STATE STRATEGIES TO PREVENT AND INTERVENE EARLY
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KEY STRATEGIES

• Naloxone

• Prescription Drug Monitoring Programs (PDMPs/PMPs)

• Emergency Commitment

• Voluntary Non-Opioid Directives
INCORPORATING NALOXONE USE FOR OVERDOSE PREVENTION

- 50 states and D.C. have naloxone access laws
  - Expands dispensing/distribution of naloxone

Types of Expansions

- Who can receive naloxone
  - Family and friends
  - First responders
  - Community-based organizations, especially those who provide services to individuals at high risk of overdose
  - School nurse or other school employee that administers medication
  - Addiction treatment programs
  - Probation or parole officers
  - Offenders with history of drug and alcohol problems upon release from prison, jail, or correctional confinement
  - Syringe service programs

- Who can dispense/distribute naloxone
  - Community organizations, e.g., Overdose Education and Naloxone Distribution Programs
Methods of Dispensing/Distribution

- Third-party prescriptions
- Standing orders and protocol orders
- Collaborative practice agreements

Results of Expanded Access

- November 2018 – *Opioid overdose laws association with opioid use and overdose mortality*, McClellan et al.
  
  - Associated with reduction in opioid overdose deaths
    ✓ Decreases: 14% overall; 23% African Americans
  
- No increases in non-medical opioid use

Co-prescribing

- Gap remains in naloxone availability
  ✓ < 1% of patients for whom clinicians should consider co-prescribing naloxone actually receive a naloxone prescription

- U.S. HHS recommendations for co-prescribing
  ✓ Certain patients with opioid prescriptions
    ➢ ≥ 50 daily Morphine Milligram Equivalent
    ➢ Respiratory conditions
    ➢ Concurrent benzodiazepine prescription
    ➢ Non-opioid substance use disorder, excessive alcohol use or mental health disorder
✓ Patients at high risk for opioid overdose
  ➢ Using heroin, illicit synthetic opioids, misusing prescription opioids
  ➢ Using other illicit drugs
  ➢ Receiving treatment for opioid use disorder
  ➢ History of opioid misuse and recently released from incarceration or other custodial settings

• State laws – encourage or require co-prescribing
  ✓ E.g., AZ, CA, FL, LA, VT, VA

Funding

• Increased demand = increased cost
  ✓ Evzio - $4,100; Narcan $125 retail, $40 per dose

• Federal options
  ✓ FDA paving way for over-the-counter sales
  ✓ Work to extend labeled shelf life
    ➢ Current labeled expiration – 18-24 months
    ➢ Nov. 2018 study results – Asst. Prof. Charles Babcock
➢ Naloxone can be used well past expiration date
➢ Ezvio – usable 12 months after expiration date
➢ Narcan – usable 10 months after expiration date

✓ State options
  ➢ Improve Medicaid and commercial insurance reimbursement
    ❖ Take-home naloxone
    ❖ Devices needed for administration
    ❖ Refills
    ❖ Pharmacy administration fees
    ❖ Time spent counseling or training

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**Reporting of Naloxone Information**

- Some states require practitioners to report non-fatal overdose information to state and/or local health officials
  ✓ E.g., AZ, NV, NM, RI, TX
  ✓ State systems for timely reporting specified diseases or conditions
    ➢ Add overdose to list

- Some states require reporting to PDMPs
  ✓ E.g., AZ, OR, VA, WV, WY

- Unintended consequence
  ✓ Denial of insurance for receipt of naloxone
  ✓ State law amendments – prohibit denial
TRANSFORMING PDMPS INTO BETTER HEALTH CARE TOOLS

- Lingering themes - original criminal justice development
  - Focus on controlled substance prescriptions
  - Healthcare access limited to prescribers and dispensers
  - Access by individuals for use by individuals
  - Health care access dependent on direct patient relationship
  - Intrastate data collection
  - Presentation in long list of prescriptions dispensed
  - Voluntary use

More Comprehensive Data

- All prescriptions
  - NE

- Diagnosis codes
  - ICD 10
  - E.g., ME

- Noncontrolled/nonscheduled substances
  - 28 states, D.C. and Guam
  - Gabapentin, e.g., MA, MN, NJ, ND, OH, VA, WV
• Non-prescription data
  ✓ Overdose deaths – E.g., NV, OK, TN, UT, WI
  ✓ Instances of opioid-related overdoses – E.g., KY, WV, WI
  ✓ Convictions for DUI/DWI – E.g., UT
  ✓ Convictions for violations of controlled substances or prescription drug laws – E.g., KY, UT
  ✓ Suspected violations of controlled substances or prescription drug laws – E.g., WI
  ✓ Reports of stolen prescriptions – E.g., NV, WI
  ✓ Patient’s voluntary non-opioid directive – E.g., RI

Data Sharing with Health Care Professionals

• Sharing beyond individual prescribers/dispensers for patient care
  ✓ Delegates
    ➢ Prescriber/dispenser liable for delegate activities
    ➢ Prescriber/dispenser must make patient care decision
    ➢ More focus on allowing unlicensed professionals
  ✓ Substance abuse treatment counselors/specialists
    ➢ 17 states
    ➢ E.g., MD, ND, UT, WI

• Sharing with institutional users
  ✓ Hospitals, health care facilities, group practices
  ✓ E.g., KY, IN, IA, MT, WA State
• Sharing beyond jurisdictional boundaries – interstate
  ✓ All states but NE have legal authority
  ✓ 45 states, D.C. and Puerto Rico engaged in sharing
  ✓ Max # of jurisdictions with which a state shares data – 38 (37 plus DC)

• Sharing with health/pharmacy IT systems
  ✓ Focus on EHRs, HIEs
  ✓ 26 states
    ➢ Statutory/regulatory language allows integration or interoperability
  ✓ States with no specific language
    ➢ interpretation allows integration or interoperability

✓ Governance laws/rules for PDMP data and other patient health data can differ
  ➢ Authorized users
  ➢ Methods of access
  ➢ Purposes of access
  ➢ Storage and retention
  ➢ Presentation to end user
  ➢ Disclosure and use in health system
  ➢ Audit trail – who requests patient data

✓ PDMP statutes/regulations – restrictions over and above HIPAA
  ➢ PDMP not a covered entity
  ➢ PDMP not a business associate of a covered entity
✓ State alignment of governance laws and rules for PDMP and other patient data
  ➢ Placement/storage of PDMP data/report in medical or health record
    ❖ 17 states plus FL proposed rule
  ➢ Access, disclosure and/or use rules applicable to other patient health information in medical or health record apply to stored PDMP data
    ❖ 7 states – CA, CO, KY, NJ, TN, TX, WA State

• Sharing for public health surveillance
  ✓ Release of de-identified data for statistical, research, policy, education
    ➢ All but 5 states – AL, MN, MI, NE, NY
    ➢ D.C., Guam, and Puerto Rico

✓ Specific language for access
  ➢ E.g., Toxicologists, epidemiologists
  ➢ E.g., Conduct of scientific studies, analysis as part of duties, or public health responsibilities
  ➢ E.g., Death fatality review teams

**Clinical Decision Support**

• Alerts/unsolicited reports to prescribers re: patients
  ✓ 35 states
  ✓ Proactive notice of concerning patient behavior
    ➢ E.g., ≥ specific daily MME
    ➢ E.g., concurrent opioid and benzodiazepine prescriptions
    ➢ E.g., visits to specific # of prescribers and/or pharmacists in a specific time period
• Practitioner led alerts
  ✓ E.g., IN, WI

• Proprietary PDMP data interpretations or visualizations
  ✓ E.g., risk scores
  ✓ No state bars development or use of interpretations like risk scores
  ✓ Challenge for PDMP Administrators
    ➢ Algorithms/criteria are undisclosed so can’t assess if accurate representation of PDMP data/report
    ➢ Some states beginning to issue legal opinions that review of interpretations are not compliance with mandated use provisions
    ❖ E.g., KY, VA

• Educational resources
  ✓ E.g., summaries or links to CDC and state prescribing guidelines

• Patient referral button/treatment locator
  ✓ E.g., link to SAMHSA or state single state authority list of treatment resources
  ✓ E.g., enhancements to display available beds and 3rd party payer information

Prescribing Practice Improvement

• Prescriber report cards, peer review reports, practice insight reports
✓ Comparative peer information re: prescribing practices and patient population data
  ➢ 24 states, D.C., and Puerto Rico
✓ Types of peer comparisons
  ➢ Prescriber’s number of milligrams per month compared to peer averages by specialty
✓ Types of patient risk factors
  ➢ Number of patients receiving designated Morphine Milligram Equivalents or more per day
  ➢ Number of patients filling prescriptions at designated # of pharmacies
  ➢ Number of patients obtaining refills
✓ PDMP or practitioner generated

• Access by Chief Medical Officers, medical directors or medical coordinators
  ✓ E.g., WA State, WV, WI
  ✓ Review of prescribing practices for practitioners under management or supervision
  ✓ Intervene to educate or help adjust possible outlier or inappropriate prescribing before matter becomes issue for licensing board

  **Mandated Use**

• States and territories
  ✓ Prescriber – 43 states and Guam
  ✓ Dispenser – 21 states
• General circumstances that trigger prescriber’s requirement to check
  ✓ Initial prescribing of designated substance
  ✓ Each prescribing of designated substance
  ✓ Prescribing for treatment of pain
  ✓ Prescribing for treatment of drug addiction
  ✓ Prescribing in worker’s compensation cases
  ✓ Prescribing when reason to believe substance is sought for illegal or non-medical purposes

IN Voluntary commitment For substance use disorders

• 37 states plus D.C. have laws

• Common concerns
  ✓ Not enough treatment for those who want to enter treatment let alone those who are forced
  ✓ Many treatment facilities are unsecured
  ✓ If individual forcibly committed leaves, commitment damages trust
  ✓ Violates civil liberties

• Parents and family members
  ✓ Last opportunity to save loved one
• Laws vary in detail but have key themes
  ✓ Application to court
  ✓ Individual to be committed afforded due process
  ✓ Persons who can initiate application
    ➢ Spouse or other relative
    ➢ Guardian
    ➢ Law enforcement officer
    ➢ Designated health professional or responsible person
  ✓ Burden of proof is clear and convincing evidence
  ✓ Criteria in all states
    ➢ Danger to self or others
    ➢ Danger to self includes inability to provide for basic needs; refuse to take care of him/herself

• Additional criteria in some states
  ➢ Impaired judgment
  ➢ Gravely disabled
  ➢ Incapacitated
  ➢ Loss of self-control over substance use

• Emergency commitment
  ✓ Short-term
    ➢ E.g., Maximum of 72 hours or less
  ✓ Stabilization and assessment purpose
  ✓ Apply to treatment program who agrees to consider commitment application
    ➢ Before application to court
  ✓ Same applicants to court can apply to treatment program
✓ Qualified clinical professional certifies in writing that criteria for commitment are met
✓ Criteria modifications
  ➢ E.g., danger to self or others must be immediate
  ➢ E.g., unable to obtain court order in time to prevent immediate danger
✓ Medical and drug and alcohol assessment may be conducted
✓ Committed individual can leave at any time and must be let go at end of maximum commitment time unless court or statute allows continued commitment

VOLUNTARY NON-OPIOID DIRECTIVES

• State laws allow patient to refuse treatment with opioids
  ✓ E.g., AK, CT, LA, MA, PA, RI
• Placed in medical record and sometimes PDMP
• Patient can revoke at any time for any reason by oral or written means
• Immunity for health professionals who comply
• Some states provide exemptions
  ✓ E.g., emergency
  ✓ E.g., override by guardian or health care proxy
QUESTIONS?

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