Washington State Department of Health

Addressing Opioid Misuse and Abuse in Washington State

Washington State Board of Health
October 12, 2016

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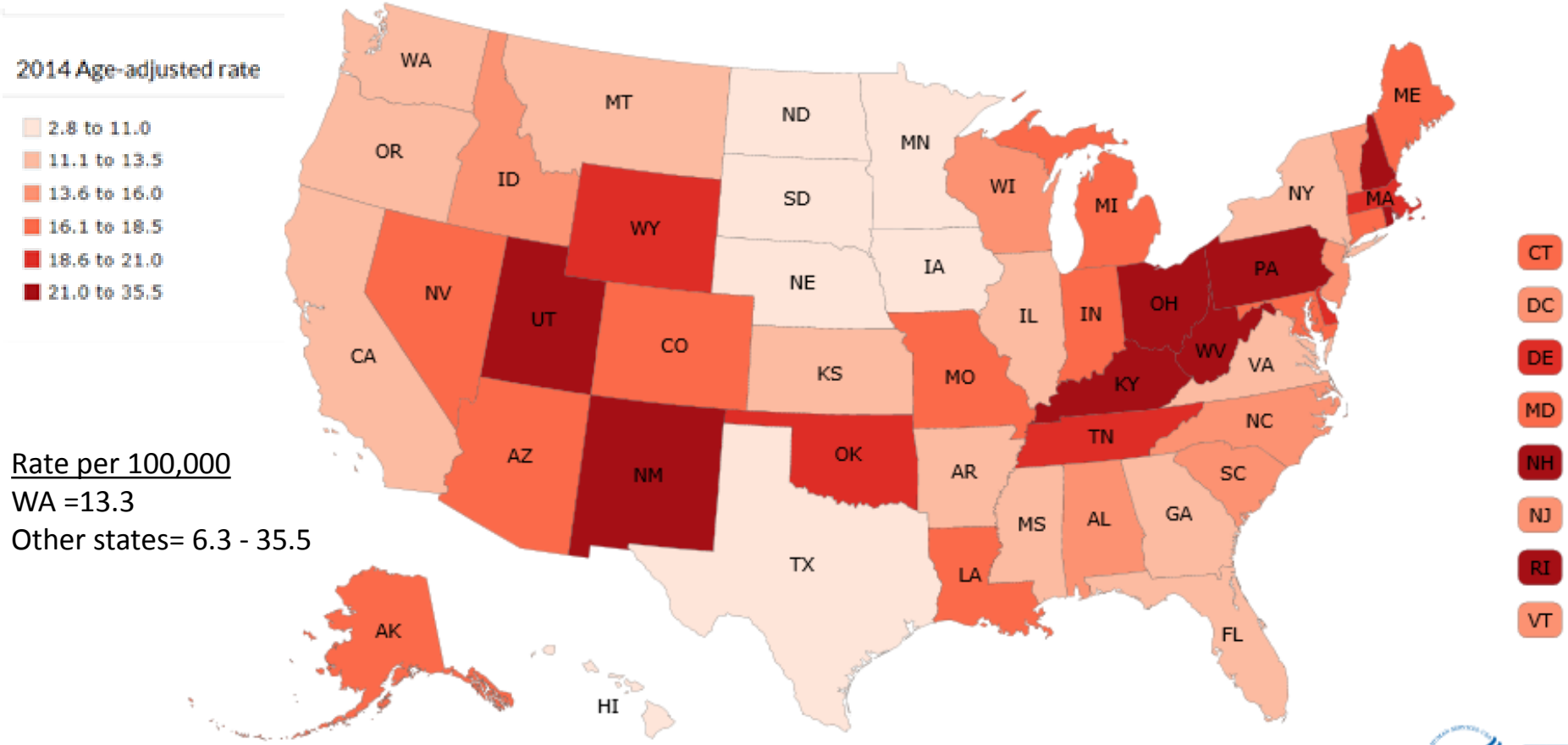
PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

Overview

- Opioid epidemic
  - ✓ Trends in morbidity and mortality
  - ✓ Relationship between prescription opioids & heroin
- State Opioid Response Plan
- Governor's Executive Order
- Policy considerations for 2017 legislative session
- How can the State Board of Health help?

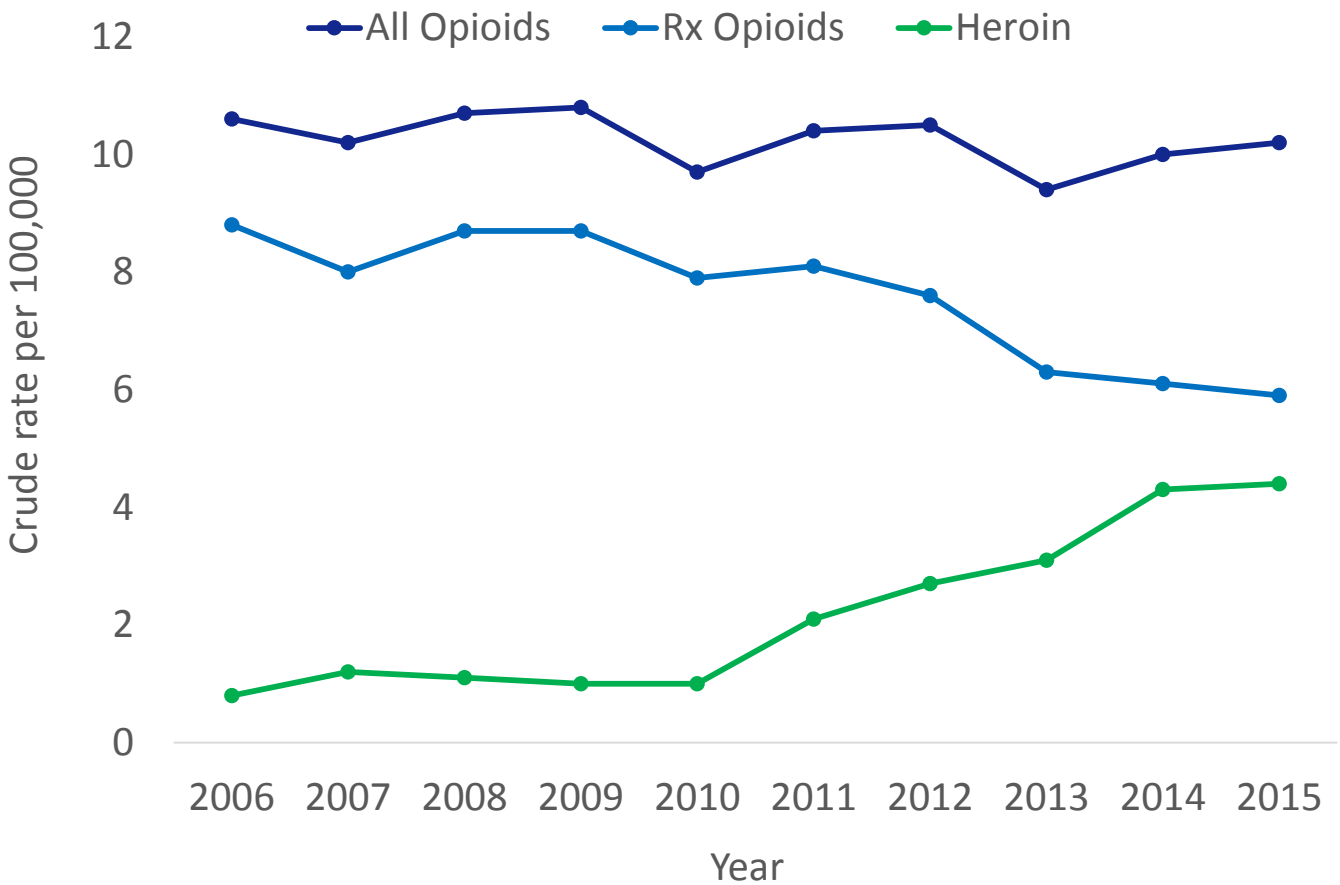
Age-adjusted Rates of Drug Overdose Deaths by State, US 2014



Rate per 100,000
WA =13.3
Other states= 6.3 - 35.5

Source: SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

Trends in the Rate of Opioid Overdose Deaths*, WA State 2006–2015



718 deaths in 2015

Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

Note: Intentional self-poisonings account for ~9% of all opioid overdose deaths

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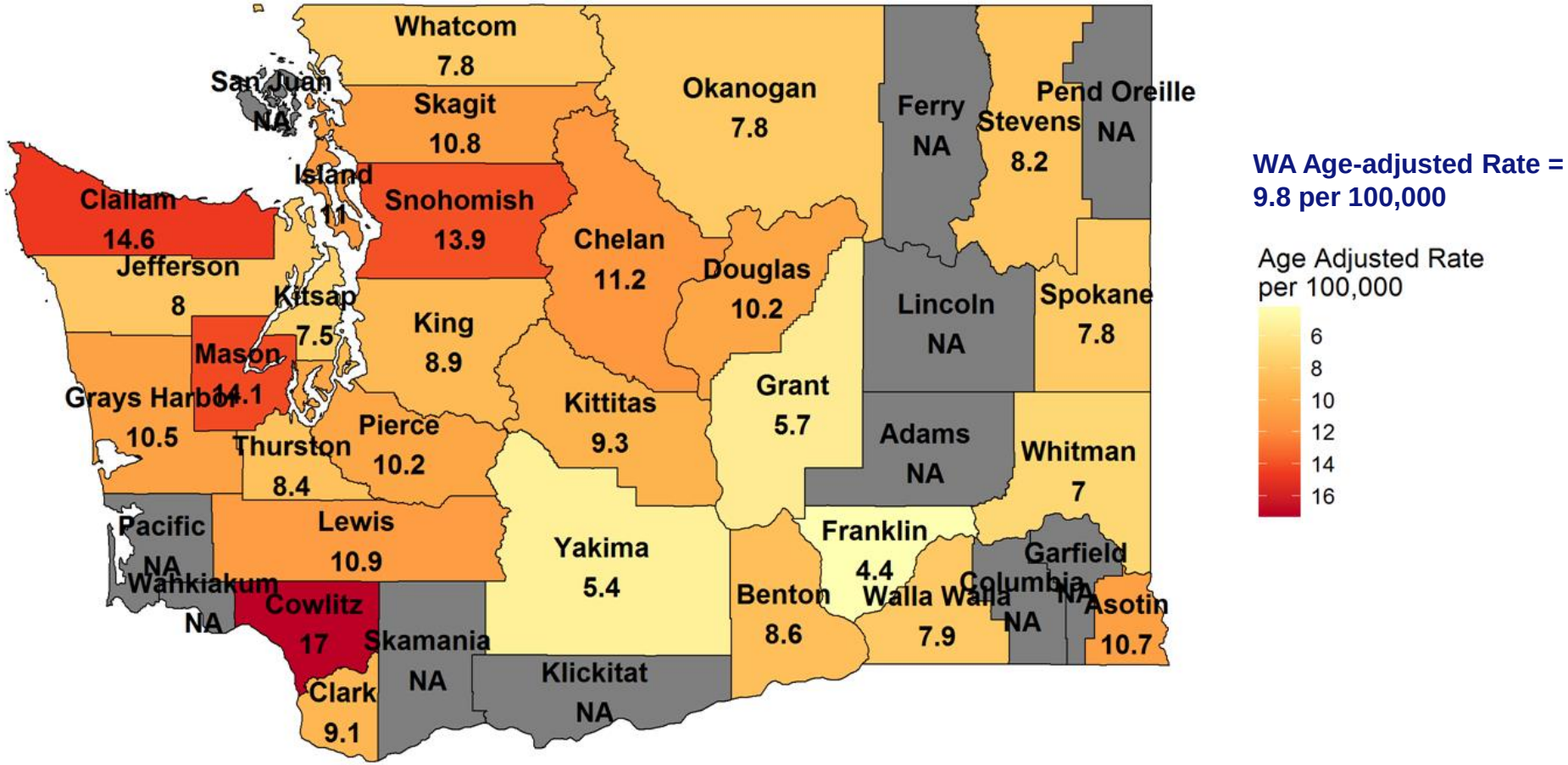
Rates of Opioid Overdose Deaths* by County of Residence, 2011–2015



Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

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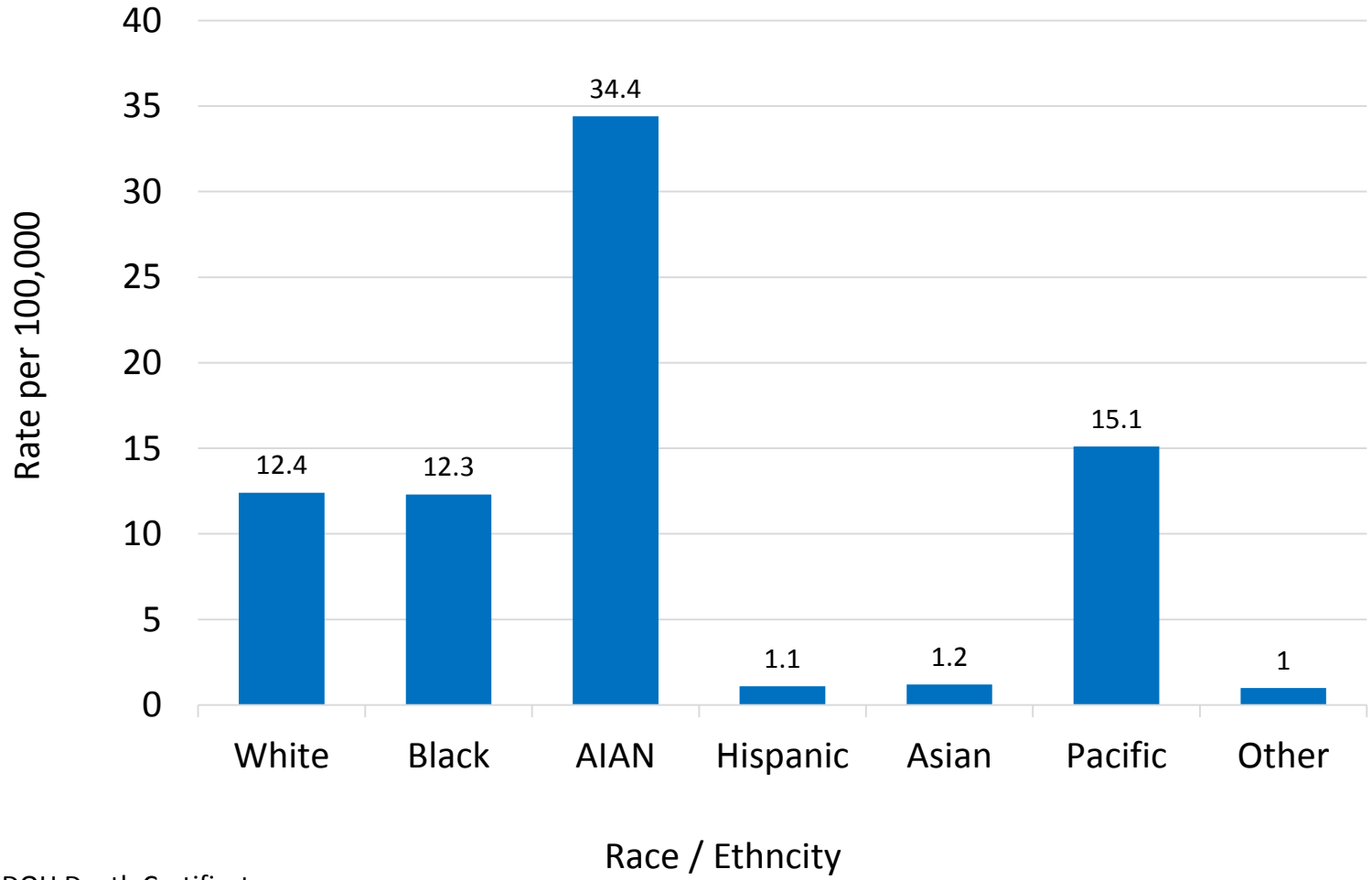
Rates of Opioid Overdose Deaths by Race/Ethnicity, WA State 2011–2015



Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

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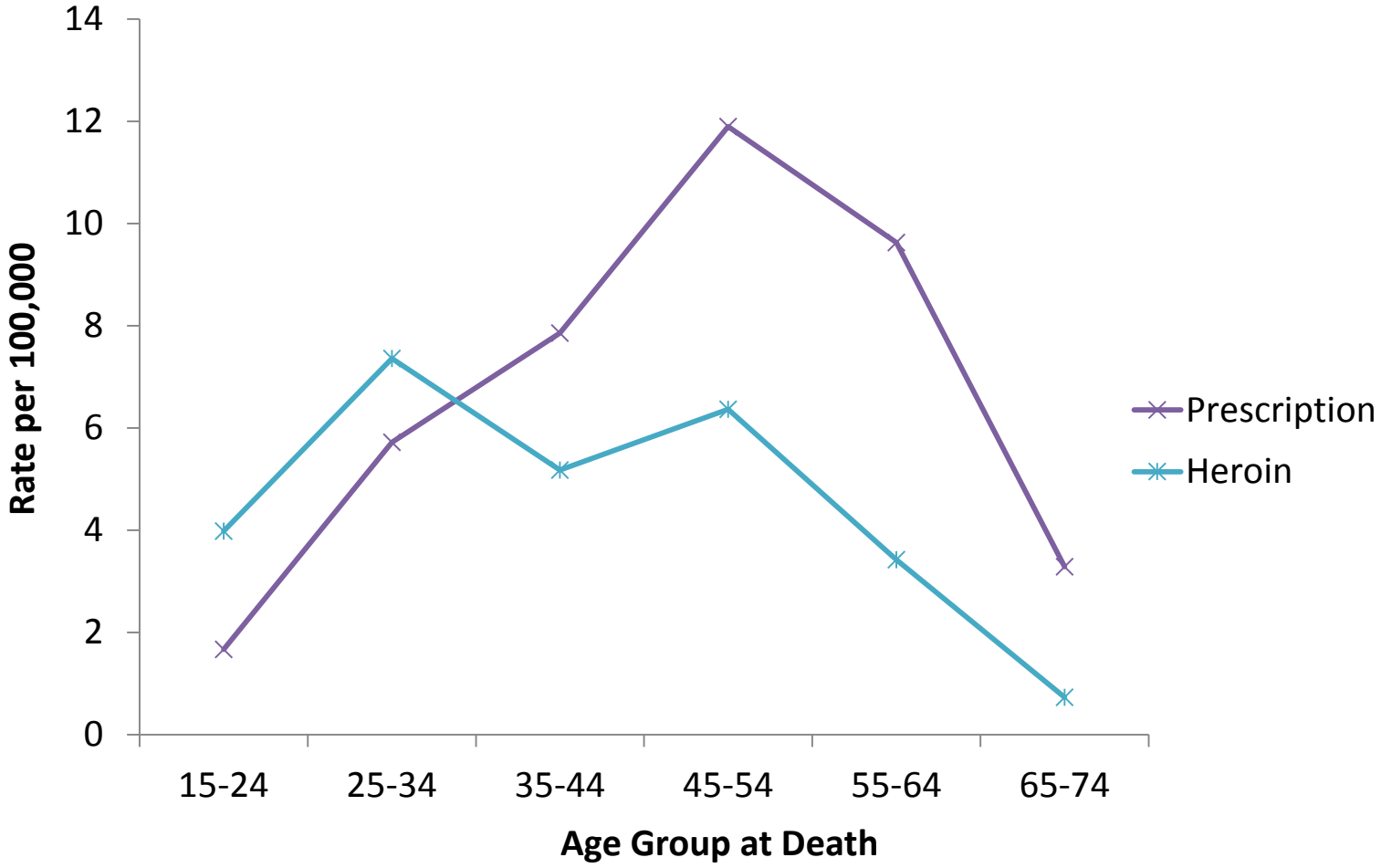
Rates of Unintentional Opioid Overdose Deaths by Age Group, WA 2012–14



Source: DOH Death Certificates, methodology identifies opioid deaths using both ICD-10 codes and the literal text on the death certificate, and excludes intentional deaths due to opioid overdose

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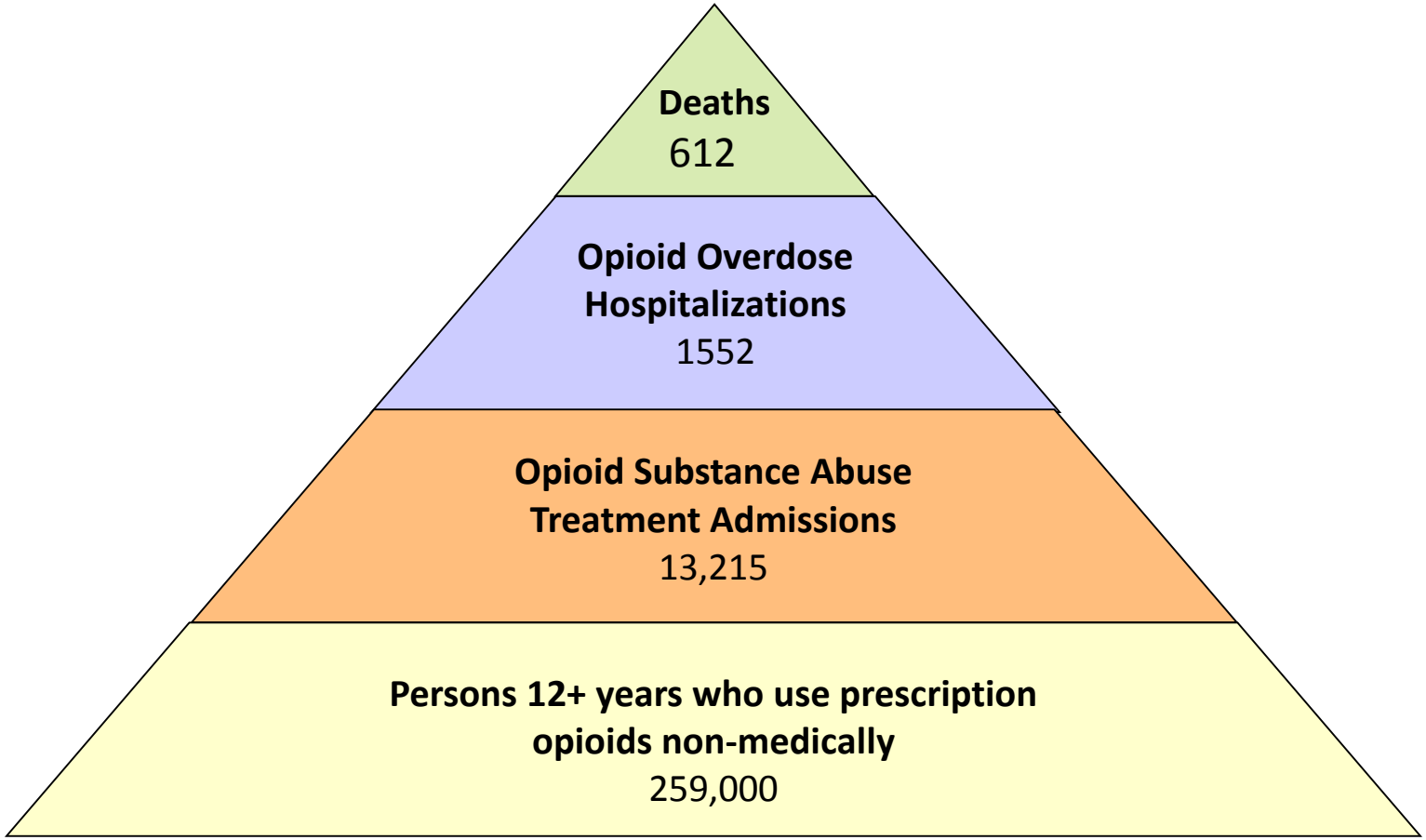
Opioid-related Disease Burden in WA



1. Opioids involved in an unintentional overdose death listed as underlying cause of death. Washington State death certificate data, 2014.
2. Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) and Oregon State Hospital Discharge Data , 2014.
3. Treatment and Assessment Report Generation Tool, 2014
4. National Survey on Drug Use and Health, 2013-2014

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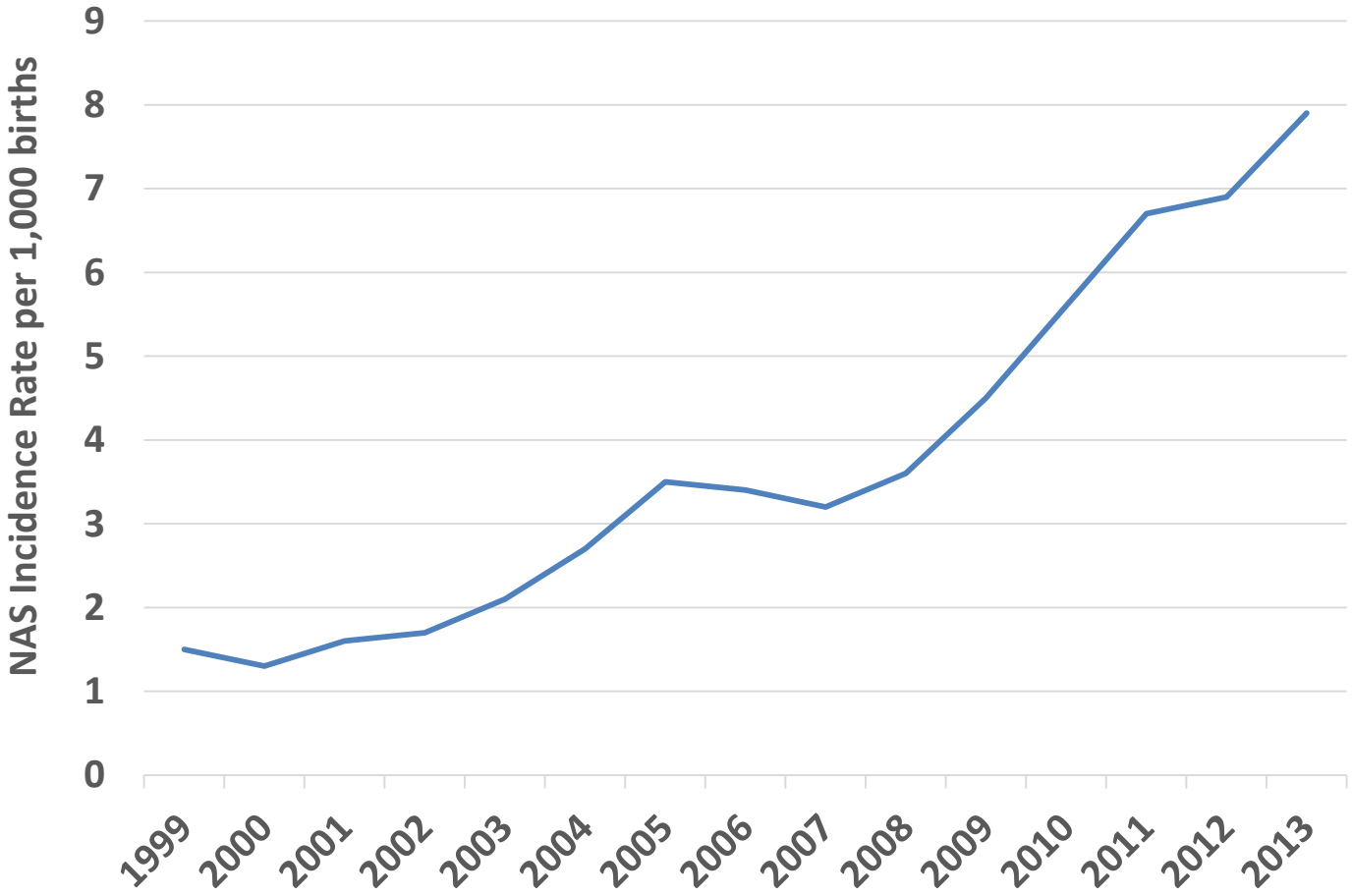
Neonatal Abstinence Syndrome Incidence Rates per 1,000 Hospital Births, WA 1990–2012



Source: MMWR 2016;65(31):799-802.

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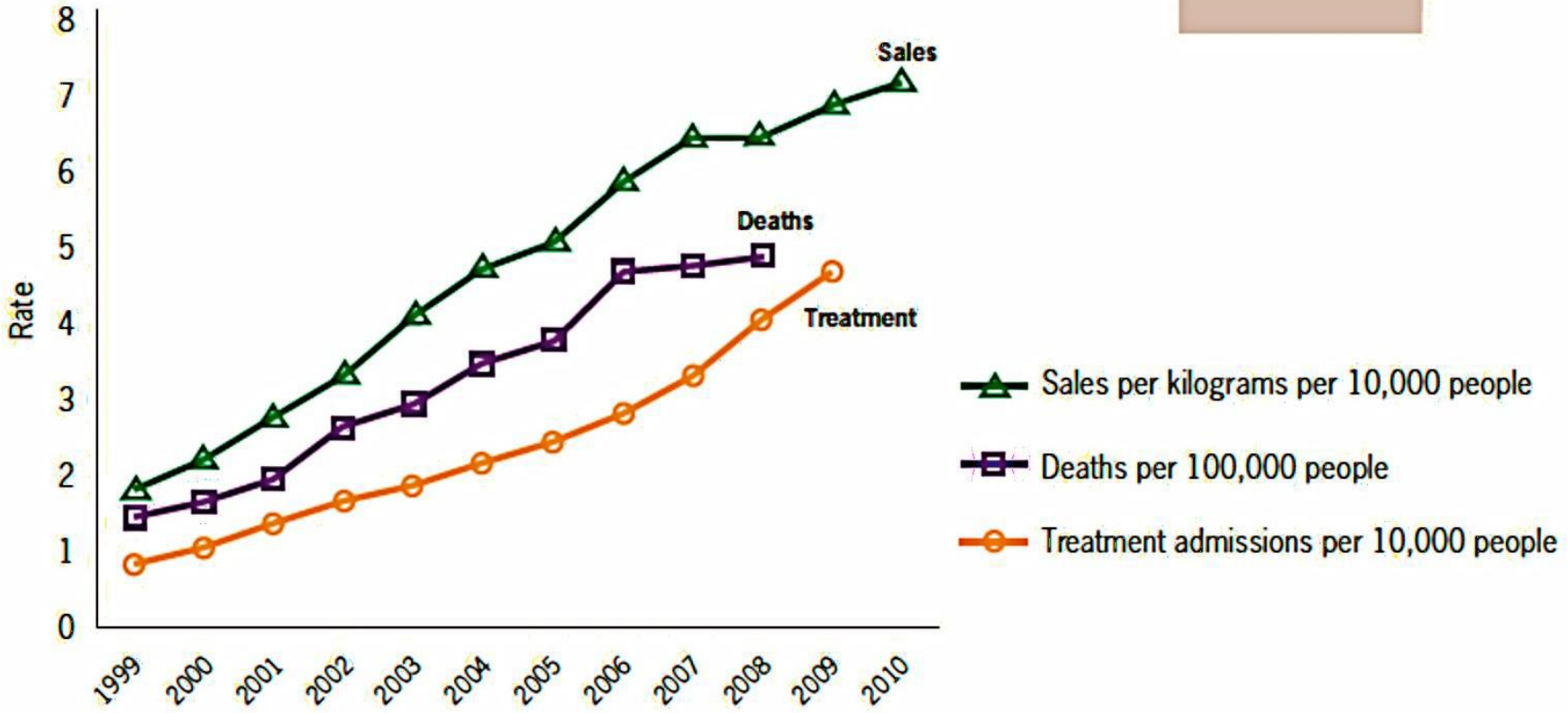
Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

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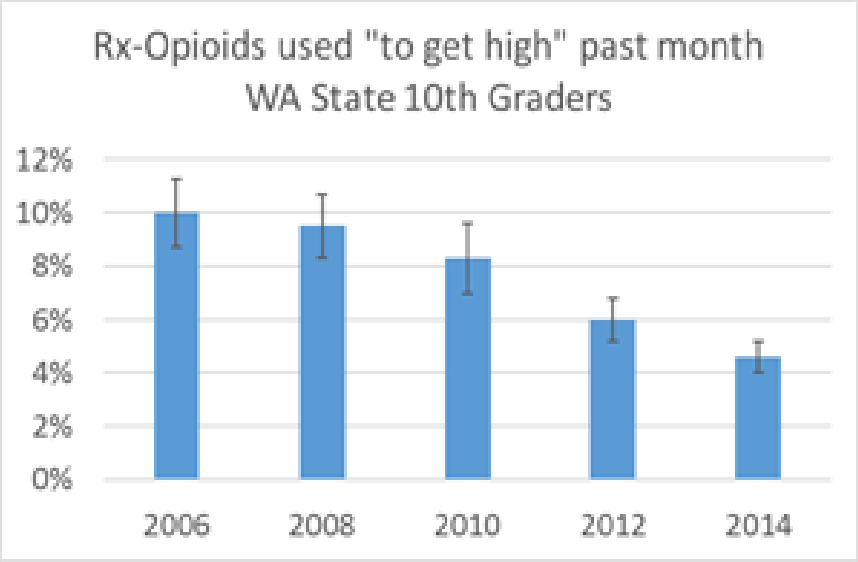
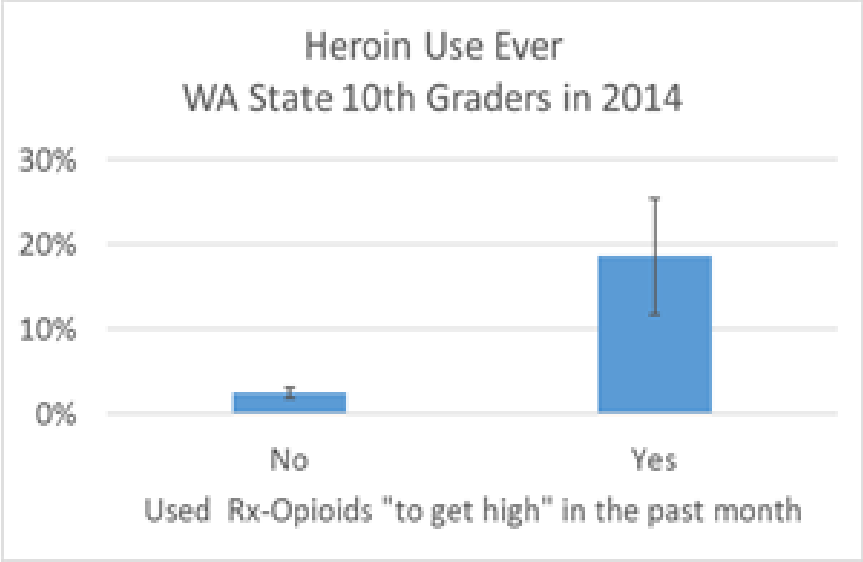
Opioid Use among Youth in Washington, 2006–2014

Trends in the use of Rx-type opiates to "get high" among 10th graders and the association with heroin use

The proportion of 10th graders reporting using prescription-type opioids to get high in the past month declined significantly from 10% to 5% from 2006-2014



Among 10th graders those who reported they had used prescription-type opioids to get high in the past month 19% had ever used heroin, compared to 3% among those not using prescription-type-opioids to get high.



SOURCE: Healthy Youth Survey, analysis Alcohol and Drug Abuse Institute, University of Washington

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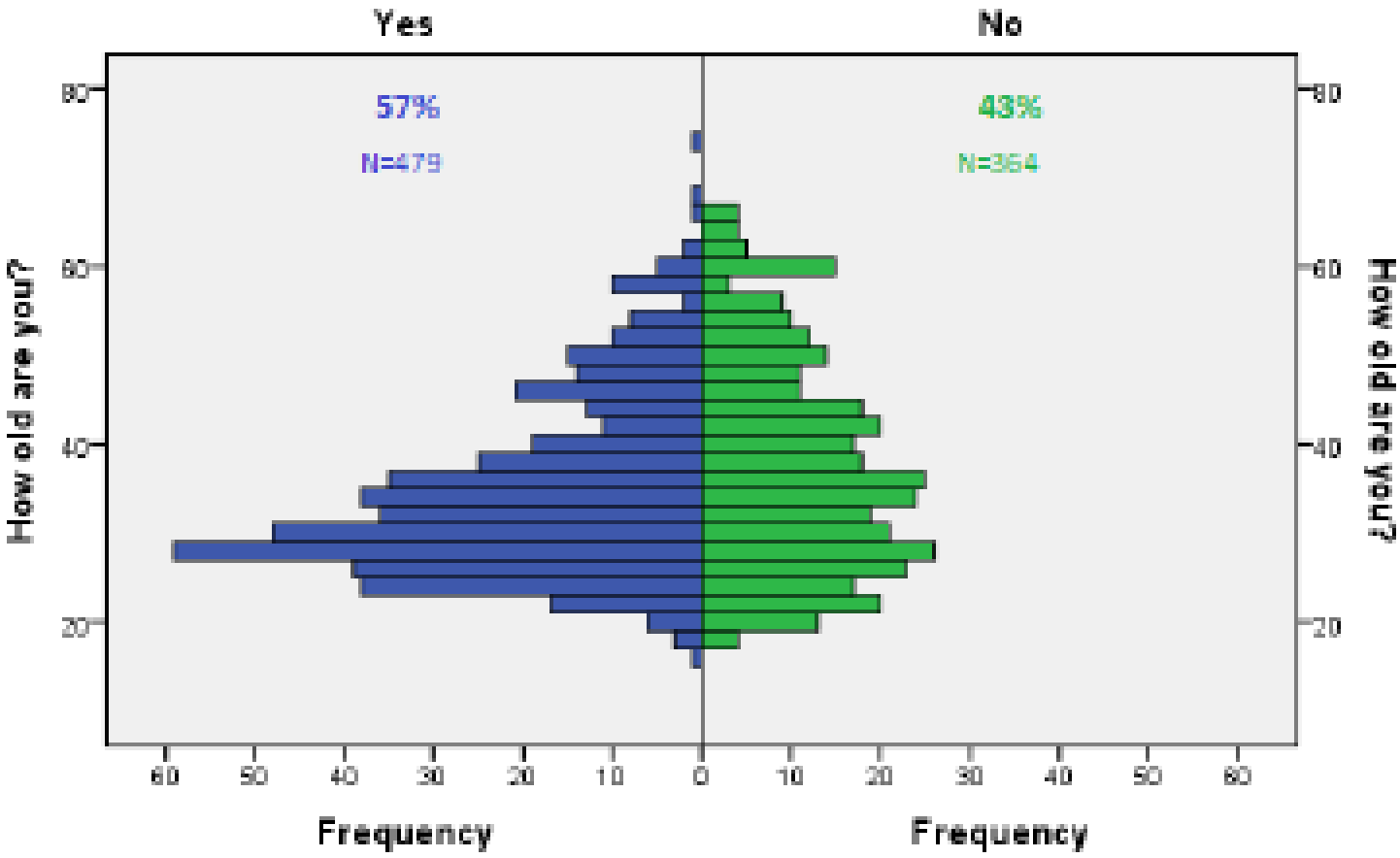
“Before you began using heroin were you hooked on prescription-type opiates?”



Source: UW Alcohol and Drug Abuse Institute, Results from the 2015 Washington State Drug Injector Health Survey (http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf)

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Prescription Opioids in Adolescence and Future Opioid Misuse

- Monitoring the Future prospective study
- Surveyed 12th graders and followed them through age 23 (n=6220)
- Legitimate opioid use before high school graduation independently associated with 33% increased risk of future opioid misuse
- Association concentrated among individuals with little drug experience and disapproval of illegal drug use at baseline

Source: Miech, et al. Prescription Opioids in Adolescence and Future Opioid Misuse. Pediatrics 2015;136(5):e1169-77.

Unintentional Poisoning Work Group

- Established in 2008 by the Department of Health
- Currently, co-lead by:
  - ✓ Department of Health
  - ✓ DSHS Division of Behavioral Health and Recovery
  - ✓ Health Care Authority
  - ✓ UW Alcohol and Drug Abuse Institute
- Open to any partners who want to participate
- Led development of State Opioid Response Plan during 2015; began implementation in 2016

Other Washington Opioid Initiatives

- King County Heroin & Rx Opioid Task Force
- WSHA/WSMA Opioid Task Force
- Olympic Peninsula Coordinated Opioid Response
- Many other local initiatives

State Opioid Response Plan

Priority Goals

GOAL 1: Prevent opioid misuse and abuse.	GOAL 2: Treat opioid dependence.	GOAL 3: Prevent deaths from overdose.	GOAL 4: Use data to monitor and evaluate.
Improve prescribing practices.	Expand access to treatment.	Distribute naloxone to people who use heroin.	Optimize and expand data sources.

Priority Actions

Leads:
Department of Labor & Industry, DSHS Division of Behavioral Health and Recovery

Lead:
DSHS Division of Behavioral Health and Recovery

Lead:
UW Alcohol & Drug Abuse Institute

Lead:
Department of Health

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State Opioid Response Plan *(continued)*

GOAL 1: Prevent opioid misuse and abuse.		
STRATEGY 1: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain.	**Lead Party**	**Status**
Educate health care providers on Agency Medical Directors' Group *Interagency Guideline for Prescribing Opioids for Pain* and the *Washington Emergency Department Opioid Prescribing Guidelines* to ensure appropriate opioid prescribing.	L&I	Ongoing
Promote the use of the Prescription Drug Monitoring Program (PMP), including use of delegate accounts, among health care providers, to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access.	DOH, Bree	Ongoing
Train, coach and offer consultation with providers on opioid prescribing and pain management (e.g., TelePain video-conferencing and e-newsletters.	HCA, COSE	Ongoing
Partner with professional associations and teaching institutions to educate dentists, osteopaths, nurses and podiatrists on current opioid prescribing guidelines.	COSE, Bree	Ongoing
Build enhancements in the electronic medical record systems to default to recommended dosages, pill counts, etc.	Bree	Ongoing
Require health plans contracted with the Health Care Authority to follow best practice guidelines on opioid prescribing.	Bree, HCA	Ongoing

State Opioid Response Plan *(continued)*

GOAL 4: Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.		
STRATEGY 1: Improve PMP functionality to document and summarize patient and prescriber patters to inform clinical decision making.	**Lead Party**	**Status**
Increase PMP reporting frequency by pharmacies from weekly to daily to reduce the lag between opioid dispensing and viewing the prescription in the PMP from 20 to 4 business days.	DOH	Ongoing
Provide easy access to the PMP data for providers through electronic medical record systems.	DOH	Ongoing
Reduce current policy and technical barriers to enable sharing of PMP data with border states	DOH	Ongoing
Consider providing MED calculations within the P)MP for chronic opioid patients with automated program alerts for providers.	DOH	Ongoing
Explore options to require health care systems to connect to the PMP through the statewide electronic health information exchange.	DOH	Ongoing

Executive Order on Opioids

- Announced October 7, 2016
- Well-aligned with the state response plan, CDC opioid prescribing guidelines, and National Governors Association Compact
- Focused on highest priority actions needed to address public health issue

National Governors Association

A Compact to Fight Opioid Addiction

Governors have long been at the forefront of efforts to prevent and treat opioid addiction, working with health care providers, law enforcement and other stakeholders to mount a comprehensive response to the opioid crisis. Although there has been progress in recent years, inappropriate opioid prescribing continues to fuel one of the deadliest drug epidemics in our nation's history, claiming the lives of 78 people every day. More Americans died from drug overdoses in 2014 than in any year on record. Driven by a spike in opioid-related deaths, drug overdose now surpasses motor vehicle crashes as the leading cause of injury death in the United States. While most opioid-related overdoses involve prescription painkillers, an increasing number are linked to heroin and fentanyl, a powerful synthetic opioid often packaged and sold as heroin. The consequences of the opioid epidemic continue to reverberate through society, ruining lives, devastating families and overwhelming the health care system, law enforcement and social services.

During the 2016 NGA Winter Meeting, governors agreed that collective action is needed to end the opioid crisis. With more lives lost every day, governors are redoubling their efforts to combat the epidemic with bold and thoughtful new strategies. While states play a central role in ending this public health and safety emergency, they cannot do it alone. Turning the tide on the epidemic requires a coordinated response across all levels of government and strong leadership from the private sector, including opioid manufacturers and prescribers.

With this compact, the undersigned commit to build on their efforts to fight opioid addiction by:

- **Taking steps to reduce inappropriate opioid prescribing, which may include:**
  - Partnering with health care providers to develop or update evidence-based opioid prescribing guidelines, which may be informed by CDC's guideline, and considering prescription limits with exceptions for certain patients and circumstances;
  - Requiring that physicians, osteopaths, nurse practitioners, physician assistants, dentists, veterinarians and all other opioid prescribers receive education on pain management, opioid prescribing and addiction throughout their training and careers;
  - Integrating data from state prescription drug monitoring programs (PDMPs) into electronic health records and requiring PDMP use by opioid prescribers and dispensers; and
  - Reducing payment and administrative barriers in Medicaid and other health plans to promote comprehensive pain management that includes alternatives to opioid painkillers.
- **Leading efforts to change the nation's understanding of opioids and addiction, which may include:**
  - Developing a communications strategy through the governor's office to raise awareness about the risks of abuse associated with opioid use and reduce the stigma of addiction;
  - Establishing social media campaigns and integrating education into schools, athletic programs and other community-based settings to raise awareness about opioid abuse and addiction among youth and other at-risk groups; and
  - Partnering with professional associations to improve understanding of the disease of addiction among health care providers and law enforcement.

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Bree Collaborative Work Group

- Purpose is to implement the AMDG / CDC opioid prescribing guidelines
- Focus on appropriate prescribing of opioids for acute pain, particularly in adolescents
  - ✓ Only prescribing opioids when appropriate
  - ✓ Only prescribing # of pills needed for acute pain
- Work group, in collaboration with partners, developing set of prescribing metrics

Number of days supplied for opioid prescriptions

DAYS SUPPLIED PER PATIENT DURING THE YEAR
STATE AVERAGE VS. LOWEST AND HIGHEST PATIENT RESIDENTIAL AREAS

FEMALE PATIENTS

Age	Lowest Residential Area		State Avg	Highest Residential Area		High/ Low
2–6	Bellevue	5.5	11.2	19.6	Edmonds	3.5 x
7–11	Bellevue	6.1	11.2	35.0	Vancouver	5.7 x
12–19	Enumclaw	6.3	11.1	45.7	Port Angeles	7.3 x
20–44	Bellevue	27.7	56.0	165.0	Moses Lake	6.0 x
45–64	Pullman	47.7	84.1	156.3	Forks	3.3 x

MALE PATIENTS

Age	Lowest Residential Area		State Avg	Highest Residential Area		High/ Low
2–6	Bellevue	6.0	11.5	22.7	Edmonds	3.8 x
7–11	Bellevue	5.5	9.5	15.7	Port Angeles	2.9 x
12–19	Coupeville	5.5	9.0	20.8	Clarkston	3.7 x
20–44	Toppenish	27.4	51.7	170.1	Aberdeen	6.2 x
45–64	Bellevue	44.7	75.6	161.4	Aberdeen	3.6 x

Washington Health Alliance

Different Regions, Different Care: A Report on Procedure Rate Variation in Washington State

August 2016

(http://wahealthalliance.org/wp-content/uploads.php?link-year=2016&link-month=08&link=2016-different-regions-different-care-report.pdf)

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Sources of Prescription Opioid Pain Relievers by Frequency of Past-year Non-medical Use: US, 2008–2011

Table 2. Source of Opioid Pain Reliever Most Recently Used by Frequency of Past-Year Nonmedical Use[a]

	Nonmedical Use, % (95% CI)				
		No. of Days Used			
Source	Any (n = 11 018 735)	1-29 (n = 7 037 205)	30-99 (n = 2 110 122)	100-199 (n = 1 103 312)	200-365 (n = 768 096)
Given by a friend or relative for free	54.4 (52.9-56.0)	61.9 (59.7-64.0)[b]	48.5 (45.6-51.5)[b]	37.7 (33.0-42.5)[b]	26.4 (20.9-32.9)
Prescribed by ≥1 physicians	19.7 (18.4-21.1)	17.9 (16.2-19.7)[b]	19.5 (17.0-22.3)[b]	26.5 (22.2-31.4)	27.3 (22.3-32.9)
Stolen from a friend or relative	4.9 (4.4-5.3)	5.3 (4.7-6.0)[b]	4.6 (3.6-5.7)[b]	4.1 (2.7-6.0)	2.9 (2.1-4.1)
Bought from a friend or relative	11.3 (10.4-12.1)	7.6 (6.7-8.5)[b]	15.6 (13.4-18.0)[b]	18.3 (15.4-21.5)	23.2 (18.0-29.3)
Bought from a drug dealer or other stranger	4.2 (3.8-4.8)	2.1 (1.7-2.6)[b]	5.3 (4.1-6.9)[b]	8.2 (6.5-10.3)[b]	15.2 (12.0-19.1)
Other[c]	5.5 (4.7-6.3)	5.3 (4.3-6.4)	6.4 (5.4-7.7)	5.2 (3.5-7.8)	5.0 (2.9-8.4)

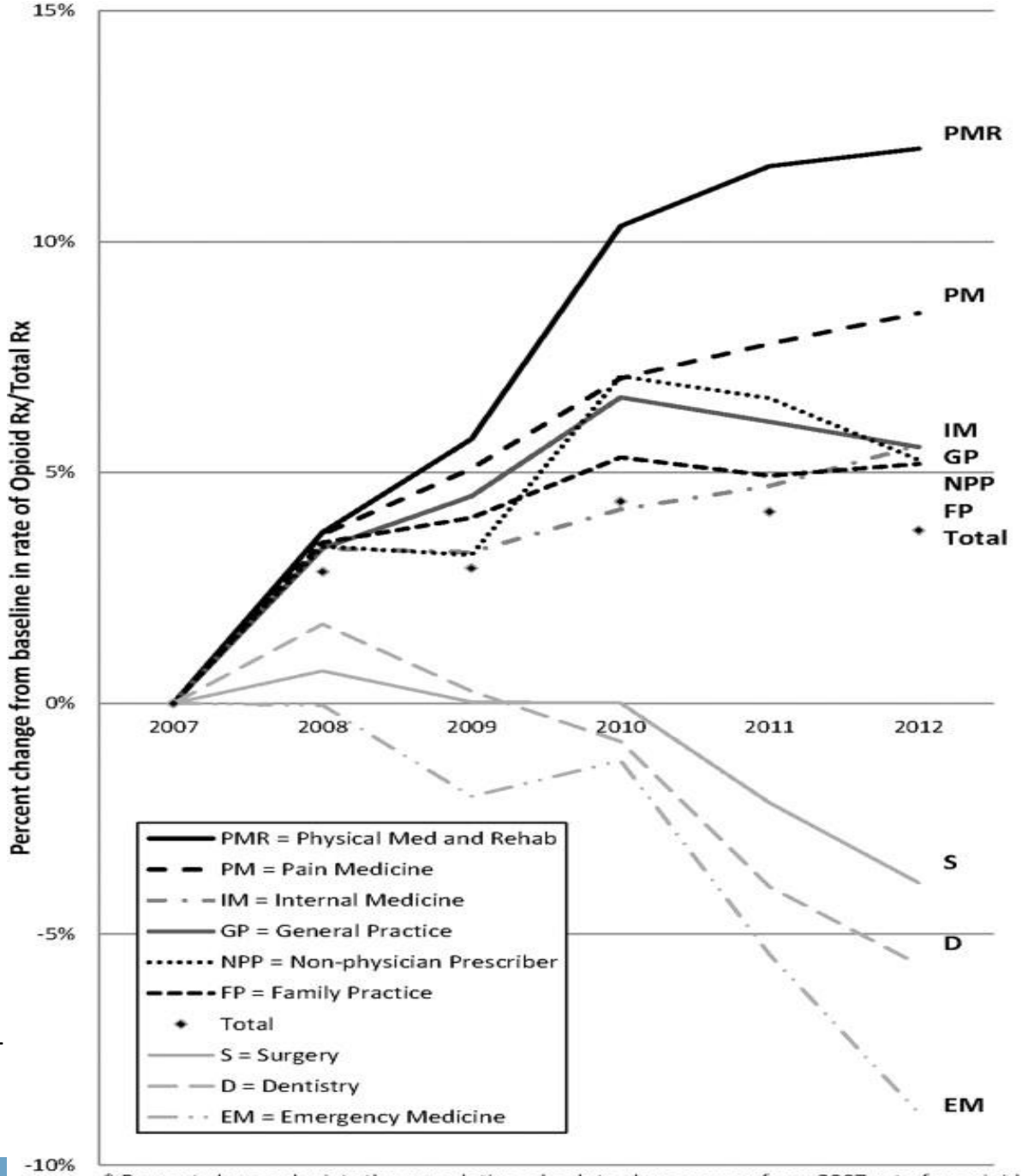
[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[5]

[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).

[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchased on the Internet; and obtained some other way.

Source: JAMA Intern Med. 2014;174(5):802-3.

Change in rate of opioid prescribing by specialty, 2007–2012*



* Percent change depicts the cumulative, absolute change away from 2007 rate for opioid prescriptions as a fraction of total prescriptions.

Sources: Levy et. A;., Trends in Opioid Analgesic–Prescribing Rates by Specialty, U.S., 2007–2012. American Journal of Preventive Medicine 2015;49(3):409-413.

Proposed Changes to RCW 70.225.040

- Clarify that healthcare facilities operated by federally-recognized Indian tribes can access Prescription Monitoring Program (PMP)
- Allow local health officers to access PMP for purpose of supporting public health objectives
- Allow PMP data to be shared with Emergency Department Information Exchange (EDIE) so that providers involved with care of patient can be notified of overdose event

Opioid Prescribing after Non-fatal Overdose

- Study of commercially insured patients with non-fatal overdose between 2000–2012 (n=2848)
- After median follow-up of 299 days:
  - ✓ Opioids dispensed to 91% of patients after overdose
  - ✓ 7% of patients (n = 212) had repeated opioid overdose
- At 2 yrs, estimated cumulative incidence of repeat overdose:
  - ✓ 17% (95% CI, 14% to 20%) for patients receiving high dosages of opioids after the index overdose
  - ✓ 15% (CI, 10% to 21%) for those receiving moderate dosages
  - ✓ 9% (CI, 6% to 14%) for those receiving low dosages
  - ✓ 8% (CI, 6% to 11%) for those receiving no opioids

Source: LaRochelle, et al. Opioid prescribing after non-fatal overdose and association with repeated overdose: A Cohort Study. Ann Int Med 2016;164(1):1–9.

Other PMP-related Policy Ideas

- Require health systems to provide seamless PMP access to their providers via the OneHealthPort
- Require healthcare providers to provide an email address for licensure
- Track naloxone in the PMP
- Track all prescription drugs in the PMP
- Require drug overdose to be reported to DOH, flag in PMP
- Authorize pharmacists to provide a partial fill

How Can the State Board of Health Help?

Questions?