



PROP

Physicians for Responsible
Opioid Prescribing



Responding to the Prescription Opioid and Heroin Crisis: *An Epidemic of Addiction*

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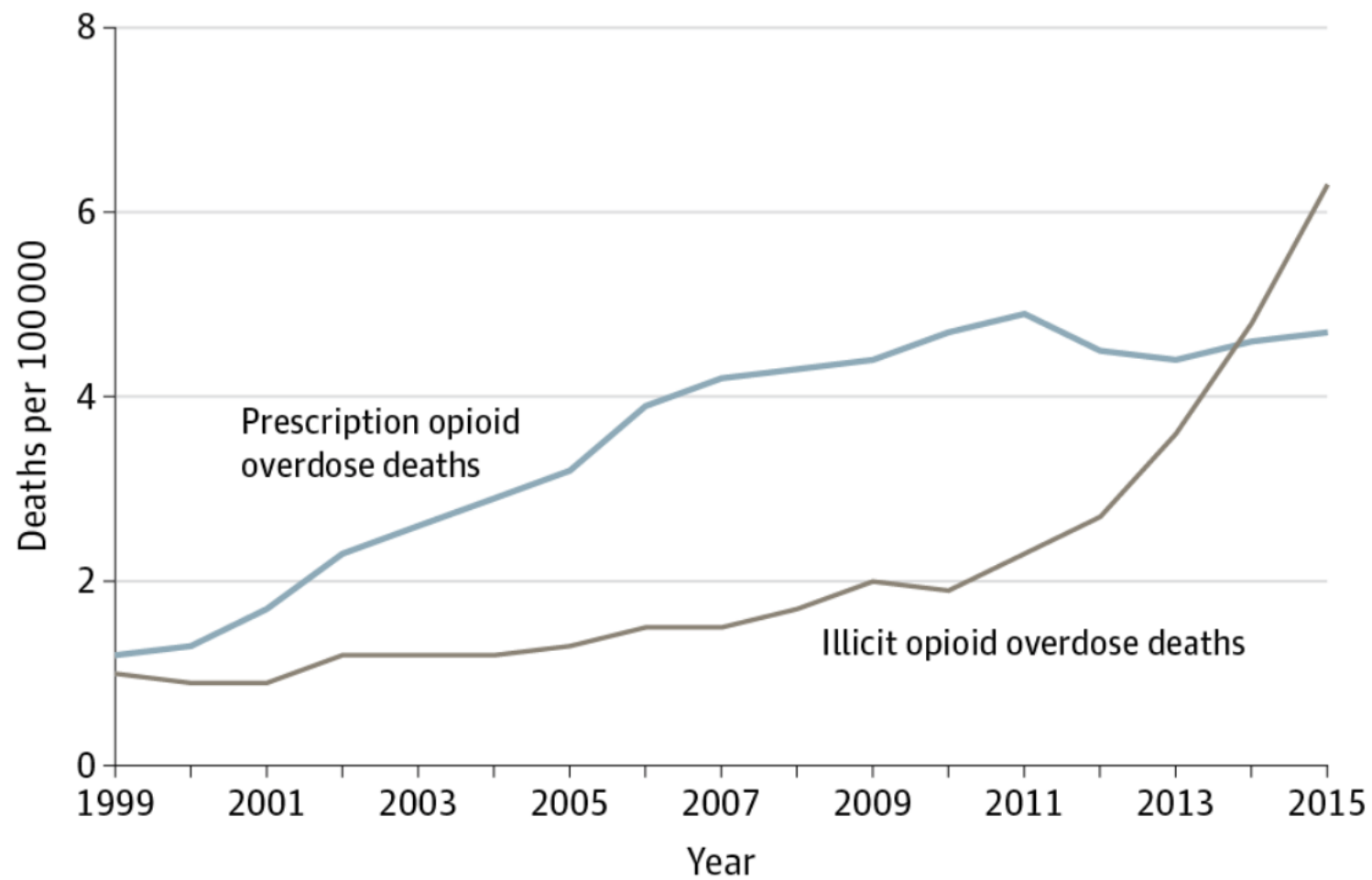
Conflict of Interests

I have no relevant financial relationships to disclose.

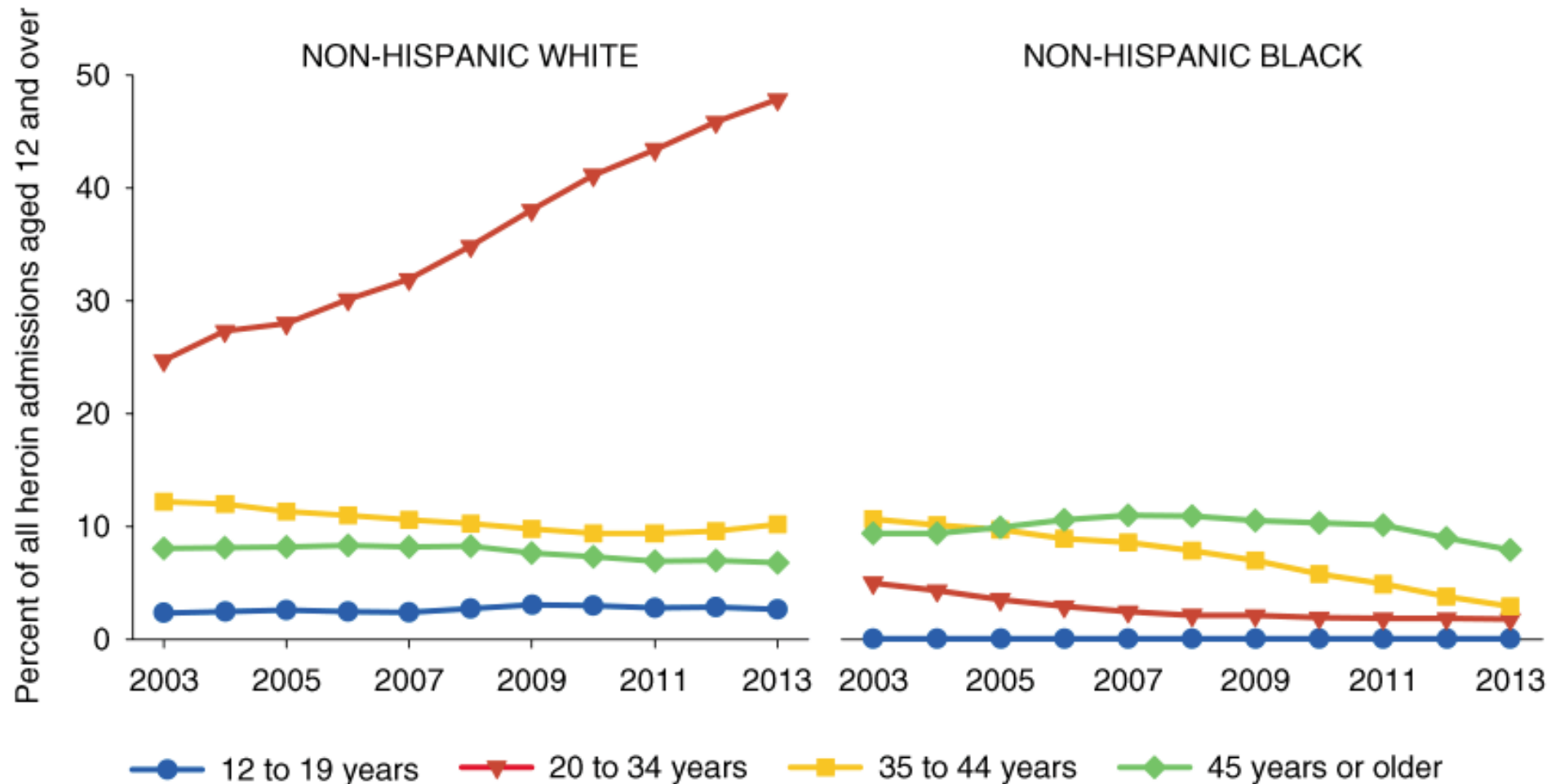
Opium



Age-adjusted opioid-related overdose deaths,^a
1999-2015

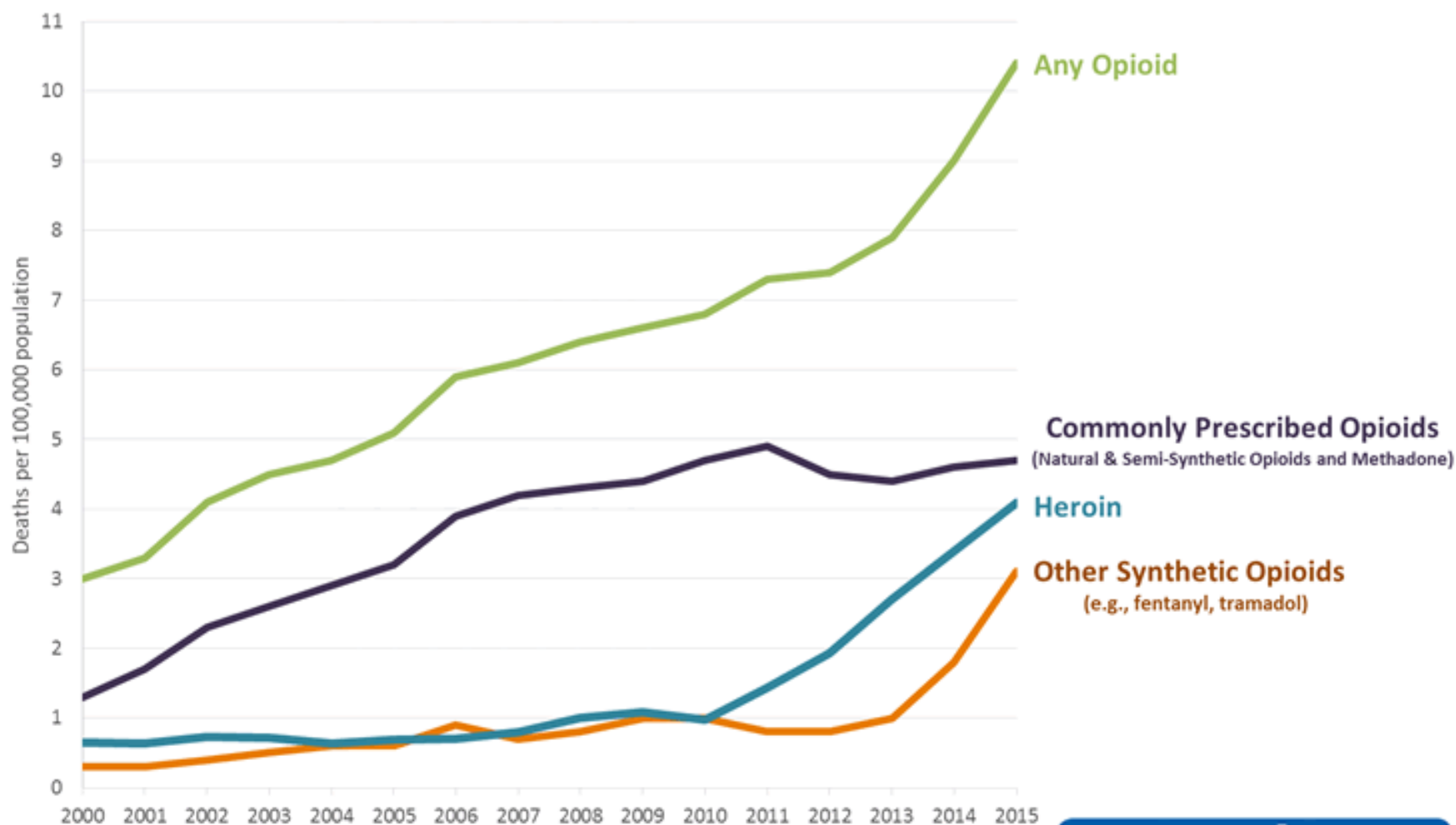


Heroin treatment admissions : 2003-2013



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.

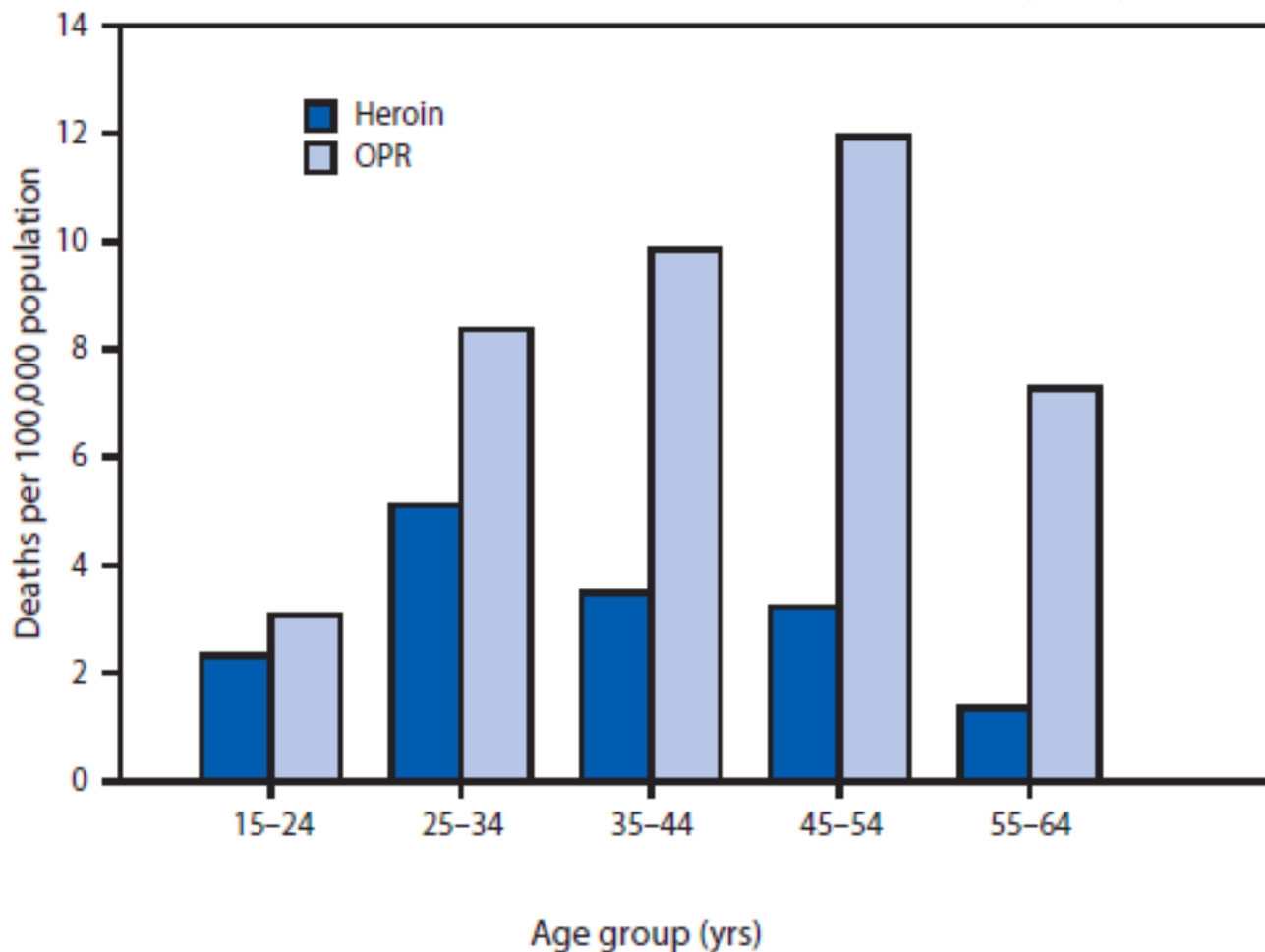
Overdose Deaths Involving Opioids, United States, 2000-2015



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. <https://wonder.cdc.gov/>.

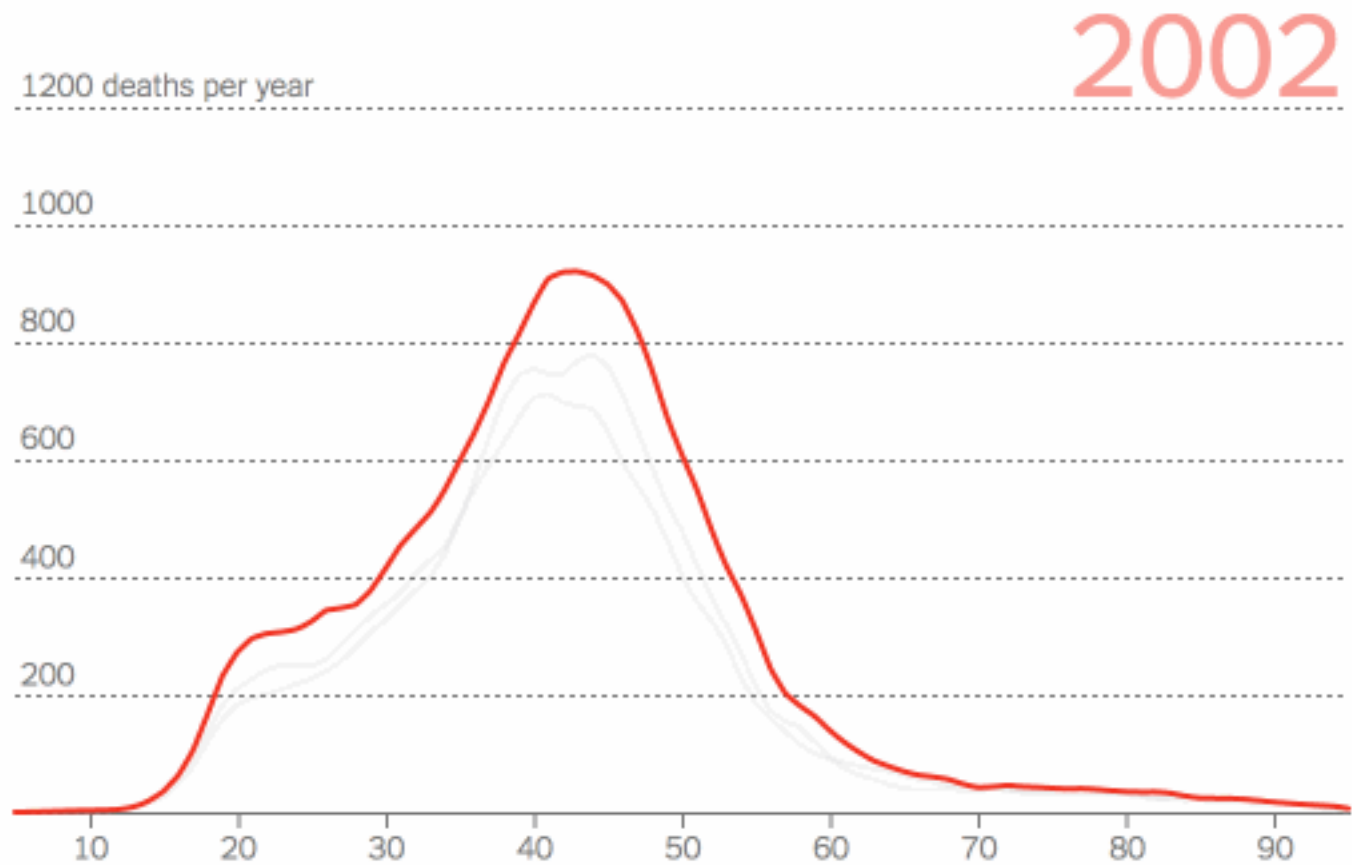
www.cdc.gov
Your Source for Credible Health Information

Death rates from overdoses of heroin or prescription opioid pain relievers (OPRs), by age group



SOURCE: CDC. *Increases in Heroin Overdose Deaths — 28 States, 2010 to 2012*
MMWR. 2014, 63:849-854

Distribution of drug deaths by age

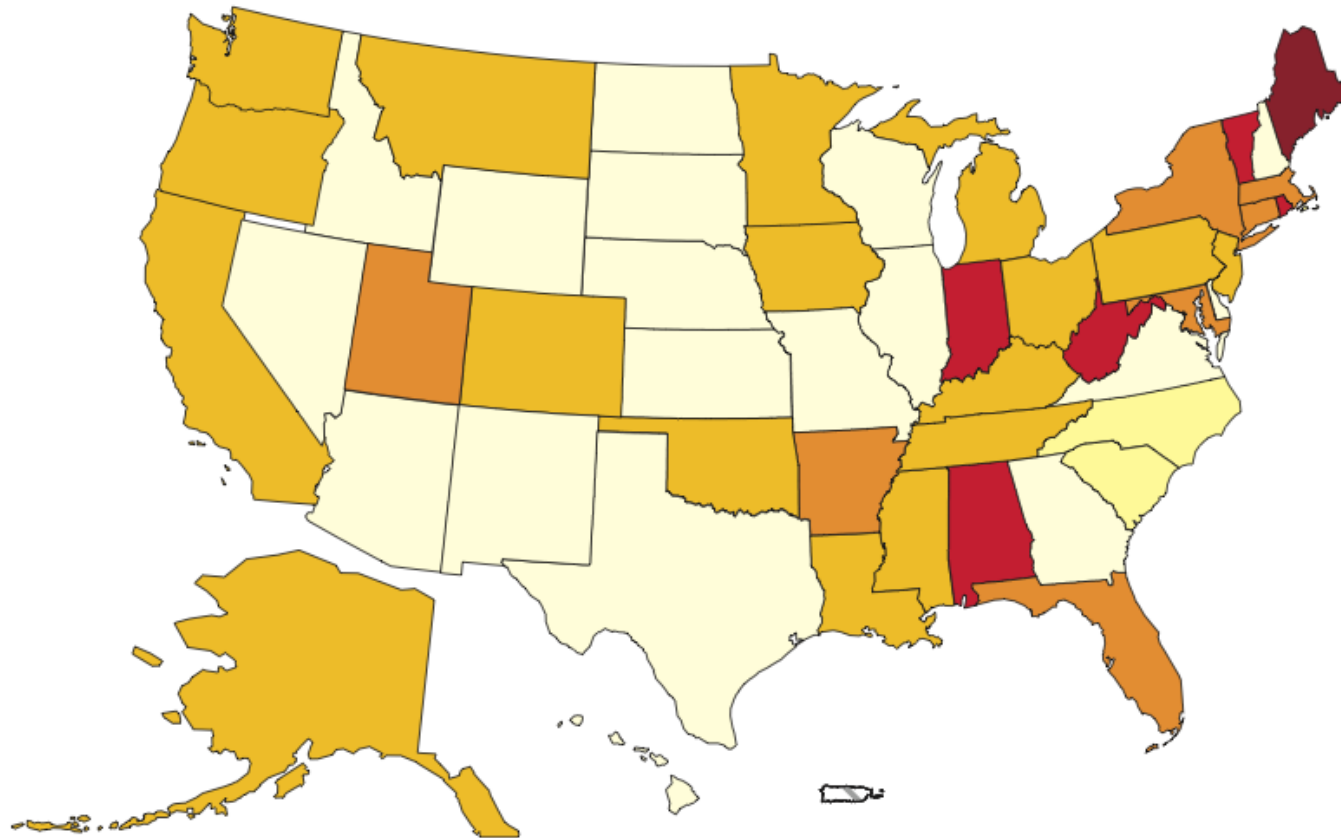


Source: J. Katz. NYT Short Answers to Hard Questions About the Opioid Crisis August 10, 2017

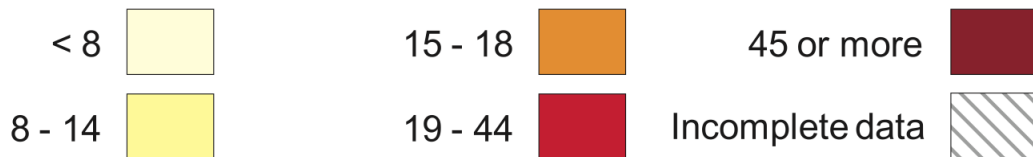
Three Opioid-Addicted Cohorts

1. 20-40 y/o, disproportionately white, significant heroin use, opioid addiction began with Rx use **(addicted after 1995)**
2. 40 y/o & up, disproportionately white, mostly Rx opioids, opioid addiction began with Rx use **(addicted after 1995)**
3. 50 y/o & up, disproportionately non-white, mostly heroin users, opioid addiction began in teen years with heroin use **(addicted before 1995)**

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

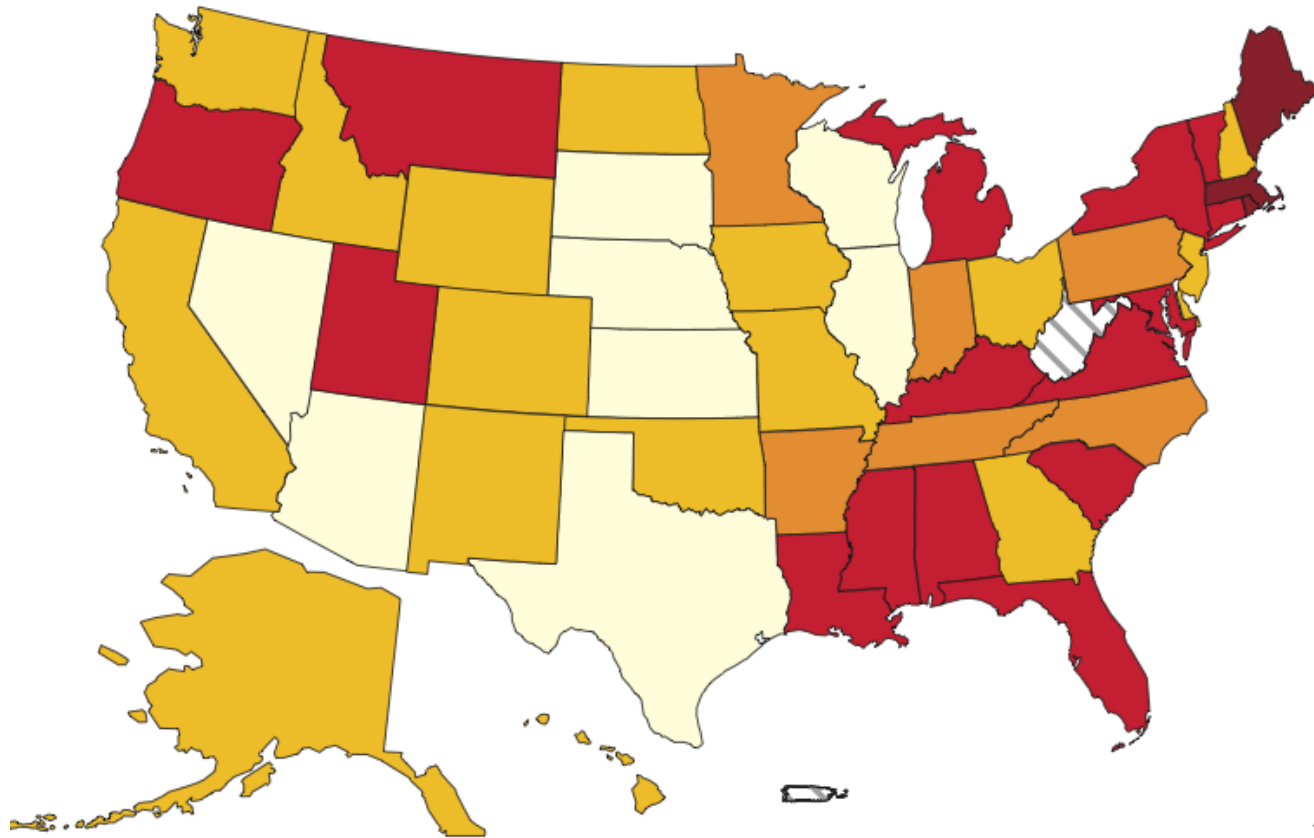


1999
(range 1 - 50)

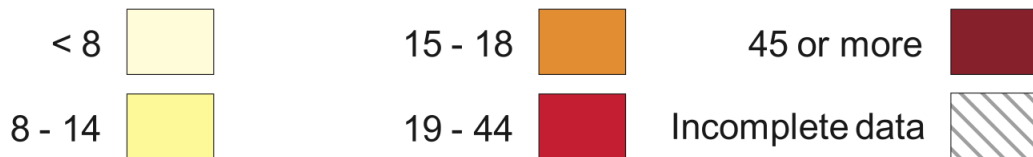


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

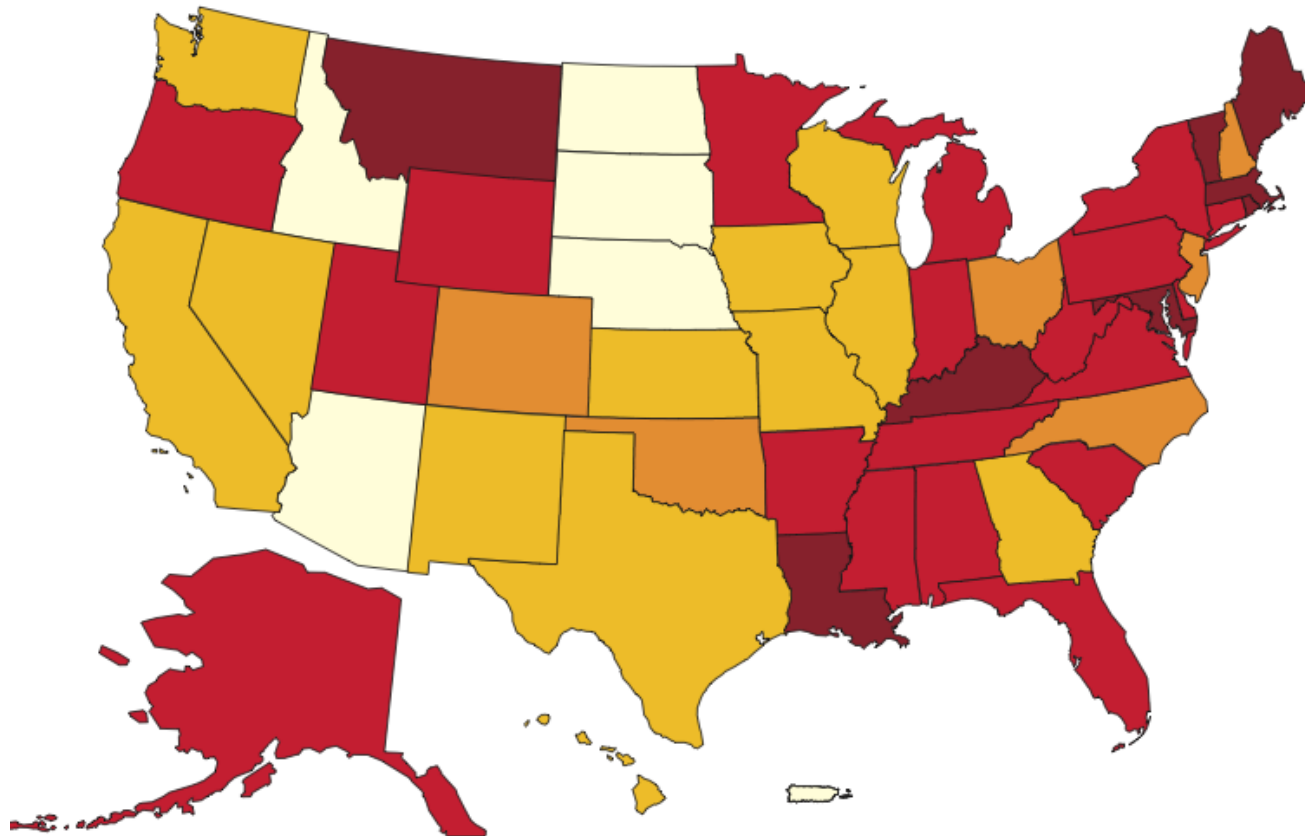


2001
(range 1 – 71)



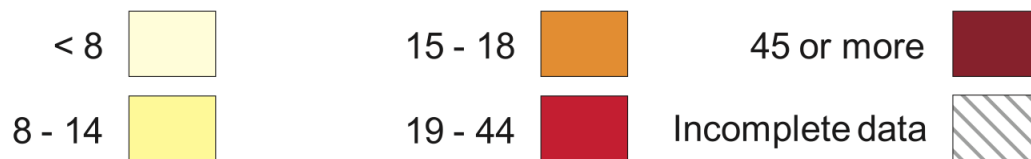
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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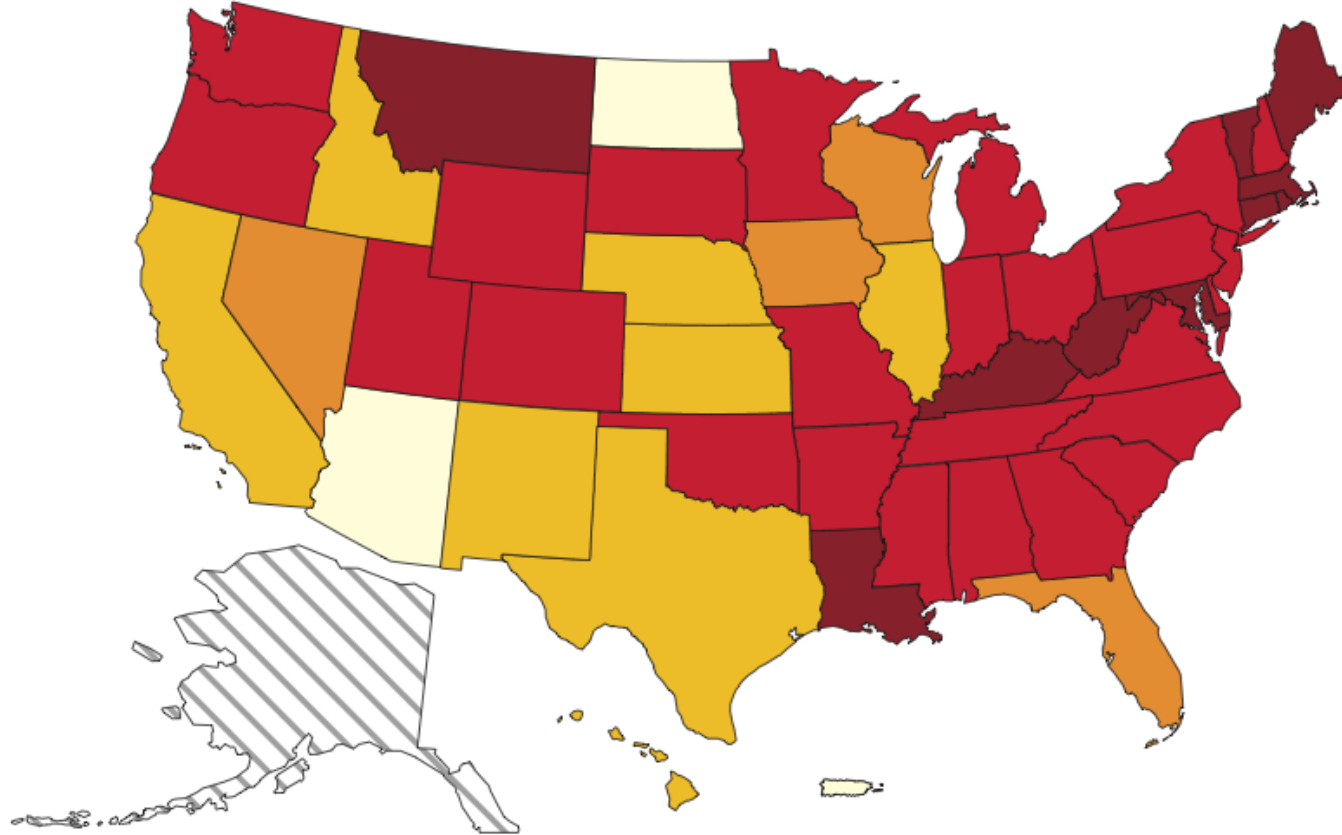
2003

(range 2 – 139)



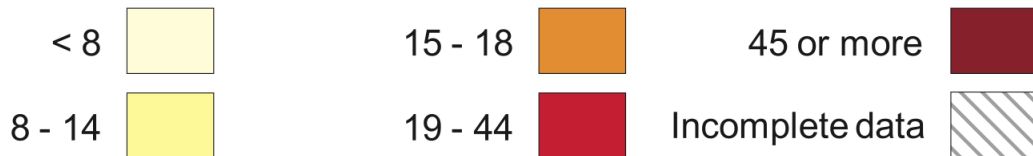
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



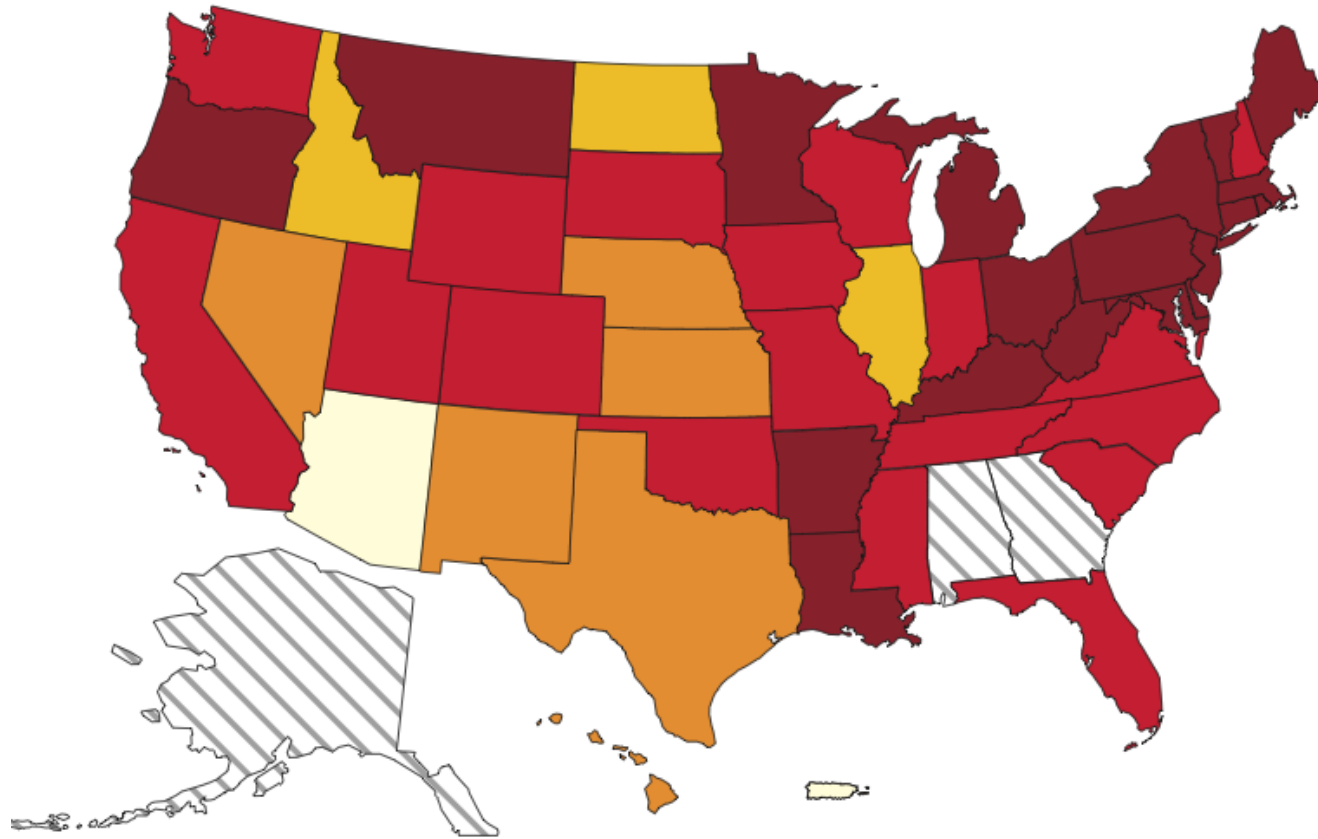
2005

(range 0 – 214)



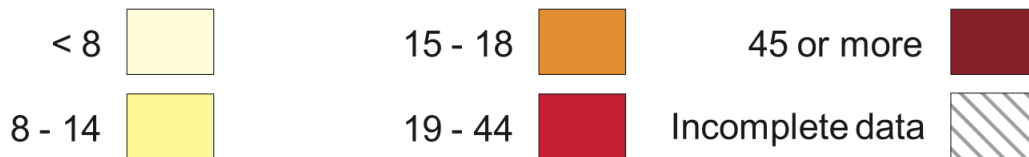
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



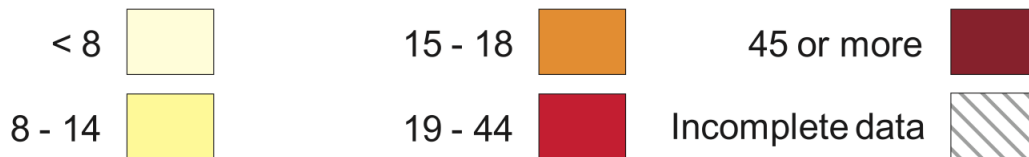
2007

(range 1 – 340)



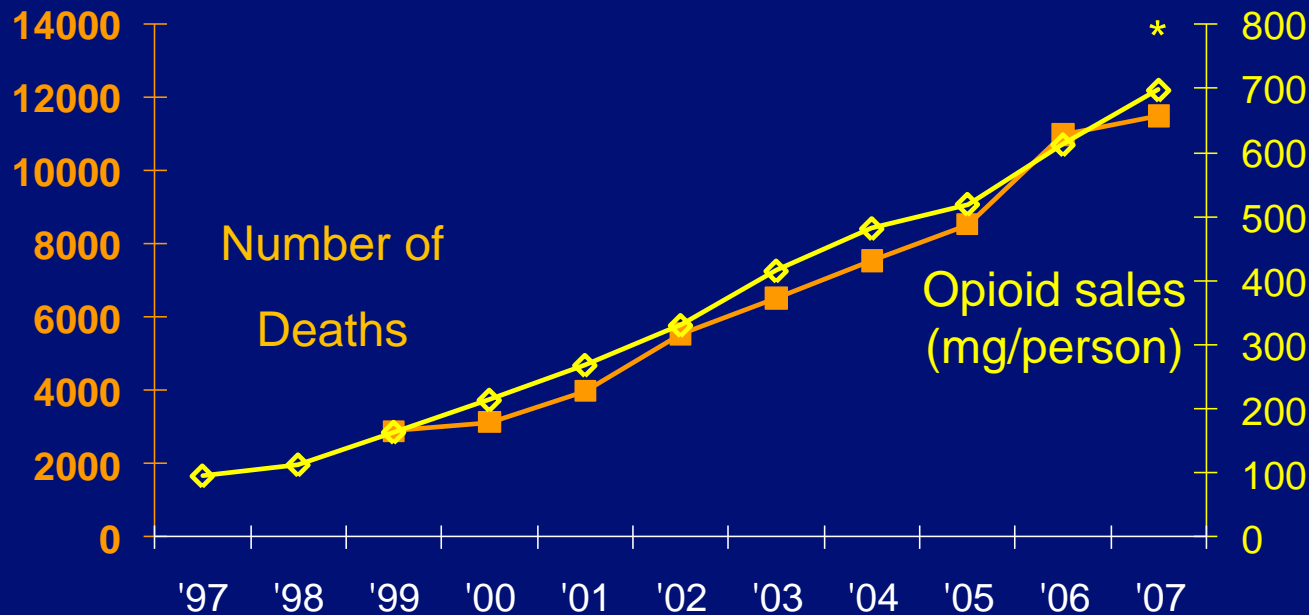
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

(range 1 – 379)



15

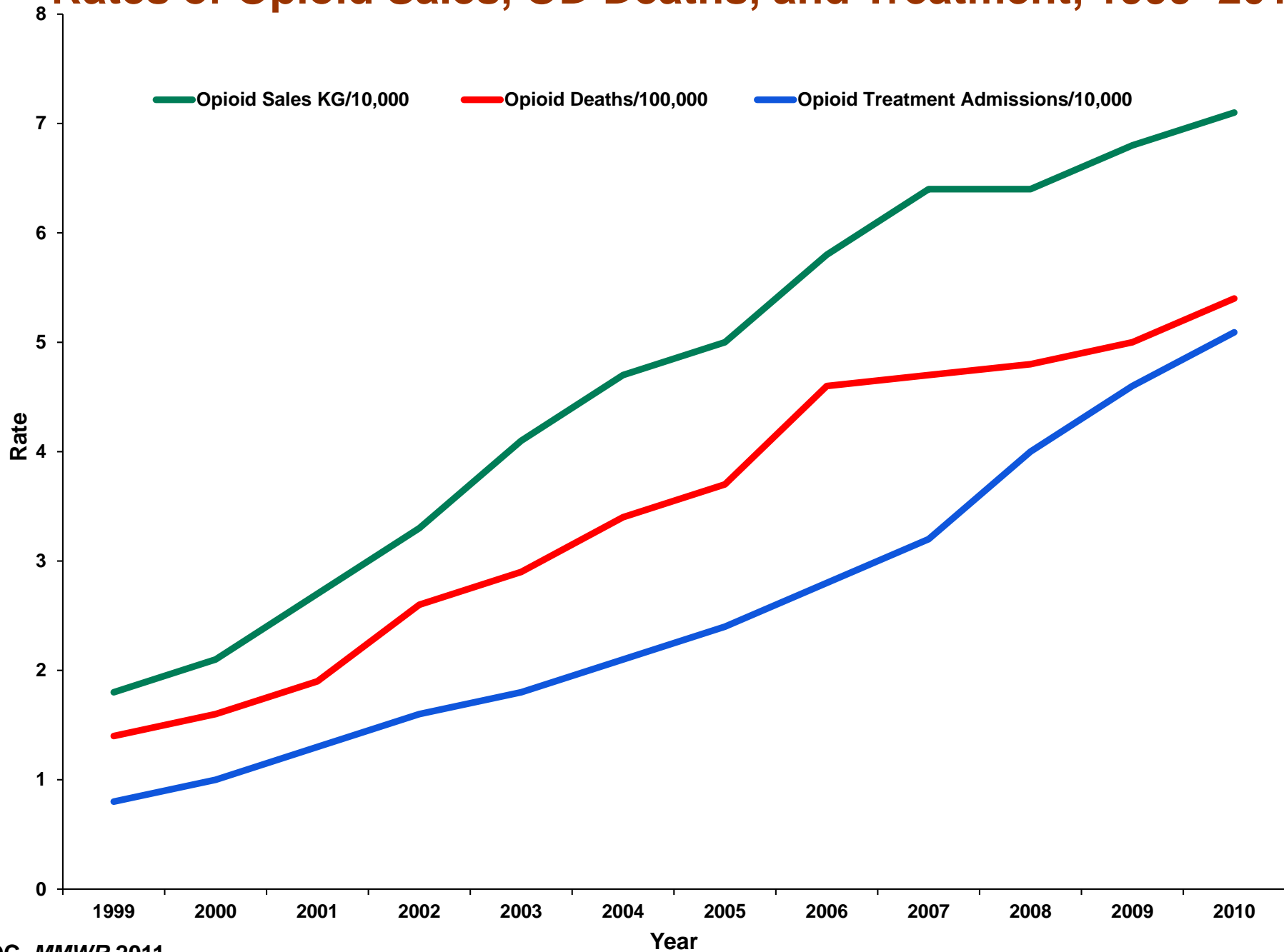
Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007



Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS

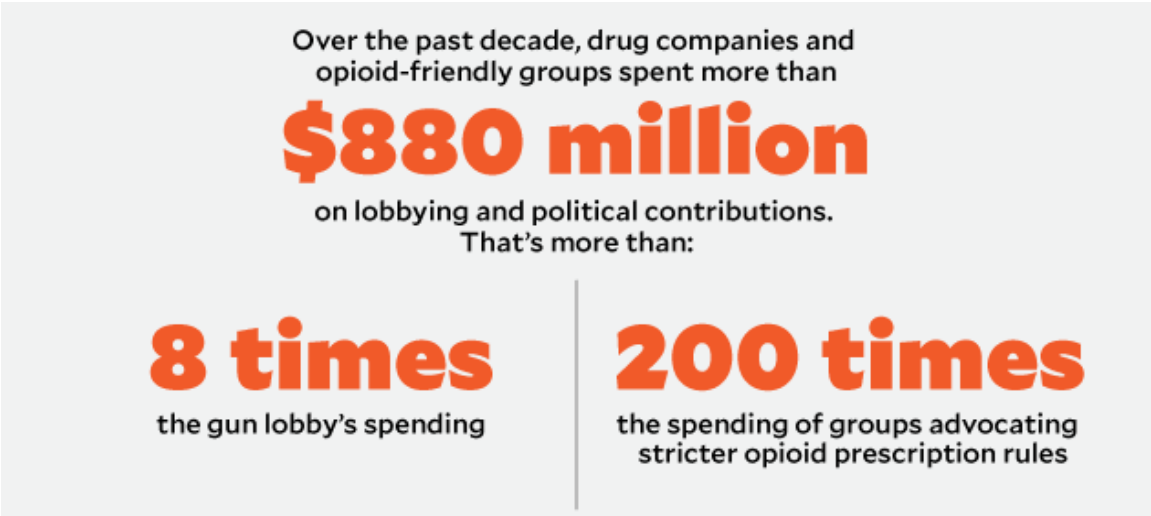
* 2007 opioid sales figure is preliminary.

Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010



Pro-painkiller lobby shapes policy amid drug epidemic

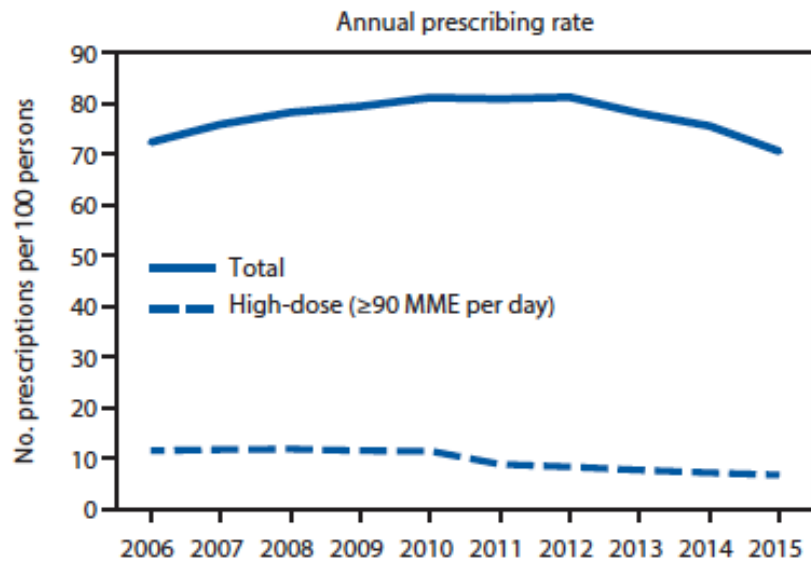
Matthew Perrone and Ben Wieder, Associated Press and Center for Public Integrity



POLITICAL SPENDING

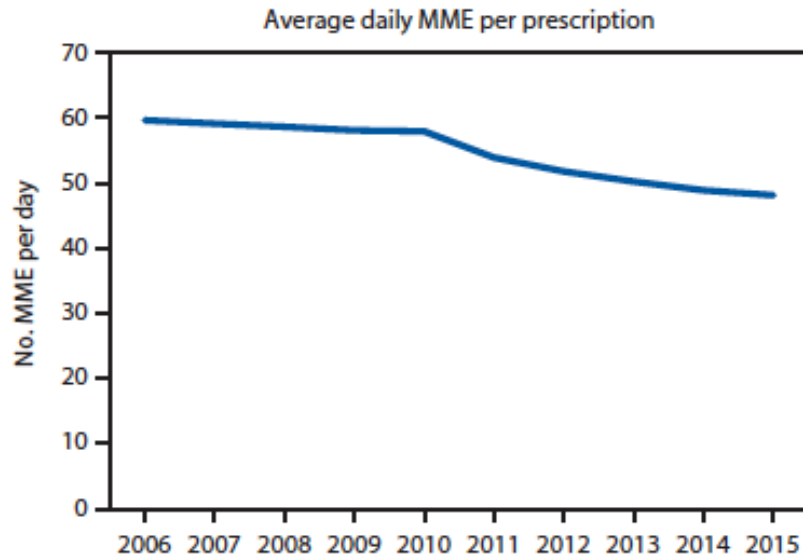
Opioid manufacturers and their allies have contributed roughly \$80 million to state and federal candidates and have spent about \$746 million on state and federal lobbying since 2006. How the spending breaks down:

to State	to Federal	for State/Federal candidates	
\$109 mil.	\$716 mil.	45%	54%
		Dems	Reps



Opioid prescribing in the U.S. peaked ~ 2011

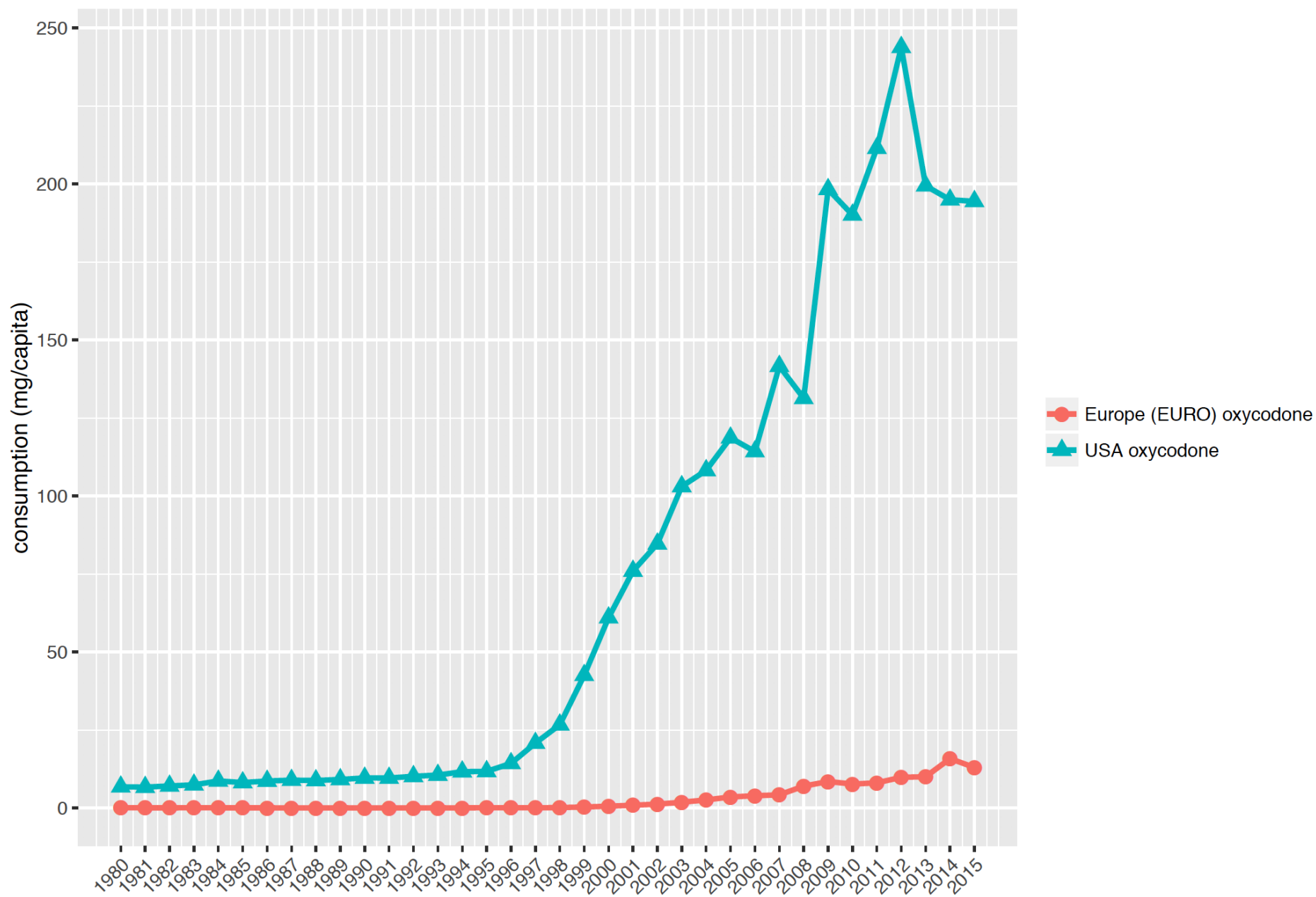
Prescribing has declined slightly since 2011



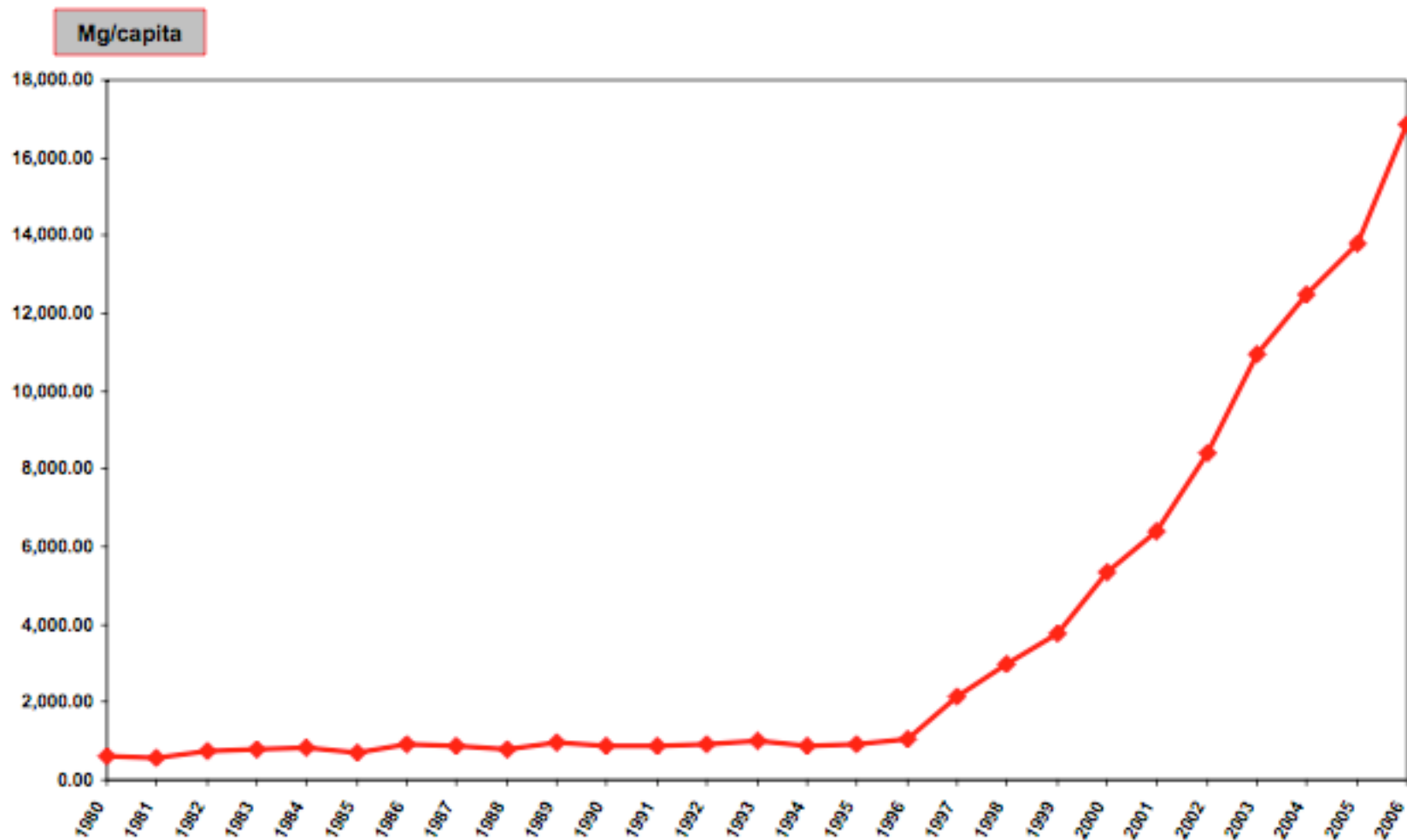
Prescribing levels in 2015 were 3 times higher than 1999

Source: Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704.

USA oxycodone consumption (mg/capita) 1980–2015

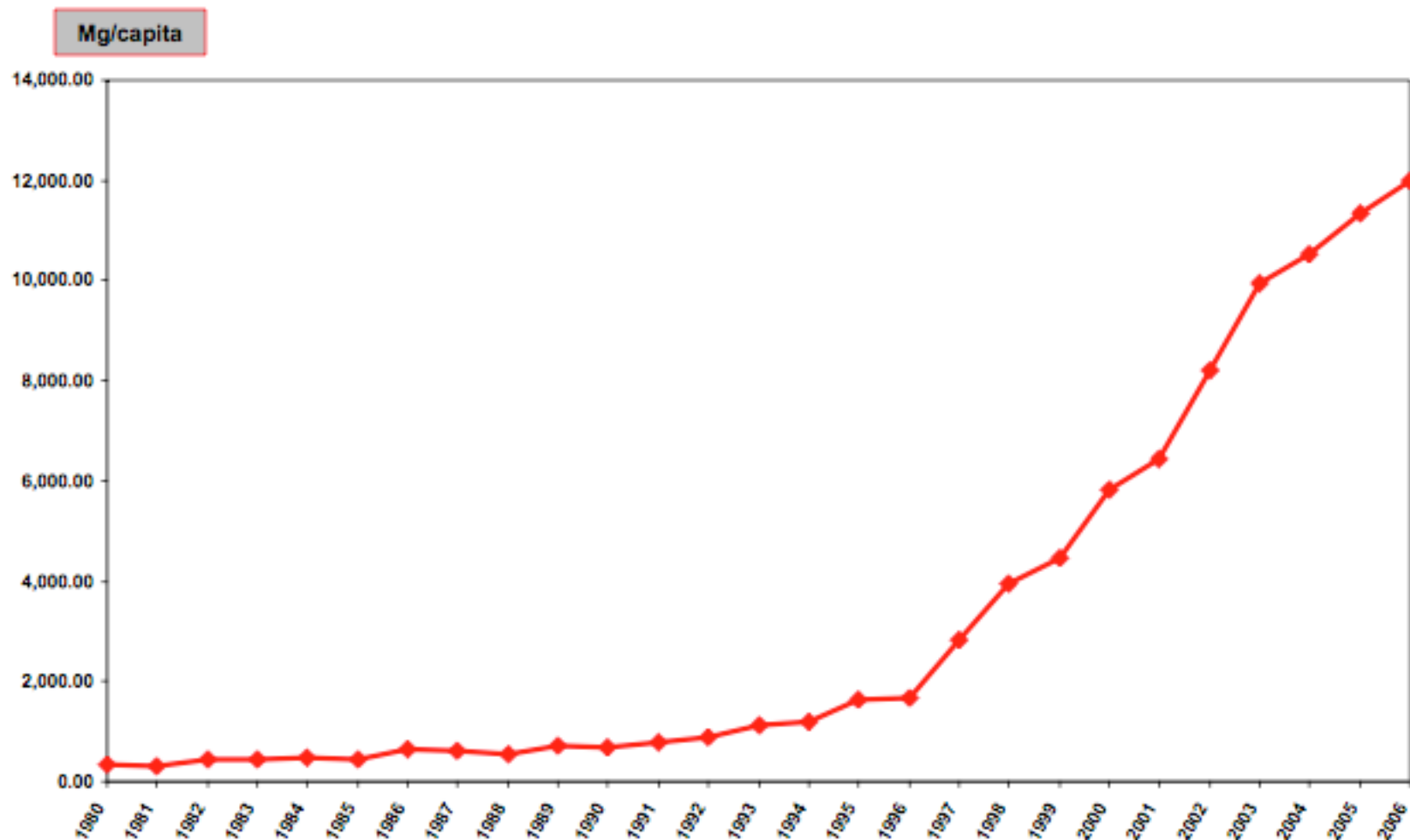


New York Consumption of Oxycodone 1980 - 2006



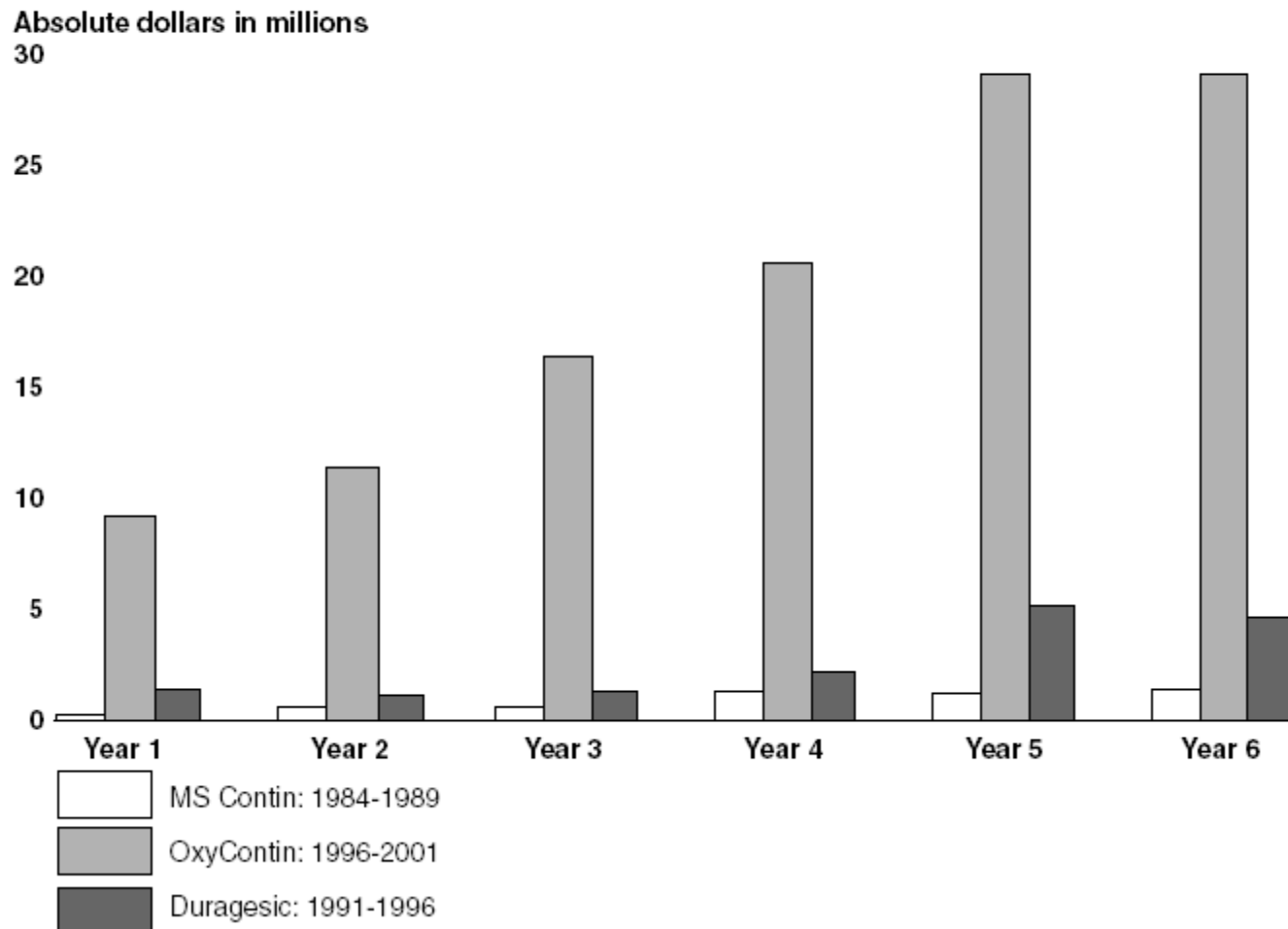
Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

New York Consumption of Hydrocodone 1980 - 2006



Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales



Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

Industry-funded “educational” messages

- Physicians are needlessly allowing patients to suffer because of “opiophobia.”
- Opioid addiction is rare in pain patients.
- Opioids can be easily discontinued.
- Opioids are safe and effective for chronic pain.

Industry-funded organizations campaigned for greater use of opioids

- Pain Patient Groups
- Professional Societies
- The Joint Commission
- The Federation of State Medical Boards



“The risk of addiction is much less than 1%”

Porter J, Jick H. *Addiction rare in patients treated with narcotics*. N Engl J Med. 1980 Jan 10;302(2):123

Cited 824 times (Google Scholar)

N Engl J Med. 1980 Jan 10;302(2):123.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients¹ who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,² Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER

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Waltham, MA 02154

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1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and

fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

Limitations: Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

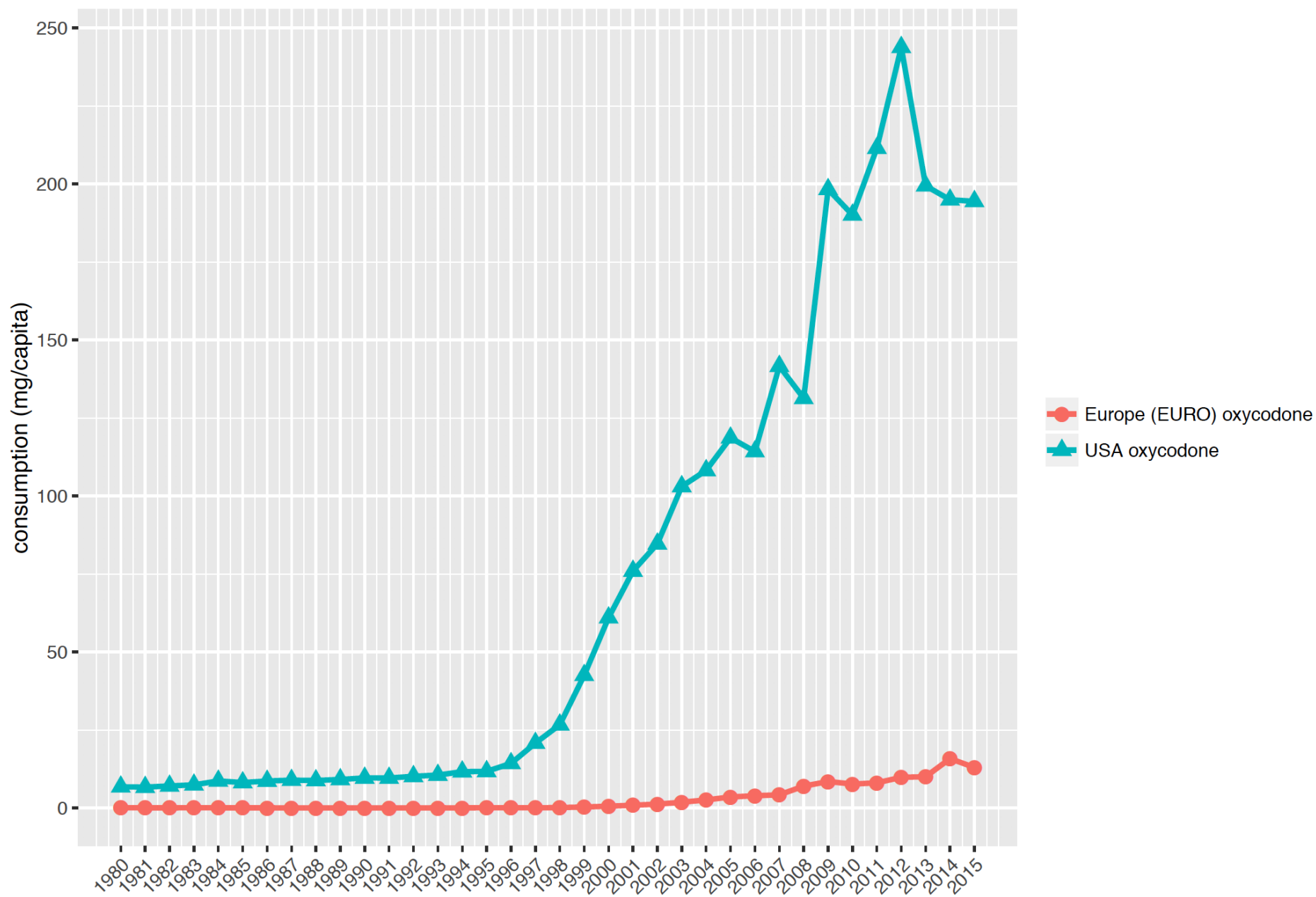
Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2015;162:276-286. doi:10.7326/M14-2559 www.annals.org
For author affiliations, see end of text.

This article was published online first at www.annals.org on 13 January 2015.

USA oxycodone consumption (mg/capita) 1980–2015



Controlling the epidemic:

A Three-pronged Approach

- **Prevent** new cases of opioid addiction.
- **Treat** people who are already addicted.
- **Reduce supply** from pill mills and the black-market.

Opioid lobby frames problem as if harms are limited to “drug abusers”

Who Will Be Affected by Rescheduling?



the AMERICAN ACADEMY *of* PAIN MEDICINE

2

This is a false dichotomy
Opioid harms are not limited to so-called “drug abusers”

35% met DSM V criteria for an opioid use disorder¹

Pain Patients



92% of opioid OD decedents were prescribed opioids for chronic pain.²

“Drug Abusers”

1. Boscarino JA, Rukstalis MR, Hoffman SN, et al. Prevalence of prescription opioid-use disorder among chronic pain patients: comparison of the DSM-5 vs. DSM-4 diagnostic criteria. J Addict Dis. 2011;30:185-194.

2. Johnson EM, Lanier WA, Merrill RM, et al. Unintentional Prescription Opioid-Related Overdose Deaths: Description of Decedents by Next of Kin or Best Contact, Utah, 2008-2009. J Gen Intern Med. 2012 Oct 16.

Frequently Discussed State-Based Interventions

- Expanding naloxone access
- Mandatory prescriber education
- Duration limits on first prescriptions
- Adding “ADFs” to Medicaid formularies
- Mandatory PDMP use

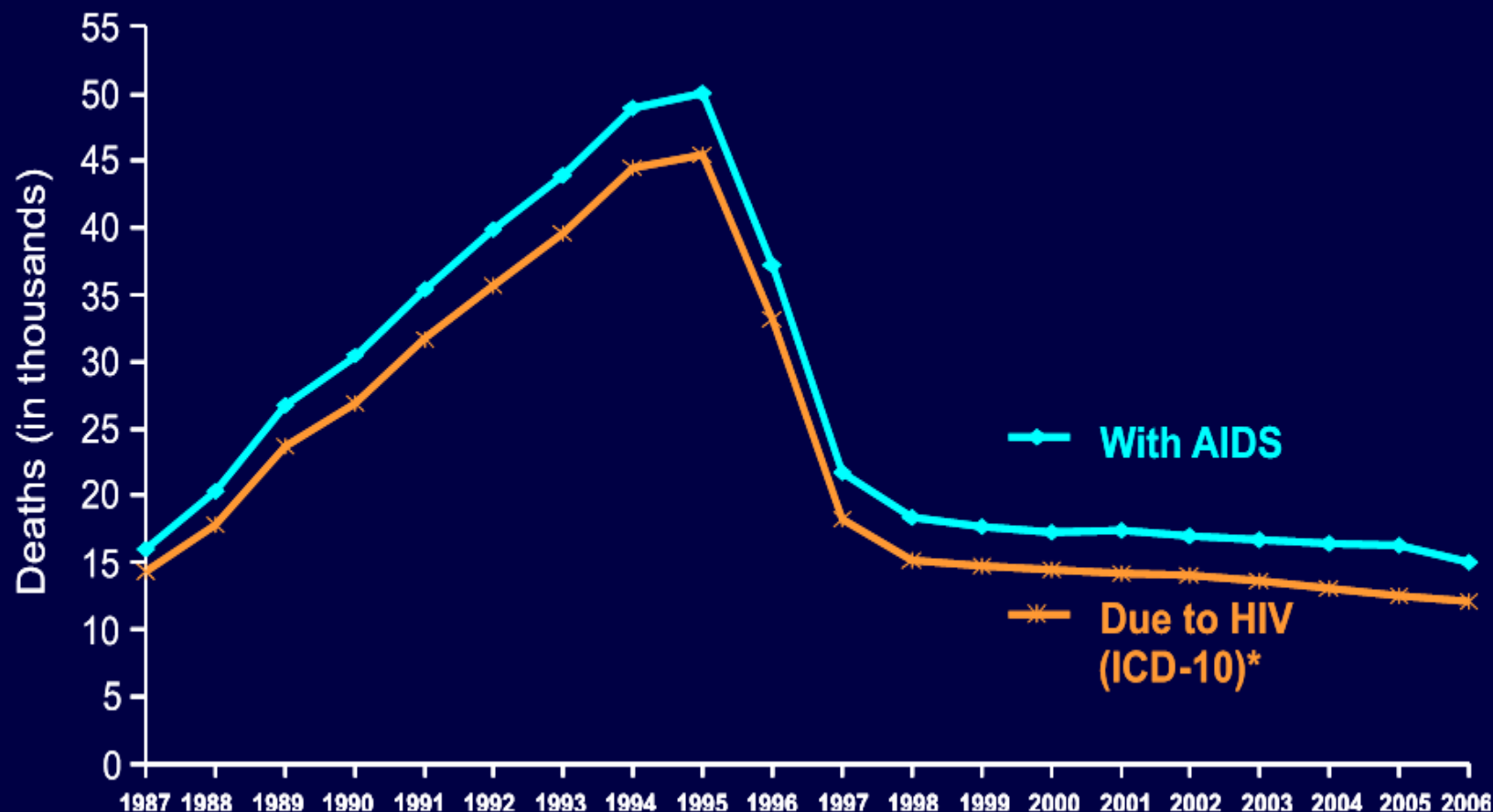
Mandatory PDMP use in NYS associated with 70% fewer scrips & 78% fewer pills

Frequency and quantity (numbers of pills) of pain medication prescriptions for dental emergency patients before and after implementation of the mandatory PDMP.

		Pre-iSTOP		Post-iSTOP-1		Post-iSTOP-2	
		prescriptions	pills	prescriptions	Pills	prescriptions	pills
Opioids	Hydrocodone	378	4145	163	1393	106	827
	Codeine	51	650	24	222	30	251
	Oxycodone	23	301	3	24	4	42
	Subtotal	452	5096	190	1639	140	1120
Non-opioids	Ibuprofen	1000	22257	1051	23600	1198	25846
	Acetaminophen	23	467	107	1645	119	1992
	Subtotal	1023	22724	1158	25245	1317	27838
Total		1475	27820	1348	26884	1457	28959

Source: Rasubala L, et al. Impact of a Mandatory Prescription Drug Monitoring Program on Prescription of Opioid Analgesics by Dentists. PLoS One. 2015 Aug; 10(8).

Comparison of Mortality Data from AIDS Case Reports and Death Certificates in Which HIV Disease Was Selected as the Underlying Cause of Death, United States, 1987–2006



*For comparison with data for 1999 and later years, data in the bottom (red) line for 1987–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.



Buprenorphine Experience in France

- Introduced in the mid 90s
- 79% decline in OD deaths in 6 years
- Use of mono product (not formulated with naloxone) associated with diversion and injection use

VIEWPOINT

Ten Steps the Federal Government Should Take Now to Reverse the Opioid Addiction Epidemic

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**Thomas R. Frieden,
MD, MPH**
Resolve,
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New York, New York.

The United States is in the midst of the worst drug addiction epidemic in its history. Prescriptions for and deaths from opioids both quadrupled between 1995 and 2010. By 2015, an estimated 92 million individuals in the United States were prescribed an opioid and there were more than 33 000 deaths from an opioid-involved overdose.¹

There are no simple solutions to ending this epidemic. Effective programs need to address 2 separate priorities: (1) prevention of addiction among people not currently addicted, and (2) treatment and risk reduction to prevent overdose and death among the millions of individuals in the United States now addicted. In this Viewpoint, we suggest 10 steps that could accelerate progress; national declarations, state-specific emergency declarations, or both could potentially facilitate implementation of these steps.²

state medical boards, and people who have survived an overdose could be linked to treatment. This feedback could foster more cautious prescribing and improve regulation of prescribing practices.

3. Promote more cautious prescribing for acute pain. Opioids are essential medicines to treat severe pain after surgery or serious injury, but they are too frequently prescribed for pain that could be treated with nonsteroidal anti-inflammatory medications (eg, molar extractions in adolescents). When opioid use is unavoidable, dosage should be as low and duration as brief as possible³; physiological dependence on and tolerance to opioids can develop in as little as 1 week. Patients taking short courses of opioid medication may experience withdrawal symptoms, including worsening of pain upon discontinuation; this may lead to continued use. According to a recent study, 1 in 5 patients



[Viewpoint](#)

Summary

- The U.S. is in the midst of a severe epidemic of opioid addiction
- To bring the epidemic to an end:
 - We must prevent new cases of opioid addiction
 - We must ensure access to treatment for people already addicted



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Strong States, Strong Nation



OVERVIEW OF STATE OPIOID POLICY AND LEGISLATION

Presented to: Oklahoma Commission on Opioid Abuse,
Attorney General Mike Hunter

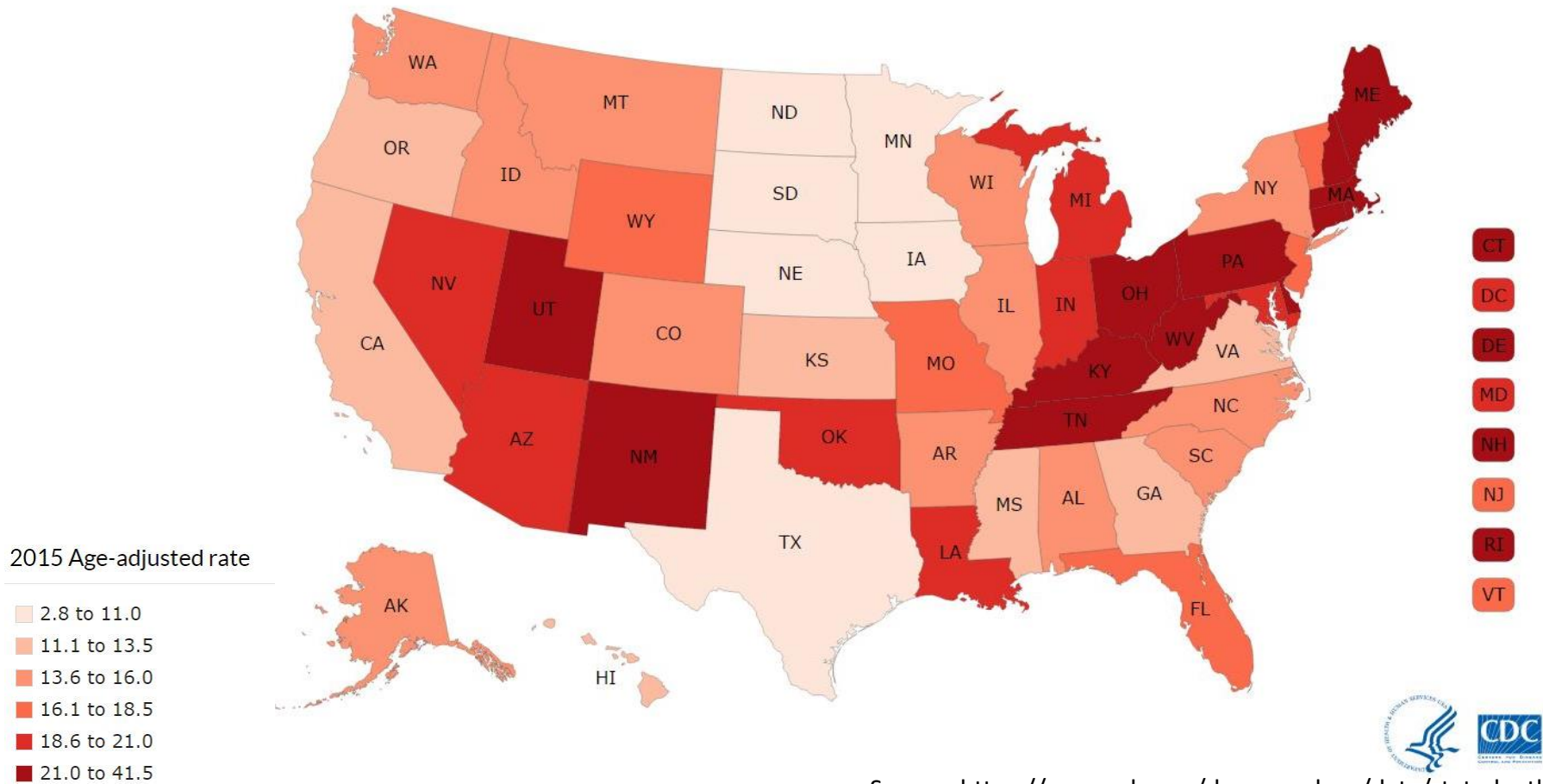
November 21, 2017



What's Covered Today

- ❑ Learn about policies adopted in other states to curtail the supply of and demand for opioids
- ❑ State strategies in prevention, intervention, treatment and recovery
 - ❑ Intersection with human services and criminal justice
- ❑ Trends and best practices available

Number and age-adjusted rates of drug overdose deaths by state, US 2015





What's the Problem?

- ❑ About half of drug overdose deaths (42/91) involve a PRESCRIPTION opioid
- ❑ Human and financial costs
- ❑ Prescription drug misuse
- ❑ Illicit drugs (e.g., heroin, fentanyl)
 - ❑ Large majority of illicit drug use started with non-medical use of prescription drugs
- ❑ Prevent misuse while maintaining access to needed medications





Prevention: PDMP

- ❑ Prescription drug monitoring programs (PDMP) among most promising state strategies
- ❑ PDMP state action and best practices:
 - ▣ Registration
 - ▣ Delegates (e.g., nurse, medical assistant) and authorized users/recipients (e.g., health, public safety, licensing board)
 - ▣ Universal use
 - ▣ Data submission (real-time)
 - ▣ Active management
 - ▣ Ease of use and access (e.g., integration with electronic health record)
 - ▣ Interstate data sharing

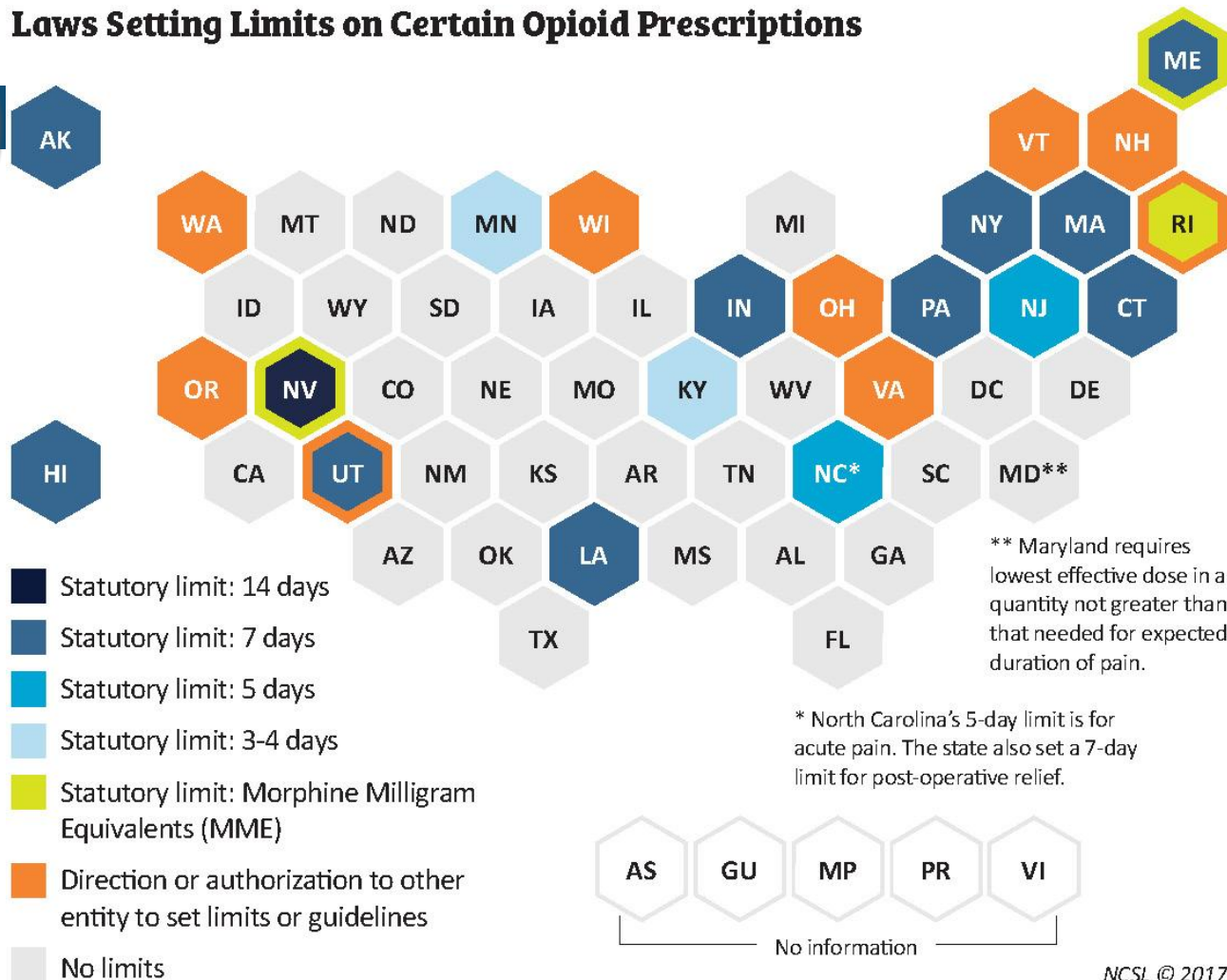


Prevention: Other State Actions

- ❑ Prescription limits or guidelines
 - ▣ 24+ states (see next map + Wisc.)
 - First time opioid prescriptions; day or MME limits
 - ▣ 9+ states allow boards to set limits (NH, OH, OR, RI, UT, VA, VT, WA, WI)
 - ▣ Centers for Disease Control and Prevention (CDC) Guideline
 - Voluntary recommendations for providers
- ❑ Provider Education & Training



Laws Setting Limits on Certain Opioid Prescriptions





Prevention: Other State Actions

- ❑ Pain clinic regulation
- ❑ Alternative pain management
 - ▣ e.g., acupuncture, massage, chiropractor
- ❑ Public education campaigns
- ❑ Drug take-back days/drop-boxes
- ❑ Non-opioid directives
- ❑ Abuse-deterrent formulations



Intervention (Rescue)

- ❑ Syringe services/exchange programs
- ❑ Naloxone access laws
 - ▣ Immunity
 - ▣ Emergency responders, law enforcement, fire fighters
 - ▣ Lay person
 - ▣ Third party prescriptions
 - ▣ Standing orders
- ❑ Good Samaritan Overdose/911 immunity



Treatment

- Only 10% with Substance Use Disorder receive treatment of any type
 - ▣ 3 FDA approved medications used with behavioral therapies
 - Proven to reduce illicit drug use, misuse, overdose risk and fatalities
- Treatment reduces:
 - ▣ Health care costs, criminal activity, withdrawal symptoms, cravings
- Treatment increases:
 - ▣ Economic, social, personal productivity, adherence to therapy, presenteeism, etc.



Hurdles to Treatment

- ❑ All treatments are not covered by all payers
 - ▣ Coverage isn't consistent across insurance companies/states
- ❑ Medicaid Fee for Service varies
 - ▣ Residential treatment is optional
- ❑ Parity Laws- “comparable coverage”
 - ▣ May have limitations which are not violations
- ❑ Many stakeholders involved





Road to Recovery Through Treatment

- ❑ Screening, Brief Intervention, Referral to Treatment (SBIRT)
- ❑ Treatment is a bottleneck in recovery
 - ▣ Not enough detox and treatment beds
 - ▣ Lack of providers in most urban and rural areas
 - ▣ Encouraging prescribers to use evidence-based MAT
- ❑ Sober living, long term recovery resources
- ❑ Ensuring parity and coverage as required by state and federal laws



Intersection with Criminal Justice & Human Services Issues

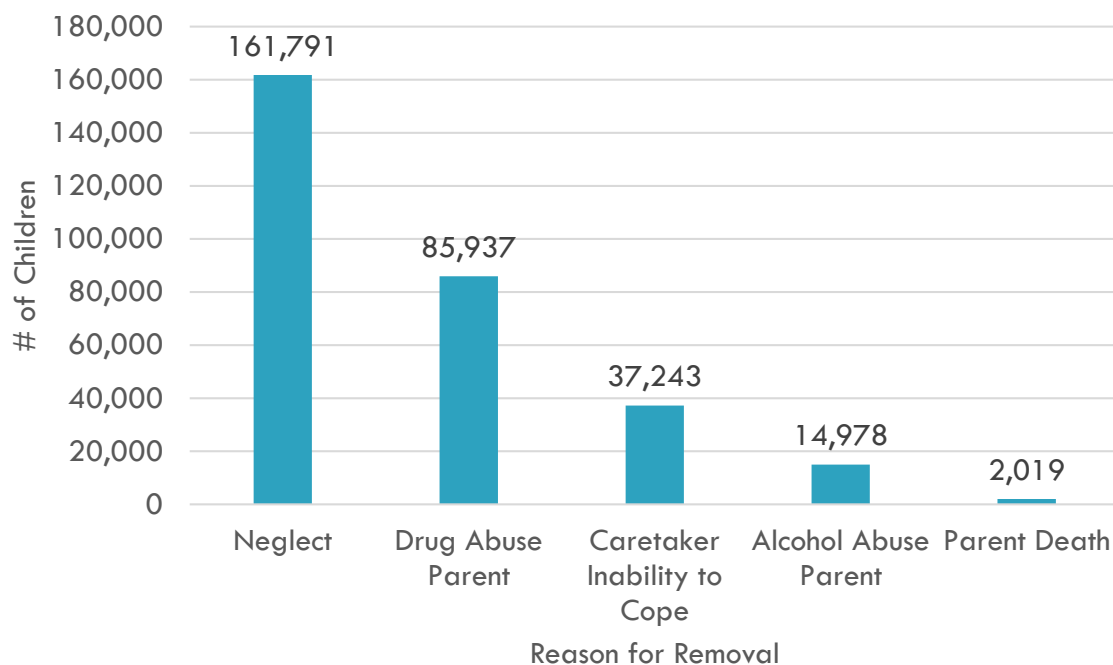
CJ: Amber Widgery- Amber.Widgery@ncsl.org
HS: Meghan McCann- Meghan.McCann@ncsl.org



Child Welfare

- Highest number of children in foster care since 2008
- State strategies
 - ▣ Plans of safe care
 - ▣ Specialty courts

Reason for Removal Related to Parental Substance Use in FY 2015





Key Questions to Ask

- ❑ What does the data show? What are the biggest issues for the state? Where do gaps exist?
 - ❑ E.g., overdoses, PDMP/prescribing, law enforcement seizures
- ❑ What recent action has been taken in the state (legislation and otherwise)? Federal funding opportunities?
- ❑ What new strategies might be needed and/or appropriate for the state?
- ❑ What agencies (e.g., public health, mental or behavioral health, child welfare, law enforcement) and other stakeholders (e.g., providers, families, insurers, etc.) need to be at the table?





Tools and Resources

- ❑ NCSL Opioid Prescribing Policies Brief www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx
- ❑ NCSL Injury Prevention Database www.ncsl.org/research/health/injury-prevention-legislation-database.aspx
- ❑ NCSL Prescription for Pain Management Brief
<http://www.ncsl.org/documents/health/PainManagement216.pdf>
- ❑ NCSL Prescription Drug Monitoring Programs Postcard
<http://www.ncsl.org/research/health/prescription-drug-monitoring-programs-postcard.aspx>
- ❑ Centers for Disease Control and Prevention
<https://www.cdc.gov/drugoverdose/index.html>
- ❑ NAAG, NGA, ASTHO all have resources



Thank You



Thoughts?

Questions?

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303-856-1423

The Forum for America's Ideas

OVERVIEW OF STATE CRIMINAL JUSTICE OPIOID POLICY AND LEGISLATION

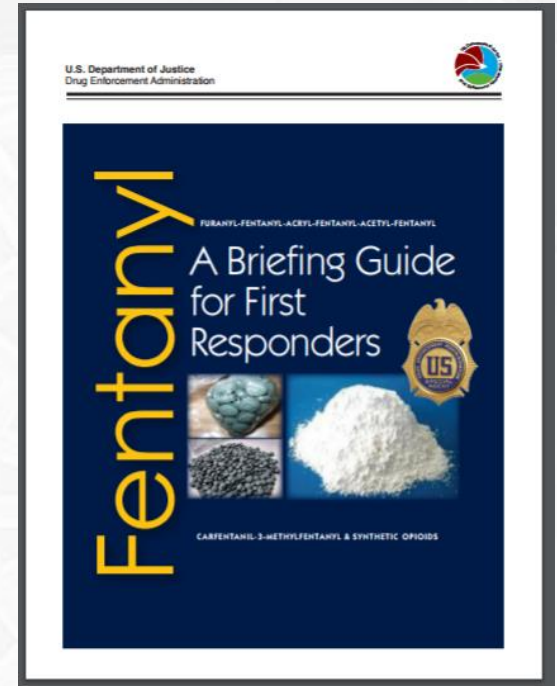
AMBER WIDGERY
NOVEMBER 2017



NATIONAL CONFERENCE *of* STATE LEGISLATURES

Naloxone

- All 50 states have a naloxone access law.
 - These provisions have often included access to naloxone for law enforcement for purposes of intervention when called to the scene of an overdose.
 - Naloxone can also be a tool for an officer's personal safety.

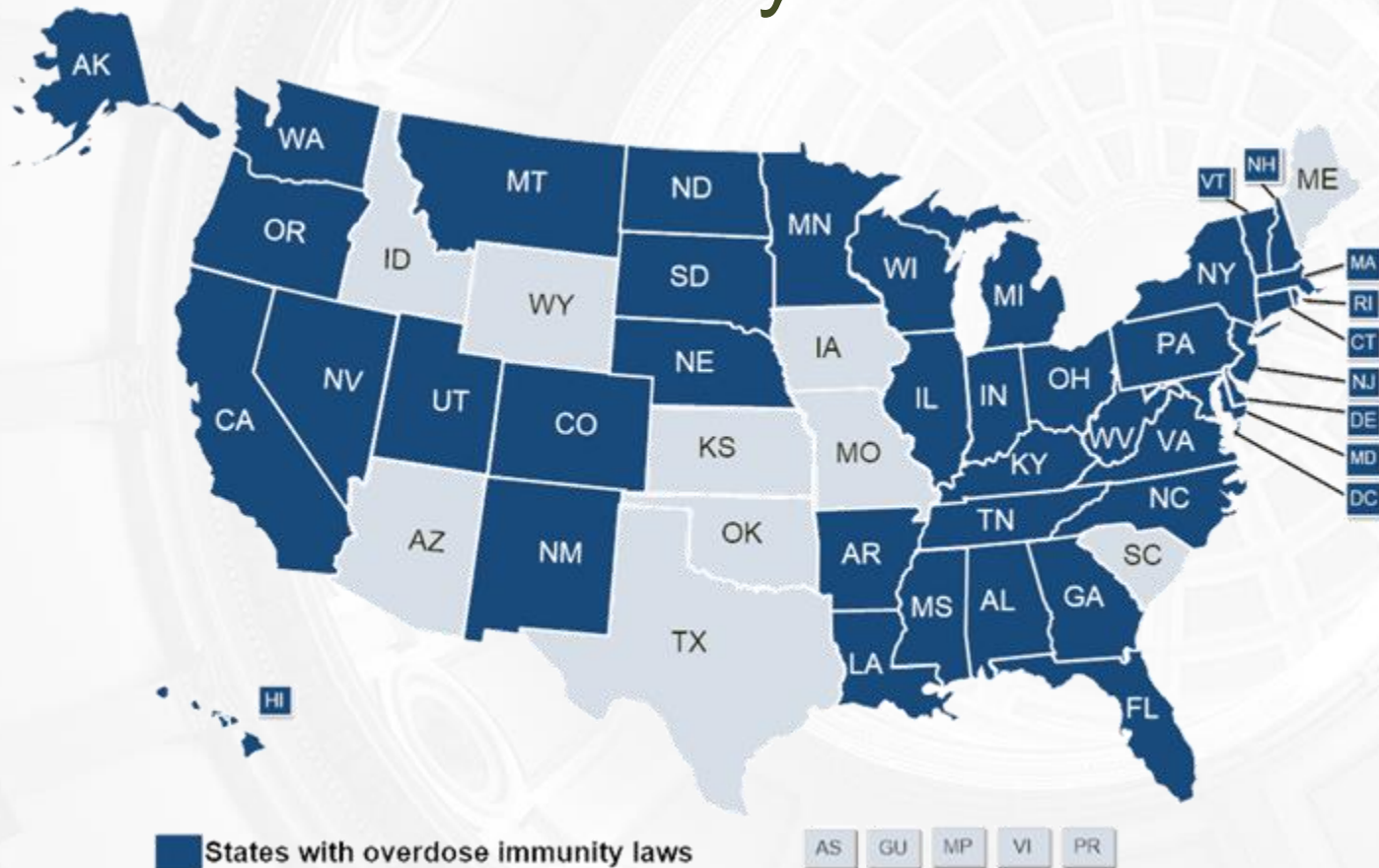


Source: [DEA Report](#)



NATIONAL CONFERENCE of STATE LEGISLATURES

Good Samaritan/911 Overdose Immunity Laws



40 States and D.C. have a Good Samaritan Law

Updated June 2017



NATIONAL CONFERENCE of STATE LEGISLATURES

Deflection

Definition:

“Stopping a citizen from entering the criminal justice system who is at immediate risk of or is at likely future risk of entering the criminal justice system due to behavioral health challenges, and instead deflecting (moving) them into the community human services system.”

Sources: Jac Charlier, TASC

Types of Programs

- Overdose Response
 - QRT – Quick Response Team
 - DART – Drug Abuse Response Team
 - PORT – Post Overdose Response Team
- Police Referral
 - LEAD – Law Enforcement Assisted Diversion
 - STEER – Stop, Triage, Engage, Educate, Rehabilitate
- Self-Referral
 - Angel Program



Recent Deflection Enactments

- California SB 843 (2016)
 - LEAD pilot program and made a \$15 million appropriation.
- Colorado 2017 Budget
 - LEAD pilot program and co-responder programs. Appropriated \$5.2 million.
- Kentucky SB 120 (2017)
 - Authorized Angel Initiative programs.
- New Jersey AB 3744 (2016)
 - Authorized law enforcement assisted addiction and recovery program.
- New Mexico HB 2 (2017)
 - Authorized funding for the study of LEAD in Santa Fe.



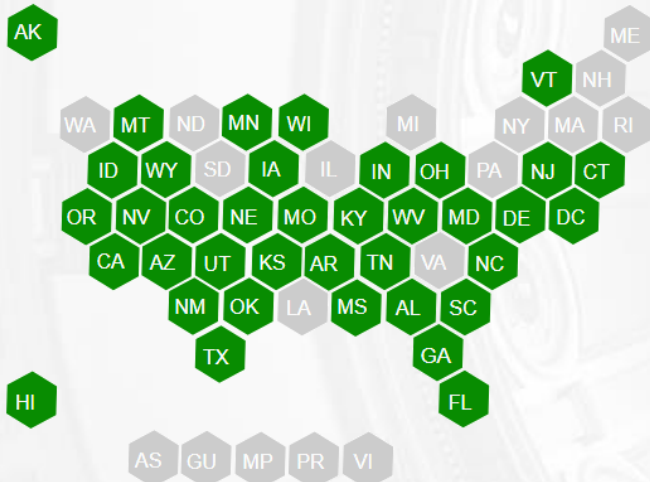
Deflection and Diversion

- Deflection is an emerging legislative trend that reroutes individuals with behavioral health needs before arrest or before contact with the justice system.
- Statutory pretrial diversion is well established in 48 states and the District of Columbia and reroutes defendants after arrest, but prior to adjudication or final entry of judgment.



Statutory Pretrial Diversion Database

General Population Diversion



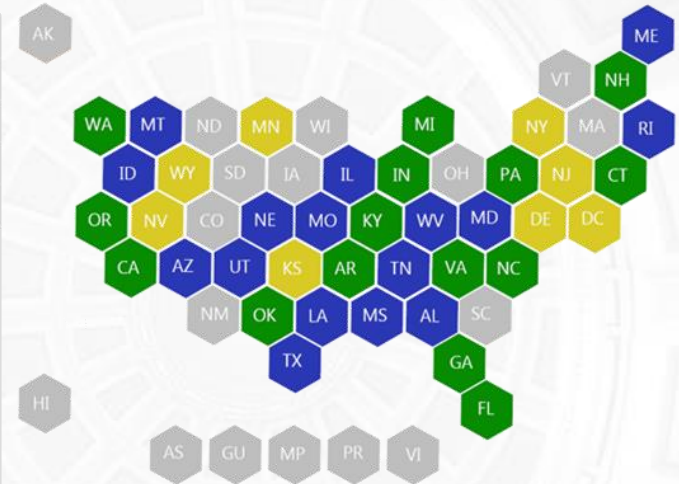
The interactive map has been designed to allow users to compare state general population diversion courts and programs. Select the state on the map for detail about general population diversion programs and courts in each state.

Thirty-seven states authorize programs that are not population specific and address the needs of defendants more generally than the programs listed above. These laws generally designate who has authorization to create a diversion program or designates administrative authority over a program to a specific individual or office such as prosecuting attorneys, local courts, or other local governmental agency. State statute also generally provides guidance on which defendants are eligible for participation in the diversion program and often specifically excludes defendants charged with a particular crime, defendants with specified criminal histories, or cases where certain circumstances, like death or bodily injury, were a factor.



Population Specific Diversion

Substance Abuse
Mental Health
Veterans/Active Military
Domestic Relations
Worthless Check
Other



SUBSTANCE ABUSE

The 16 states in ■ have statutorily authorized specialty courts aimed at addressing the needs of defendants charged with a drug offense or who have substance use related needs. The 8 states in ■ have statutorily created diversion programs for defendants charged with a drug offense or who have substance use related needs. The 15 states in ■ have statutorily authorized both specialty courts and diversion programs.

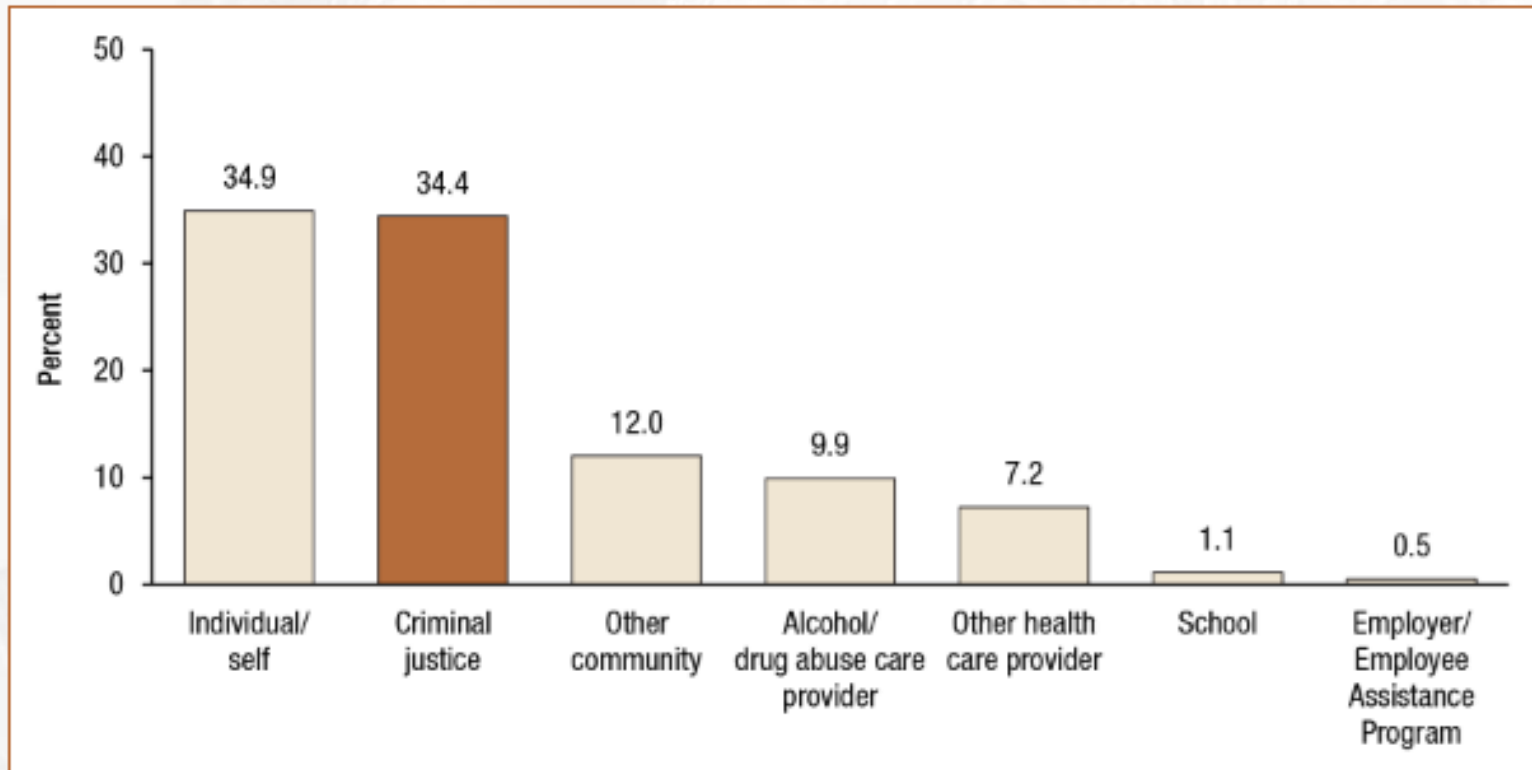
[Check out statutory citations and a chart of population-specific programs.](#)

[Statutory Pretrial Diversion Database](#)



NATIONAL CONFERENCE of STATE LEGISLATURES

According to Substance Abuse and Mental Health Services Administration (SAMHSA), the criminal justice system is the single largest source of referral to substance abuse treatment.



Source: SAMHSA Treatment Episode Data Set – Discharges (TEDS-D), 2011.

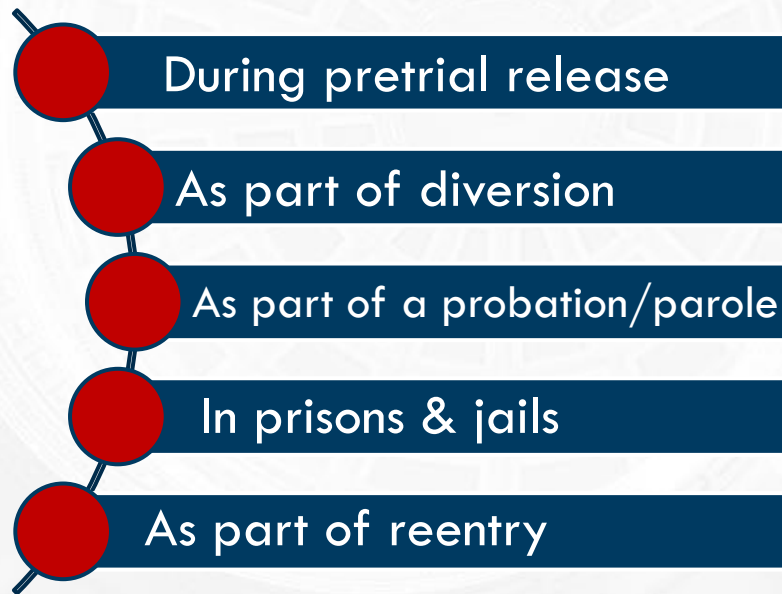
Sources: [SAMHSA Report](#)



NATIONAL CONFERENCE *of* STATE LEGISLATURES

States have expanded access to Medication Assisted Treatment (MAT) throughout the criminal justice system.

**MAT has
been
authorized:**



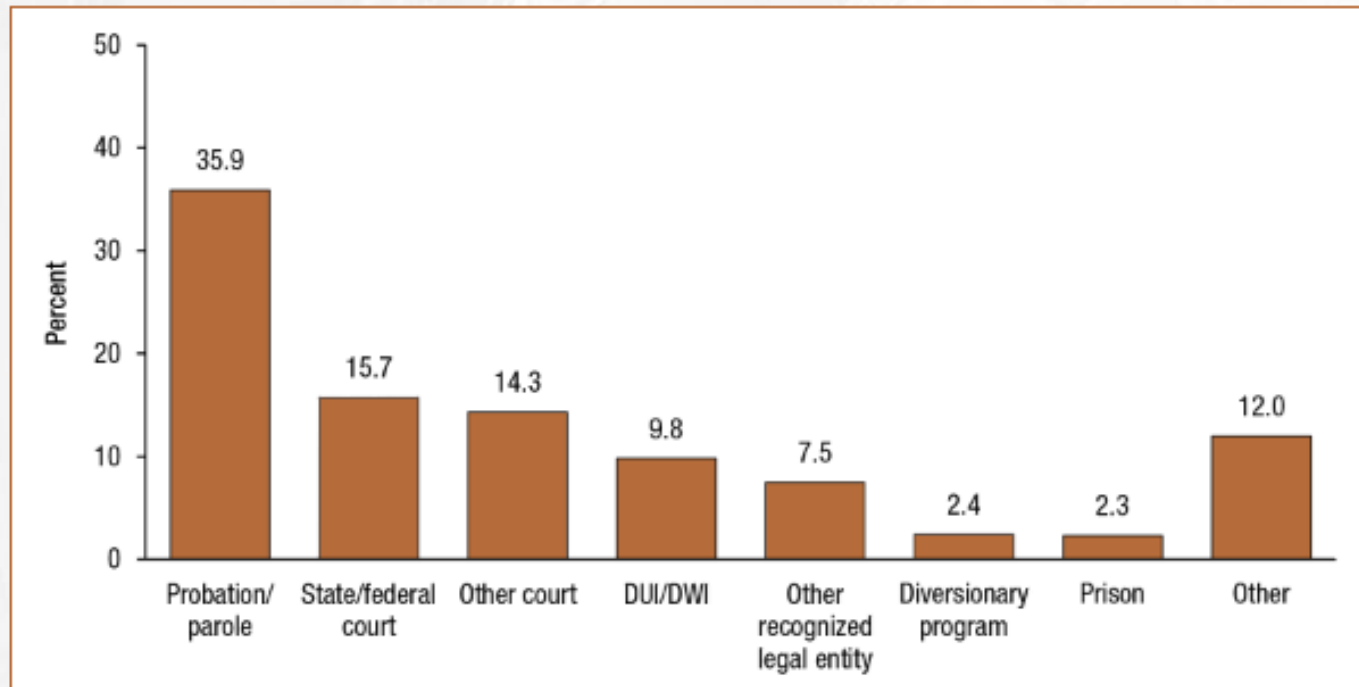
Recent MAT Diversion Enactments

In recent years, at least 12 states have enacted new laws addressing the use of medication assisted treatment in treatment courts and diversion programs.

- Florida HB 5001 (2016)
- Illinois HB 5594 (2016)
- Indiana SB 464; HB 1304; HB 1448 (2015)
- Michigan HB 5294 (2016)
- Missouri HB 2012 (2016)
- New Jersey SB 2381 (2015)
- New York AB 6255 (2015)
- Ohio HB 59 (2013)
- Tennessee SB 2653 (2016)
- Virginia HB 30 (2016)
- Wisconsin AB 657 (2016)
- West Virginia HB 2880 (2015)



Increasing Treatment for Incarcerated & Supervised Individuals



The majority of justice-involved referrals to treatment come from probation and parole.

Source: SAMHSA Treatment Episode Data Set-Discharges (TEDS-D), 2011.



Recent MAT Enactments Affecting Incarcerated & Supervised Individuals

In recent years, at least 10 states have enacted new laws addressing the use of medication assisted treatment correctional facilities and by supervision agencies.

- California SB 843 (2016)
- Florida HB 5001 (2016)
- Indiana SB 464; HB 1304; HB 1448 (2015)
- Kentucky SB 192 (2015)
- Michigan HB 5294 (2016)
- Missouri HB 10 (2015); HB 10 (2013)
- New Jersey SB 2381 (2015)
- Pennsylvania HB 1589 (2016); SB 524 (2015)
- Tennessee HB 1374 (2015)
- West Virginia HB 2880 (2015)



States are revising criminal penalties

1

Easing mandatory minimum penalties

2

Decreasing possession penalties while maintaining or increasing trafficking penalties

3

Creating new penalties and scheduling new synthetic opioids



Questions?

Contact me at:

amber.widgery@ncsl.org



NATIONAL CONFERENCE *of* STATE LEGISLATURES



Director of Governmental Affairs

TERRY A. SIMONSON

Tulsa County Courthouse
500 South Denver
Tulsa, Oklahoma 74103
918.724.3005

Terry A. Simonson

Since 1979, Terry's career has been a balance of both public service and the practice of law.

He has been the Chief of Staff, General Counsel, and/or the Court Administrator for three (3) Tulsa Mayor's (Inhofe, Crawford, and Bartlett). He also served as the Deputy County Commissioner to County Commissioner Randi Miller, Public Information Officer for Tulsa County, and the Chief of Staff/Director of Governmental Relations for four (4) Tulsa County Sheriff's.

Intermixed between his public service, he practiced law in Oklahoma in the Federal and State courts for over twenty (20) years.

He has served as a state lobbyist for public and private sector entities and has written several bills which have been signed into law by Oklahoma's Governors.

He serves or has served on a number of boards and committees, including the Legal Affairs Committee for the National Sheriff's Association, the Oklahoma Horse Racing Commission, the Oklahoma Legislature's Municipal Finance Committee, the Tulsa Chamber of Commerce One Voice Committee, the INCOG Board of Directors, and many others.

He has been the President of several Tulsa County Republican organizations and served as the Tulsa County Republican Party Chairman for six (6) years.



Director of Governmental Affairs

TERRY A. SIMONSON

Tulsa County Courthouse
500 South Denver
Tulsa, Oklahoma 74103
918.724.3005

November 21, 2017

To: Oklahoma Attorney General's Commission On Opioid Abuse

Fr: Terry A. Simonson - Director of Governmental Affairs

Re: Tulsa County Opioid Task Force Report

Dear Commissioners:

Beginning this past summer, an outstanding group of representatives from both the public and private sectors began meeting to collaborate on what could legislatively be done in 2018 to address the chronic opioid epidemic in Oklahoma. Specifically the Task Force's mission has been to focus on the accessibility to controlled opioid substances. Attachment "A" is the roster of Task Force representatives and the entities they represent.

After much discussion and research, the Task Force concluded that it was time for Oklahoma to implement mandatory electronic prescribing for all controlled substances. In essence, to remove paper prescriptions from being issued by practitioners which can be easily forged and recreated. We have learned, as Attachment "B" shows, pharmacies in Oklahoma are already prepared to accept electronic prescribing but physicians lag behind with its usage.

While some states have expanded the electronic prescribing mandate to both controlled and non-controlled drugs, to address the public health and public safety crisis currently facing Oklahoma, the Task Force decided to start by focusing only on those scheduled controlled substances on Attachment "C".

Where this is being used, the benefits to electronic prescribing are well known and documented, as Attachment "D" outlines.

It appears from the research, that the legislative solution may start by amending 63 O.S. § 2-309 which currently states: *"Electronic prescribing may be utilized for Schedules II, III, IV, and V, subject to the requirements set forth in 21 CFR, Section 1311, et seq."* See Attachment "E". This language needs to be amended to replace *"may"* with *"shall"*.

The DEA passed regulations in 2010 regarding the use of electronic prescriptions for controlled substances, which state, in part,: *"While not mandatory, electronic prescriptions for controlled substances may be subject to state laws and regulations. If state requirements are more stringent than the DEA's regulations, the state requirement would supersede any less stringent DEA provision."*

Finally, the Task Force reviewed the recently implemented laws in New York regarding mandatory e-prescribing. Attachment "F" are some highlights of this law.

The work of the Task Force has been presented to Tulsa County House Representative Glen Mulready who has agreed to authorize the staff attorneys in the House of Representatives to draft a legislative bill once the special session adjourns. The pre-filing deadline for 2018 bills is December 8th. Rep. Mulready is considering asking State Senator AJ Griffin to be the Senate sponsor.

While awaiting the draft bill, presentations have been made to a number of public, private, and political groups. This has included both the Tulsa County Sheriff's and Tulsa Police Departments Fraternal Order of Police organizations. Presentations have also been made before Tulsa's Leadership Vision, a private sector business group as well as a number of state representatives, senators and county elected officials. It was also presented to the Council of Tulsa Area Governments that voted to endorse and support this measure.

On behalf of the Task Force, it is respectfully requested that this effort be supported and endorsed by the Attorney General's Opioid Commission.

ATTACHMENT "A"

MEMBERS OF TULSA COUNTY'S E-PRESCRIBING TASK FORCE

- Director of the Tulsa County Social Services
- Three (3) officers from the Tulsa Police Department
- Three (3) Assistant Attorney Generals from the Oklahoma AG's Office
- Two (2) agents from the Drug Enforcement Administration
- One (1) compliance officer from the Oklahoma State Board of Pharmacy
- Two (2) pharmacists from CVS Pharmacy
- One (1) investigator from the Oklahoma State Dental Board
- Two (2) pharmacists from Reasor's Pharmacy
- Two (2) regulators from the Oklahoma Board of Osteopathic Examiners
- Two (2) agents from the Oklahoma Bureau of Narcotics & Dangerous Drugs
- Two (2) pharmacists from Walgreens Pharmacy

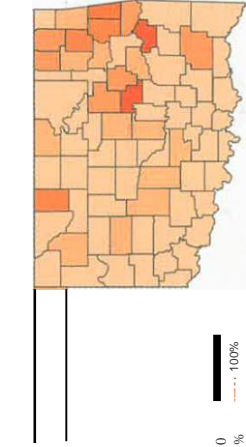
ATTACHMENT "B"

OK EPCS Prescriber and Pharmacy Enablement Status - September 2017 PRESCRIBER STATUS



State	Total Prescribers (1)	Active E-Prescribers (2)	Active E-Prescribers EPCS Enabled (3)	% Active E-Prescribers	% EPCS Enabled Prescribers	Total New Rx (4)
OK	13,939	8,208	1,130	58.9%	8.1%	1,462,150
National	13,939	8,208	1,130	58.9%	8.1%	1,462,150

% EPCS Prescriber Enablement By County



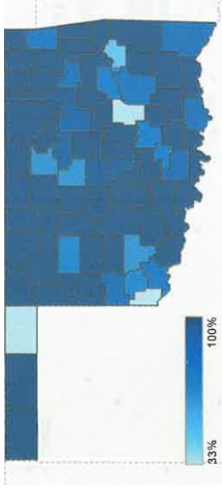
79% e-prescribers have sent an EPCS transaction in the last 30 days

- 1.Total Prescribers:** total prescribers in both acute and ambulatory settings based on Endianity data excluding Dentists. Prescribers licensed in multiple states only counted once towards National total.
- 2.Active E-Prescribers:** prescribers that have sent e-prescriptions to pharmacies over the Surescripts network in the last 30 days.
- 3.Active E-Prescribers EPCS Enabled:** prescribers who use an EHR software that is EPCS certified and audit approved. These prescribers may not yet be sending EPCS transactions, but have sent an e-prescription in the past 30 days.
- 4.Total New Rx and EPCS Transactions:** Surescripts network transactions in the current month from all prescriber settings.

Analysis of Dentists: while dentists were excluded from the Total Prescribers (1) metric, e-prescribing dentists were included in calculations (2) and (3) above. Here are the dentist specific metrics:

Total Prescribers	1,886	Active E-Prescribers	61	Active E-Prescribers EPCS Enabled	44
% Rx Active Pharmacies	96.9%	% EPCS Enabled Pharmacies	95.7%	Total New Rx (4)	6,874,273
EPCS Enabled Pharmacies (3)	779				
Active Rx Pharmacies (2)	789				
Total Pharmacies (1)	814				

% EPCS Pharmacy Enablement By County



Methodology:

- 1.Total Pharmacies:** total number of pharmacies in the country based on NCPDP data.
- 2.Active Rx Pharmacies:** ready and processing e-prescriptions from prescribers applications
- 3.EPCS Enabled Pharmacies:** certified and audit approved software at prescriber , ready to receive EPCS transactions from prescribers. Training may be needed
- 4.Total New Rx and EPCS Transactions:** Surescripts network transactions in the current month from all prescriber settings.

The Surescripts network data contained herein is provided on an "as is" basis for informational purposes only. Surescripts makes no warranties, either expressed or implied, concerning the accuracy, completeness, reliability or suitability of the data and assumes no liability for any damages caused by inaccuracies in this data or arising from the use or misuse of such data. No part of this document may be reproduced without the written permission of Surescripts.

-Prescribing of Controlled Substances (EPCS)

Surescripts has upgraded its nationwide network to support Electronic Prescribing of Controlled Substances (EPCS). With this capability expansion, Surescripts creates a pathway for physicians to manage all their prescriptions within the electronic workflow, no longer having to prescribe controlled substances using separate methods of paper, phone, and fax.

FACT: 12% of today's prescriptions are controlled substances.

FACT: Processing these prescriptions outside of electronic fulfillment creates a dual work stream for physicians

EPCS certification from Surescripts offers an opportunity to reduce healthcare costs and improve the safety and efficiency of a process relied upon by millions of patients every day.

Enabling EPCS

The Drug Enforcement Administration (DEA) Interim Final Rule (IFR) eliminates a final major barrier in total electronic prescribing. Surescripts is committed to enabling and optimizing the EPCS process for pharmacies, software vendors and prescribers. Through a collaboration with pharmacy and physician vendors, we have gained valued and necessary experience to support the industry's efforts to move forward with EPCS, in states where it is approved.

To date, there are several EPCS certified and audited pharmacies, and pharmacy and physician software vendors on the Surescripts network. Looking forward, Surescripts will continue to monitor the EPCS process to assure quality, security and safety across the network. We invite participants that currently use Surescripts for their e-prescribing services, as well as new vendors, to become enabled for EPCS. However, to send controlled substances electronically, participants must take steps to meet DEA requirements.

Steps Required to Implement EPCS



Physician Software Vendors

1. Update e-prescribing software to meet all requirements specified in the IFR and SCRIPT messaging that supports EPCS
2. Undergo a third-party audit to ensure the software meets all DEA EPCS requirements
3. Achieve Surescripts Certification
4. Make audit results available to Surescripts, along with a Surescripts EPCS Audit Attestation Form



Pharmacy Software Vendors*

1. Update e-prescribing software to meet all requirements specified in the IFR and SCRIPT messaging that supports EPCS
2. Undergo a third-party audit to ensure the software meets all DEA EPCS requirements
3. Achieve Surescripts certification
4. Make audit results available to Surescripts, along with a Surescripts EPCS Audit Attestation Form

*And Chain Pharmacies that have developed their own software



Prescribers

1. Verify EPCS is legal in your state*
2. Ensure that your e-prescribing software is Surescripts certified
3. Receive an audit report supplied by your software vendor indicating compliance with the IFR
4. Adhere to new ID verification procedures and access controls: ID Proofing, Two Factor Authentication, Digital Signing

*This does not constitute legal advice. Prescribers should consult an attorney to ensure that EPCS is permitted in their state.

The Surescripts Path to EPCS Certification

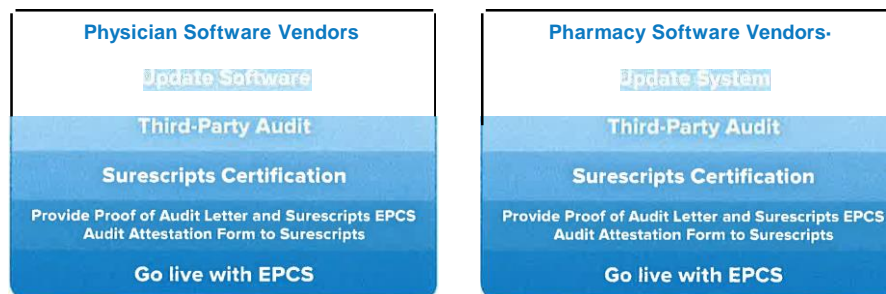
Physician and pharmacy software vendors - Applications must receive certification from Surescripts to access the Surescripts network. Surescripts certification¹ assures the seamless end-to-end electronic processing of controlled substance prescriptions. If your physician or pharmacy software is already certified by Surescripts for e-prescribing, simply contact your Alliances representative to discuss a plan for EPCS certification or email alliances@surescripts.com.

New to Surescripts? Software application vendors and pharmacies not currently certified by Surescripts for core e-prescribing services must have contracts in place with Surescripts before certification can begin.

Then, Surescripts provides: technical documentation, educational sessions, setup and connectivity to the Surescripts staging and certification environment, as well as access to implementation consultants² who provide knowledge and expertise to help guide you through the process.

1. Surescripts certification is based on NCPDP guidelines and adherence to DEA guidelines and regulations.

2. Additional fees apply. Contact your Alliances representative for more information.



*And Chain Pharmacies that have developed their own software

Surescripts Brings Clarity and Value to the EPCS Process

Security

Only qualified application vendors and pharmacies that have completed Surescripts Certification and have a third-party Proof of Audit Letter are able to connect to the Surescripts network for EPCS.

Surescripts' EPCS service checks prescriptions for the digital signature or digital signature flag.

If prescriptions are not electronically deliverable, they will be returned to the prescriber for an alternate delivery method.

Leadership

Surescripts fosters a collaborative approach designed to facilitate success for all network participants.

By carefully monitoring key program aspects during our initial deployment phase, we have gained the knowledge needed to optimize the EPCS experience.

About Surescripts

The Surescripts network supports the most comprehensive ecosystem of healthcare organizations nationwide. Pharmacies, payers, pharmacy benefit managers, physicians, hospitals, health information exchanges and health technology firms rely on Surescripts to more easily and securely share health information. Guided by the principles of neutrality, transparency, physician and patient choice, open standards, collaboration and privacy, Surescripts operates the nation's largest health information network. By providing information for routine, recurring and emergency care, Surescripts is committed to saving lives, improving efficiency and reducing the cost of health care for all. For more information, go to www.surescripts.com and follow us on **Twitter** @Surescripts.

For more information, contact your Surescripts Alliances representative about EPCS Certification or email alliances@surescripts.com.

ATTACHMENT "C"

Controlled Substances Drug Schedule

Based on each drug's (1) potential for abuse; (2) safety;
(3) addictive potential, and (4) legitimate medical applications

Schedule I

No currently acceptable medical use and a high potential for abuse:

Heroin	LSD	Marijuana	Peyote	Ecstasy
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Schedule II

High potential for abuse, less abuse potential than Schedule I drugs

Cocaine	Methadone	Dilaudid	Demerol	OxyContin
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Ritalin	Adderall	Methamphetamine	Fentanyl	Dexedrine
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Schedule III

Moderate to low potential for physical and psychological dependence

Vicodin	Codeine	Steroids	Testosterone
---------	---------	----------	--------------

Schedule IV

Low potential for abuse and low risk of dependence

Xanax	Valium	Ambien	Talwin	Darvon
-------	--------	--------	--------	--------

ATTACHMENT "D"

Benefits of E- Prescribing

- Prevents prescription drug errors
- Automated clinical decision support
- Speeds up the medication reconciliation process
- Helps meet meaningful use requirements for e - prescriptions
- Instant notification of allergies, drug interactions, duplicate therapies and other clinical alerts
- Track patient fulfillment of prescriptions
- Reduces the number of lost prescriptions
- Enables physicians to electronically prescribe controlled substances in a single workflow
- Enables better monitoring of controlled substance prescriptions
- Staff spends less time responding to prescription refill requests
- Reduces the risk of readmissions
- Improves medication adherence
- Improves verification of insurance

ATTACHMENT "E"

63 O.S. § 2-309

OSCN Found Document: Prescriptions

A. 1. Except for dosages medically required for a period not to exceed forty-eight (48) hours which are administered by or on direction of a practitioner, other than a pharmacist, or medication dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled dangerous substance included in Schedule II, which is a prescription drug as determined under regulation promulgated by the Board of Pharmacy, may be dispensed without the written prescription of a practitioner; provided, that in emergency situations, as prescribed by the Board of Pharmacy by regulation, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist in a manner to be prescribed by rules and regulations of the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.

2. Electronic prescribing may be utilized for Schedules II, III, IV, and V, subject to the requirements set forth in 21 CFR, Section 1311 et seq.

3. The transmission of written prescription by practitioner to dispensing pharmacy by facsimile or electronic transmission with electronic signature is permitted only under the following conditions:

a. for Schedule II drugs, the original prescription must be presented and verified against the facsimile at the time the substances are actually dispensed, and the original document must be properly annotated and retained for filing, except:

(1) home infusion pharmacy may consider the facsimile to be a "written prescription" as required by Section 2-101 et seq. of this title and as

required by Title 21 U.S.C., Section 829(a). The facsimile copy of the prescription shall be retained as an original prescription, and it must contain all the information required by Section 2-101 et seq. of this title and 21 CFR, Section 1306.05(a), including date issued, the patient's full name and address, and the practitioner's name, address, DEA registration number, and signature. The exception to the regulations for home infusion/IV therapy is intended to facilitate the means by which home infusion pharmacies obtain prescriptions for patients requiring the frequently modified parenteral controlled release administration of narcotic substances, but does not extend to the dispensing of oral dosage units of controlled substances,

(2)the same exception is granted to patients in Long Term Care facilities (LTCF), which are filled by and delivered to the facility by a dispensing pharmacy, and

(3)an electronic prescription with electronic signature may serve as an original prescription, subject to the requirements set forth in 21CFR, Section 1311 et seq., and

b. for drugs in Schedules III and IV, a facsimile copy of a written, signed prescription transmitted directly by the prescribing practitioner to the pharmacy can serve as an original prescription. Electronic prescribing may be utilized for Schedules III and IV subject to the same requirements as set forth in 21 CFR, Section 1311 et seq.

4. Prescriptions shall be retained in conformity with the requirements of this section and Section 2-307 of this title. No prescription for a Schedule II substance may be refilled.

B. 1. Except for dosages medically required for a period not to exceed forty-eight (48) hours which are administered by or on direction of a practitioner, other than a pharmacist, or medication dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled dangerous substance included in Schedule III or IV, which is a prescription drug as determined under regulation promulgated by the Board of Pharmacy, may be dispensed without a written or oral prescription.

2.A written or oral prescription for a controlled dangerous substance in Schedule III or *N* may not be filled or refilled more than six (6) months after the date thereof or be refilled more than five times after the date of the prescription, unless renewed by the practitioner.

3.A written or oral prescription for any product containing hydrocodone with another active ingredient shall not be refilled.

B.No controlled dangerous substance included in Schedule V may be distributed or dispensed other than for a legitimate medical or scientific purpose.

C.Except for dosages medically required for a period not to exceed forty eight (48) hours which are administered by or on direction of a practitioner, other than a pharmacist, or medication dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, tincture opium camphorated, commonly known as paregoric, may not be dispensed without a written or oral prescription. The refilling of a prescription for paregoric shall be unlawful unless permission is granted by the prescriber, either written or oral.

D.Whenever it appears to the Director that a drug not considered to be a prescription drug under existing state law or regulation of the Board of Pharmacy should be so considered because of its abuse potential, the Director shall so advise the Board of Pharmacy and furnish to the Board all available data relevant thereto.

E."Prescription", as used herein, means a written or oral order by a practitioner to a pharmacist for a controlled dangerous substance for a particular patient, which specifies the date of its issue, and the full name and address of the patient; if the controlled dangerous substance is prescribed for an animal, the species of the animal; the name and quantity of the controlled dangerous substance prescribed; the directions for use; the name and address of the owner of the animal and, if written, the signature of the practitioner.

F.No person shall solicit, dispense, receive or deliver any controlled dangerous substance through the mail, unless the ultimate user is personally known to the practitioner and circumstances clearly indicate

such method of delivery is in the best interest of the health and welfare of the ultimate user.

ATTACHMENT "F"

Highlights Of New York Electronic Prescribing Legislation

- As of March 27, 2016 it will be mandatory for practitioners, excluding veterinarians, to issue electronic prescriptions for controlled and non-controlled substances. This will require additional security features and registration of the certified software application.
- This law went into effect three (3) years after the New York Department of Health promulgated regulations allowing for electronic prescriptions of controlled substances in March of 2013
- There are a number of exceptions allowed to electronic prescribing (see attached)
- Software must meet federal security requirements for EPCS which can be found on the DEA website
- Must complete the identity proofing process as defined in the federal requirements
- Must obtain a two factor authentication as defined in the federal requirements
- Must register the DEA certified EPCS with the Bureau of Narcotics Enforcement
- There appears to be a limit on the supply of controlled substances that can be prescribed: 5 days
- Definition of an electronic prescription does not allow a prescription generated on an electronic system that is printed out or transmitted via facsimile.
- Physician still has to consult PMP

FACTS ABOUT OPIOIDS

1 in 3 American Adults Are Prescribed Opioids Every Year.
That means of the 100,000 fans that fill O.U.'s Memorial Stadium, about 30,000 of them have taken or are taking a prescribed opioid drug.

According to an article which appeared in the *Annals of Surgery-2017* "*In 2015, United States drug overdose deaths exceeded 50,000; 30,000 involved opioids. There were more deaths from opioid overdose than not only from motor vehicle accidents, but also than from the HIV/AIDS at the peak of the epidemic in 1995*"

In 2010, the DEA issued regulations permitting, but not requiring, electronic prescribing for controlled substances. These regulations state: "*While not mandatory, electronic prescriptions for controlled substances may be subject to state laws and regulations. If state requirements are more stringent than DEA's regulations, the state requirements would supersede any less stringent DEA provision.*" This opens the door for Oklahoma legislation that would make it mandatory that all Scheduled Controlled Substances have to be prescribed.

The technology for prescribing is widely available, but few doctors use it. Although 81% of pharmacies are enabled to receive computerized opioid prescriptions and more than 90% of physicians have electronic medical record systems which would enable them to e-prescribe for controlled substance - only 8% of physicians are in practices that have enabled that capability and use it to electronically prescribe opioids.

Not everyone who dies from an opioid overdose is an addict. Others who have died it occurred by: (1) taking more than prescribed; (2) combining them with other central nervous system depressants, like alcohol; and (3) an unknown condition that reacts to the opioid.

Overdosing comes from the slowing of the respiratory system which creates respiratory depression, which is a reduction of the number of breaths that we take each minute, which is normally from 12 to 20 breaths per minute. Being an addict and being dependent are not the same things

More than half of all opioid prescriptions are issued to patients suffering from some form of mental condition that limits their ability to cope or function successfully without taking the medication. In most cases the prescriptions are for anxiety and depression.

Back pain is one of the most common reasons for receiving opioids.

Many young adults receive these drugs from their dentist and oral surgeons.

Between 2013 and 2015 there were 68,177 physicians who received in excess of \$46 million in payments from drug companies marketing narcotic pain relievers.

The vast majority of opiate abusers receive the drugs they use through diversion from other family members excess supply of pills.

Surgeon often over prescribe because under federal regulations, patients stranded with an insufficient supply for their pain have no straightforward way to get a refill without a written prescription

Electronic prescriptions would make it far easier for surgeons to write smaller prescriptions that meet the needs of 80% of patients knowing they could remotely order an additional supply if a patient needed it.

Opioid Commission Meeting

November 21, 2017



Treatment Initiatives, Barriers and Training in the Oklahoma Opioid Epidemic

JASON BEAMAN D.O., M.S., M.P.H., FAPA
ASSISTANT CLINICAL PROFESSOR

CHAIR, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
OKLAHOMA STATE UNIVERSITY

Board Certified:

Forensic Psychiatry
Psychiatry
Family Medicine


Treatment Initiatives



- Project ECHO
- OSU Center for Wellness and Recovery
- Expanded Access

Project ECHO






Better Health. Brighter Future.

5,000
employees across the U.S.

LEARN MORE




THE HILL


New federal grants to help train rural doctors to fight addiction


BY SARAH FERRIS - 07/16/16 11:52 AM EDT


3 COMMENTS

95 SHARES

 SHARE

 TWEET

 PLUS ONE



Mnuchin pledges to fight carried interest loophole in tax reform plan

FINANCE — 39M 48S AGO

Carter Page wanted Trump to take 2016 trip to Russia

NATIONAL SECURITY — 47M 50S AGO

House Freedom Caucus backs bill to end diversity visa lottery

HOUSE — 1H 11M AGO

Bill Clinton hits Trump, tax reform plan in Georgetown speech

IN THE KNOW — 1H 56M AGO

Dame furious over Air

The Obama administration is committing \$9 million to rural health officials in three states that are testing the waters of telemedicine as they try to stem the rising tide of overdose deaths.


The latest set of federal grants, which was announced at a meeting of the National Governors Association, will go to Oklahoma, Colorado and Pennsylvania over the next three years.

All three states have committed to using a telemedicine-style training program to help expand treatment in areas that have been historically underserved by healthcare providers.

States will use a model called Project ECHO, in which rural primary care doctors watch videos by urban speciality doctors who are trained in complex health problems like opioid addiction.


The Project ECHO approach, which was developed by the University of New Mexico, became widely touted after its use to help primary care doctors treat hepatitis C.

A recent study published in the journal Substance Abuse found that the model is a strong tool to help expand anti-addiction treatment



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Project ECHO™



Addiction Medicine TeleEcho Specialist Team



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OSU Psychiatry ECHO



OSU Psychiatry ECHO



OSU Psychiatry ECHO



OSU Center for Wellness and Recovery



OSU Center for Health Sciences announces initiative to combat opioids

Tulsa center to boost research, open addiction and pain clinics, improve training

By Randy Krehbiel Tulsa World Nov 3, 2017 Updated 9 hrs ago 1



Shrum



The Oklahoma State University Center for Health Sciences is undertaking additional research, education and treatment initiatives in an effort to combat opioid abuse and other forms of addiction, state and university officials said Friday.

"Too many Oklahoma lives have been cut short from opioid overdose," Dr. Kayse Shrum, president of OSU-CHS, said during a news conference at the school's west Tulsa campus. "Once-capable men and women find themselves unable to function at home and at work."

Shrum and Dr. Jason Beaman, head of the OSU-CHS psychiatry and behavior sciences department, said the school will open an addiction clinic in association with 12&12, a Tulsa addiction treatment program, and a pain management clinic, probably at the OSU Medical Center downtown.

Officials said OSU-CHS will also put additional resources into researching addiction and addiction treatment, and in the training of treatment professionals.

The entire initiative is under the OSU Center for Wellness and Recovery banner.

Shrum noted the school recently initiated Project Echo to bring addiction information and treatment and pain management



White
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- Afraid they'll lose their jobs, Tulsa teachers are enduring attacks from kindergartners, pre-K students
- Murder charge dropped against 19-year-old who testified about beating death of Tulsa man
- Man sentenced to life in prison for revenge killing Mohawk Park



OSU CHS Center for Wellness and Recovery



- Education
- Clinical
- Research
- Advocacy

Education



- Addiction Medicine Course
- Partnership with 12&12
 - 3rd year medical students
 - Psychiatry residents
- CME Events

Clinical



- Addiction Medicine Clinic
- Comprehensive Pain Management Clinic

Research



- Pain Receptors
- Opioid Receptors
- Public Health
- Adverse Childhood Experiences
- Much Much Much More

Advocacy



- Utilize research to help inform public policy
- Advocate for expanded treatment
- Advocate for the practice of Evidence Based Medicine

Expanded Access



Working on mechanisms to ensure that every OSU resident has an x-waiver prior to graduating

Barriers to Care



- Poor prescribing in the first place
- Limited number of experts
- Funding issues
- Limited number of “beds”
- Very limited access in rural areas

Training



- Addiction Medicine Fellowship
 - Starts in July
 - 2 Board Certified Addiction Medicine Experts in Oklahoma every year
- *Partnership with OSU, 12&12 and ODMHSAS

Questions?



Jason.beaman@okstate.edu



Medical Data Report

Opioid Utilization Supplement

For the state of:

OKLAHOMA

October 2017

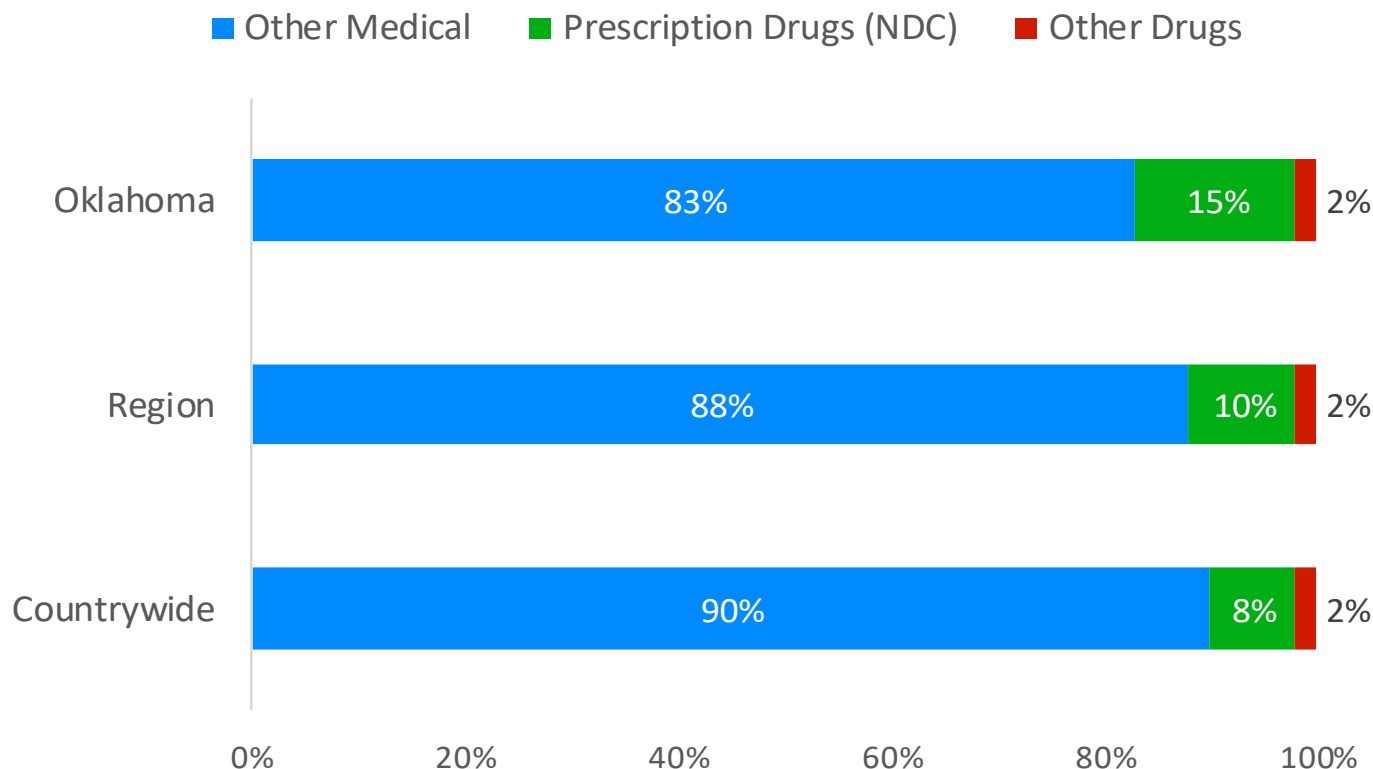


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Prescription Drug Statistics

Chart 1

Drug Share of Medical Payments

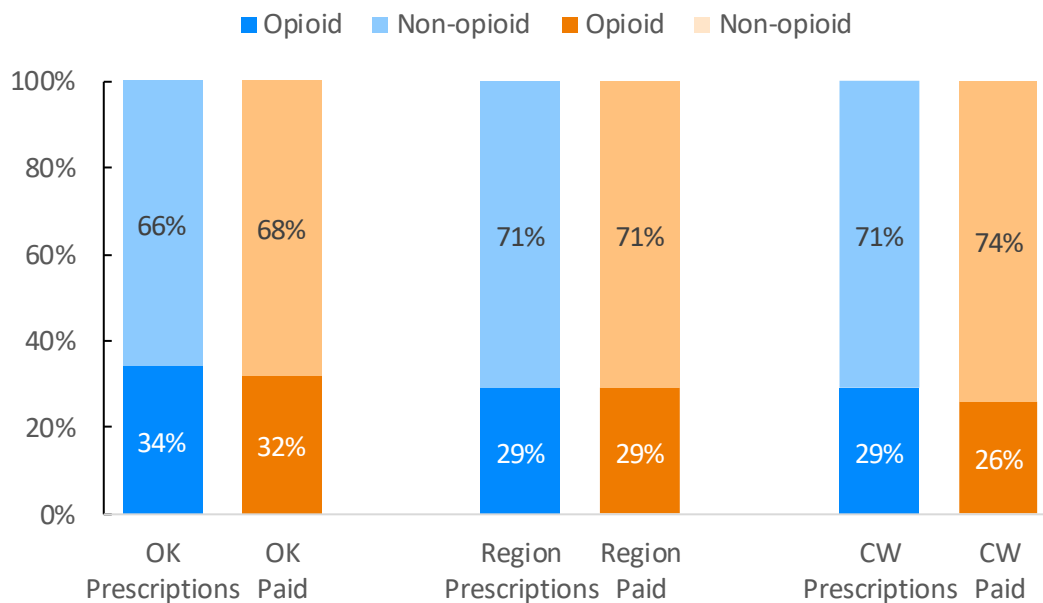


Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Chart 2

Opioid Distribution of Prescriptions and Payments



Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Chart 3

Top 10 Workers Compensation Opioid Drugs by Prescription Counts for Oklahoma

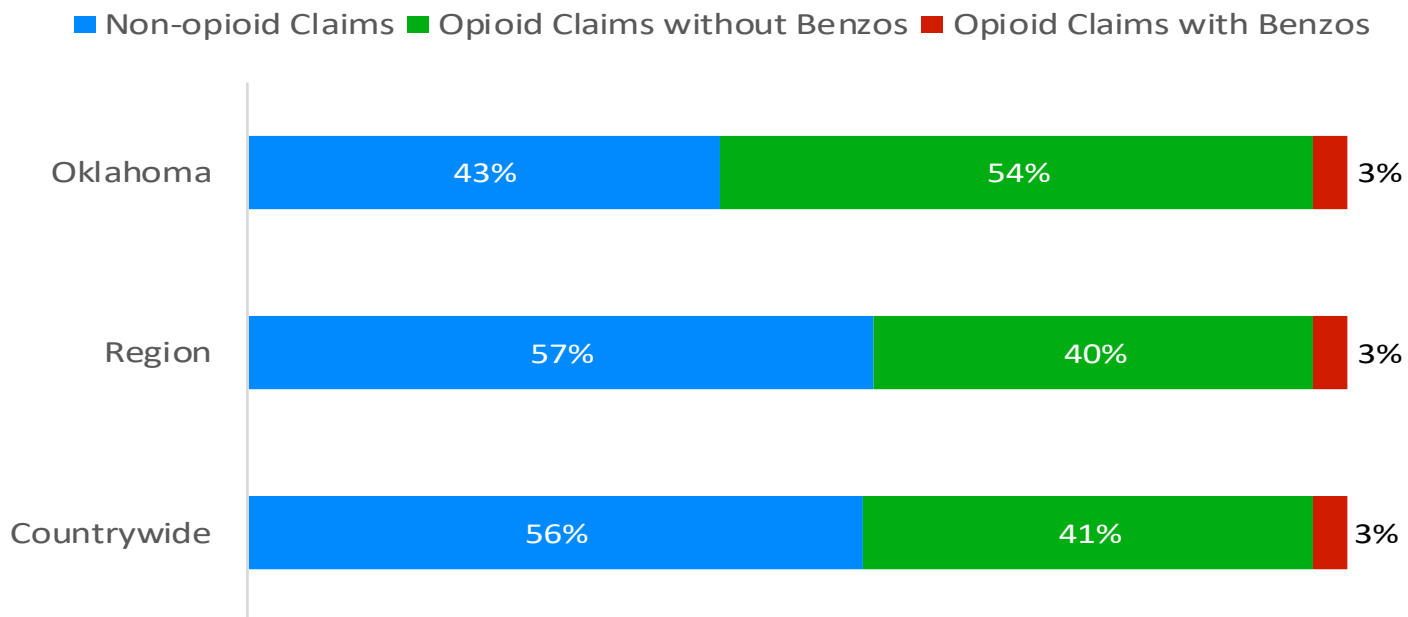
Name of Opioid Drug	Type B/G	% of Drug Prescriptions	PPU Oklahoma	PPU Region	PPU Countrywide
Hydrocodone Bitartrate-Acetaminophen	G	12.6%	\$0.62	\$0.56	\$0.58
Oxycodone HCl-Acetaminophen	G	5.4%	\$2.18	\$1.66	\$1.76
Tramadol HCl	G	5.3%	\$0.81	\$1.12	\$1.16
Oxycodone HCl	G	3.0%	\$1.61	\$1.36	\$1.27
Morphine Sulfate	G	2.0%	\$2.47	\$2.35	\$2.24
Oxycontin®	B	1.1%	\$8.85	\$8.70	\$8.43
Acetaminophen-Codeine Phosphate	G	1.0%	\$0.55	\$0.51	\$0.47
Fentanyl Transdermal System	G	0.6%	\$22.76	\$22.21	\$21.89
Hydromorphone HCl	G	0.3%	\$1.87	\$2.29	\$1.97
Butrans®	B	0.3%	\$115.12	\$113.14	\$111.33

Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Chart 4

Rx Claim Distributions

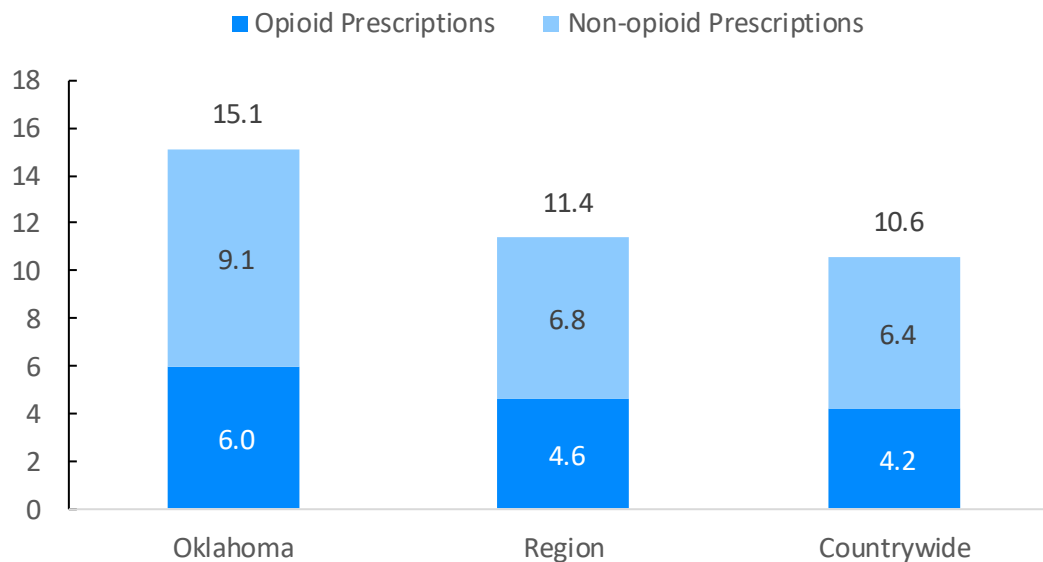


Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Chart 5

Average Number of Prescriptions per Opioid Claim

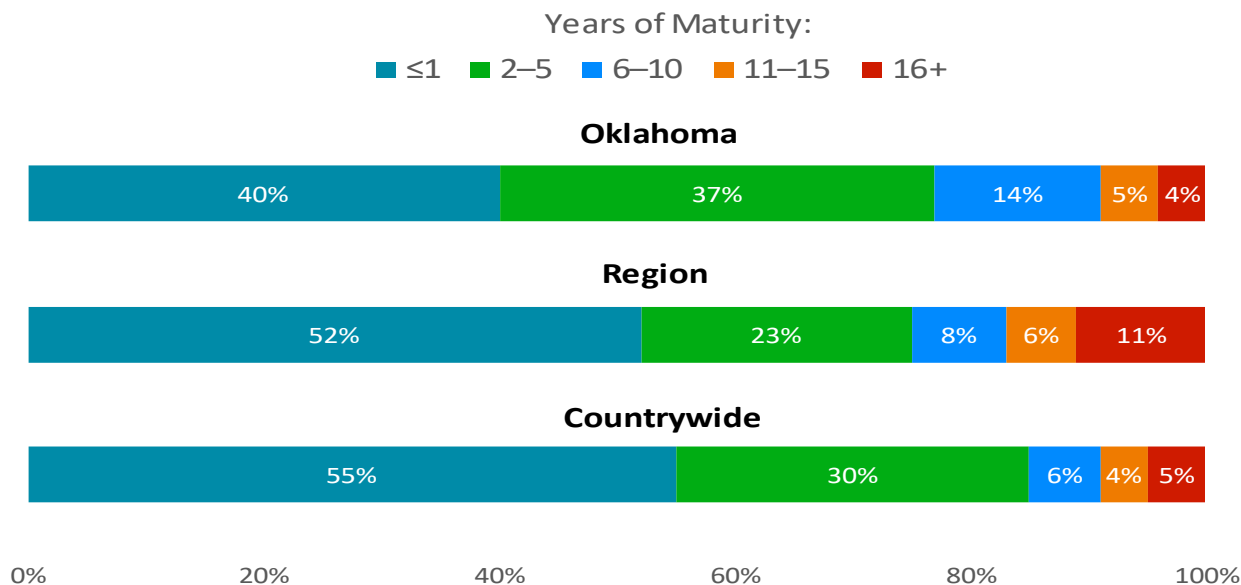


Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Chart 6

Opioid Claim Distribution by Claim Maturity



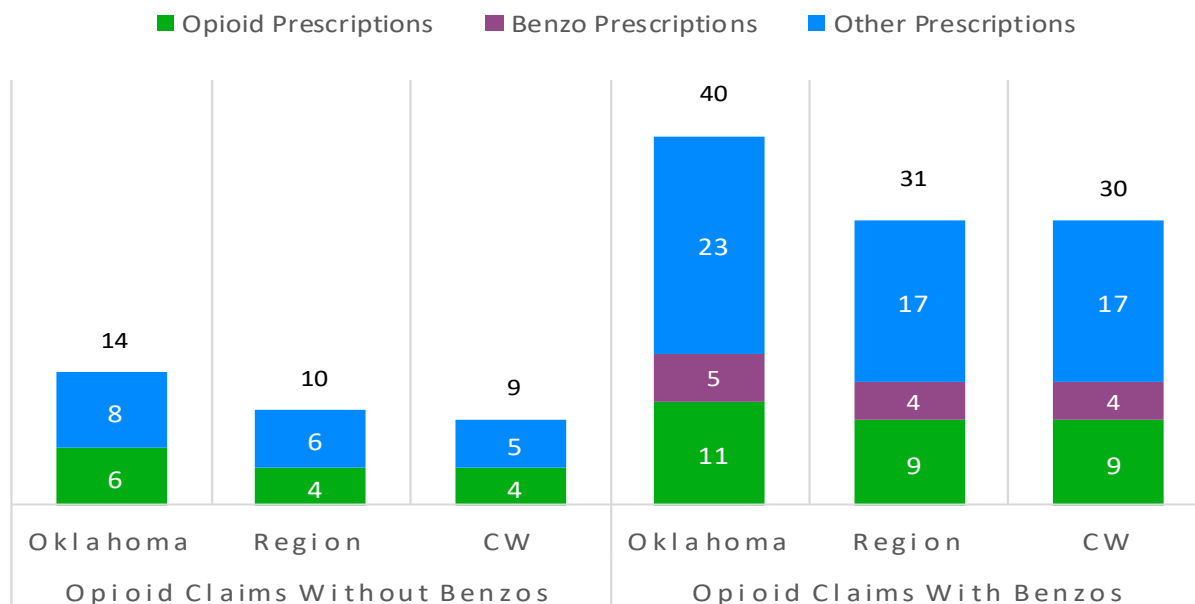
Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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Concurrent Usage of Opioids and Benzodiazepines

Chart 7

Average Number of Prescriptions by Claim Type



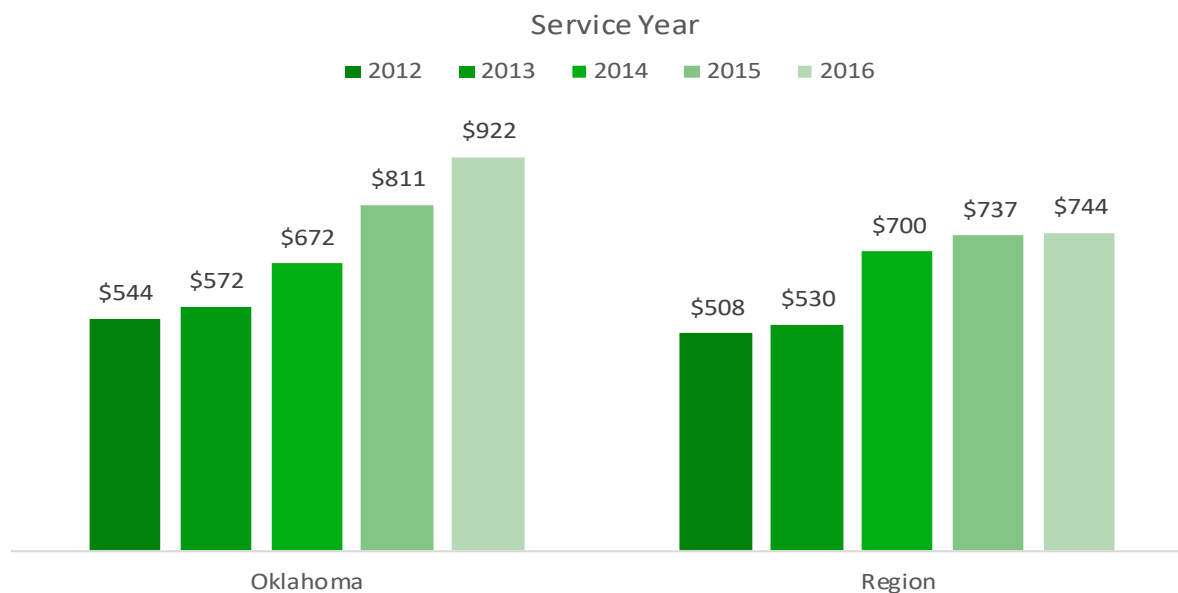
Source: NCCI Medical Data Call, Service Year 2016. Region includes AZ, KS, and NM. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

"Dangers of Mixing Opiates & Benzos: Vicodin, Xanax, Oxycodone, Valium." American Addiction Centers. N.p., n.d. Web. 16 Nov. 2016.

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Chart 8

Average Opioid Payment per Opioid Claim by Service Year

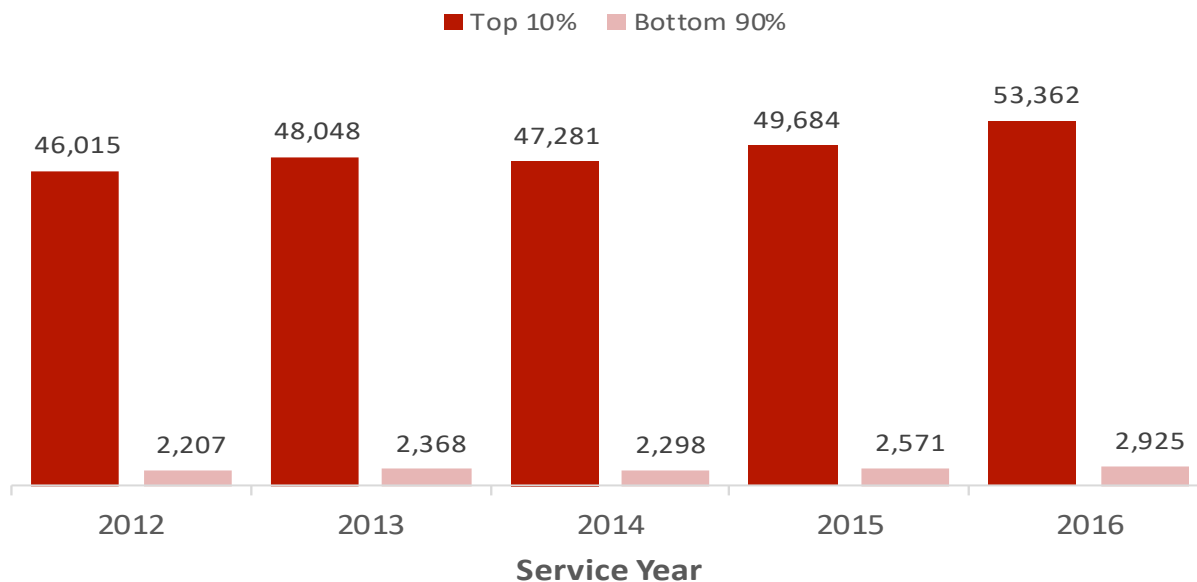


Source: NCCI Medical Data Call. Region includes AZ, KS, and NM.

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Chart 9

Average Yearly MME Prescribed per Opioid Claim for Oklahoma



Source: NCCI Medical Data Call.

https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf