



Governor's Task Force on Prescription Drug and Heroin Abuse

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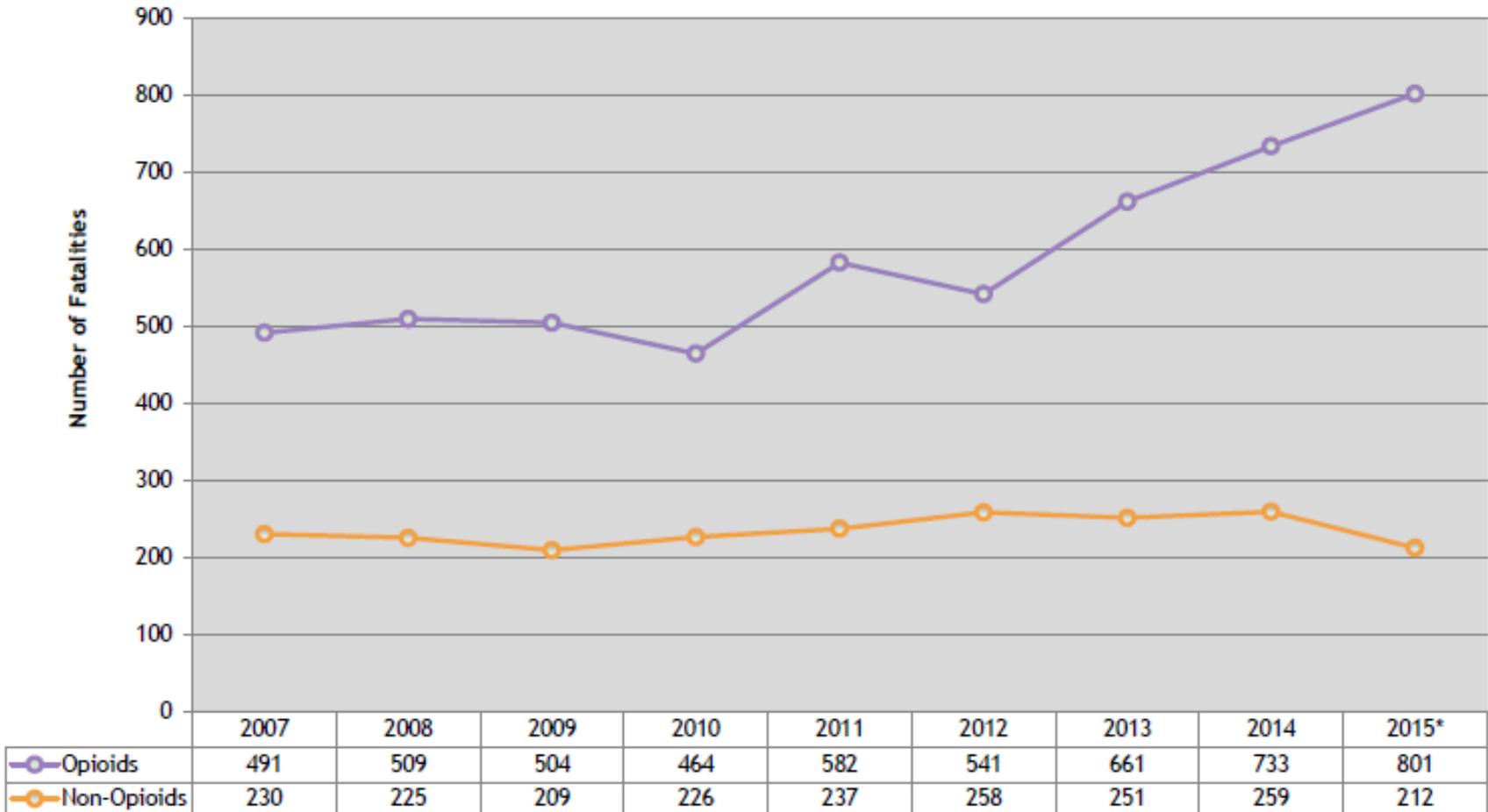


Agenda

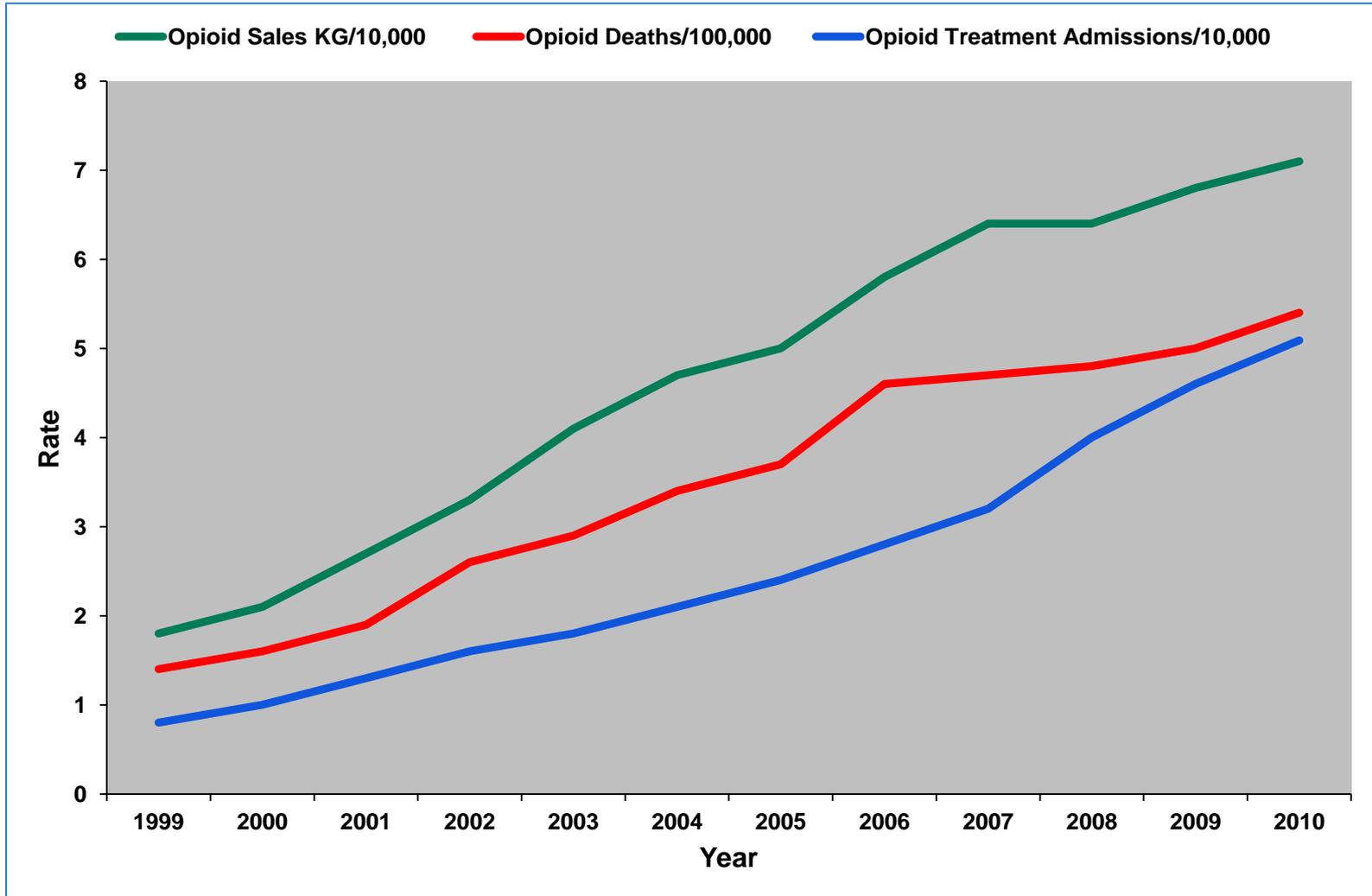
- ❑ Defining the Problem with Data
- ❑ Task Force Establishment and Structure
- ❑ Recommendations and Legislation
- ❑ RE – Defining the Problem (and Solutions)
- ❑ Appendix: Full list of Task Force Recommendations

□ Defining the Problem with Data

Total Number of Fatal Opioid Overdoses vs. Non-Opioid Overdoses by Year of Death, 2007-2015
(Data for 2015 is a Predicted Total for the Entire Year)

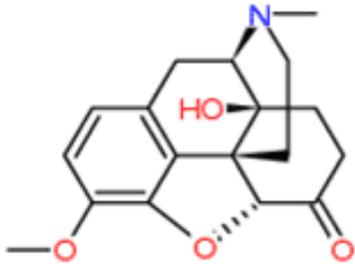


Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010

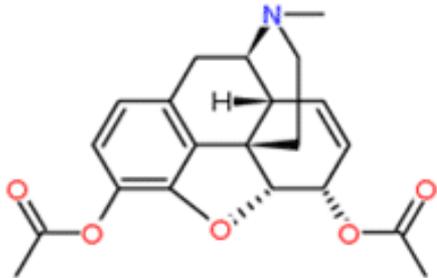


CDC. *MMWR* 2011. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w. Updated with 2009 mortality and 2010 treatment admission data.

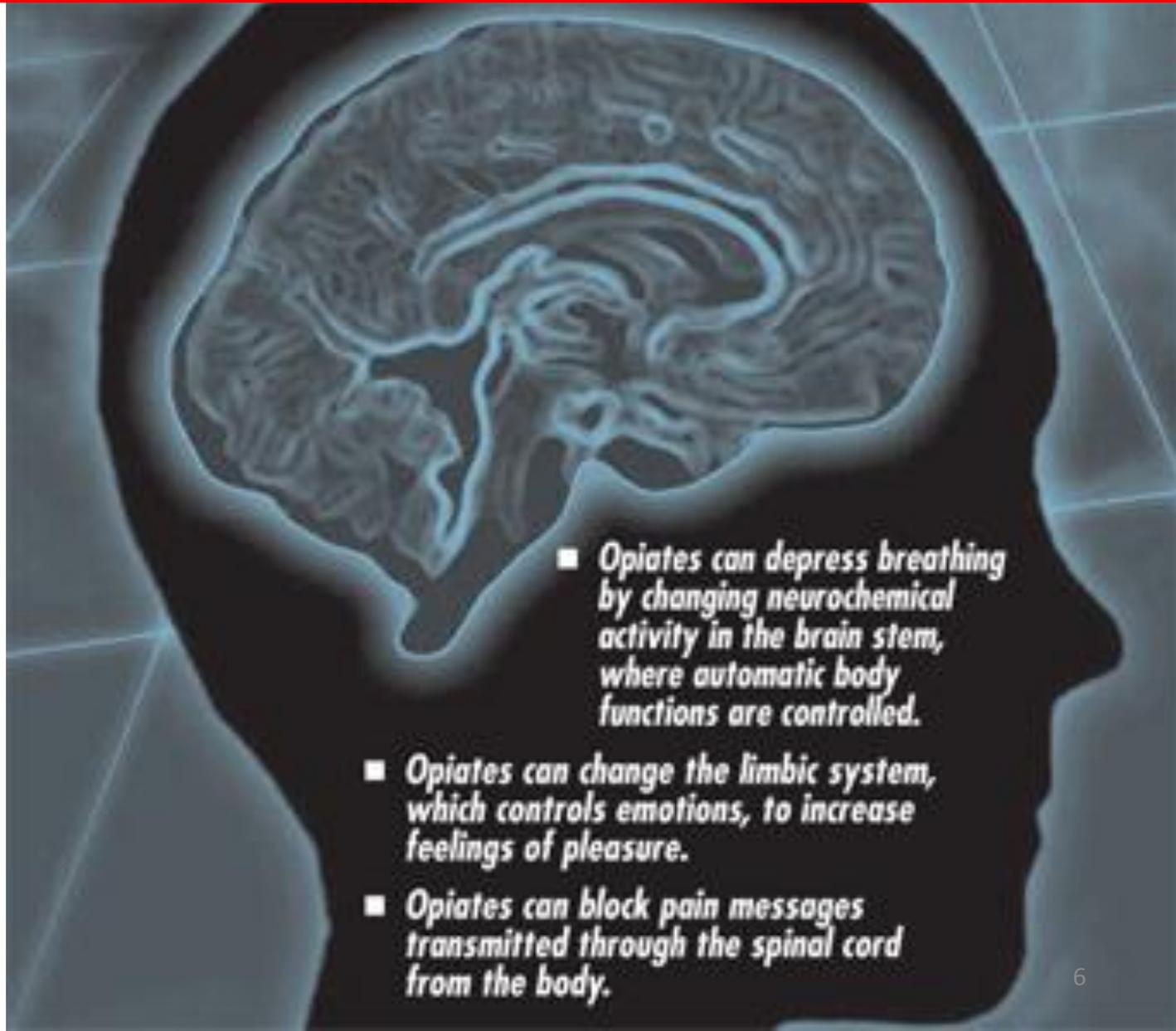
Similarities between Heroin and Prescription Opioids



OXYCONTIN (OXYCODONE)



HEROIN

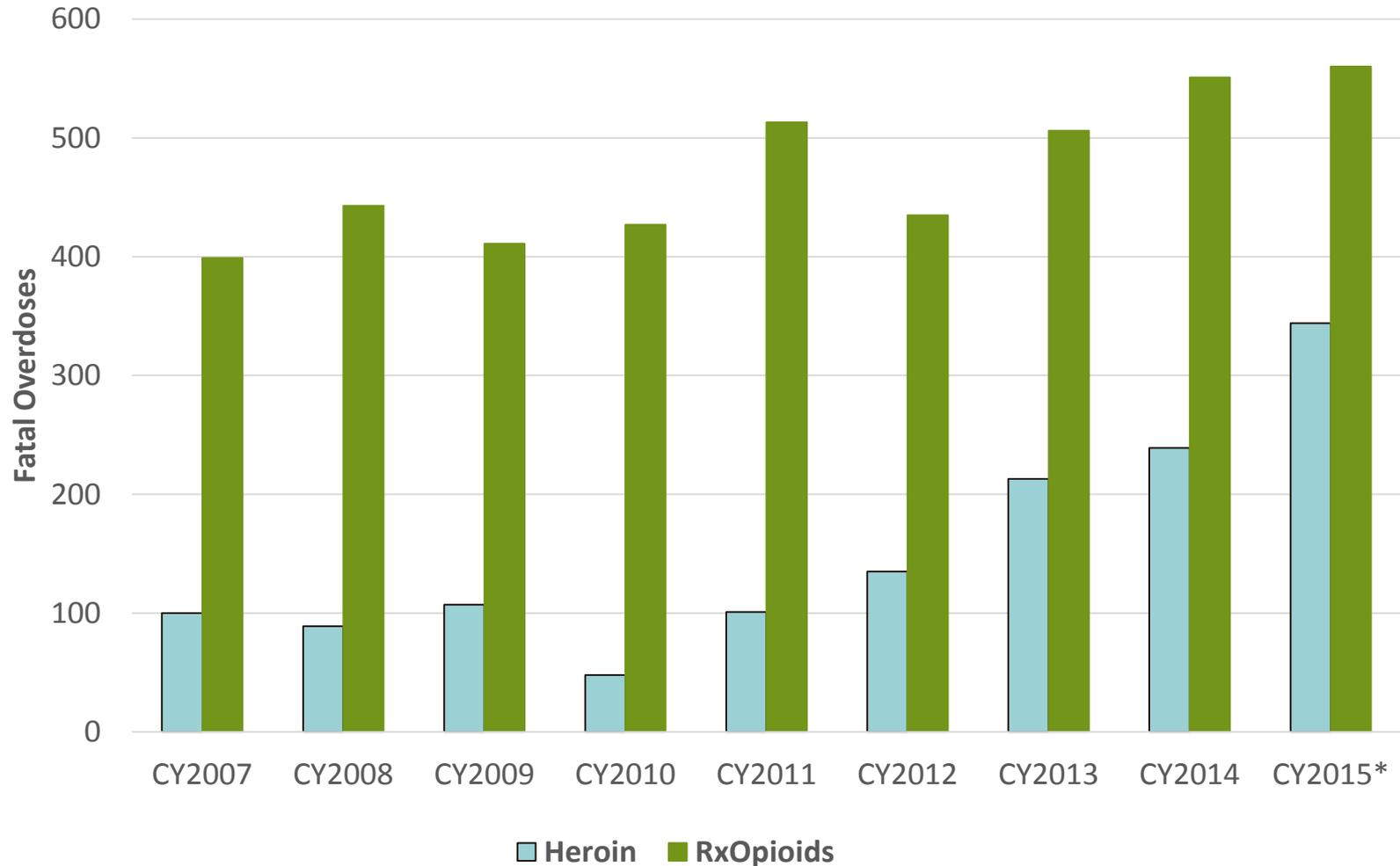


- *Opiates can depress breathing by changing neurochemical activity in the brain stem, where automatic body functions are controlled.*

- *Opiates can change the limbic system, which controls emotions, to increase feelings of pleasure.*

- *Opiates can block pain messages transmitted through the spinal cord from the body.*

Fatal Overdose in Virginia: Prescription Opioids and Heroin



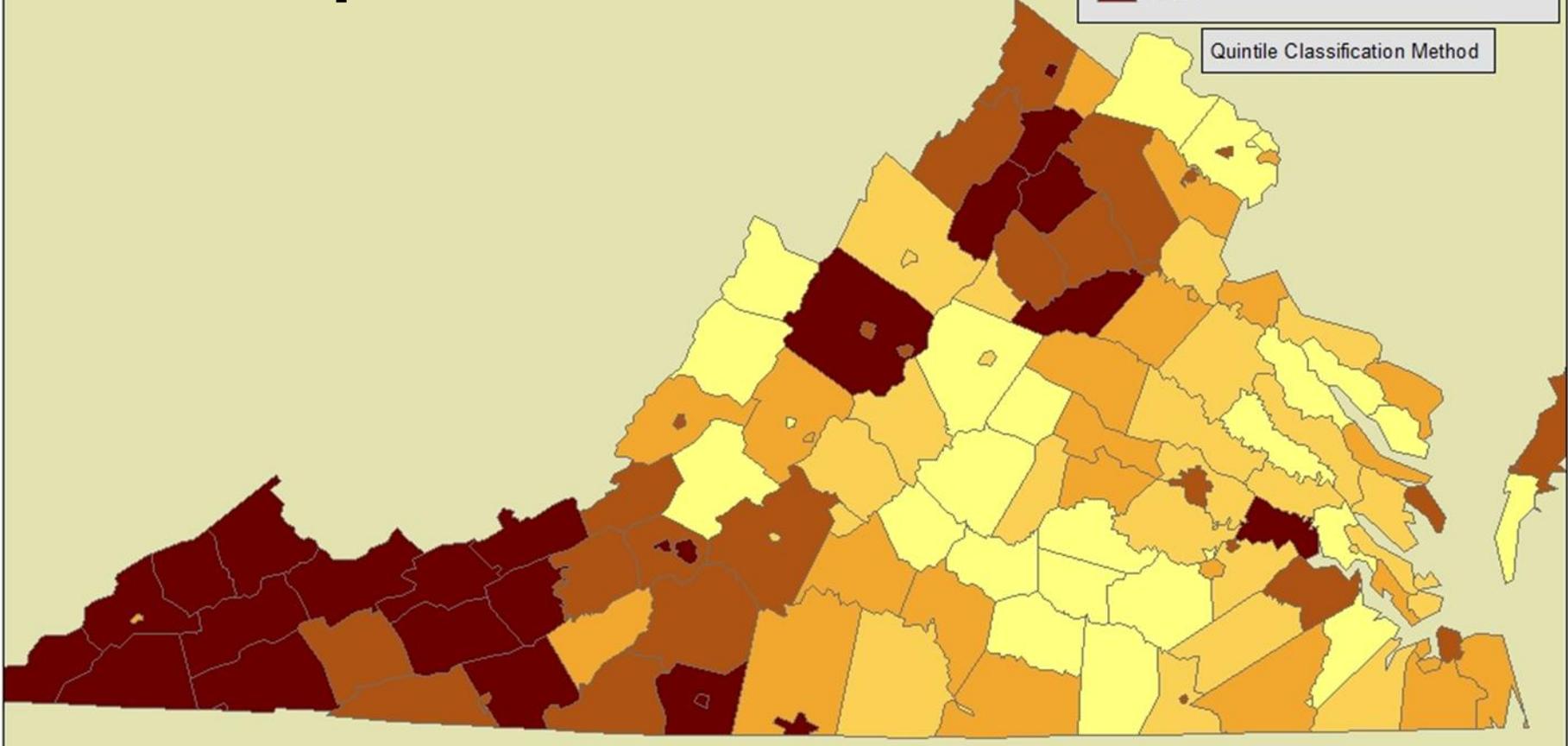
Data Source: OCME Fata Drug Overdose Quarterly Report <http://www.vdh.virginia.gov/medExam/ForensicEpidemiology.htm>
*2015 data are incomplete.

Prescription Opioid Deaths per 100,000

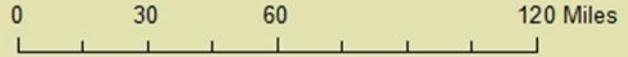
Legend
Virginia Counties
Prescription Opioid Deaths per 100,000 Population

0 - 23
24 - 35
36 - 50
51 - 78
79 - 280

Quintile Classification Method



Fatal Drug Overdose Quarterly Report (Totals 2007 - 2014)
Sources: Virginia Department of Health - Office of the Chief Medical Examiner
US Census 2012 Estimates
Prepared by VCU Office of Health Innovation November 2015

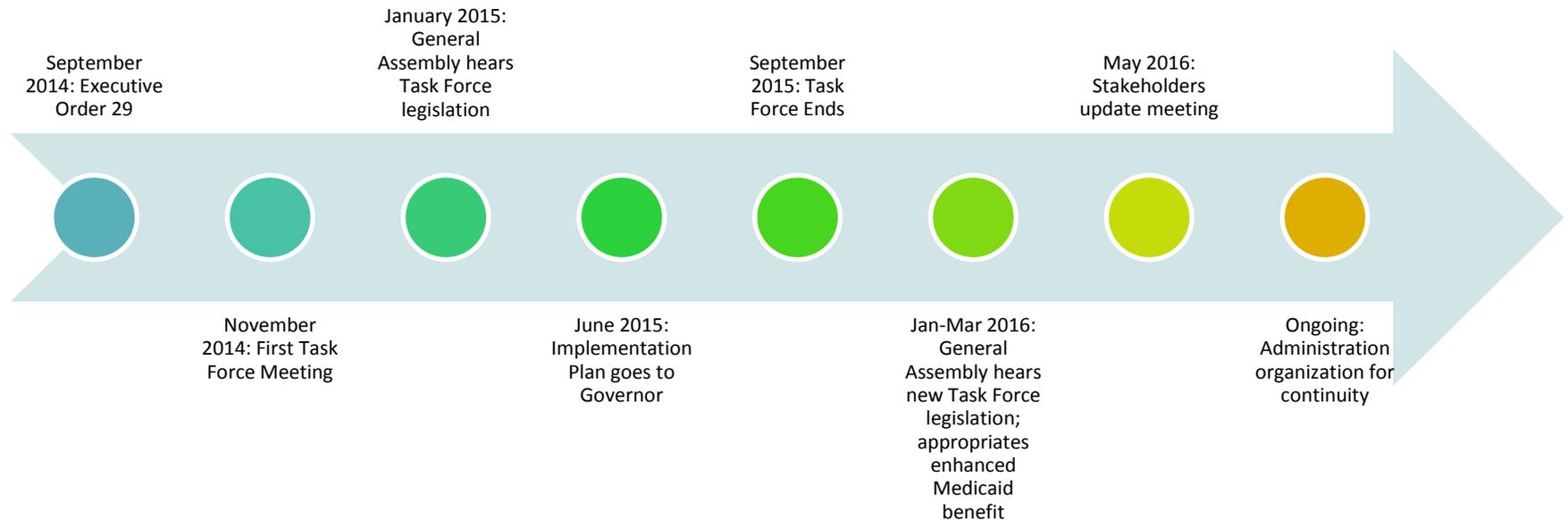


□ Task Force Establishment and Structure

- *Healthy VA Plan*: Executive Order 29
- Co-chaired by Secretary Hazel & Secretary Moran; 32 multi-disciplinary members, 5 workgroups
 - ❖ Education
 - ❖ Treatment
 - ❖ Storage & Disposal
 - ❖ Data & Monitoring
 - ❖ Law Enforcement

☐ Recommendations and Legislation

Five meetings between November 2014 and September 2015, resulting in **51 recommendations**



2015 Task Force Legislative Initiatives

✓ *HB1458 (O'Bannon)*

- Expanded pilot to make Naloxone/Naloxone training accessible to first responders throughout Virginia
- Allowed pharmacists to dispense naloxone under standing order

✓ *HB1841 (Herring)* – Expanded mandatory PMP registration to dispensers

✓ *HB1810 (Herring)* – Protected PMP from civil lawsuits

✓ *HB 1738 (Hodges)* – Required hospices to notify pharmacies about the death of a patient

2016 Task Force Legislative Initiatives

✓ *HB829 (Stolle)*

- Mandates Continuing Medical Education for providers regarding proper prescribing, addiction, and treatment

✓ *SB287 (Wexton)*

- Reduces dispenser reporting time from 7 days to 24 hours, allows clinical consultation with pharmacists regarding patient history, & places copy of PMP report in patients' medical history

✓ *HB657(O'Bannon/Herring)*

- Sends unsolicited reports on egregious prescribing/dispensing behavior to agency enforcement

✓ *SB513 (Dunnavant)/HB293 (Herring)*

- Requires query of PMP for all opioid prescriptions over 14 days

✓ *HB583 (Yost)*

- Provides certification for substance abuse peer support

2016 Medicaid Benefit Enhancement

Six Substance Use Disorder (SUD) Treatment Supports for Current Medicaid Members in the Budget

- 1 Expand short-term SUD inpatient detox to all Medicaid members
- 2 Expand short-term SUD residential treatment to all Medicaid members
- 3 Increase rates for existing Medicaid/FAMIS SUD treatment services
- 4 Add Peer Support services for individuals receiving SUD benefit
- 5 Require SUD Care Coordinators at Medicaid health plans
- 6 Provide Provider Education, Training, and Recruitment Activities

Task Force Policy and Programmatic Initiatives

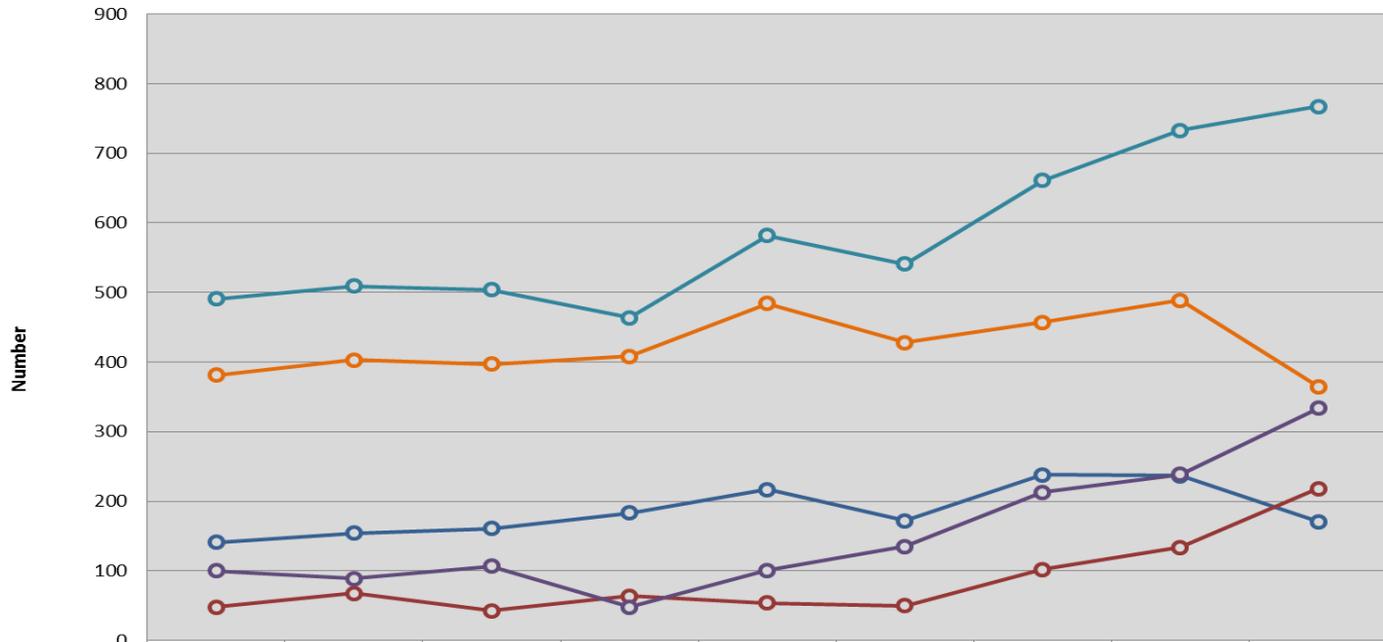
- Added morphine equivalent doses per day (MEDD) score to PMP patient reports
- Created Health and Criminal Justice Data Committee
- Hosted Appalachian Opioid Summit to discuss cross-border policy and practice to address overdose epidemic with neighboring states

Task Force Policy and Programmatic Initiatives - Education

- State website - Summer 2016
- Professional education:
 - Law Enforcement and Corrections; naloxone training for law enforcement
 - Counseling and Social Work trainings; academic and continuing education
 - Medical School collaboration
- Public education collaborative with neighboring states

RE-Defining the Problem

Number of Drugs Causing or Contributing to Death in Fatal Drug Overdoses by Drug Name/Drug Category and Year of Death, 2007-2015*



	2007	2008	2009	2010	2011	2012	2013	2014	2015*
— Benzodiazepines	141	154	161	183	217	172	238	237	171
— Fentanyl	48	68	43	64	54	50	102	134	218
— Heroin	100	89	107	48	101	135	213	239	334
— Rx Opioids (Excluding Fentanyl)**	381	403	397	408	484	428	457	489	365
— All Opioids***	491	509	504	464	582	541	661	733	767

*Data for 2015 is incomplete, preliminary, and subject to change.

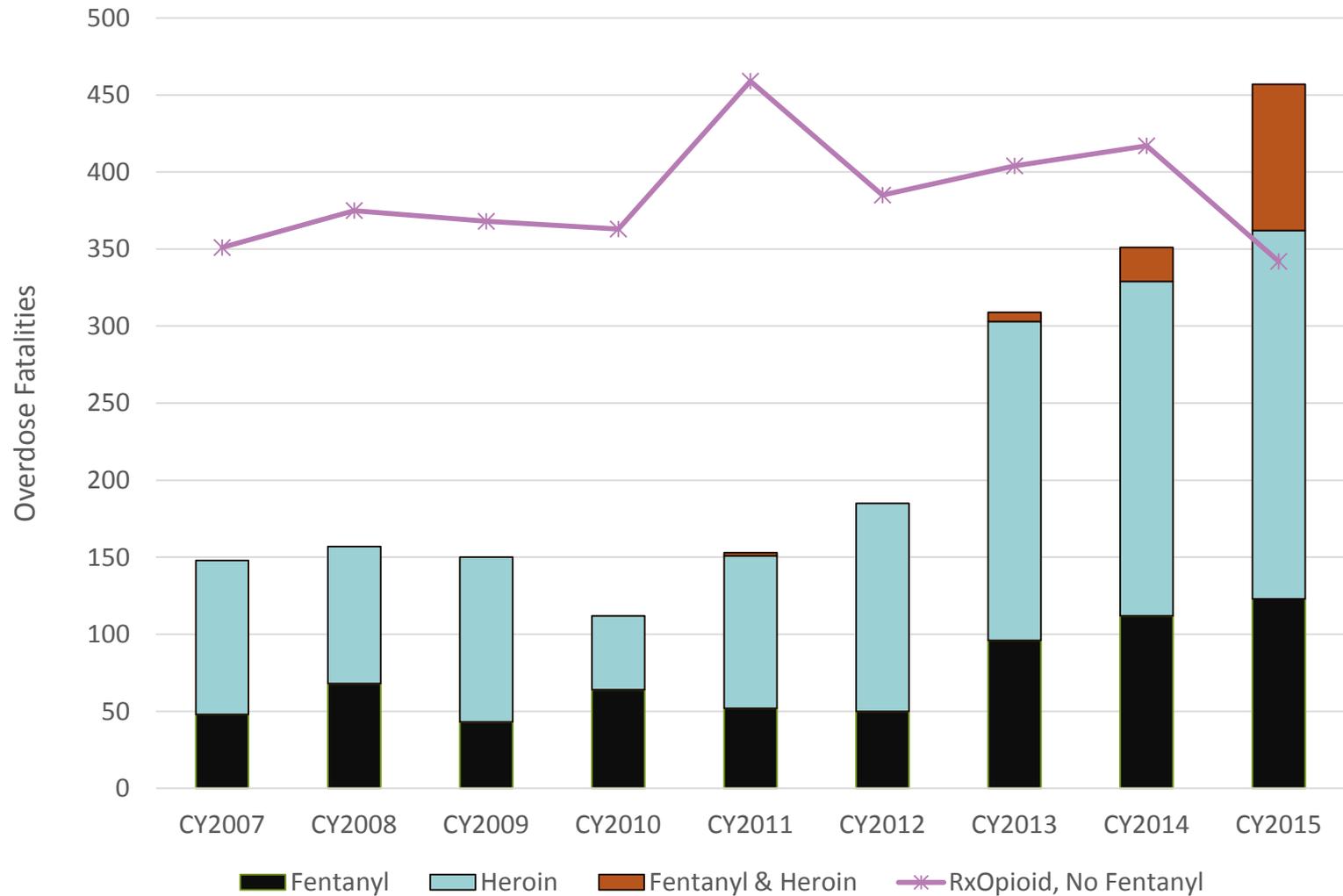
** 'Rx Opioids' **excludes** fentanyl from the analysis because although historically fentanyl has been produced by pharmaceutical companies, recent law enforcement investigations have uncovered that in 2013 and forward, most fentanyl causing or contributing to death originated from illicit production of the drug

***'All Opioids' includes heroin, fentanyl, all Rx opioids, and 'opioids unspecified'

****Additional drugs may have caused or contributed to death

*****These data are not mutually exclusive due to fatal overdoses most commonly having more than one substance causing or contributing to death

Fatalities: Fentanyl and/or Heroin



2013-14	17%	5%	267%	3%
2014-15*	10%	10%	332%	-18%

Data Source: OCME Fata Drug Overdose Quarterly Report <http://www.vdh.virginia.gov/medExam/ForensicEpidemiology.htm>

*2015 data are incomplete.

Fentanyl and Synthetic Analogues

- Surgical analgesic, primarily for moderate-to-severe cancer pain, developed in 1960s, available as trans-dermal patch in 1990s
- “China White:” Opioid epidemic created opportunity for dealers to manufacture fentanyl (as opposed to diverted pharmaceutical) and then mix with heroin

S1: Changing a Culture of Acceptability

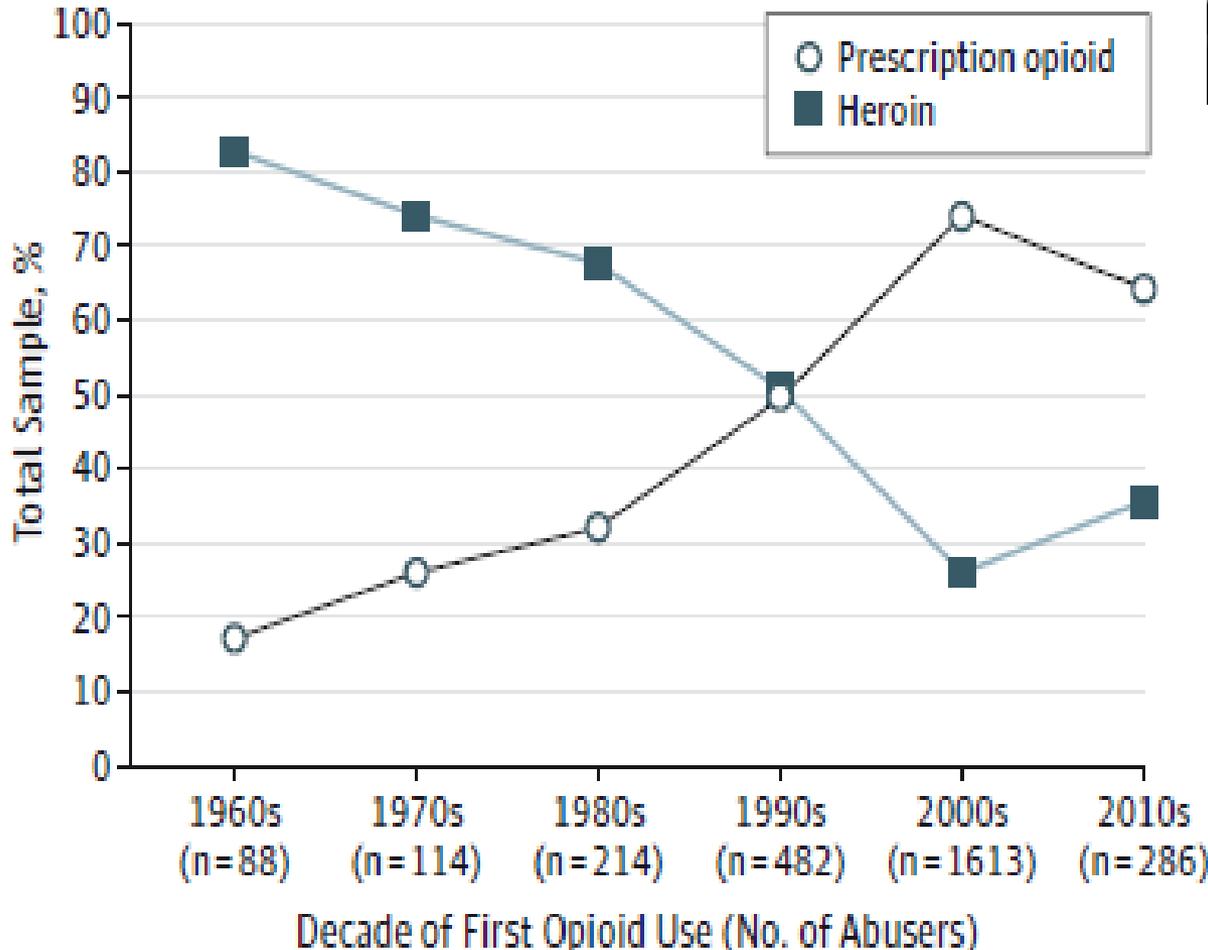
Virginia Foundation for Healthy Youth 2015 Youth Survey (N= 5043) found that:

- 1.4% of students had tried heroin
- 1.2% currently using
- 7.5% currently took a Rx drug without a Rx

Which Drug is the First Opioid Used in Addicts?

Shifting Pattern of Heroin vs. Prescription Opioid First

Percentage of Heroin-Addicted Treatment Admissions that Used Heroin or Prescription Opioid as First Opioid



1960s: more than 80% started with heroin.

2000s: 75% started with prescription opioids.

2010-2013: Increasing initiation with heroin

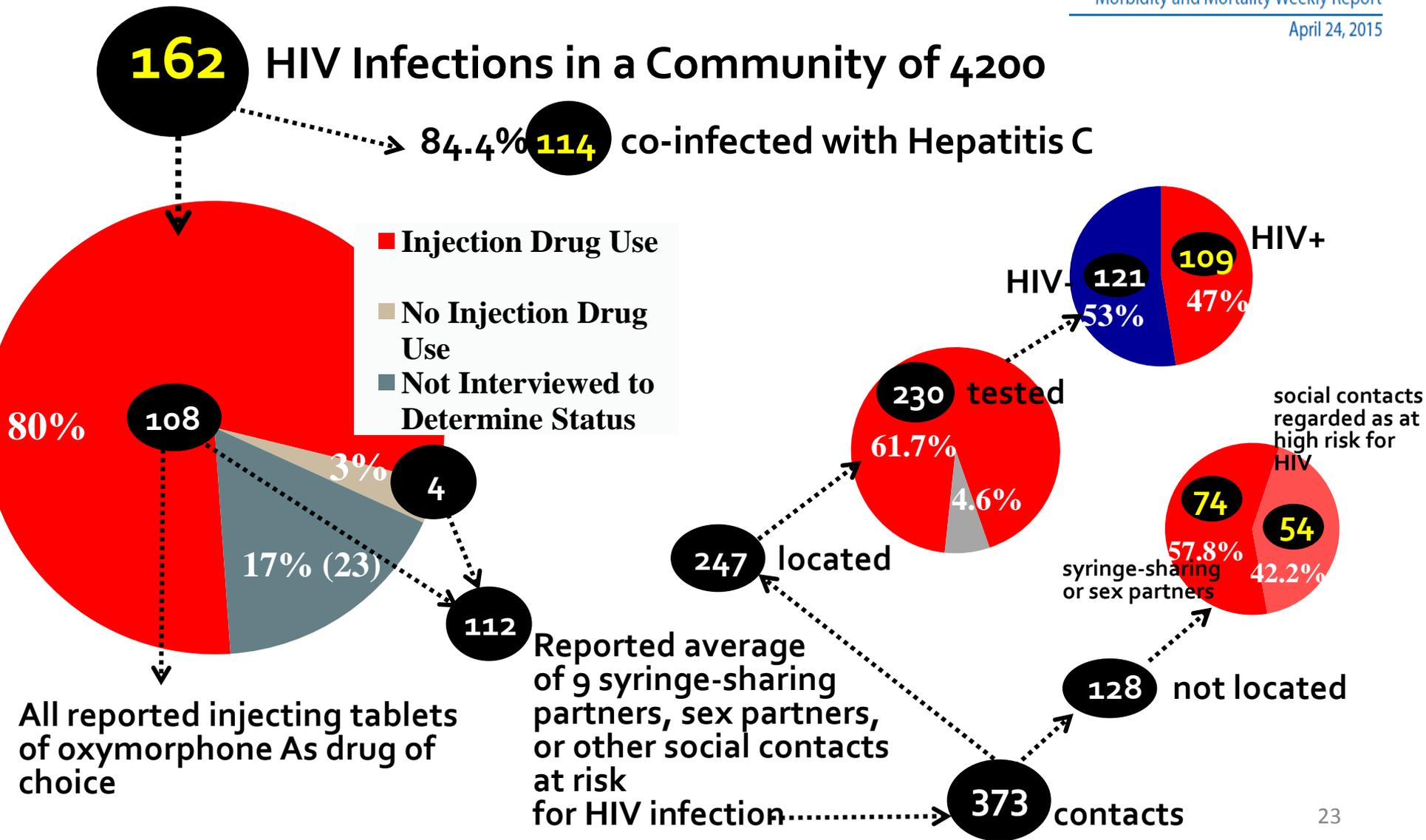
Source: Cicero et al. JAMA Psychiatry. 2014;71(7):821-826

S2: Harm Reduction

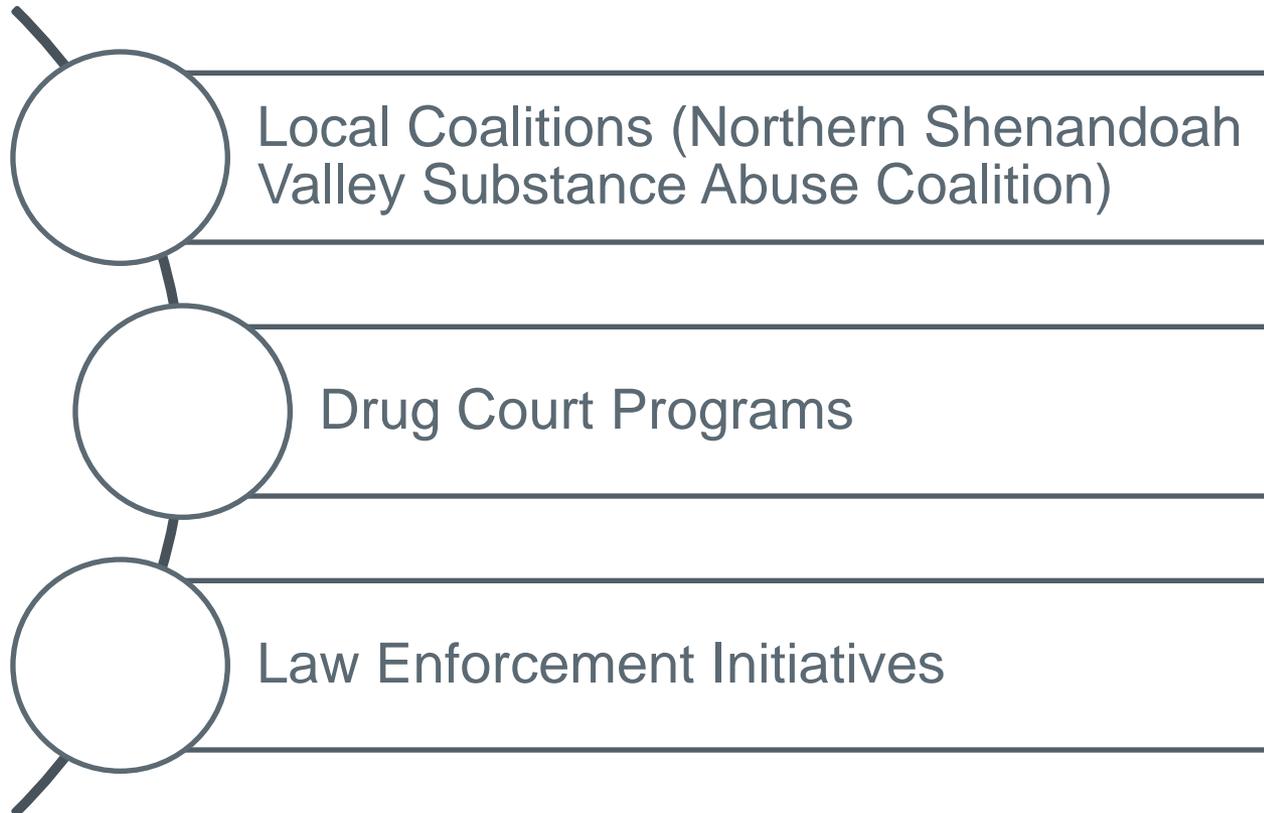
- **Naloxone:** Dead people can't recover
- **Emerging Health Crises:** HepC and HIV among opioid and heroin users, who tend to be
 - White
 - Under 30
 - equally male/female
 - *non-urban* (suburban, rural)



Outbreak of HIV Linked to IDU of Oxymorphone Indiana, 2015



S3: Support for Local Activities



Common thread: Inclusion of RECOVERY COMMUNITY

To Do

- Determine ongoing governance structure to ensure focus/collaboration over time
- Fall Stakeholders Meeting
- 2017 Legislative initiatives

Questions & Contact Info

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Task Force Website:

<http://www.dhp.virginia.gov/taskforce/default.htm>

Appendix- Education Recommendations

Education Workgroup

- Develop a State website as an informational hub on prescription drug and heroin abuse. (Sec IV, A)
- Create and send “Dear Colleague” letters and stock op-eds. (Sec IV, B)
- Encourage placement of stationary disposal containers in every locality and subsequently inform Virginians of their locations. (Sec V, Z)
- Encourage the distribution of lock boxes with controlled substance prescriptions when dispensed. (Sec V, Y)
- Send a letter to all prescribers and dispensers about the PMP, focusing on the urgency of the overdose epidemic. (Sec III, I)
- Annual outreach to opioid prescribers (based on PMP data) regarding appropriate prescribing of controlled substances. (Sec V, J)
- Send a letter to health professions schools in Virginia regarding development of pain management and addiction training curricula. (Sec IV, B)
- Develop an educational curriculum for law enforcement, corrections, corrections, probation and parole, EMTs, CIT officers, and School Resource Officers. (Sec IV, D)
- Develop a law enforcement training program regarding naloxone administration if the existing pilot is expanded to include law enforcement (coinciding recommendation referred from the Enforcement Workgroup). (Sec III, F)
- Referral from the Storage and Disposal Workgroup: Education for doctors on how to prescribe medication in proper doses to limit excess quantities of drugs. (Sec V, D)
- Collaborate with appropriate medical and healthcare school leadership to encourage them to provide curricula in health professional schools (medical, nursing, pharmacy, physician assistants, optometry, and dental) on the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse. (Sec V, A)
- Work with schools of social work to encourage education on addiction, treatment resources, and resource coordination for students going on to work as mental health providers. (Sec V, B)
- Evaluate options for continuing medical education (CME), including incentives and consequences to encourage participation in CME of opioids to treat pain while minimizing the risk of addiction and substance abuse. (Sec V, D)
- Provide further education for judges, prosecutors, and defense attorneys on the nature and causes of addiction and alternatives to incarcerations, particularly Drug Courts. (Sec V, M)
- Develop Public Service Announcements and collateral marketing materials. (Sec V, DD)

Appendix- Storage & Disposal Recommendations

Storage and Disposal Workgroup

- Increase disposal opportunities via drug take-back events held within communities. (Sec IV, C)
- To increase disposal opportunities via drug take-back events within law enforcement agencies, increase number of law enforcement agencies participating as drug collection sites. (Sec V, AA)
- Increase disposal opportunities via mail-back programs and collection boxes provided by pharmacies. (Sec V, BB)
- Determine preferred methods for disposing of unwanted/needed drugs; determine federal rule impact of existing drug disposal/take-back programs. (Sec III, H)
- Require hospice to notify pharmacies about the death of a patient. (Sec III, D)
- Determine ongoing funding sources for drug disposal. (Sec V, CC)
- Determine Virginia's need to promulgate regulations regarding pharmacy collection and mail back programs via legal guidance. (Sec III, J) Review and update the OAG's "Take Back Event" document (Sec III, K)
- Explore the feasibility of using mobile incinerators for drug disposal. (Sec III, L)

Appendix – Treatment Recommendations

Treatment Workgroup

- To reduce stigma and increase access to treatment services, provide education about addiction and MAT to health care providers, students, Community Service Boards, law enforcement, and communities. (Sec IV, E)
- Explore ways to enhance access to MAT through CSBs, Drug Treatment Course, and jail-based treatment. (Sec V, N)
- Increase training opportunities for health care professionals, both in training and in practice, on how to treat addiction and how to diagnose or manage chronic pain. (Sec V; A, D)
- Enhance and enforce a standard of care for treatment with office-based buprenorphine. (Sec V, S)
- Ensure health plans are complying with the Mental Health Parity and Addiction Equity Act by providing adequate coverage for treatment, including MAT. (Sec IV, G)
- Examine and enhance Medicaid reimbursement for substance abuse treatment services. (Sec IV, H)
- Expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose. (Sec III, A; Sec V, X)
- Explore and expand use of appropriate peer support services, with necessary oversight. (Sec IV, F)
- Expand use of the PMP. (Sec V, L)
- Increase access to naloxone by allowing pharmacists to dispense naloxone under proper protocols. (Sec III, E)
- Establish a loan forgiveness program for medical professionals who agree to participate in a residency program that meets accreditation standards established by either the American Board of Addiction Medicine, the subspecialty certification in addiction medicine of the American Board of Psychiatry and Neurology, or the Board of Osteopathic Specialties Co-Joint Board in Addiction Medicine, and who agree to practice in Virginia for at least five years. Provide additional incentives to individuals who agree to practice in Medically Underserved Areas. (Sec V, C)
- Pursue opportunities to increase the number and the capacity of drug treatment courts operating in Virginia. (Sec V, O)
- Make evidence-based substance abuse treatment, including the use of medication assisted treatment, available in local jails, focusing especially on providing the skills necessary to maintain sobriety and live successfully in the community. (Sec V, R)
- Support pregnant women and women with dependent children by coordinating responses among providers of substance abuse treatment, health care, social services and law enforcement to effectively address their substance abuse treatment needs. (Sec V, T)
- Increase capacity to treat adolescents who are abusing or are dependent on opioids. (Sec V, U)

Appendix – Data & Monitoring

Recommendations

Data and Monitoring Workgroup

- Expand mandatory PMP registration and amend mandatory use of PMP data. (Sec III, B)
- Require reporting of prescriber National Provider Identifier for prescriptions for human patients and “Species Code” as a required data element. (Sec V, K)
- Clarify that PMP data shall not be available for use in civil proceedings. (Sec III, C)
- Add Morphine Equivalent Doses per Day information to PMP patient reports to provide prescribers with information as to the cumulative amount of opioid medication a patient is currently receiving in order to gauge potential risk of overdose. (Sec III, G)
- Develop clinically-oriented criteria for unsolicited reports to prescribers on specific patients. (Sec V, J)
- Develop individual prescriber feedback reports that describe actual prescribing practices. (Sec V, E)
- Direct applicable agencies to share data on prescription drug and heroin abuse, overdoses, drug seizures, arrest information, etc. to analyze information to mitigate harm. (Sec V, F)
- Create a Health and Criminal Justice Data Committee, comprised of data analysts from applicable agencies within the Secretariats of Public Safety & Homeland Security and Health & Human Resources, to study data for the purpose of better understanding the ways in which criminal justice and public health issues intersect, with the goal of improving government responses to crises, as well as identifying and responding to concerns before they become crises. (Sec V, F)
- Reduce the timeframe in which dispensers must report to the PMP from within 7 days of dispensing to within 24 hours of dispensing. (Sec V, G)
- Expand access to PMP information on a specific patient to clinical pharmacists and consulting prescribers practicing on healthcare teams treating that specific patient. (Sec V, H)
- Clarify that PMP reports may be placed in the medical record. (Sec V, I)

Appendix – Enforcement Recommendations

Enforcement Workgroup

- Evidence-based practices should be used to provide the criminal justice system with viable alternatives to incarceration for all drug abusers. (Sec V, P)
- Enact legislation allowing prosecutors to criminally charge predatory dealers who distribute drugs which directly cause fatal overdoses. (Sec V, V)
- Expand access to naloxone for all first responders as optional, not mandatory, resource and include immunity from liability. (Sec III, A)
- As a matter of policy, if the state determines that incarceration is an appropriate punishment for addicts who have continued contact with the criminal justice system, treatment options should be made available during their periods of confinement. (Sec V, Q)
- Data on overdoses should be reported to a non-law enforcement agency whereby certain people, such as law-enforcement, would have limited access to the information (similar to the PMP). (Sec V, W)
- The Executive Branch should publicize the passage of Senate Bill 892/House Bill 1500, which provides a 'safe harbor' affirmative defense for an individual who calls 911 or notifies emergency personnel that someone in his presence is suffering from an overdose. (Sec V, EE)



Opiate Versus Opioid



Natural

codeine
morphine
*heroin

Semi-synthetic

hydrocodone
oxycodone
meperidine
hydromorphone
oxymorphone
buprenorphine

Synthetic

methadone
fentanyl
tramadol

Your body makes its own opioids which are called “endorphins.”