MSHP Annual Meeting 2016

Addressing the Opioid Crisis through a Public Health Lens

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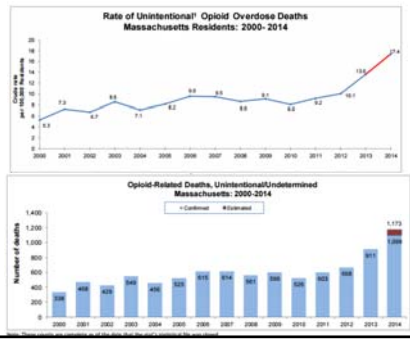
Commissioner of the Massachusetts Department of Public Health

Objectives

- Describe the current state of the opioid crisis in the Commonwealth.
- Discuss the core competencies for the prevention and management of prescription drug misuse.
- Evaluate the role of pharmacists and prescribers in the initiatives put forth by the Commonwealth.

The opioid epidemic burden in Massachusetts



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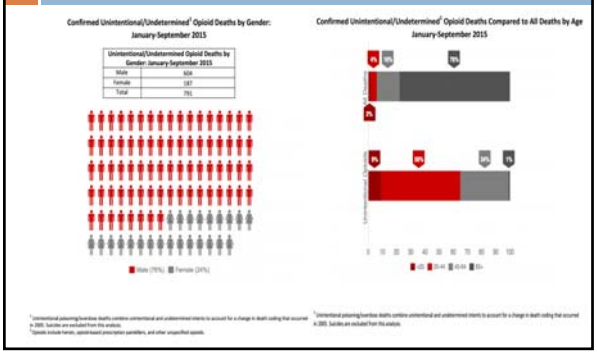

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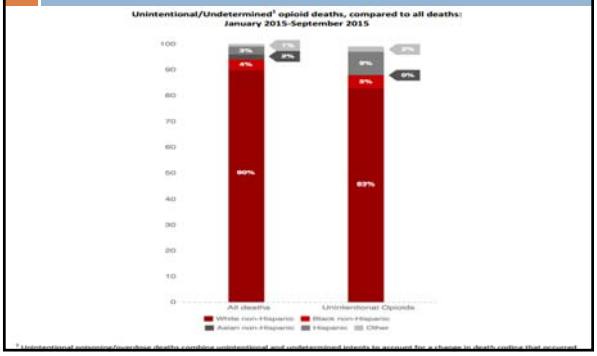


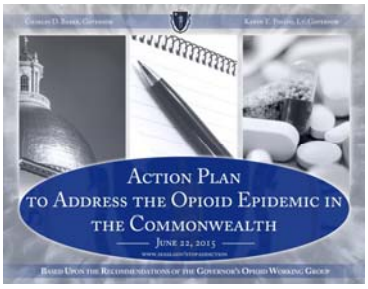
More people died in motor vehicle accidents than from opioid overdoses in 2013

A Yes

B No

Governor Baker's Opioid Working Group

Prevention Intervention Treatment Recovery



Progress To-Date

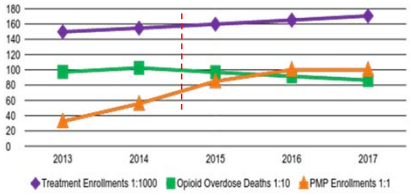
- Adding over 200 new treatment beds across the state;
- Working to redesign, redevelop and relaunch the Prescription Monitoring Program (PMP) online system;
- Passing legislation requiring pharmacists to enter data into the PMP within one business day (24 hours), down from 7 days of receipt of prescription;
- Establishment of a cross-institutional agreement by the Commonwealth's four medical schools and the Massachusetts Medical Society in developing a first-in-the-nation, cross-institutional set of core competencies that will be incorporated in all of the medical school's curriculum for medical students, ensuring critical and necessary best practices for prescription drug use and management are taught;
- Establishment of a cross-institutional agreement by the Commonwealth's three dental medicine schools and the Massachusetts Dental Society mirroring the medical schools in developing a cross-institutional set of core competencies;
- Holding Drug Take-Back Day at 133 sites across the Commonwealth to collect unused prescription drugs for safe disposal;
- Convening of the state's Drug Formulary Commission;
- Reinforcing the requirement that all DPH licensed addiction treatment programs must accept patients who are on methadone or buprenorphine medication;
- Planning for the transfer of women civilly committed under Section 35 at MCI Framingham to Taunton State Hospital by Spring 2016;
- Issuance of Division of Insurance guidelines to commercial insurers on the implementation of the substance use disorder recovery law (Chapter 258) which requires insurers to cover the cost of medically necessary clinical stabilization services for up to 14 days without prior authorization;
- Improving the affordability of naloxone for all 351 Massachusetts communities through a state bulk purchasing arrangement;
- Strengthening the state's commitment to residential recovery programs through rate increases

Substance Use Disorders: Addressing Opioid Overdoses

Vision: Curb the rate of increase of opioid related overdose deaths.

Goal: Decrease the number of opioid overdose deaths through a multi-prong approach, including increasing the number of providers actively using the Prescription Monitoring Program by 80%; increase enrollments for services by 10%.

Rationale: Factors contributing to opioid overdose deaths include limited access to treatment and prescription drug abuse.



Notes: Estimated opioid related overdose deaths based on 5% annual decrease.
PMP estimates only includes providers and not delegates.

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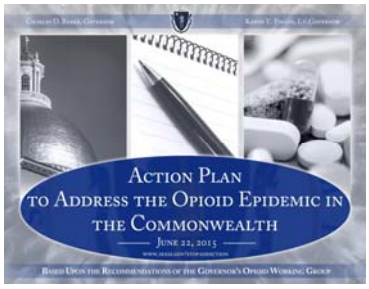
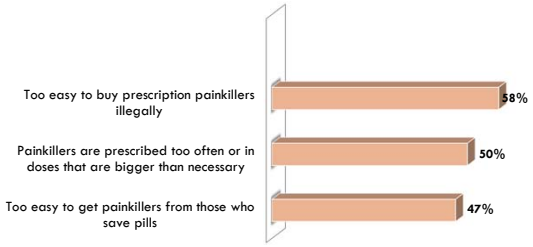


Survey: reason for prescription painkiller misuse



Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

Framing Core Competencies

- **Core competencies are framed from the perspective of an encounter with a patient** who typically presents with pain (including dental or orofacial) and/or other symptoms for which a prescription medication with the potential for misuse may be indicated.
- **The goal of the stated core competencies is to support future prescribers**, over the course of their education and at the time prescribing habits are being formed, with both skills and a foundational knowledge in the *prevention* of prescription drug misuse, serving as a vital bridge between student education and residency training and/or practice.
- **The Working Groups recognizes these competencies as integral to the abilities of all students, residents, and practicing prescribers** to safely and competently prescribe prescription drugs, and to successfully prevent, identify, and treat substance use disorders.

Medical Core Competencies: Primary Prevention Domain

❑ **Preventing Prescription Drug Misuse:** *Screening, Evaluation, and Prevention*

1. Evaluate a patient's pain using age, gender, and culturally appropriate evidence-based methodologies.
2. Evaluate a patient's risk for substance use disorders by utilizing age, gender, and culturally appropriate evidence-based communication skills and assessment methodologies, supplemented with relevant available patient information, including but not limited to health records, family history, prescription dispensing records (e.g. the Prescription Drug Monitoring Program or "PMP"), drug urine screenings, and screenings for commonly co-occurring psychiatric disorders (especially depression, anxiety disorders, and PTSD).
3. Identify and describe potential pharmacological and non-pharmacological treatment options including opioid and non-opioid pharmacological treatments for acute and chronic pain management, along with patient communication and education regarding the risks and benefits associated with each of these available treatment options.

Medical Core Competencies: Secondary Prevention Domain

❑ **Treating Patients At-Risk for Substance Use Disorders:** *Engage Patients in Safe, Informed, and Patient-Centered Treatment Planning*

4. Describe substance use disorder treatment options, including medication-assisted treatment, as well as demonstrate the ability to appropriately refer patients to addiction medicine specialists and treatment programs for both relapse prevention and co-occurring psychiatric disorders.
5. Prepare evidence-based and patient-centered pain management and substance use disorder treatment plans for patients with acute and chronic pain with special attention to safe prescribing and recognizing patients displaying signs of aberrant prescription use behaviors.
6. Demonstrate the foundational skills in patient-centered counselling and behavior change in the context of a patient encounter, consistent with evidence-based techniques.

Medical Core Competencies: Tertiary Prevention Domain

❑ **Managing Substance Use Disorders as a Chronic Disease:** *Eliminate Stigma and Build Awareness of Social Determinants*

7. Recognize the risk factors for, and signs of, opioid overdose and demonstrate the correct use of naloxone rescue.
8. Recognize substance use disorders as a chronic disease by effectively applying a chronic disease model in the ongoing assessment and management of the patient.
9. Recognize their own and societal stigmatization and biases against individuals with substance use disorders and associated evidence-based medication-assisted treatment.
10. Identify and incorporate relevant data regarding social determinants of health into treatment planning for substance use disorders.

Most individuals who use prescription opioids non-medically obtain the pills from a drug dealer or stranger.

A True

B False

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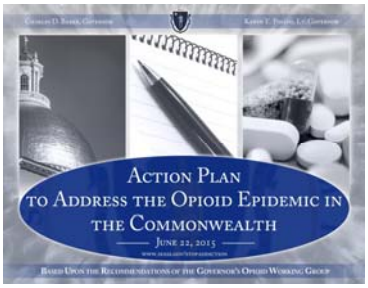
Prevention Intervention Treatment Recovery



Opioid misuse education

#State Without StigMA

HelpLine
1-800-327-5050

Quantity of Prescriptions, Annually

This table includes all Schedule II and III opioid prescriptions dispensed and reported to the MA Online PMP, for both in- and out-of-state residents.

CY 2011-2014 Schedule II and III Opioids (# Prescriptions & Solid Quantity)		
Calendar Year	# Prescriptions	Solid Quantity
2011	4,617,213	259,987,388
2012	4,813,484	270,482,258
2013	4,770,214	268,458,043
2014	4,664,391	256,725,851

Quantity of Prescriptions, Annually

MA Prescription Monitoring Program County-Level Data Measures
(Calendar Year 2015 Quarter 3)

County (County classifications are by patient zip code; patient state must also = MA)	Census Population	Total Schedule II Opioid Prescriptions	Total Number of Schedule II Opioid Solid Dosage Units	Individuals Receiving Schedule II Opioid Prescription	% of Individuals Receiving Schedule II Opioid Prescription (of total population)	Individuals with Activity of Concern	Rate of Individuals with Activity of Concern (per 1,000)
Barnstable	214,990	38,668	2,265,034	17,236	8.0	50	2.9
Berkshire	130,016	21,759	1,159,681	9,201	7.1	16	1.7
Bristol	552,780	105,646	6,417,793	43,996	8.0	80	1.8
Dukes	17,256	2,998	184,103	1,430	8.3	<5	NR
Essex	762,550	106,631	5,819,688	49,471	6.5	84	1.7
Franklin	71,221	13,249	761,731	5,424	7.6	<5	NR
Hampden	467,319	89,679	5,239,295	37,932	8.1	71	1.9
Hampshire	159,586	23,490	1,490,259	9,585	6.0	11	1.1
Middlesex	1,552,802	153,631	8,453,458	76,147	4.9	110	1.4
Nantucket	10,399	1,851	69,432	820	7.9	0	0.0
Norfolk	681,845	83,522	4,879,055	39,537	5.8	74	1.9
Plymouth	501,919	81,352	4,852,146	36,950	7.4	78	2.1
Suffolk	755,503	74,212	4,489,042	35,244	4.7	60	1.7
Worcester	809,196	124,143	8,036,139	54,511	6.7	87	1.6
MA	6,745,408	920,631	54,107,443	417,486	6.2	725	1.7

Note1: Individuals with activity of concern "thresholds" for this report are based ONLY on a 3-month time period; see notes on previous page; CY15-Q3
Note2: Counts greater than 0 but less than or equal to 5 are not reported. Rates based on these small values also are not reported (NR).

Reversing an Overdose: Use of Naloxone

Three Key Stakeholders in Naloxone Expansion

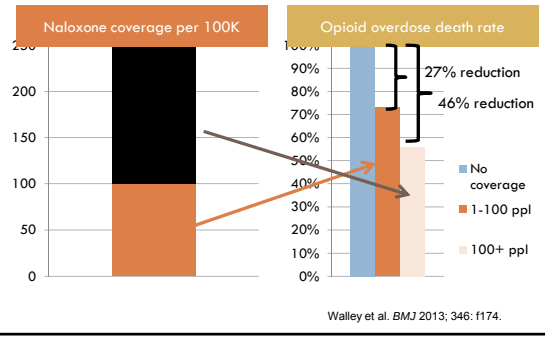
- Bystanders
- First Responders
- Pharmacies/Prescribers

Bystander program model

- One statewide medical director who authorizes the training and distribution under a standing order.
- The naloxone is purchased by the DPH State Office of Pharmacy Services with funds from the DPH Bureau of Substance Abuse Services under the Medical Director's license.
- Programs receive naloxone and atomizers from DPH BSAS program.
  - Assemble kits, and then train/distribute.
  - Full kit is two doses, two nasal atomization delivery devices, and instructions for use.

- Training includes how to reduce risk and prevent an overdose, recognize signs of an overdose, access emergency medical services, and administer intra-nasal naloxone.
- Bystanders are instructed to deliver naloxone when opioid overdose occurs in addition to other prevention/intervention. After being trained, each participant receives a naloxone kit.

Fatal opioid overdose rates reduced where OEND implemented



Walley et al. *BMJ* 2013; 346: f174.

Three Key Stakeholders in Naloxone Expansion

- Bystanders
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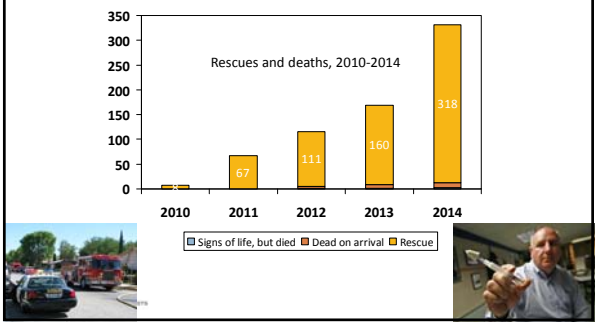
First responders model

- In emergency situations, historically only paramedics have administered naloxone via injection in the event of an overdose.
- 2005, the Boston EMS applied for a Special Project Waiver from the DPH Office of Emergency Medical Services (OEMS)
  - allow EMT's to administer naloxone via intra-nasal spray.
  - first use of intra-nasal administered naloxone in Massachusetts.
- 2010 DPH began a pilot program to equip First Responders with intra-nasal naloxone.
- 2014 regulations amended to allow first responders to carry naloxone with medical director oversight

Police & Fire naloxone rescues 2010-2014(Massachusetts DPH First Responder Pilot)



Prescribers and Pharmacists

- Bystanders
- First Responders
- Pharmacies/Prescribers

Pharmacies and prescribers model

- Historically, writing a prescription for naloxone to a person at risk of an overdose not common clinical practice and pharmacies were not equipped to fill prescriptions for naloxone.
- Some inpatients, emergency departments, health centers developed standing orders for hospital pharmacies to furnish naloxone on discharge
- 2014: DPH regulation change to permit standing order narcan in pharmacies
  - Allow pharmacists to establish a standing order with a prescriber for dispensing naloxone rescue kits.
- MassHealth and other insurers cover prescriptions for naloxone.
- When a pharmacy has an established standing order for naloxone, customers do not need a prescription to be dispensed a naloxone rescue kit. The customer's insurance will be billed and a co-pay or full price will be charged depending on the insurance coverage.

Naloxone (i.e. Narcan) use results in a 46% reduction in opioid overdose deaths in communities.

A True

B False

Other Highlighted Progress to date

- Redesigning, redeveloping and relaunching the Prescription Monitoring Program (PMP) online system;
- Passing legislation requiring pharmacists to enter data into the PMP within one business day (24 hours), down from 7 days of receipt of prescription;
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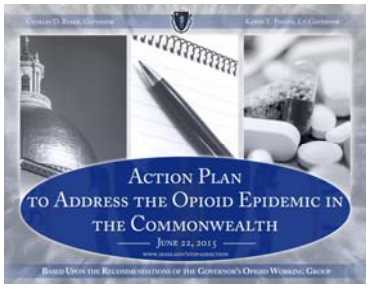
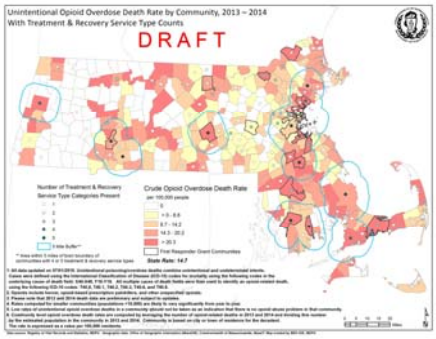


Hotspotting: Unintentional Opioid Death Rate by Community, with Treatment counts



Treatment and Recovery: Progress To-Date

- Adding over 200 new treatment beds across the state;
- Planning for the transfer of women civilly committed under Section 35 at MCI Framingham to Taunton State Hospital by Spring 2016;
- Reinforcing the requirement that all DPH licensed addiction treatment programs must accept patients who are on methadone or buprenorphine medication;
- Strengthening the state's commitment to residential recovery programs through rate increases retroactive to July 1, 2016.
- Issuance of Division of Insurance guidelines to commercial insurers on the implementation of the substance use disorder recovery law (Chapter 258) which requires insurers to cover the cost of medically necessary clinical stabilization services for up to 14 days without prior authorization;

Substance Use, Treatment, Education and Prevention Law (STEP)

Ch. 52 of the Acts of 2016

- Requires on a 7 day supply for an opiate prescription; allows for a pharmacist to fill for lesser amount than the prescription is written for
- Allows the Municipal Police Training Committee to establish a course within the recruit basic training curriculum to train offers on procedures for response to calls for assistance on drug related overdoses
- Amends the Civil Liberties law so that any person who administers naloxone is not liable for injuries resulting from the injection
- Effective July, Anyone presenting to ER suffering from an OD shall receive prior to discharge and within 24 hours a substance abuse evaluation
- Changes the law under section 35 that a warrant shall continue for up to 5 consecutive days or until an individual is brought before the court; whichever is sooner

Key Takeaways

- We must treat opioid misuse as a disease, and the current opioid crisis as a public health issue
  - Ensuring appropriate prevention, intervention, treatment, and recovery options is key
- Prescriber education has been a priority for DPH and this administration
  - Core competency education agreements have been signed by medical and dental schools, with more stakeholders coming