epidemic. Others say there are so many stakeholders involved that it's difficult to know where to begin to coordinate efforts. However, collaboration among state and local leaders, public health experts, health care providers, insurers and others is critical.

There isn't one off-the-shelf solution to curb the epidemic, but policymakers are taking action to address the crisis and save lives. This handbook will detail those efforts and outline other steps policymakers can take to help mitigate the opioid crisis.

A blue-tinted photograph of a city skyline, likely New York City, with a person in the foreground. The person is out of focus, wearing a dark jacket and a light-colored shirt. The city skyline is visible in the background, with various buildings and structures. The overall tone is somber and reflective.

**THIS HANDBOOK
WILL DETAIL
THE STEPS
POLICYMAKERS
CAN TAKE TO HELP
MITIGATE THE
OPIOID CRISIS.**

An aerial night photograph of Seattle, Washington, featuring the Space Needle prominently in the center. The city lights are visible against the dark sky. In the top left corner, there is a white line-art overlay of a chemical structure, specifically a benzene ring with various substituents. The title 'HOW WE GOT HERE' is centered in a white box.

HOW WE GOT HERE

The opioid crisis emerged slowly in the late 1990s. During that time, medical standards adapted to incorporate pain as the fifth vital sign, causing doctors to focus on getting patients to a state of zero pain. Opioids emerged as a solution, but they also created unintended consequences.

Dr. Gary Franklin, who has served as the medical director for the Washington State Department of Labor and Industries since 1988, says lobbying by advocacy groups and drug manufacturers led to a prevailing belief in the medical community that less than 1 percent of patients would become addicted to opioids.⁸

Consequently, the state's medical boards and commissions relaxed regulations and guidance for prescribing opioids. A few years later, Dr. Franklin and his pharmacy manager noticed an increase in Washington residents filing workers' compensation claims related to lower backaches and sprains before they died. They found many of the deaths could be linked to prescription opioids.

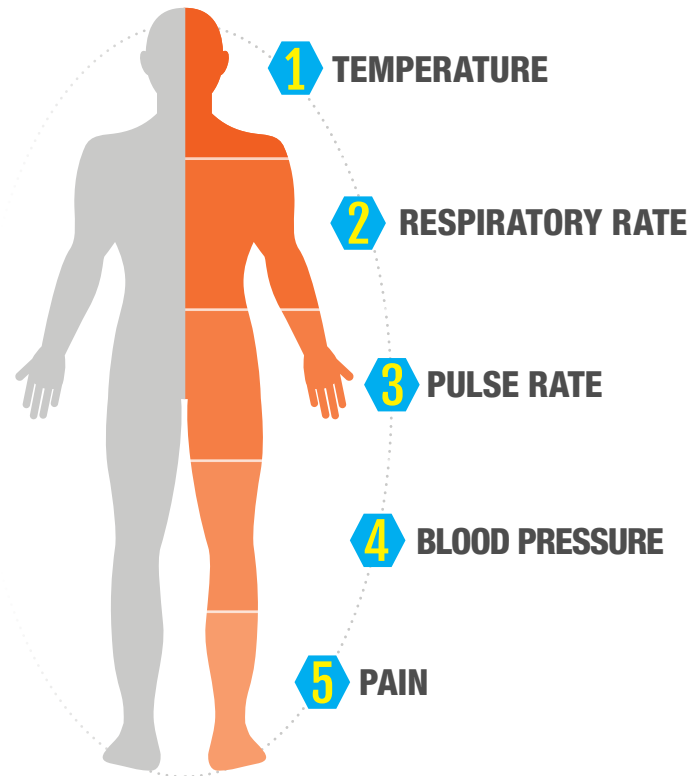
In 2005, Dr. Franklin published the first report in the country about prescription opioid deaths, and in 2007 Washington became the first state to create opioid prescribing guidelines for primary care doctors. Prescribing guidelines are a core element of Washington's continued efforts. The state has reduced deaths associated with prescribed opioids by 37 percent — the largest decline in the country.⁹

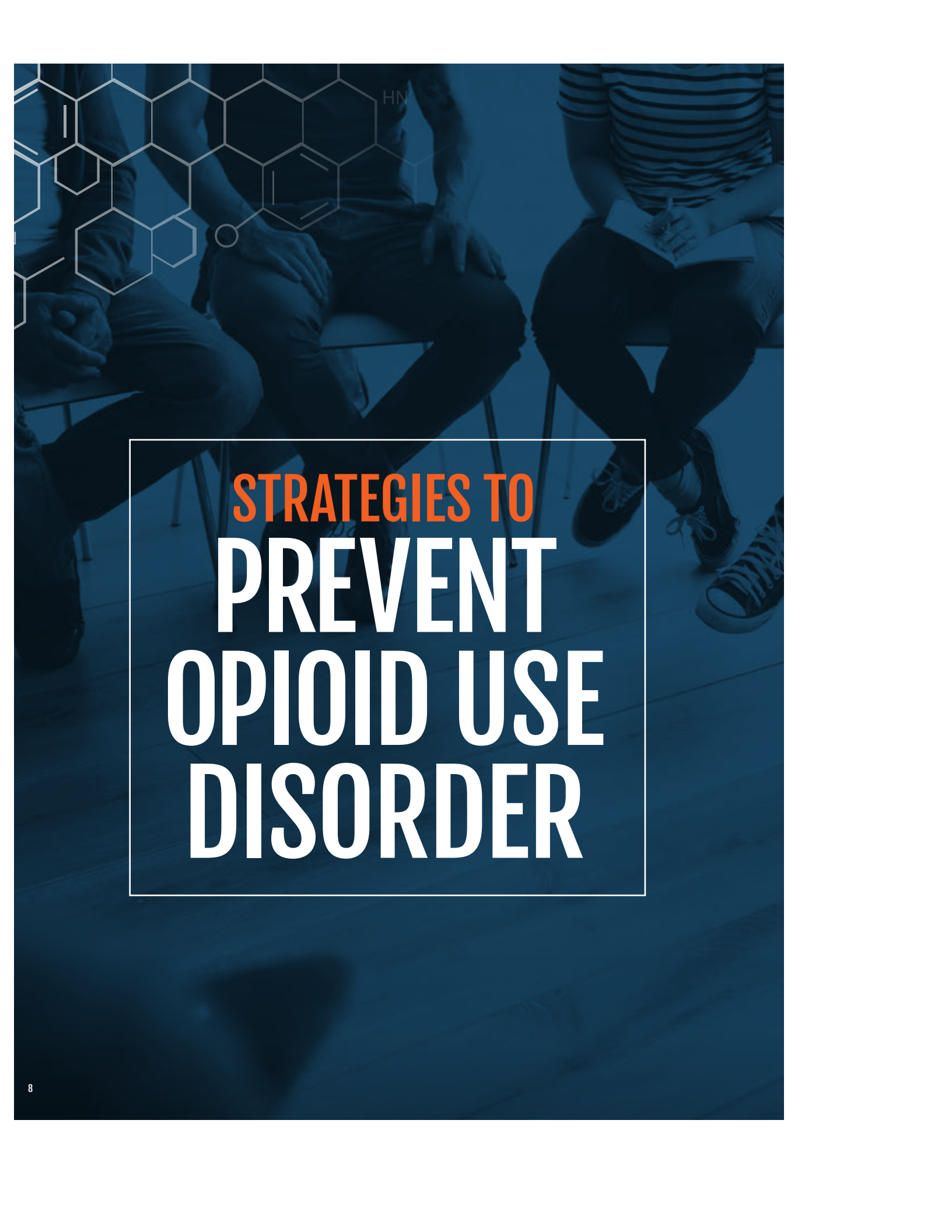
"Just creating a guideline that had a number in it, an anchor, we believe was a huge deal for doctors when they were previously taught that there was no ceiling on dose," Dr. Franklin says. "Now we know there is a strong relationship between dosing and overdose."

THE FIFTH VITAL SIGN



There are four primary vital signs; however, nearly two decades ago medical standards began to incorporate pain as the fifth vital sign, which some experts say led to overprescription of opioids.



The background of the slide features a blue-tinted photograph of several individuals sitting in a circle on chairs, viewed from above. Overlaid on the top left of the image is a white chemical structure diagram, specifically a complex polycyclic aromatic hydrocarbon. The text 'STRATEGIES TO PREVENT OPIOID USE DISORDER' is centered within a white rectangular border. The word 'STRATEGIES TO' is in orange, while 'PREVENT OPIOID USE DISORDER' is in white.

STRATEGIES TO PREVENT OPIOID USE DISORDER

Washington's story illustrates that cautious prescribing is one effective way to combat the crisis. While intended to relieve patients of pain, the issue, many experts say, is these drugs aren't the best solution for non-cancer chronic pain and their effect on the brain is so strong almost anyone can become addicted.

"I think probably 99 percent of people, if they took opioids for 30 days or 40 days, are going to become dependent," Dr. Franklin says.

Almost 10 years after the state of Washington issued the first prescribing guidelines, the CDC followed suit in 2016, releasing a guideline with 12 recommendations guided by three underlying principles:

- ▶ 1. Non-opioid therapy — including non-opioid medications such as acetaminophen or ibuprofen, as well as non-pharmacological therapies like exercise therapy — is preferred for chronic pain, excluding active cancer, palliative and end-of-life care.
- ▶ 2. When opioids are used, the lowest possible effective dosage should be prescribed. A common guideline is: "Start low and go slow."
- ▶ 3. Providers should always exercise caution when prescribing opioids, monitor all patients closely and make sure patients are well educated with respect to the risks of taking these

medications, including the potential for becoming dependent.

The CDC's guideline also includes a checklist for doctors, with line items such as optimizing opioid therapies and setting criteria for stopping or continuing opioid use.

The guidance is a step in the right direction, say experts like Dr. Andrew Kolodny, who serves as the executive director of Physicians for Responsible Opioid Prescribing (PROP). Dr. Kolodny, a leading public health expert who has spent his career treating addiction and has been at the forefront of advocating for more cautious prescribing, says it's one of the keys to preventing opioid addiction.

"At the end of the day, the common pathway toward becoming opioid addicted is repeated use," he says. "Through more cautious prescribing, the patient is less likely to get addicted, and you're less likely to stock people's medicine chest with leftover pills that can lead to addiction."¹⁰

PRESCRIPTION LIMITS AND MEDICATION SAFETY PROGRAMS

While guidelines help communicate information about the dangers of over prescription, states are enacting laws to better regulate prescribing practices.

In 2016, 22 states took some action to combat the opioid crisis, with some adopting opioid prescription limits or passing legislation that addresses prescribing to the Medicaid population.¹¹ New York, for example, set a seven-day limit for opioid prescriptions prescribed during a

3 PRINCIPLES OF THE CDC'S GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

1 UTILIZE NON-OPIOID THERAPIES

2 PRESCRIBE THE LOWEST POSSIBLE OPIOID DOSAGE — "START LOW AND GO SLOW"

3 EXERCISE CAUTION WHEN PRESCRIBING AND MONITOR PATIENTS CLOSELY

*Learn more about the
CDC Guideline for Prescribing
Opioids for Chronic Pain and
access the checklist at:
[www.cdc.gov/drugoverdose/
prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)*

“Through more cautious prescribing, the patient is less likely to get addicted, and you’re less likely to stock people’s medicine chest with leftover pills that can lead to addiction.

— DR. ANDREW KOLODNY, EXECUTIVE DIRECTOR, PHYSICIANS FOR RESPONSIBLE OPIOID PRESCRIBING

patient’s first doctor’s visit for acute pain. In New Jersey, Gov. Chris Christie signed a bill in February 2017 that limits initial prescriptions to five days, while Arizona Gov. Doug Ducey signed an executive order in 2016 setting a seven-day limit for the state’s Medicaid recipients. Additionally, 46 Medicaid programs now have prescription caps — most of which only accept opioid prescriptions after all other options have been exhausted.¹² However, it’s important to note that these do not apply to cancer, palliative care or end-of-life cases.

Insurers also are taking action in this area and initiating innovative work. In 2012, Blue Cross Blue Shield of Massachusetts launched a Prescription Pain Medication Safety Program, which it developed in partnership with doctors, pharmacists, and pain management and addiction experts.¹³ The program requires a treatment plan between doctors and patients that considers non-opioid options, a patient-signed risk assessment for addiction, an opioid agreement between the patient and prescriber outlining expected behavior of both parties, and the usage of a single pharmacy or pharmacy chain for all opioid prescriptions. The program also requires prior authorization

for all new short-acting opioids prescribed for more than 30 days and all new long-acting opioid prescriptions. A recent CDC study found the program was effective, which could indicate these types of collaborations may lead to more comprehensive prevention strategies that halt new addictions.

“After Blue Cross [Blue Cross Blue Shield of Massachusetts] implemented a new opioid utilization program, there was a significant decrease in both the number of opioid prescriptions among its members as well as a reduction in the percentage of members with a prescription for opioid-based medications,” says Dr. Macarena Garcia, the CDC study’s lead author. “The implication is that evidence-based utilization management practices can promote best practices in opioid prescribing, while reducing the risk of misuse of these medications.”¹⁴

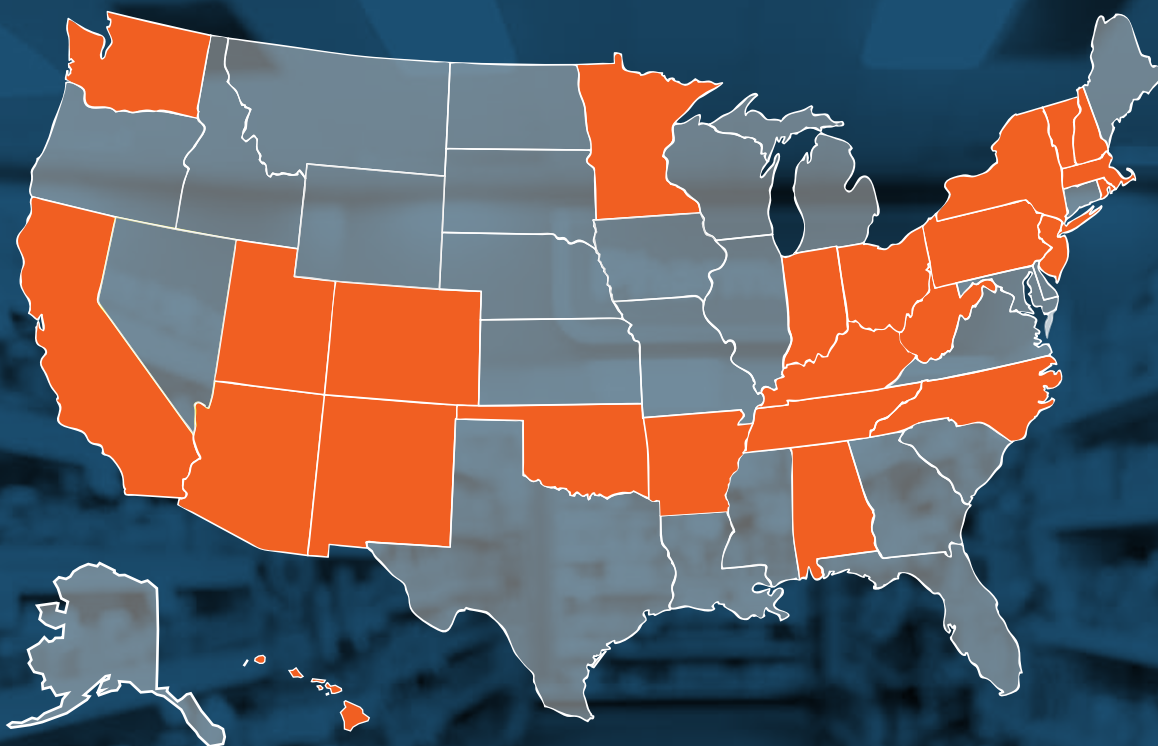
PRESCRIPTION DRUG MONITORING PROGRAMS & PREVENTING DOCTOR SHOPPING

Most states also use prescription drug monitoring programs (PDMPs), which are statewide databases with prescribing and dispensing data from pharmacies and health care providers. PDMPs help prevent individuals from

doctor or pharmacy shopping — the practice of visiting multiple physicians or pharmacies to obtain an opioid prescription — and to pinpoint hot spots for opioid misuse. Every state except Missouri has an operational PDMP.¹⁵

According to Dr. Kolodny, one important way states can optimize their existing PDMPs is by mandating doctors consult them before writing a prescription, which could flag a patient who is making appointments with multiple prescribers. In Ohio, for example, doctors must use the state’s PDMP — the Ohio Automated Rx Reporting System (OARRS). Their state medical license renewal is dependent on registration in the system. The state’s Board of Pharmacy can see who is checking OARRS and the state’s medical, nursing or dental boards can send a letter to the prescriber to encourage him or her to check the database. This effort has reduced the number of prescribed opioids in Ohio.¹⁶

While ensuring compliance is one benefit of PDMPs, state medical boards also can use this data to monitor prescribing practices and intervene when they see outliers. Third-party payers, including



GETTING TOUGH ON OPIOID PRESCRIPTIONS

In 2016 and 2017, **several states** adopted opioid prescribing guidelines or limits, or passed legislation that addresses the Medicaid population. Some examples include:

ARIZONA: 7-day limit on opioid prescriptions for Medicaid recipients

NEW YORK: 7-day limit on opioids prescribed during a patient's first doctor's visit for acute pain

NEW JERSEY: 5-day limit on initial opioid prescriptions

SOURCE: WWW.NSC.ORG/RXDRUGOVERDOSEDOCUMENTS/PRESCRIPTION-NATION-2016-AMERICAN-DRUG-EPIDEMIC.PDF



UNIVERSITY OF KENTUCKY RESEARCHERS FOUND THAT PRESCRIPTION DRUG MONITORING PROGRAMS LED TO A NEARLY 10 PERCENT REDUCTION IN OPIOIDS PRESCRIBED TO MEDICAID PATIENTS.

insurers and health plan sponsors, could add value if given access to this data. Currently, payers may only have access to data for prescriptions they've paid for, but not for patients who pay out of pocket, creating a blind spot for payers who are trying to help by monitoring their data. Giving payers access to this level of PDMP data could bolster efforts and foster collaboration with states as strategic partners to prevent abuse and misuse.

There's already strong evidence that illustrates how effective PDMPs can be. University of Kentucky researchers found that PDMPs led to a nearly 10 percent reduction in opioids prescribed to Medicaid patients and an equal reduction in Medicaid spending on these prescriptions. These figures were mostly associated with mandates for prescriber registration, the study's researchers said, adding that their "findings support the use of mandates of registration in prescription drug monitoring programs as an effective and relatively low-cost policy."¹⁷ Other research found that PDMPs were associated with a reduction in opioid-related deaths, and enhancing PDMPs and adding more robust features like weekly data updates and

closely monitoring more drugs likely to be abused could prevent two deaths per day.¹⁸

PDMPs can be an even more powerful tool for combating the opioid epidemic if their use is more widespread and if more stakeholders can access them. The Substance Abuse and Mental Health Services Administration's (SAMHSA) "Enhancing Access to PDMPs" project notes that PDMPs are underused and that there are limitations on authorized users and barriers to data exchange and interoperability, among other challenges.

The agency issued 45 recommendations for how clinical decision-makers can take better advantage of PDMPs.¹⁹ The recommendations include streamlining the registration process so more stakeholders can input data, expanding the pool of authorized health care professionals who can access PDMPs, defining a standard data set included in reports, and adopting the National Information Exchange Model (NIEM) Program specification for sharing PDMP data across public and private agencies and partners.

"We've been doing training and working to make sure states have

PDMPs that make it easy to obtain and use data, and to get it in a format that is useful for the physician or the prescriber," says Dr. Kimberly Johnson, director of SAMHSA's Center for Substance Abuse Treatment.²⁰

Some states, like Pennsylvania, already have redesigned their PDMPs. Pennsylvania Secretary of Policy and Planning Sarah Galbally says the state passed a prescription drug monitoring amendment, which included additional reporting requirements and shortened the time dispensers have to enter this information from 72 hours to 24 hours. The state requires a mandatory query for every prescription of opioids and benzodiazepines, a class of psychoactive drugs used to treat anxiety, insomnia and other conditions. Querying the PDMP database can also help mitigate circumstances in which a patient is prescribed opioids, skeletal muscle relaxers and benzodiazepines at the same time — "the triple threat" — in addition to letting a provider know whether a patient is being prescribed a drug to treat opioid use disorder.

"Making sure the system is queried every single time was really important to catching

individuals who might be 'doctor shopping' or being over prescribed opioids," Galbally says.²¹

FRAUD MONITORING

Prescription opioids can be diverted, which contributes to misuse and opioid use disorder. Individuals who engage in provider and pharmacy shopping — and some providers who knowingly write them prescriptions — contribute to the problem. Due to this, there need to be systems in place to help root out (or prevent) fraud.

The Centers for Medicare & Medicaid Services (CMS) have several initiatives to combat fraud, including the Quarterly Pharmacy Risk Assessment and the Prescriber Risk Assessment. The agency also launched the National Benefit Integrity Medicare Drug Integrity Contractor's (NBI MEDIC) Pill Mill Doctor Project to identify prescribers with a high risk of fraud, waste and abuse, which allows CMS to educate plan sponsors and make referrals to law enforcement when appropriate. CMS also employs the Medicare Overutilization Monitoring System (OMS).

CMS queries state Medicaid agencies about their drug utilization review processes to flag inappropriate opioid use. States are federally required to have effective Medicaid fraud and abuse monitoring programs, but unfortunately many rely on a "pay and chase" model to address fraud only after it occurs.²² Some states, including New York and Texas, are using data to perform risk analysis and detect fraud sooner.²³

CASE STUDY: OHIO

A Holistic Approach to Battling the Epidemic



Ohio has been aggressively tackling the opioid crisis, investing \$1 billion from the state's budget to assist its local communities.²⁴ Ohio's strategy has four key pillars: treatment and recovery, prevention, education and tougher penalties for drug traffickers and pill mill operators.

Ohio created the Cabinet Opiate Action Team, a group comprising addiction prevention, treatment, health care, public health and law enforcement experts who coordinate the efforts of the state's 16 Cabinet agencies.

Tracy Plouck, director of Ohio's Department of Mental Health and Addiction Services, says pill mills, overprescribing and illegal drug trafficking, as well as people obtaining drugs from friends and family, all have contributed to the opioid epidemic.

"We've designed different interventions that help at different points along this continuum," she says.²⁵

These interventions include working with doctors and other health care providers to create prescribing guidelines; scheduling law enforcement and other experts to talk to more than 100,000 students about wellness, substance use and making healthy decisions; distributing related educational materials to 60,000 parents; and collaborating with local universities to create curricula about prevention.

The state also partnered with local justice departments to provide mental health and addiction services in local jails, short-term transitional benefits for released offenders and funding for drug courts. Ohio's drug courts have been successful. A study by Case Western Reserve University during the program's first year found a 114 percent increase in participants' employment status after graduation, and safe and stable housing increased by almost 29 percent for these individuals. Re-arrest rates also were lower, Plouck says, as crimes committed by program participants dropped 86 percent.

Ohio also embraced Medicaid expansion for addiction treatment. Since January 2014, about 500,000 people in the expansion population have accessed at least one mental health or addiction service — including inpatient and outpatient services or medication.²⁶ The state plans to use part of the annual \$26 million it will receive over the next two years from the 21st Century Cures Act to expand capacity statewide for medication-assisted treatment (MAT) and to execute treatment and intervention strategies in counties that have the highest volume or penetration per capita of accidental overdose deaths. Plouck says federal funding has helped the state confront the opioid epidemic, but it isn't a cure-all.

"Money alone isn't going to solve this. It takes community collaboration," she says.

Insurers, pharmacy managers and other organizations have launched fraud monitoring efforts as well. The Healthcare Fraud Prevention Partnership brought the federal government, state agencies, law enforcement, private health insurance plans and health care anti-fraud associations together to develop strategies to combat health care fraud.²⁷ The National Association of Medicaid Fraud Control Units, which is part of the National Association of Attorneys General (NAAG), also has uncovered health care provider fraud, recouped program dollars and punished unscrupulous practitioners.

Individual attorneys general and state attorneys across the country also are doing additional work on this front. For example, Florida State Attorney Dave Aronberg recently launched a task force to investigate substance abuse treatment providers who run sober homes or recovery residences and who may be exploiting the current opioid crisis and not providing patients with quality care. The task force recommended that Florida's legislature create a "vibrant, adequately funded system of oversight" for sober home providers and that recovery residences be certified and managed by a certified recovery residence administrator. Overall, creating substance abuse treatment industry standards should make local and state fraud monitoring efforts more effective.²⁸

MEDICAID LOCK-IN PROGRAMS

Medicaid beneficiaries are prescribed opioids at twice the

MEDICAID BENEFICIARIES ARE PRESCRIBED OPIOIDS AT TWICE THE RATE OF THE REST OF THE POPULATION, AND RESEARCH INDICATES THEY ARE AT THREE-TO SIX-TIMES GREATER RISK OF A FATAL OVERDOSE.

rate of the rest of the population, and research indicates they are at three- to six-times greater risk of a fatal overdose.²⁹ Medicaid lock-in programs — which identify patients who are high risk for controlled substance abuse and require them to use a single doctor or pharmacy for their opioid prescriptions — are one policy solution for addressing this issue.

Forty-six states have lock-in programs, but they differ in terms of program design and how each state defines and identifies high-risk individuals. These programs are often effective tools to coordinate care among health care providers, and prevent doctor shopping and duplicate therapies that could lead to unintentional overdoses, excessive dosage or diversion.

A 2014 study found that additional information around evaluating the design and effectiveness of Medicaid lock-in programs is necessary, and that this data could help states make their programs more impactful.³⁰ The study also suggested integrating PDMP surveillance data with each state's Medicaid prescription

claims data to identify people who may be doctor shopping or overutilizing services.

Lock-in programs can also save money for state Medicaid programs. One study by the Oklahoma Health Care Authority, which involved 52 members of SoonerCare's pharmacy lock-in program, found the program led to reduced prescription drug use; fewer pharmacy, physician and ER visits; and a savings of about \$600 per member for the first 12 months post lock-in.³¹

DRUG TAKE-BACK DAYS

Unused medications pose a risk for accidental exposure, misuse and abuse. Research indicates many individuals with opioid use disorder get prescription drugs from friends or relatives. The National Survey on Drug Use and Health found 70 percent of people age 12 or older who reported non-medical use of pain relievers got the drugs from a friend or relative by purchasing them or by stealing them.³²

Another study found half of patients prescribed opioids have leftover pills and the same number couldn't remember receiving information from their health care provider about

how to safely store or dispose of unused medication.³³ Safe storage and disposal are paramount to mitigating the crisis — patients should be encouraged with messaging such as “Don’t share; lock it up; dispose appropriately.”

To help, the federal Drug Enforcement Administration (DEA) launched a semi-annual National Prescription Drug Take-Back Day, which provides a safe, convenient and responsible way to dispose of prescription drugs, while also educating the public about the potential for medication abuse. During its April 2017 event, the DEA collected 450 tons of unused prescription drugs at 5,500 collection sites across the country.³⁴

States, counties and cities also host drug take-back initiatives. In Somerset County, N.J., officials recovered more than 2,700 pounds of unused prescription drugs at their 2016 take-back events and drop boxes.³⁵ In Lake County, Ill., the cross-collaborative Lake County Opioid Initiative collected 12,000 pounds of unused medication in 2016, according to Lake County State’s Attorney Michael Nerheim.³⁶

National retailers are participating in drug take-back efforts, too. Walgreens offers safe medication disposal kiosks at 600 stores in 45 states.

PROVIDER AND CONSUMER EDUCATION

Educating clinicians about prevention and early intervention for opioid use disorder is critical, but it must

include the right training. “There have been educational efforts in place for a while now, and they haven’t worked,” says Dr. Kolodny. “Part of the reason they haven’t worked is that the educational messages weren’t good. The way to get there is not through voluntary education, but through mandatory training. However, the training has to be the right curriculum.”

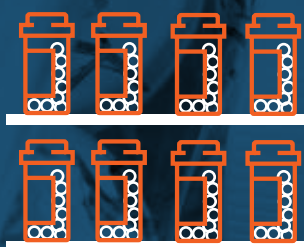
In Pennsylvania, the state’s physician general engaged the Pennsylvania Medical Society, deans from the state’s medical schools and other medical training programs to develop prescriber education campaigns for students and continuing education for practitioners.

Training for doctors and other health care providers is critical and should be integral to policymakers’ efforts to prevent addiction and increase access to treatment. In Massachusetts, medical students at the University of Massachusetts, University of Boston, Harvard University and Tufts University will receive training in core competencies developed by the state’s public health commissioner to assess addiction risk in patients before prescribing medications, identify how to treat high-risk patients and approach opioid use disorder as a chronic condition rather than a drug abuse problem.

Three Massachusetts dental schools also teach students about effective pain care, when to prescribe opioids and how to identify misuse. This effort is important because dentists are the third-highest prescribers of opioids.³⁷

WHAT HAPPENS TO UNUSED OPIOID PRESCRIPTIONS?

MORE **50%** OF PATIENTS WITH OPIOID PRESCRIPTIONS HAVE LEFTOVER PILLS.



NEARLY HALF OF PATIENTS PRESCRIBED OPIOIDS DON’T RECALL RECEIVING INFORMATION ABOUT SAFE DISPOSAL.

70% OF PEOPLE AGE 12 AND OLDER GET PAIN RELIEVERS FOR NON-MEDICAL USE **FROM A FRIEND OR RELATIVE** — BY PURCHASING THEM OR BY STEALING THEM.



**STRATEGIES TO
TREAT
OPIOID USE
DISORDER**

From drug treatment courts to medication-assisted treatment (MAT), states are adopting several approaches to effectively treat individuals with opioid use disorder.

DRUG TREATMENT COURTS

Many experts agree opioid addiction is a disease and should be treated as such, rather than a criminal offense. Drug treatment courts have existed for nearly 30 years, but some counties now use them as prison diversion programs to stop the cycle of opioid use disorder.

“Nobody benefits by putting people addicted to drugs in jail. It’s really not a smart way to approach it,” says Lake County State’s Attorney Nerheim.

Research bolsters Nerheim’s argument. Eighty percent of prisoners have a history of drug abuse; 50 percent are addicted to drugs; 60 to 80 percent of prisoners abusing drugs commit a new crime after release; and approximately 95 percent of addicted prisoners relapse when they’re released, according to National Association of Drug Court Professionals (NADCP) data.³⁸

Lake County’s drug treatment court is a two-year program for offenders with extensive criminal histories. Those in the program must report to court once a week and provide a urine sample to prove they’re drug free.

The drug court team helps participants identify appropriate employment and discourages participants from having relationships with drug abusers. The state of Illinois previously only allowed offenders to participate in drug court once per lifetime but amended the law so counties could treat more people.

INCARCERATION: A FAILED SOLUTION FOR OPIOID USE DISORDER?

80%
OF INMATES
HAVE A HISTORY
OF DRUG ABUSE.



50% 
OF INMATES
ARE ADDICTED
TO DRUGS.

60%–80%
OF PRISONERS
ABUSING DRUGS
COMMIT A
NEW CRIME 
AFTER RELEASE.

95%
OF ADDICTED
PRISONERS
RELAPSE 
WHEN THEY’RE
RELEASED.

The Lake County Opioid Initiative also launched “A Way Out,” a separate prison diversion program for first-time offenders, and works with several treatment providers — some of whom accept individuals without insurance. Additionally, anyone can walk into a local police department, voluntarily ask for help, surrender their drug paraphernalia and enter an inpatient or outpatient treatment program.

“What you’re seeing now is that law enforcement is just as aggressive in trying to reduce demand by going out and helping those who are addicted to drugs and committing crimes based on

that addiction,” Nerheim says. “The effort with these people should be treatment rather than incarceration.”

MEDICATION-ASSISTED TREATMENT

Medication-assisted treatment (MAT) uses a combined approach of counseling; behavioral therapies; and medications like buprenorphine, methadone and naltrexone to treat patients with substance use disorders. When these approaches are delivered together to treat a chronic disease like opioid use disorder, they can be highly effective. MAT can help sustain recovery but is significantly underused, according to SAMHSA.³⁹

The Surgeon General’s report, “Facing Addiction in America,” also advocates for the use of MAT.

However, the report also acknowledges that not enough treatment programs offer these medications.

“Many people, including some policymakers, authorities in the criminal justice system and treatment providers, have viewed maintenance treatments as ‘substituting one substance for another’ and have adhered instead to an abstinence-only philosophy that avoids the use of medications, especially those that activate opioid receptors,” the report notes.

The Impact of More Funding

In summer 2016, the U.S. Department of Health and Human Services announced \$53 million in funding to 44 states to increase treatment access, reduce opioid deaths, improve prevention efforts, and support more data collection and analysis to identify hot spots of misuse and overdose.⁴⁰ In September 2016, the Department of Justice also announced an \$8.8 million grant to 20 states to create or enhance their PDMPs.⁴¹

However, the largest funding source comes from the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act (CARA). In April 2017, HHS Secretary Tom Price announced the first of two rounds of grant money — as authorized by the 21st Century Cures Act — for each of the 50 states, the District of Columbia and

six territories, with the first totaling nearly \$485 million. Funding was allocated according to each state’s overdose death rate and “unmet need for opioid addiction treatment.” CARA also allocated \$1 billion in new funding for the next two years for opioid addiction prevention and treatment programs.⁴² The funding is helping states implement evidence-based strategies to curb the epidemic and treat high-risk and high-need groups.

“[The grants] are really designed specifically to address the funding gap states have,” says SAMHSA’s Dr. Johnson.



“Such views are not scientifically supported; the research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.”⁴³

Experts say MAT is more effective than abstinence-only drug treatment programs because it combines psychosocial support and medications to curb withdrawal symptoms. While there isn’t consistent data on abstinence-only programs because they rely on self-reporting, one U.K. study examined data from more than 150,000 people treated for opioid use disorder and found that people who used buprenorphine or methadone had a lower mortality rate than those who went through any type of abstinence-focused treatment.⁴⁴

Federal agencies also encourage MAT as an integral part of the recovery process. In 2016, the U.S. Department of Health and Human Services announced a policy change that removed regulations restricting doctors’ ability to administer MAT and increased the cap for how many patients they could treat using this approach to 275 patients per year.⁴⁵

CASE STUDY: BALTIMORE

Multi-Agency Collaboration in Action

In Baltimore, heroin-related deaths have increased by 73 percent and fentanyl-related deaths have increased 10-fold over the past few years.⁴⁶ Officials are tackling the epidemic with a wide range of initiatives, says Dr. Leana Wen, Baltimore city health commissioner.

Baltimore has a standing order for naloxone, a lifesaving antidote administered by nasal spray or injection to reverse opioid-related overdose, which allows pharmacies and overdose response program employees or volunteers to dispense the medication. In the last two years, the city has conducted 20,000 trainings, which has resulted in 800 saved lives, Wen says.⁴⁷

In 2016, Baltimore created a citywide, multi-agency Fentanyl Task Force that meets monthly and develops recommendations.

“One of our recommendations was to have real-time alerts for fentanyl overdoses,” Wen says. “The police and fire departments and our partners all contribute every day to these alerts, on an hourly basis, when there are spikes for overdoses. We then have outreach teams that go out to areas where overdoses are occurring to target education and outreach accordingly.”

Baltimore also has a prison diversion program and a 24/7 hotline that connects people with substance abuse and mental health professionals. Wen says the focus is getting people treatment on demand. The city received \$3.6 million in funding to create a stabilization center that will serve as a 24/7 emergency room for addiction and mental health treatment.

Wen says more cities will be able to better fight the epidemic if the thinking around addiction shifts.

“If addiction was treated as if it were any other disease, we would undoubtedly expand investments for on-demand treatment, expand investments in prevention and expand investments in the public education that is desperately needed to end this epidemic,” Wen says.



OPIOID ADDICTION INFORMATION FOR LOVED ONES

The American Society of Addiction Medicine (ASAM) created an opioid addiction treatment guide for patients, friends and families that provides an overview of the different treatment approaches and information on where to find providers and support groups.

Learn more here:

<https://www.asam.org/quality-practice/patient-guidelines-resources>



CREDENTIALING TREATMENT CENTERS

Identifying the most effective forms of treatment is only half the battle. Ensuring patients get treatment from providers and care facilities that follow evidence-based practices and are thoroughly trained to help them is just as critical.

Many stakeholders already recognize this. For example, the Georgia Legislature recently passed the “Narcotic Treatment Programs Enforcement Act,” which the governor signed into law in May 2017.⁴⁸ Among other things, the law provides for minimum standards of quality and services for narcotic treatment programs as well

What About Abuse-Deterrent Formulations?

Abuse-deterrent formulations (ADFs) are drugs that can’t be crushed, melted or otherwise manipulated, so drug abusers cannot snort or inject them. These drugs could be part of a multi-faceted solution to address the opioid epidemic, but they also give some patients, parents and loved ones a false sense of security. They’re an important tool for doctors, but they’re not necessary for everyone. Despite ongoing efforts, ADF abuse still happens. ADFs can be abused when taken orally and some states are hesitant to view them as a primary solution to the opioid epidemic.

Governors have vetoed opioid legislation involving ADFs. New York Gov. Andrew Cuomo and New Jersey Gov. Chris Christie both vetoed bills mandating health insurance cover these formulations. Their veto messages cited limited research on the effectiveness of the drugs and their high price tag.

“In addition to the lack of clarity regarding the efficacy of these drugs, abuse-deterrent opioids cost approximately three times more than opioids without these formulations. By all accounts, this bill will cost the state over \$11 million each year, the benefits of which, as noted, are still uncertain,” Gov. Christie wrote.⁴⁹

In addition, the FDA's advisory committees recently rejected OPANA ER — a popular ADF — and deemed that its risks do not outweigh its benefits.⁵⁰



as licensure of programs. Organizations like the American Society of Addiction Medicine (ASAM) and the University of New Mexico's Project ECHO help equip addiction treatment and primary care providers with the necessary resources and up-to-date training.

COORDINATED CARE

ASAM created an opioid addiction treatment guide for patients, friends and families that provides an overview of the different treatment approaches for opioid addiction and information on where to find providers and support groups.⁵¹ In 2017, the organization will launch a new program that allows physicians to become certified in the sub-specialty of addiction medicine, which should increase the number of qualified treatment providers.

Project ECHO, which pioneered a collaborative virtual training approach that allows health care providers across the country to learn from others and enhance patient care, has created an opioid addiction treatment curriculum that teaches providers about evidence-based screening and treatment guidelines for opioid disorder, effective team-based care models, and prevention and pain management approaches. ECHO collaboratives are usually managed by state universities and offer low-cost programs that states can implement. Experts say programs like this help providers acquire new skills and gain new competencies that will benefit millions of people with opioid use disorder.⁵²

CASE STUDY: NEW YORK

ECHO: A Knowledge Network to Reduce Opioid Use Disorder



In New York, drug-related deaths increased 40 percent between 2009 and 2013, with opioid-related deaths accounting for the majority of this increase. From 2010 to 2014, opioid-related ER visits increased 73 percent, and 42 percent of admissions to state-certified substance treatment programs in 2014 included opioid use as the reason for admission compared to 19 percent only four years before.⁵³

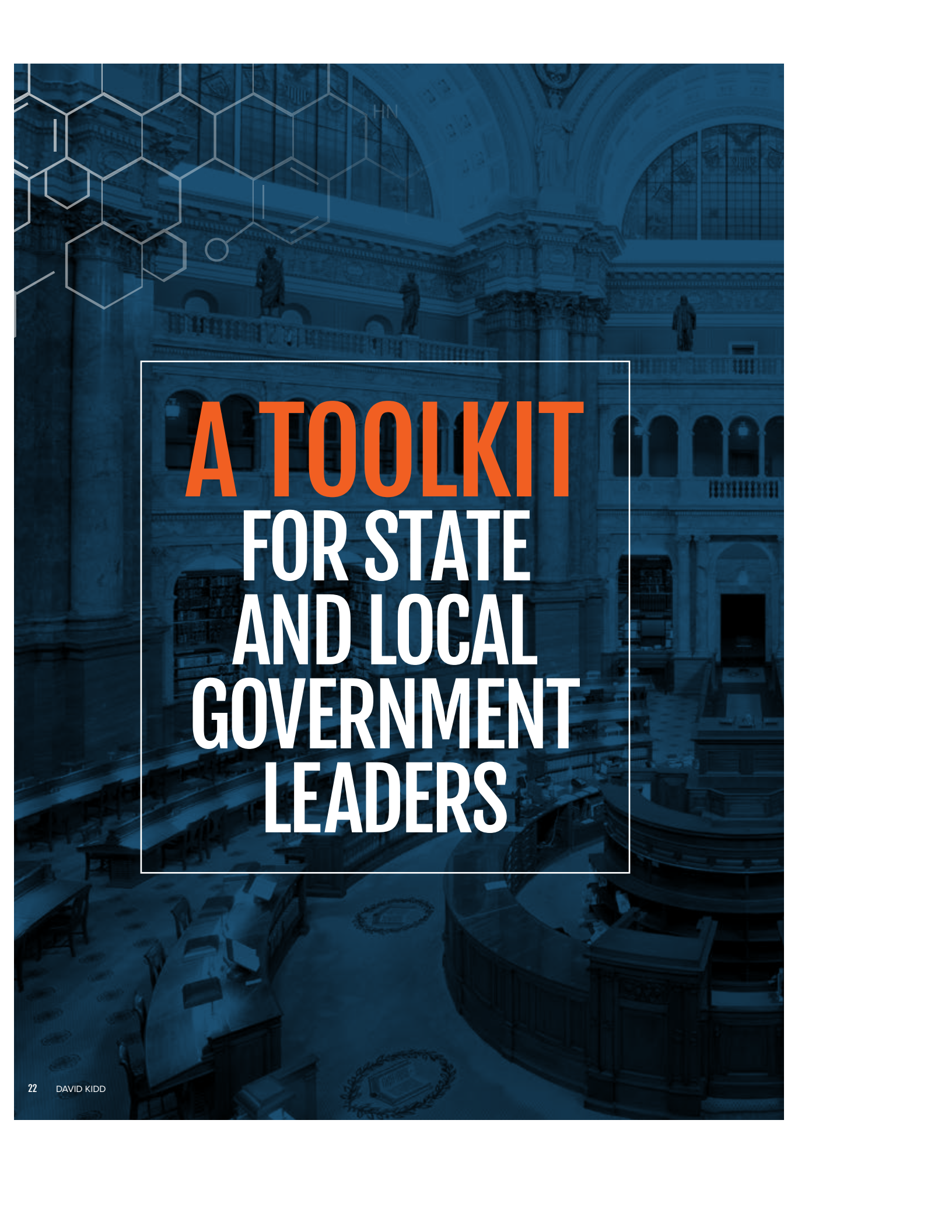
In 2016, insurance providers, the NYS Office of Alcoholism and Substance Abuse Services (OASAS), addiction treatment provider Huther Doyle and several prescribers worked together to launch the Western New York Collaborative ECHO for Chronic Pain, Opiate Prescription and Medication Assisted Treatment, Substance Use Disorder, which has been deemed the “first insurer-led ECHO in the world.”

The Extension for Community Healthcare Outcomes program, known as ECHO, is open to primary care providers at all levels — including physicians, physicians assistants, nurses, psychologists, pharmacists, social workers, mental health specialists, physical therapists, chiropractors and more — as well as Suboxone providers with an interest in prevention of addiction, MAT and pain management.

The program has included more than 20 bi-weekly, 90-minute sessions on how to identify signs of opioid dependence and misuse, have difficult conversations with patients about this behavior, prescribe opioids appropriately, fill out MAT forms and more. The sessions also discuss non-opioid pain medications and provide information about evidence-based therapies for opioid use disorder.

Participants join the sessions virtually via webcam so they can interact with each other and cultivate a knowledge network to share ideas and better combat the opioid crisis.

Past participants noted that they appreciated learning more about MAT and said the sessions improved their skill set as a provider. Eighty-seven percent also said they felt more comfortable explaining naloxone to patients, administering and prescribing it.



A TOOLKIT FOR STATE AND LOCAL GOVERNMENT LEADERS



Across the country, state and local leaders, nonprofits, health care organizations and other partners are employing strategies that have saved thousands of lives and put their communities in a better position to curb new addictions, expand treatment access and educate the public about the dangers of opioids. They exemplify progress and their efforts have yielded several best practices other policymakers can adopt to combat this epidemic locally.

TAKE ACTION

Consider these strategies in your state or local government.

- ✓ **PROMOTE THE CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN**
- ✓ **FOCUS ON TRAINING CURRENT AND FUTURE PRESCRIBERS**
- ✓ **LAUNCH DRUG TAKE-BACK PROGRAMS**
- ✓ **DEVELOP TOOLS TO SUPPORT SAFE PRESCRIBING**
- ✓ **ESTABLISH CROSS-AGENCY PARTNERSHIPS OR CONVENE COMMUNITY STAKEHOLDER GROUPS**
- ✓ **DEVELOP PUBLIC EDUCATION CAMPAIGNS**
- ✓ **EXPAND AND IMPROVE TREATMENT ACCESS**
- ✓ **INCREASE USE OF AND IMPROVE INTERFACES FOR PDMP DATA**
- ✓ **ENCOURAGE COORDINATED CARE**
- ✓ **SUPPORT CRIMINAL JUSTICE DIVERSION PROGRAMS**



PROMOTE THE CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Review the CDC guideline — which was created with the input of multiple stakeholders from different sectors — and consider what elements you can incorporate into your own guidelines. The U.S. Surgeon General’s report, *“Facing Addiction in America,”* also includes key research findings and provides guidance about ways local communities can address drug addiction.

FOCUS ON TRAINING CURRENT AND FUTURE PRESCRIBERS

Partner with dental and medical schools and other health care provider training programs to develop prescriber education curricula. For example, in Massachusetts, medical schools must conduct yearly verbal substance misuse screenings in two grade levels and collaborate with the state’s education and public health departments on addiction education policies.

LAUNCH DRUG TAKE-BACK PROGRAMS

Consider scheduling drug take-back days throughout the year and work with the DEA on its semi-annual Drug Take-Back events. Placing drop-off boxes in various locations and supporting similar programs can help citizens safely dispose of unused or expired prescription medication.



DEVELOP TOOLS TO SUPPORT SAFE PRESCRIBING

Help physicians make better decisions about opioid prescriptions. For instance, Washington officials created an online Opioid Dosage Calculator to encourage more cautious prescribing (it’s also available as an app) and Ohio created a *“Health Resource Toolkit for Addressing Opioid Abuse.”* In 2015, CMS launched a New Medicare Part D Opioid Drug Mapping Tool that local officials can use to see the number and percentage of opioid claims in their area.



ESTABLISH CROSS-AGENCY PARTNERSHIPS OR CONVENE COMMUNITY STAKEHOLDER GROUPS

Conduct regular meetings, establish communication, and form workgroups and subcommittees to help your state develop consensus-oriented policy solutions. For example, the Bree Collaborative, a governor-appointed group of purchasers, insurers, providers, state agencies, university leaders, hospitals and physicians, worked to devise strategies for implementing Washington state’s Interagency Guideline on Prescribing Opioids for Pain. The city of Baltimore’s multi-agency Fentanyl Task Force also brought together diverse stakeholders to create recommendations for addressing the epidemic.

DEVELOP PUBLIC EDUCATION CAMPAIGNS

Launch public education campaigns focused on raising risk awareness, chronic pain management and opioid overdose prevention. Alabama, for example, created awareness posters, radio spots and PSAs for its “Zero Addiction” campaign. In Oregon, a group called Oregon Pain Guidance made videos to help educate providers about safe prescribing practices and treatment. The group also collaborated with a local TV station on a series of videos that featured people in recovery and offered tips on how to recognize opioid dependency and better treat pain. The videos appear across multiple channels, including social media, where they can reach young people who are at great risk for opioid misuse.



EXPAND AND IMPROVE TREATMENT ACCESS

Consider using funding to build capacity and sustainable solutions. For example, federal funding available through the 21st Century Cures Act, which focuses on the uninsured and high-need groups, will help states expand access to treatment, such as psychosocial counseling and medication-assisted treatment (MAT). States also should catalog available treatment options in their community and aid the public in finding qualified, accredited treatment providers, as this can be an obstacle to quickly getting patients necessary care.

Also consider funding “warm hand-off” programs to get more people into treatment. These programs transfer patients directly from the ER — where they’ve been treated for an overdose — to a qualified drug treatment provider, thereby reducing the likely risk of a repeat overdose after that individual leaves the hospital. This approach may encourage patients who might not have sought treatment to get help.

ENCOURAGE COORDINATED CARE

Advocate for more coordinated approaches for fighting the opioid epidemic. For example Pennsylvania employs what it calls a “no wrong door policy” so individuals can approach a law enforcement officer, a doctor or another member of the community and be offered services to transition into treatment — without the threat of incarceration. The ECHO treatment model is also a way to bring multidisciplinary groups together to share knowledge, improve patient care and increase access to evidence-based treatment.

INCREASE USE OF AND IMPROVE INTERFACES FOR PDMP DATA

Encourage doctors to use prescription drug monitoring program (PDMP) data before they write prescriptions, or change regulations for when data must be entered. PDMPs are a valuable tool to curb doctor and pharmacy shopping and provide more transparency about prescriber history, which is why payers should have access to this data. It may also be valuable to establish parameters to encourage PDMP data sharing among programs and partners.



SUPPORT CRIMINAL JUSTICE DIVERSION PROGRAMS

Explore ways to leverage drug treatment courts or similar prison diversion programs to provide treatment to people who may not otherwise receive it. It’s important to collaborate with law enforcement in this effort. For example, in Lake County, Ill., anyone can walk into a police department, voluntarily surrender their drug paraphernalia and ask to enter a drug treatment facility.



CONCLUSION

The CDC estimates there are enough opioid prescriptions for every American adult to have their own bottle.⁵⁴ More cautious prescribing is key to preventing future addictions, but so are law enforcement strategies that target pill mills and illegal drug trafficking.

From prescription limits, PDMPs and prescriber education to multi-agency workgroups and diversion programs, states and localities are using multiple strategies to combat opioid use disorder. Baltimore, Washington, Ohio, Massachusetts and Pennsylvania serve as models for other states to jump start their efforts, but the most important thing for policymakers to remember is this epidemic is a multi-faceted problem that requires multi-faceted policy solutions.

“There is no single spot on the continuum of interventions that is the magic bullet,” says Plouck,

director of Ohio's Department of Mental Health and Addiction Services. “A community can start where it makes sense for them to start, demonstrate some progress and then go on from there. Sometimes people look at this challenge in the aggregate and think this isn't winnable and there's so much that needs to be done — but really you just have to take it piece by piece.”

**BALTIMORE, WASHINGTON,
OHIO, MASSACHUSETTS
AND PENNSYLVANIA SERVE
AS MODELS FOR OTHER
STATES TO JUMP START
THEIR EFFORTS.**



This piece was developed and written by the Governing Institute Content Studio, with information, input and support from the Blue Cross Blue Shield Association.

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