THE OPIOID CRISIS: EMERGING RISKS AND CHALLENGES

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What you'll learn

PART ONE
Scope of Crisis & Emerging Issues

PART TWO
Response: State Strategic Plan
United States
- Highest rate of opioid use in the world
- 2014-19,000 people died of prescription opiate/opioid overdose
- 22,000 infants/year born addicted to opioids
- $53.4 billion a year in lost productivity, medical & legal costs

Montana
2011-2013:
- 369 prescription OD deaths
- 7,200 admissions and ED visits
- 72-82 opiate prescriptions/100 people

More than one in 20 MT teens reported recreational use of an opioid at least once in the past year

Factors Contributing to the Epidemic
- Little or no education on pain management
- Pressure to treat pain
  - Pain as the “fifth vital sign”
  - CMS regulations on recognition and management of pain
  - Patient satisfaction surveys include pain control...impact reimbursement
- Expectation that pain is never acceptable
- Aggressive marketing by drug companies
- Multiple social factors...“Deaths of Despair”
Emerging Risks and Challenges

**Roadmap**

- RX to Illicit Drugs
- Adulterated Drugs & Overdoses
- Emergency Services
- Hospital Admissions
- Special Populations
- Diversion & Workplace Drug Use
- Increased Morbidity & Mortality
- Increased Costs
- Increased Liability

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**FROM PRESCRIPTION OPIOIDS TO STREET DRUGS**

- Prescription drug use-misuse
- Supply is interrupted
- Patient begins taking opioid, becomes dependent or addicted
- Patient not treated for SUD or withdrawal
- Heroin & other illicit drugs cheaper, easily available
- Patient seeks medication from illicit sources
From Prescription Opioids to Street Drugs

Adulterated Drugs and Overdoses

Counterfeit and Adulterated Drugs

The threat has changed and worsened with the appearance and wider use of new opioid drugs.

- Heroin more pure & potent than in past...users at higher risk of overdose
- Counterfeit pain pills resembling prescription opioids, adulterated with fentanyl, U-47700, carfentanil (10,000x more potent than heroin)
- Deaths associated with fentanyl and analogs surged 79% between 2013-2014
- New fentanyl analogs: acrylfentanyl and tetrahydrofuran fentanyl, can be absorbed through the skin, are more powerful, may not respond to naloxone, or require repeated doses
EMERGENCY SERVICES
EMS, Law Enforcement, ED Staff Exposure

Police officer overdoses after brushing fentanyl powder off his uniform

Three Nurses Revived With Narcan After Opioid Patient Treated at Ohio Hospital

2 paramedics treated for exposure to heroin, fentanyl while on call

K-9 Police Dogs Overdose from Fentanyl and Synthetic Opioids

DEA has issued a guide to address handling of drugs in the environment and use of PPE

Fentanyl-type drugs can be absorbed via skin, mucous membranes, or by inhalation
Exposure to small quantities may result in respiratory depression and death
First responders & ED staff at high risk due to environmental exposure

Are your first responders, EMS and ED staff prepared for encountering this new wave of drugs?

NALOXONE DISTRIBUTION PROGRAMS

Naloxone saves lives, BUT programs as they exist are not enough
• Does not reduce number of overdoses...prevents death at that moment
• No deterrent effect...if untreated, user will return to use after resuscitation
• Naloxone administration is increasingly inadequate for revival of users of adulterated drugs
• Newer drugs are “refractory” for Naloxone, requiring doses exceeding 4 mg (usual dose 0.1-0.2 mg IV)
• May require continuous naloxone infusion
• In spite of treatment with naloxone, in one cluster of overdoses, several patients died, while others suffered major organ damage
Montana Hospitalizations for Opioid Overdoses
- 2009-2014: 24% increase
- Women more likely to be hospitalized
- Age 65+ most likely to be hospitalized
- Low income people at greatest risk
- People in small metropolitan areas more likely to be hospitalized


Opioid overdose admissions requiring intensive care increased 34%
Mortality rate of patients averaged 7%, increased to 10% in 2015
Average cost of care per admission rose 58% from $58,517 in 2009 to $92,408 in 2015
Number of deaths of ICU patients with opioid overdoses increased substantially

Number of admissions for opioid abuse/dependence with associated serious infection doubled from 2002-2012
- Endocarditis infections increased 1.5 times
- Osteomyelitis infections more than doubled
- Septic arthritis and epidural abscess cases almost tripled
- Average cost per hospital stay $187,000
- OHSU Study of readmissions
  - $55,493 for endocarditis readmissions
  - $68,774 for osteomyelitis readmissions

Hospital costs for treating opioid abuse/dependence with associated serious infection quadrupled to $700 million in 2012
INFECTIOUS DISEASE: HIV

- Outbreak in Scott County, Indiana
- 181 newly infected with HIV in one year in town of 5000
- Incidence rate > than any country in sub-Saharan Africa
- 88% injected oxymorphone during previous 12 months
- Shared needle use or sexual contact with someone with HIV
- 92% were co-infected with hepatitis C virus

"Abuse and injection of prescription opioid analgesics was the root cause of this HIV outbreak, and these issues affect many communities." Philip Peters, MD, CDC Division of HIV/AIDS Prevention

Without stopping the opioid epidemic, or ensuring that IV drug users have access to sterile needles, infectious diseases will continue to spread.

INFECTIOUS DISEASE: HEPATITIS C

- New Hep C infections tripled over five years
- Estimated 34,000 new hepatitis C infections in U.S. in 2015
- 20-29 year olds have highest infection rate, primarily a result of IV drug use associated with opioid epidemic
- Rate of women of childbearing age positive for Hep C increased by 22% from 2011-2014
- Rate of infants born to women with Hep C increased by 68%
- Death rates from Hep C reached all-time high, surpassing total combined deaths from 60 other infectious diseases reported to CDC

INFECTIOUS DISEASE: HEPATITIS C

- Montana has infection rate higher than national average (CDC)
- 2017 study shows women who inject drugs have a 38% higher risk of contracting HCV than males, after adjustment for injecting behaviors (NIDA)

In 2017 Montana legislature passed SB228: Exempting needle and syringe exchange providers from drug paraphernalia laws
HOSPITAL ADMISSIONS: ACETAMINOPHEN-INDUCED ACUTE LIVER FAILURE

Acetaminophen-induced acute liver failure (ALF) far exceeds other causes of acute liver failure in the US.

Risk factors: chronic pain, alcohol or narcotic use, taking multiple preparations containing APAP
- ALF rose 21% over three years
- 63% used narcotic-containing compounds containing APAP
- 81% reported taking APAP for acute or chronic pain syndromes
- Exacerbated by concurrent alcohol use
- 27% died without transplantation
- 8% underwent liver transplantation

Patients may not be aware of potential toxicity of APAP, may use when opioids do not control pain
Provider may be liable for not warning patient about risks

HOSPITAL ADMISSIONS: LOPERAMIDE MISUSE/ABUSE

- OTC anti-diarrheal medication available as tablet, capsule, or liquid
- Acts on opioid receptors...when taken in large quantities, produces effects similar to opioids
- Used/misused to produce/enhance euphoria or to avoid opioid withdrawal symptoms
- Number of poison center calls involving loperamide more than doubled from 2010 to 2014
- High doses may result in serious cardiac events: prolonged QT interval, Torsades de pointes, other ventricular arrhythmias, syncope, and cardiac arrest
- Naloxone may be effective, will not reverse cardiac effects...electrical pacing or cardioversion may be required

Consider loperamide in unexplained cardiac events, particularly among persons identified with OUD

SPECIAL POPULATIONS

TEEN USE AND OVERDOSES

- Teen overdose deaths increased in 2015 after declining since 2007
- Overdose death rates for girls aged 15-19 nearly doubled
- Overdose death rates tripled for boys
- Majority of 2015 teen overdose deaths were unintentional and from opioids
- Montana teens have third-highest rate of prescription drug abuse in the US—70% get drugs from family members
- >23% Montana's students report misusing prescription drugs by 12th grade
- 78% have had conversations with parents about the dangers of alcohol and marijuana, only 24% have discussed prescription drugs

MATERNAL AND NEONATAL MORBIDITY AND MORTALITY

Dependence on opioids during pregnancy is associated with an increased risk of adverse outcomes for infants and mothers

- 14.4% of pregnant women receive prescription opioid
- Five-fold increase in number of delivering mothers using or dependent on opiates...23,099 mothers per year
- Texas study showed opioid overdose second highest cause of maternal death, higher than PIH, hemorrhage, or sepsis

ACOG recommendation in brief:
- Early universal screening, brief intervention, and referral for treatment (SBIRT)
- Screening using validated tool (NIDA Quick Screen, etc.) on first visit
- Avoid use of opioids for pain management
- For pregnant women with OUD, opioid agonist therapy is recommended over medically supervised withdrawal

https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy
MATERNAL AND NEONATAL MORBIDITY AND MORTALITY

Montana has 5-10 babies per 1000 births that suffer from severe withdrawal

Newborns in Opioid Withdrawal Journal of Neonatology, 2015

Older Adults and the Opioid Crisis

- People >65 have highest and fastest growing rates of OUDs
- Opioid-related hospitalizations in Medicare patients increase 10% per year
- 15% of Medicare recipients prescribed opioids when discharged from the hospital; three months later, 42% still taking them
- Elderly people become targets for drug diversion, and financial, physical, and emotional abuse
  - In 2017, 412 people in 30 states charged in Medicare fraud schemes totaling $1.3 billion in false billing, including for prescribing and distributing opioids
  - Patients recruited by offers of gifts or cash for submitting Medicare billing information

DIVERSION AND WORKPLACE DRUG USE
Substance Abuse in the Healthcare Workforce

- Absenteeism: workers with OUD miss 3x more work, 29 days/year
- Turnover: 43% workers with OUD have more than one employer during past year
- Increased liability: 54% of adults with OUD report driving under the influence during past year
- Increased medical and insurance costs:
  - Workers with OUD >2x as likely to have been hospitalized in the past 12 months; if hospitalized, stay >2x as long
  - Workers with OUD use emergency services 4x as often as others
  - Healthcare costs for workers with OUD cost are 2x higher than others


National Safety Council 2017, Prescription Drug Abuse Epidemic; Painkillers Driving Addiction, Overdose

- Absenteeism: workers with OUD miss 3x more work, 29 days/year
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- Increased liability: 54% of adults with OUD report driving under the influence during past year
- Increased medical and insurance costs:
  - Workers with OUD >2x as likely to have been hospitalized in the past 12 months; if hospitalized, stay >2x as long
  - Workers with OUD use emergency services 4x as often as others
  - Healthcare costs for workers with OUD cost are 2x higher than others

What are Your Responsibilities?

- To follow and uphold the law regarding controlled substances
- To ensure controlled substances are prescribed and dispensed appropriately
- To protect your practice/facility from becoming an easy target for drug diversion
- To be aware of situations where drug diversion can occur and safeguards that can be enacted to prevent diversion
Recognizing Drug Impaired Staff

- Work absenteeism – excessive or without notification
- Frequent disappearances at work, unexplained absences
- Frequent trips to the bathroom or area where drugs are kept
- Unreliable work performance alternating high/low productivity
- Mistakes made due to inattention, poor judgment
- Confusion, memory loss, difficulty concentrating
- Intergenerational relations with colleagues, staff and patients suffer
- Rarely admits errors or accepts blame for errors or oversights
- Heavy “wastage” of drugs
- Sloppy recordkeeping, documentation, suspect entries and drug miscounts/shortages
- Inappropriate prescribing of controlled substances
- Insistence on personal administration of narcotics to patients

Clear policy on impaired staff and providers

Opioid Associated Violence

- Two fold increase in pharmacy robberies: Walgreens and CVS have installed time-release safes and added security guards in some stores
- 22-year-old Spokane man robbed Walgreen's pharmacy in Missoula three times in one year, demanding Oxycontin, Xanax and cash. Authorities found an estimated 10,000 prescription pills in the man’s bedroom
  “One of the unintended consequences of all of this is they will simply quit carrying these products and when they do, these patients don’t have access to the medication they need,” said National Association of Boards of Pharmacy executive director Carmen Catizone.

2015 survey of American Society of Interventional Pain Physicians (ASIPP):

- 52% said patients had threatened them in the context of prescribing opioids
- 7% of the threats involved a gun
- 65% have had to call security
- 3% reported being injured by a patient
- 8% said they carry a gun for protection

What is your policy for potentially violent patients? Are staff trained in de-escalation techniques, workplace safety?
OBJECTIVES OF A PAIN MANAGEMENT POLICY

- Limiting opioid use, prescribing and dispensing
  - Provider education to change prescribing and dispensing patterns
  - Address potential for diversion
  - Address alternatives for pain management
  - Protect prescribers by standardizing prescribing
  - Address safety and security issues
- Education and informed consent regarding opioids and addiction
- Identifying and managing opioid-dependent populations
  - Compassionate, consistent care to taper off medications
  - Education on pain management and alternatives
  - Detoxification programs
  - Long term ongoing care

Developing Policies

- Strong leadership from Administration, Medical Staff, Nursing, Social Work, and Pharmacy operations
- Assess community needs
- Assess patient needs and your ability to meet them
- Review patients receiving ≥120 MME per day (revise down as you move forward)
- Develop support agreements between primary care and specialists
- Prescribing and dispensing policies:
  - Adopt evidence-based prescribing guideline such as CDC
  - Require use of PDMP
- Provide pain management education to prescribers on current evidence-based pain assessment and safe opioid prescribing practices
Developing Policies

Performance feedback:
- Institute pharmacy calls to prescribers for high dose, high quantity prescriptions
- Provide feedback to providers with >average #prescriptions, high doses, long durations
- Audit patient visits for documentation, rationale, alternatives

Decision support tools:
- Adding features to the EHR:
  - Medication and safety alerts
  - Risk assessments
  - Maximum doses
  - Links to guidelines
  - Prompts for alternative treatments or medications
  - Add a link to PDMP
- Standard protocols/order sets for prescribing opioids

Focus on high risk areas:

Surgery
- Surgeons: limit number of narcotic pills to 5-15 for post-op pain control
- Set expectations: tell patients that they would manage their pain with acetaminophen and NSAIDs

Emergency Department
- No longer provide opioid injectables for exacerbations of chronic, non-cancer, non-hospice pain
- Use SUD assessment tools to identify at risk patients
- PDMP mandatory for patients
- Avoid posting information on narcotic prescribing that might discourage patients from seeking emergency care (EMTALA)
SUMMARY

- Understand the scope of the drug crisis, how it occurred, and the unintended consequences of our actions to limit supplies of opioids
- Recognize the impact of the journey from legal to illegal drugs: adulterated street drugs, overdoses, and new drugs resistant to naloxone
- Identify potential consequences of powerful opioids on first responders, law enforcement, and ED staff, and potential actions to protect staff
- Understand the changing opioid crisis and how it influences the rate of hospitalizations and ED visits, including overdoses, emergence of infectious disease, morbidity and mortality and rising costs
- Evaluate the effects of the crisis on special populations: teens, the elderly, and maternal / neonates
- Analyze issues such as diversion, workplace drug use, and opioid associated crime
- Continue to address the challenges through use of evidence-based guidelines and tools, and by working with State and Federal agency experts

QUESTIONS?

Contact us
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UMIA
OBJECTIVES FOR TODAY’S PRESENTATION

- Review the Opioid Abuse Strategic (DRAFT) Plan
- Highlight ongoing projects supported by the plan

CDC - GRANT FUNDING: FOCUS ON REDUCING OPIOID DEATHS

Data-Driven Prevention Initiative - (DDPI) 3 year grant–began Sept. 1st, 2016

- Planning to better coordinate opioid abuse prevention in Montana
- Developing data systems to track opioid abuse
- Considering Substance Use Disorder (SUD) more broadly in the plan
DPHHS / EMS & TRAUMA SYSTEMS – OPIOID ABUSE STRATEGIC PLANNING PROCESS

Five meetings began Nov. 30th, 2016

Over course of One Year

Final planning meeting - Aug 28th, 2017

OUTOUR PROCESS

1st meeting
- Mapping current activities
- Grouping Activities into Key Areas of Focus
- Setting agenda for future meetings

2nd and 3rd meetings
- Information gathering on current work
- Identifying priorities within Key Areas of Focus

4th and 5th meetings
- Small group work to develop the plan

LAST MEETING: AUG. 28TH FIVE SMALL GROUPS

Prevention, Education and Awareness
- Primary prevention, public education and awareness
- Vicki Turner, Prevention Resource Center, DPHHS

Enforcement
- Shane Hight, Department of Justice – Division Criminal Investigations - (DCI) Narcotics Bureau

Monitoring
- PDMP and Drug Utilization Review
- Marcie Booth, Montana Board of Pharmacy

Treatment
- Community based, inpatient and mandatory
- Bobbi Perkins, Chemical Dependency Bureau, DPHHS

Community and Family Resources
- Naloxone training and access, peer support and recovery, work with families, harm reduction
- Christa Weathers, Open Aid Alliance
**TASK FOR EACH WORK GROUP**

- **Overall Goal**
  - Metric #1, #2, #3
  - Priority area for action #1 - Lead
  - Priority area for action #2 – Lead
  - Priority area for action #3 - Lead

- **Populations most at risk:**
  - #1
  - #2

**CRITERIA FOR SELECTING PRIORITY AREAS FOR ACTION**

- Evidence-Based and Data-Driven
- Sustainable
- Realistic and Achievable
- Comprehensive
- Multi-Disciplinary
- Trauma Informed
- Addresses and Empowers Groups Most at Risk

**SUGGESTIONS GIVEN TO SMALL WORK GROUPS**

- Think Big P and little p - policies
- Consider how to better implement, administer or fund the policies and systems we already have
- Ask:
  - What do we need to STRENGTHEN or SUPPORT?
  - What do we need to DEVELOP?
- Timeline: 2 years+
WHAT WE DID SINCE THE LAST MEETING - JUNE 21ST

- Reviewed the work groups recommendations
- Wordsmithing, comparing with evidence/national models
- Draft goals, metrics, areas for action
- Emailed draft plan in advance of meeting

EVIDENCE BASED/NATIONAL MODELS USED

- Association of State and Territorial Health Officials (ASTHO) - 2014 Policy Inventory

6 KEY INDICATORS

1. Mandatory Prescriber Education
2. Opioid Prescribing Guidelines
3. Eliminating Pill Mills
EXAMPLES FROM ASTHO: EDUCATION

- Policies requiring prescribers to receive training on responsible opioid prescribing before obtaining DEA registration to prescribe controlled substances
- Health professional licensing boards imposing pre-service curricular requirements for training in substance use/addiction
- Policy requiring prescribers of controlled substances to obtain continuing education in pain management prior to license renewal

EXAMPLES FROM ASTHO: ELIMINATING PILL MILLS

- "Pill mill" is a term used primarily by local and state investigators to describe a doctor, clinic or pharmacy that is prescribing or dispensing powerful narcotics inappropriately or for non-medical reasons
- Policy requiring Emergency Room (ER) or acute care facilities to follow protocols for prescribing opioids
- Policy for exercising disciplinary action against prescribers in violation of safe and appropriate prescribing practices
- Policy specifying general procedures for licensing pain management clinics
EXAMPLES FROM ASTHO: NEONATAL ABSTINENCE SYNDROME – (NAS)

- Develop statewide plan to address NAS
- Policy to make NAS a reportable condition
- Safe harbor policy for pregnant women who access prenatal care and addiction treatment

PLAN FORMAT

ACKNOWLEDGEMENTS

PROCESS

BACKGROUND DATA
OVERALL GOAL

Reduce Overdose Deaths

Data source: Montana Office of Vital Records
PARTNERSHIPS

GOAL

Increase coordination and data sharing across sectors to effectively utilize resources for reducing overdose deaths

METRIC #1 NUMBER OF OPIOID/SUD TASK FORCE MEETING ANNUALLY

Current 5 meetings = Nov. 2016 thru Aug. 2017
Goal Maintain Quarterly Meetings in 2017

METRIC #2 NUMBER OF MEETINGS BETWEEN STATE HEALTH AND JUSTICE SYSTEM LEADERS

Current 0 meetings
Goal Increase to 4 in 2017
METRIC #3 NUMBER OF DATA SYSTEMS ACCESSED ANALYZED BY DDPI EPIDEMIOLOGIST

Current
4 Sources = Vital Statistics, Hospital Admissions, Emergency Room Visits, and Syndromic Surveillance

Goal
Increase Data Sources

KEY AREA FOR ACTION
SUPPORT ONGOING CROSS SECTOR MEETINGS BETWEEN STAKEHOLDERS WORKING TO ADDRESS OPIOID USE DISORDER

STRATEGIES AND LEADS
• Convene the Montana Opioid Task Force four times per year - Lead: DPHHS-DDPI
• Convene quarterly meeting between health and justice system state leadership - Lead: DPHHS and DCI

KEY AREA FOR ACTION
ENHANCE CROSS SECTOR SURVEILLANCE OF OPIOID USE AND OVERDOSE

STRATEGIES AND LEADS
• Develop a prescription drug burden document that includes analysis of all major sources of available public health and justice system data related to OUD/SUD-Lead: DPHHS-DDPI
• Publish regular surveillance reports with new analyses on opioid use data-Lead: DPHHS-DDPI
**PREVENTION AND EDUCATION**

**GOAL**
Reduce the misuse and abuse of opioids and other substances in Montana communities

**METRIC #1 HIGH SCHOOL PRESCRIPTION MISUSE IN THE LAST MONTH**

- **Current** 15.6%
- **Goal** Decrease

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**Percent of Montana high school students who reported ever taking any prescription medication without a prescription**

- Measured by the question: "During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Ritalin, Adderall, and Xanax) without a doctor's prescription?"
**METRIC #2 LIFETIME HIGH SCHOOL METHAMPHETAMINE USE**

- **Current**: 7.7%
- **Goal**: Decrease

Source: Youth Risk Behavior Survey 2015, Montana Office of Public Instruction. Measured by: During your life, how many times have you used methamphetamine (also called speed, crystal, crank, or ice).

**METRIC #3 PAST YEAR NON-MEDICAL PAIN RELIEVER USE AMONG ADULTS AGED 18+**

- **Current**: 3.2%
- **Goal**: Decrease

Source: Annual Averages Based on 2013-2014 National Survey on Drug Use and Health (NSDUH).

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**Percent of Montanans who reported non-medical use* of a prescription medication in the past year**

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, 2010-2014.

* Defined as: “use of these drugs without a prescription or use that assumed simply for the experience or feeling that the drug caused.”
METRIC #4 RETAIL OPIOID PRESCRIPTION DISPENSING RATE

Current: 82 per 100 people
Goal: Decrease

Source: Centers for Disease Control and Prevention, Opioid Overdose Data
https://www.cdc.gov/drugoverdose/maps/state-maps.html

OPIOID PRESCRIPTION RATE PER 100 PEOPLE, 2016
MONTANA = (64.1 TO 82.9)

Source: Centers for Disease Control and Prevention, Opioid Overdose Data
https://www.cdc.gov/drugoverdose/maps/state-maps.html

OPIOID PRESCRIPTION RATE PER 100 PEOPLE
BY COUNTY, 2016

10 Montana Counties prescription rate is greater than 112 include Lincoln, Flathead, Beaverhead, Deer Lodge, Silver Bow, Cascade, Yellowstone, Philips, Custer, and Dawson

Source: Centers for Disease Control and Prevention, Opioid Overdose Data
https://www.cdc.gov/drugoverdose/maps/state-maps.html
METRIC #5 HEAVY OR BINGE DRINKING AMONG ADULTS AGED 18+

Current: 25.94%
Goal: Decrease

Source: 2014 Behavioral Risk Factor Surveillance System

KEY AREA FOR ACTION
INCREASE PUBLIC AWARENESS ABOUT THE DANGERS OF OPIOID MISUSE AND PROPER STORAGE AND DISPOSAL OF UNUSED PRESCRIPTION OPIOIDS

STRATEGIES AND LEADS

- Support a statewide media campaign that includes harm reduction and storage and disposal messaging, targeting at-risk groups such as seniors-Lead: DPHHS-DDPI
- Increase awareness of prescription drop boxes statewide-Lead: Prevention Specialists
- Support take-back drop box events held at least twice a year-Lead: Law Enforcement and Prevention Specialists and Community Coalitions

KEY AREA FOR ACTION CONTINUED
INCREASE PUBLIC AWARENESS ABOUT THE DANGERS OF OPIOID MISUSE AND PROPER STORAGE AND DISPOSAL OF UNUSED PRESCRIPTION OPIOIDS

STRATEGIES AND LEADS CONTINUED

- Support prevention specialists in Montana communities to implement evidence-based OUD/SUD prevention activities-Lead: Prevention Specialists and DDPI Funded mini-grants
- Support robust, well-funded community coalitions driving evidence-based prevention activities under the SAMHSA’s prevention framework in all Montana communities -Lead: Prevention specialists
KEY AREA FOR ACTION

DECREASE OVERPRESCRIBING OF OPIOIDS THROUGH THE PROMOTION OF THE CDC’S “GUIDELINES FOR PRESCRIBING OPIOIDS”

STRATEGIES AND LEADS CONTINUED

- Increase the number of providers receiving education from the Know Your Dose website - Lead: Montana Medical Association
- Support policies and programs to increase provider education on opioid prescribing guidelines - Lead: DPHHS DDPI
- Support policies to increase prescribing according to the CDC guidelines - Lead: DPHHS DDPI
- Analyze Medicaid claims data to evaluate provider opiate prescribing practices in Montana and provide feedback to providers - Lead: DPHHS

ENFORCEMENT

GOAL

Reduce illegal distribution of opiates and other drugs from dealers and strengthen partnerships between the justice system and treatment providers

METRIC #1 RATE OF NARCOTICS RELATED ARRESTS

Current 24.6% of arrests*

Goal Decrease

**“Group A” Arrests
Opiate Arrests

Source: Montana Incident-Based Reporting System, Property Drug Related Data

Arrests Involving Opiates

Source: Montana Incident-Based Reporting System, Property Drug Related Data

METRIC #2 RATE OF OPIOIDS SEIZED

11% of drugs seized are opioids

Goal: Increase %
### METRIC #3 NUMBER AND CAPACITY OF DRUG TREATMENT COURTS

- **Current:** 30 Courts
- **Goal:** Increase

As of 2012, this is the number of courts I could find. From: http://courts.mt.gov/drugcourt#

Victoria Troeger, 8/25/2017
METRIC #4 NUMBER AND CAPACITY OF OPIOID DIVERSION PROGRAMS

Current (?)  Goal Increase

METRIC #5 NUMBER OF JAILS AND DOC FACILITIES OFFERING MEDICATED ASSISTED TREATMENT – (MAT)

Current (?)  Goal Increase

KEY AREA FOR ACTION
SUPPORT ENFORCEMENT AND PROSECUTION OF DRUG TRAFFICKING, INCLUDING PILL DIVERSION

STRATEGIES AND LEADS

- Develop drug interdiction teams-Lead: Montana Highway Patrol
- Support the work of the Montana Fusion Center and Pill Diversion Agents-Lead: Montana Division of Criminal Investigation – (DOJ-DCI)
KEY AREA FOR ACTION
INCREASE ACCESS TO DRUG COURTS, DIVERSION AND PEER SUPPORT PROGRAMS IN THE MONTANA JUSTICE SYSTEM

STRATEGIES AND LEADS CONTINUED
- Identify communities underserved by drug courts and work to identify treatment courts in these communities. Lead: Office of the Court Administrator
- Support the development of diversion to treatment programs for low-level substance use offenders in local jurisdictions. Lead: Montana Board of Crime Control
- Support the development of peer support/crisis diversion programs with local law enforcement agencies. Lead: Montana Peer Support Network

KEY AREA FOR ACTION
INCREASE THE NUMBER OF JAILS AND DOC FACILITIES PROVIDING EVIDENCE-BASED SUD TREATMENT, INCLUDING MEDICATION ASSISTED TREATMENT

STRATEGIES AND LEADS CONTINUED
- Increase the number of jails in Montana that provide access to Substance Use Disorder (SUD) Treatment, including MAT. Lead: Montana Board of Crime Control
- Increase access to evidence-based treatment in Department of Corrections facilities, including MAT. Lead: Dept. of Corrections
- Support policies to support continuity of SUD treatment and MAT for individuals being released from protective custody. Lead: DPHHS, DOC and Medicaid

MONITORING
GOAL
Increase the use of monitoring to target interventions and reduce prescription drug misuse
**METRIC #1** NUMBER OF PROVIDERS REGISTERED WITH THE MONTANA PRESCRIPTION DRUG REGISTRY – (MPDR)

Current: 3,530 as of March 2017

Goal: Increase

**METRIC #2** NUMBER OF MONTHLY PATIENT HISTORY SEARCHES

Current: 30,145 as of March 2017

Goal: Increase

Eligible vs Registered:

- Total Eligible: 28.5%
- Total Registered: 49.9%
METRIC #3 NUMBER AND CAPACITY OF ACADEMIC DETAILING PROGRAMS

ACADEMIC DETAILING: NON-COMMERCIAL-BASED EDUCATIONAL OUTREACH. THE PROCESS INVOLVES FACE-TO-FACE (1:1) EDUCATION OF PRESCRIBERS BY TRAINED HEALTH CARE PROFESSIONALS, TYPICALLY PHARMACISTS, PHYSICIANS, OR NURSES.

Current: 2  
Goal: Increase

STRATEGIES AND LEADS

KEY AREA FOR ACTION
INCREASE MPDR FUNCTIONALITY AND USE

- Support a policy to make MPDR use mandatory-Lead: Montana Board of Pharmacy
- Support efforts to integrate MPDR information into provider software for Electronic Health Records and pharmacy operating systems-Lead: Board of Pharmacy

STRAATEGIES AND LEADS

KEY AREA FOR ACTION
INCREASE MPDR FUNCTIONALITY AND USE

- Increase physician, allied health professional and pharmacist education on the proper prescribing guidelines and the use of the MPDR.-Lead: MMA, EMS, AAR, AFP, Pharmacies, Montana Healthcare Foundation
- Facilitate access to de-identified PDR data for the DDPI for analysis-Lead: Montana Board of Pharmacy
- Create partnerships with stakeholders by providing de-identified PDR reports to law enforcement and mental health /drug treatment services -Lead: DPHHS DDPI Initiative

STRAATEGIES AND LEADS

KEY AREA FOR ACTION
INCREASE MPDR FUNCTIONALITY AND USE

- Increase physician, allied health professional and pharmacist education on the proper prescribing guidelines and the use of the MPDR.-Lead: MMA, EMS, AAR, AFP, Pharmacies, Montana Healthcare Foundation
- Facilitate access to de-identified PDR data for the DDPI for analysis-Lead: Montana Board of Pharmacy
- Create partnerships with stakeholders by providing de-identified PDR reports to law enforcement and mental health /drug treatment services -Lead: DPHHS DDPI Initiative
KEY AREA FOR ACTION

USE MPDR AND OTHER HEALTH SYSTEM DATA TO INFORM PROVIDER EDUCATION AND OUTREACH, INCLUDING ACADEMIC DETAILING

STRATEGIES AND LEADS CONTINUED

• Use monitoring system data to target education and awareness outreach programs to communities showing a need for such information (i.e. hotspots)
  Lead: DPHHS DDPI

• Support academic detailing efforts that utilize monitoring data to target education to providers—Lead: Veteran’s Administration and Montana Medicaid

TREATMENT

GOAL

Expanded access to evidence-based, recovery oriented, appropriately targeted treatment for all Montanans
METRIC #1 NUMBER OF ADULT CLIENT ADMISSIONS TO STATE APPROVED PROVIDERS

- Current: 5,806
- Goal: Increase

Data Source: SAMS, 2012-2015

METRIC #2 NUMBER OF BUPRENORPHINE WAIVERS

- Current: 16
- Goal: Increase

Source: 2017 Manatt: Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana

METRIC #3 NUMBER OF MEDICALLY ASSISTED TREATMENT – (MAT) PROVIDERS

- Current: 41
- Goal: Increase
Number of physicians certified to prescribe buprenorphine?

VT5 Victoria Troeger, 8/25/2017

41 doctor offices that provide MAT

VT6 Victoria Troeger, 8/25/2017

4 Methadone clinics

VT7 Victoria Troeger, 8/25/2017
Percent of Clients Receiving MAT at SUD Facilities

Source: 2017 Manatt Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana

METRIC #4 NUMBER OF LICENSED ADDICTION COUNSELORS - (LACS)

Current

Goal

Increase

Montana Department of Labor and Industry, current as of June 2014

Number of Licensed Addiction Counselors, Montana

Source: Montana Department of Labor and Industry
KEY AREA FOR ACTION
INCREASE MONTANA'S CAPACITY TO SERVE AND TREAT PEOPLE WITH SUBSTANCE USE DISORDER USING BEST PRACTICES

STRATEGIES AND LEADS
- Train and increase number of LACs and dually licensed mental health and substance use providers—Lead: MSU Bozeman and DPHHS
- Maintain SUD treatment funding through the Medicaid HELP Act—Lead: DPHHS
- Increase number of state approved substance use providers who can access Medicaid reimbursement, including supporting tribally operated clinics and Urban Indian Health Clinics to become state approved—Lead: DPHHS Chemical Dependency Bureau
- Increase capacity of existing state approved providers to serve a greater number of Montanans across the continuum of care—Lead: DPHHS Chemical Dependency Bureau

STRATEGIES AND LEADS
- Support healthcare providers to integrated primary care, substance use and mental health services in one clinical location to best assess and serve patients with SUD—Lead: Montana Healthcare Foundation
- Increase the number of providers implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT)—Lead: Montana Healthcare Foundation

KEY AREA FOR ACTION
INCREASE NUMBER OF INTEGRATED BEHAVIORAL HEALTH PROGRAMS

STRATEGIES AND LEADS CONTINUED
- Develop a Hub and Spoke Model for comprehensive MAT care in Montana—Lead: DPHHS Chemical Dependency Bureau
FAMILY AND COMMUNITY RESOURCES

**GOAL**
Expand access to supportive resources for individuals and families affected by SUD, including those in recovery

**METRIC #1 NUMBER OF LICENSED PEER MENTORS**
- Current: 0
- Goal: Increase

**METRIC #2 PERCENT OF CHILDREN IN CHILD FAMILY SERVICES DIVISION - (CFSD) OUT-OF-HOME PLACEMENT WITH PARENTAL OUD/SUD INDICATED ANNUALLY**
- Current: 66.5%
- Goal: Decrease
KEY AREA FOR ACTION
INCREASE ACCESS TO AND TRAINING ON NALOXONE

STRATEGIES AND LEADS
• Provide in-person trainings on the recognition of opioid overdose and propose naloxone use to EMS, Fire, Law Enforcement and School Nurses in all Montana counties-Lead: DPHHS DPPI and STR Grant
• Distribute naloxone to trained first responder groups in high risk areas-Lead: STR Grant
• Track naloxone use statewide-Lead: DPHHS DDPI
• Develop standing order for naloxone in Montana-Lead: DPHHS

KEY AREA FOR ACTION
INCREASE ACCESS TO PEER MENTORS, SOBER HOUSING AND OTHER EVIDENCE BASED RECOVERY SUPPORTS

STRATEGIES AND LEADS
• Finalize process for credentialing peer mentors in Montana and provide reimbursement for peer mentors through the Substance Use Prevention and Treatment Block Grant-Lead: DPHHS Chemical Dependency Bureau
• Support development of additional sober living and housing facilities for individuals in recovery and leaving protective custody-Lead: DPHHS and DOC

KEY AREA FOR ACTION
INCREASE ACCESS TO NEEDLE EXCHANGE PROGRAMS AND OTHER HARM REDUCTION INITIATIVES

STRATEGIES AND LEADS
• Support the development of additional needle exchange and other harm reduction initiatives in Montana communities-Lead: Open Aid Initiative
KEY AREA FOR ACTION

REDUCE THE STIGMA ASSOCIATED WITH SUD AND INCREASE INPUT FROM PEOPLE WITH LIVED EXPERIENCE WITH SUD/OUD INTO STATE PROGRAMS AND PLANNING PROCESES

STRATEGIES AND LEADS CONTINUED

• Invite peer mentors and drug courts graduates to future task force meetings. Lead: DPHHS DPPI

• Support mental health, substance use and trauma informed training for justice system staff and first responders. Lead: CIT Montana and ChildWise

NEXT STEPS – TASK FORCE

• Final feedback/suggestions by mid-September
• Voting on top choices by each work group
• DPHHS will take back to wordsmith and develop final version – be done by end of September
• Develop a strategy with individuals with SUD or who are in Recovery

THANK YOU!

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