



How Delaware is Addressing the Opioid Epidemic

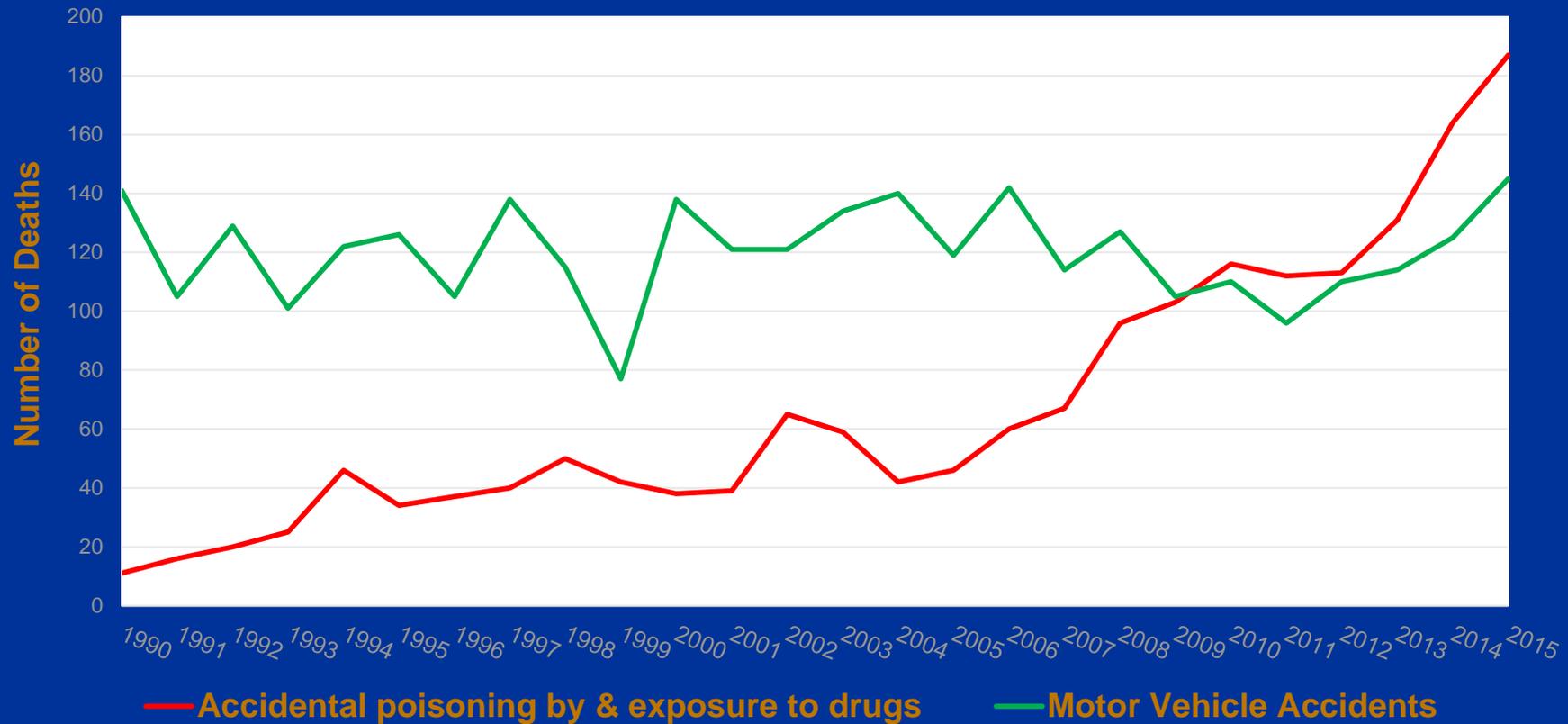
KARYL T. RATTAY, MD, MS
DIRECTOR, DIVISION OF PUBLIC HEALTH



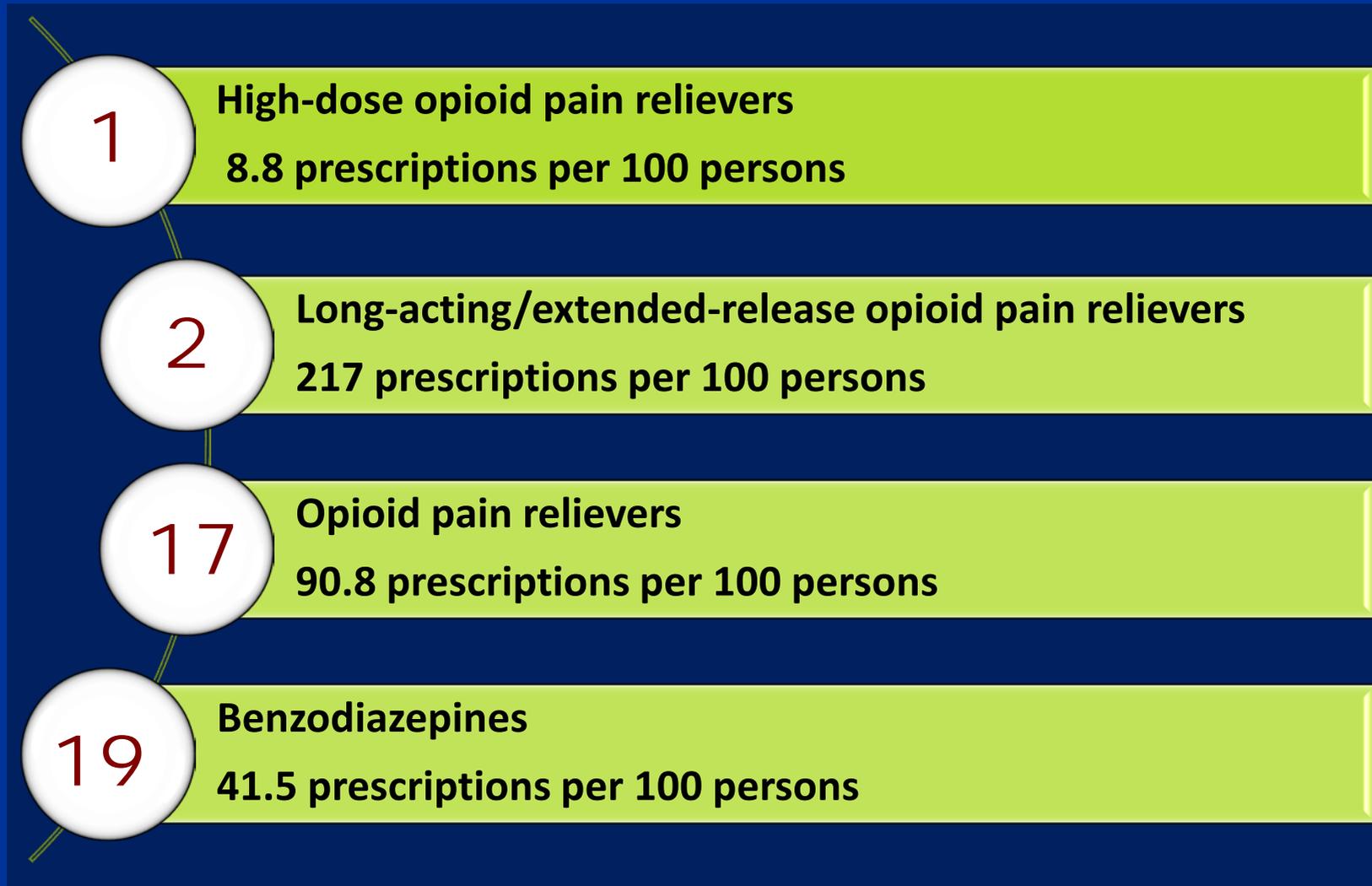
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

2009: When drug overdose deaths exceeded motor vehicle deaths

Number of Deaths for Selected Causes, Delaware 1990-2015



Prescribing rates - Delaware's rank



Source: IMS Health data; [Paulozzi LJ](#), [Mack KA](#), [Hockenberry JM](#); Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC. Vital signs: variation among States in prescribing of opioid pain relievers and benzodiazepines - United States, 2012. [MMWR Morb Mortal Wkly Rep](#). 2014 Jul 4; 63(26):563-8.

Delaware's Heroin Epidemic



State's tightening of access to prescription drugs, raised their on-the-street cost.

- 1 Oxycodone pill = \$20-\$30
- Hit of heroin = \$3.

Heroin overdose deaths rose dramatically in 2013-2015.

Synthetic Opioids: Fentanyl and Carfentanil

Fentanyl: synthetic painkiller

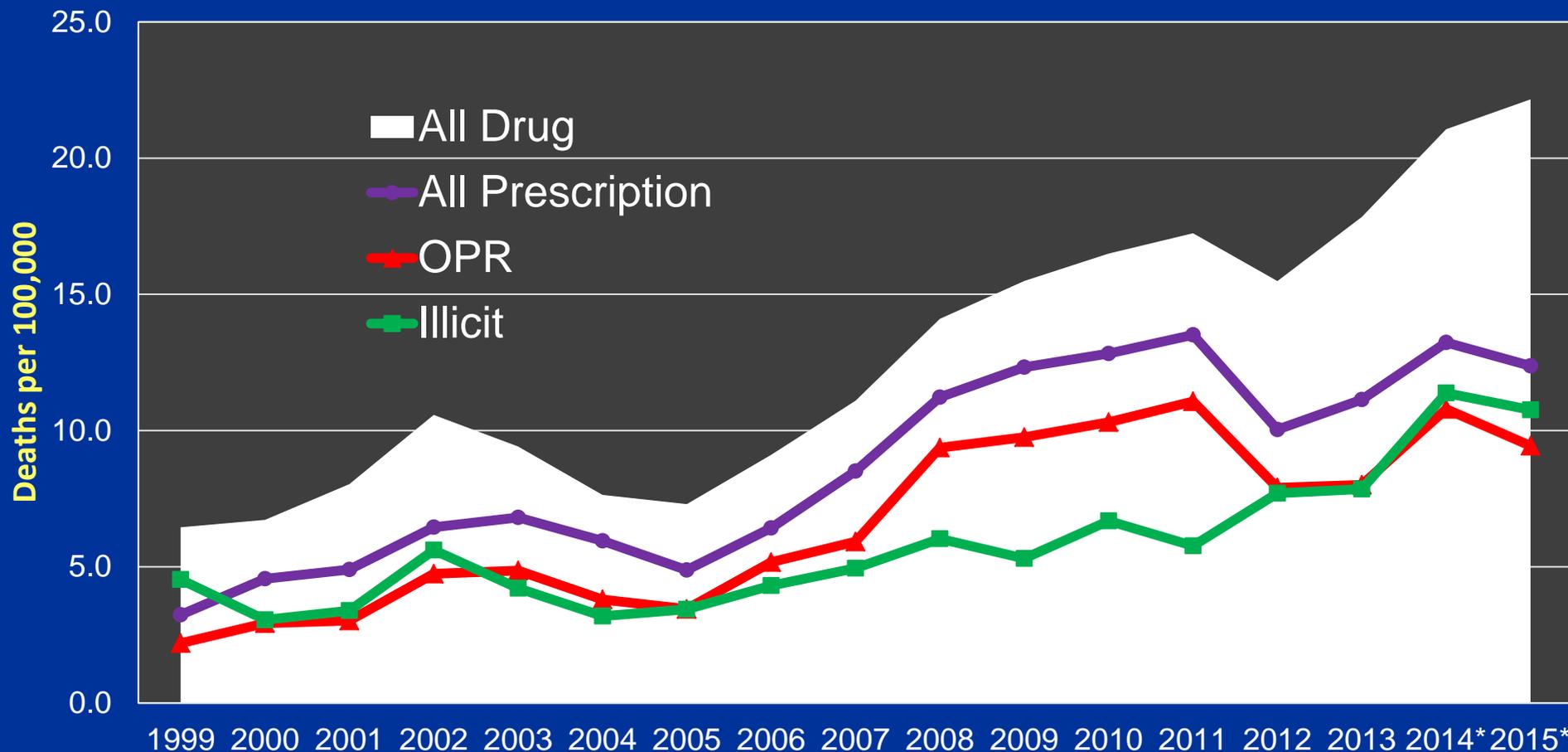
- Pure white powder or laced with cocaine or heroin
- 120 fentanyl-related overdose deaths in Delaware in 2016
- 80% of overdose deaths involved men



Carfentanil: extremely potent synthetic veterinary drug

- 2 deaths in Pennsylvania as of Feb. 13.

Drug Poisoning Deaths by Category, Delaware, 2006-2015



OPR refers to Opioid Pain Relievers, which are included in the Prescription drug category.

Mortality rates are adjusted to the 2000 US Standard Population

*2014 and 2015 are preliminary

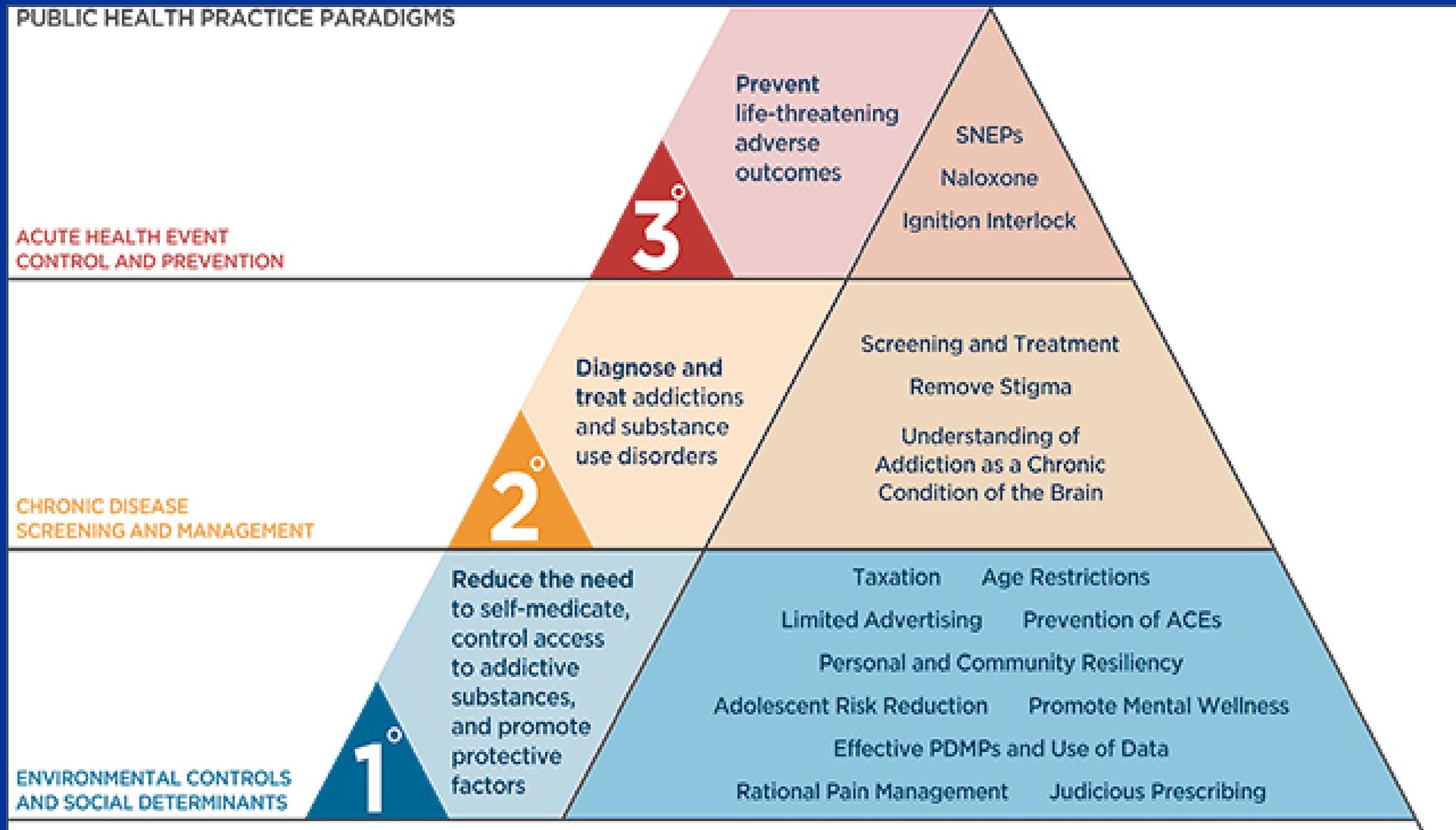
Source: Delaware Division of Public Health, Health Statistics Center. (2016).

Drug category based on T-codes and Cause of Injury Field



**We are in the midst of an
opioid epidemic.**

Substance Misuse and Addictions Prevention Framework



Source: Association of State and Territorial Health Officials



Getting the Right People to the Table

Prescription Drug Action Committee (PDAC)

- Coordinates public, private and community efforts to combat prescription drug abuse, misuse, and diversion.
- Led by the Delaware Division of Public Health and the Medical Society of Delaware, PDAC has a broad and diverse membership.
- Is implementing its priority recommendations.
- Read the PDAC report at:

<http://dhss.delaware.gov/dhss/dph/pdachome.html>

PDAC Leadership

PDAC Chairs

- **Chair, Karyl Rattay, MD,MS,**
Director, Division of Public Health
- **Vice Chair, John Goodill, MD,**
Medical Society of Delaware

PDAC Sub-Committee Chairs

- **Provider Education:**
John Goodill, MD
Delaware Pain Initiative
- **Public Education:**
Fran Russo-Avena RN
Red Clay School Nurse
- **Control and Surveillance:**
Hooshang Shanehsaz , RPh
Delaware Pharmacist Society
- **Access to Treatment:**
Mike Barbieri PhD
Director, Division of Substance Abuse and Mental Health

What are the committees working on?

- Provider Education
 - Safe opioid prescribing and pain management
- Public Education
 - Youth and their families; general public
- Control and Surveillance
 - Drug Take-back and Surveillance
- Access to Treatment
 - Access to Effective SUD Treatment
 - Naloxone
 - Linking Those Who Have Overdosed to Treatment

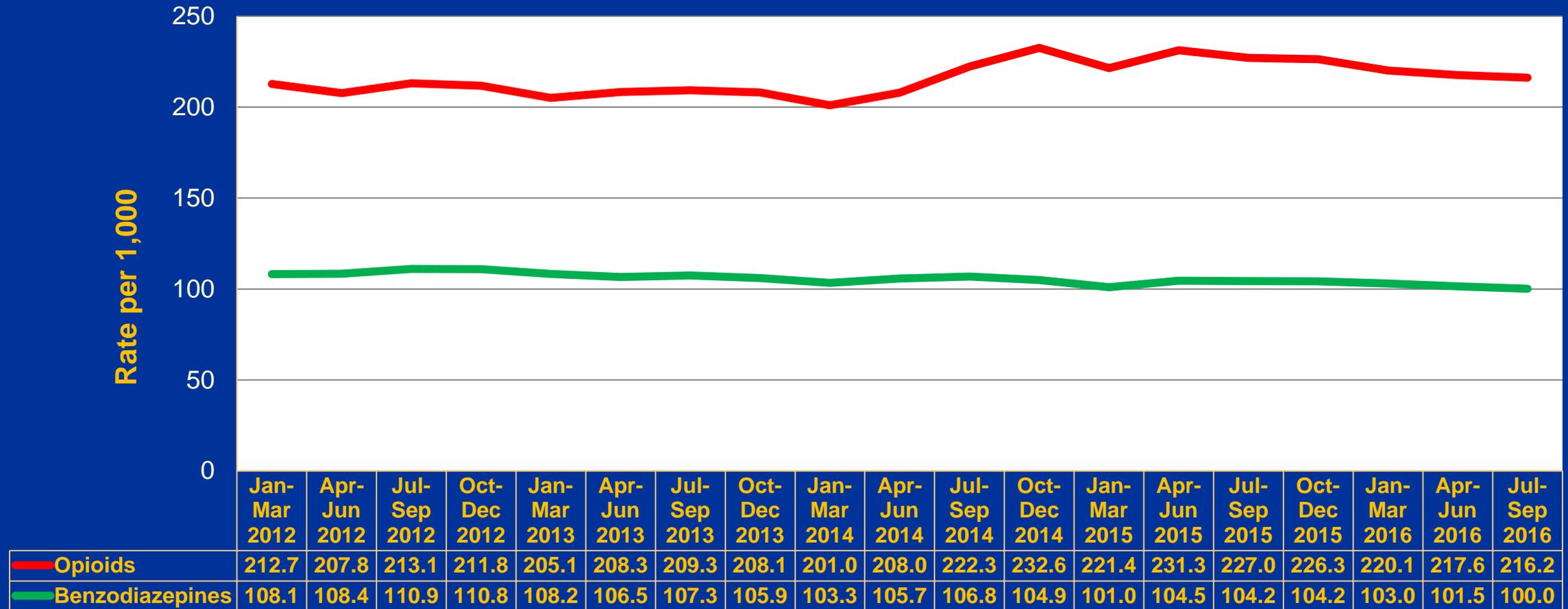


Interventions in place: Primary Prevention



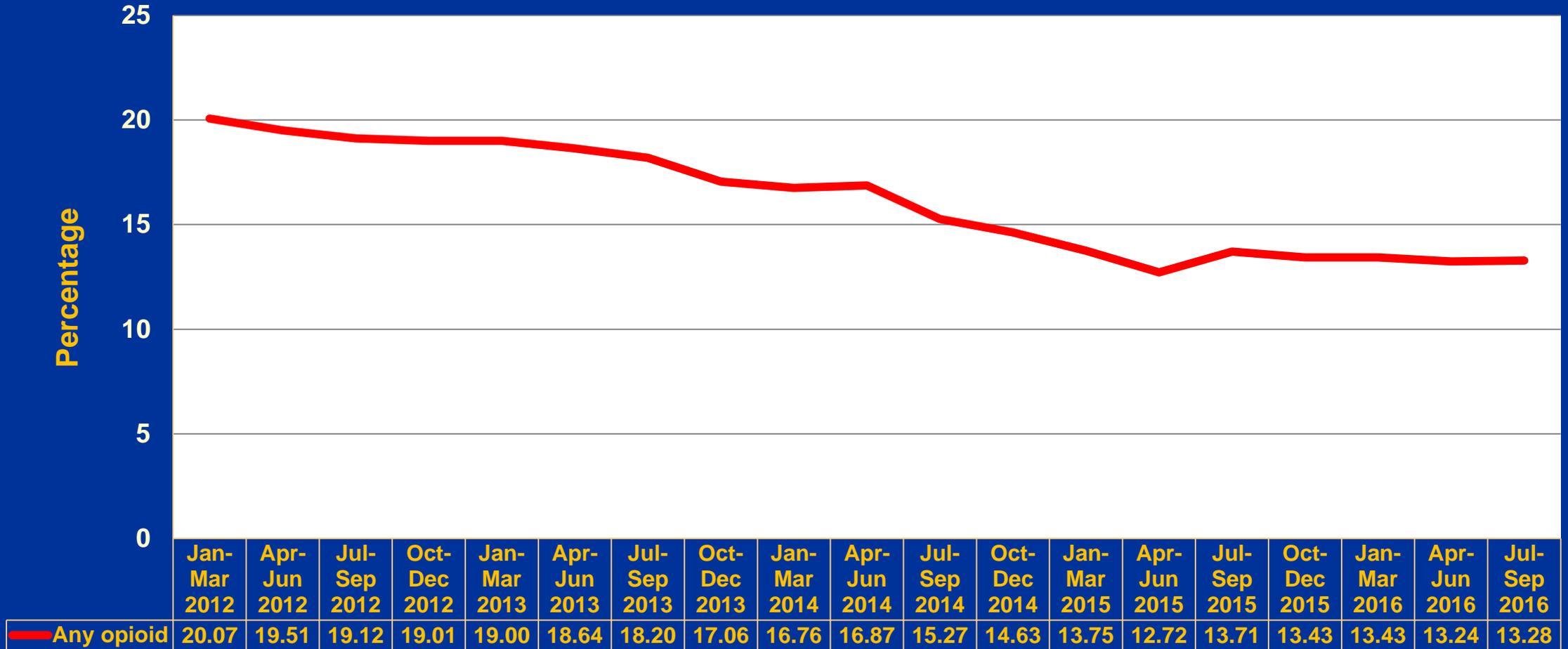
- **Prescription Drug Monitoring Program (PMP)**
- **Provider education**
- **Delaware's Board of Medical Licensure and Discipline Regulation 18.**
- **Hospice disposal policy**
- **Secured script program and e-prescribing**

Quarterly opioid and benzodiazepine prescription rates per 1,000 residents, Delaware, January 2012 - September 2016



Source: Delaware PMP (Department of State) as provided by Brandeis University, Table 1.1

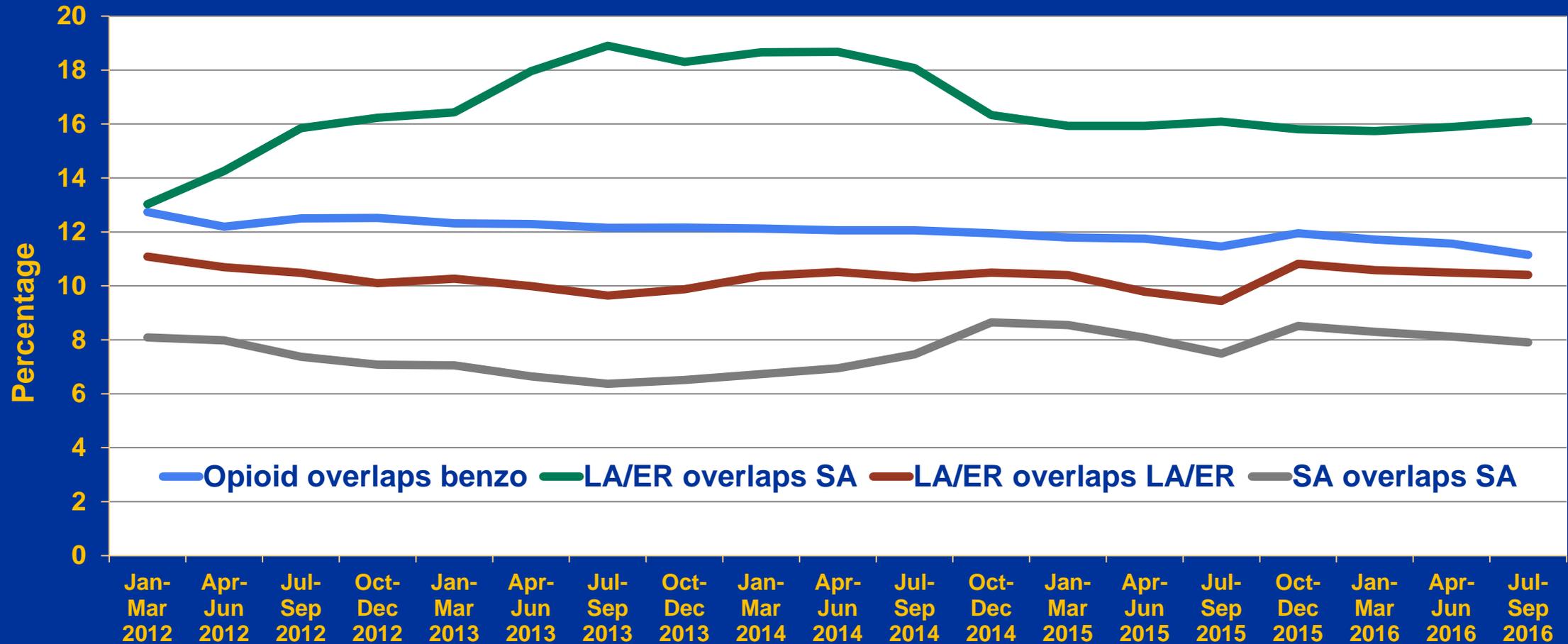
Quarterly percentage of patients receiving >100 MMEs¹ daily, Delaware, January 2012 - September 2016



¹ MMEs = Morphine Milligram Equivalents

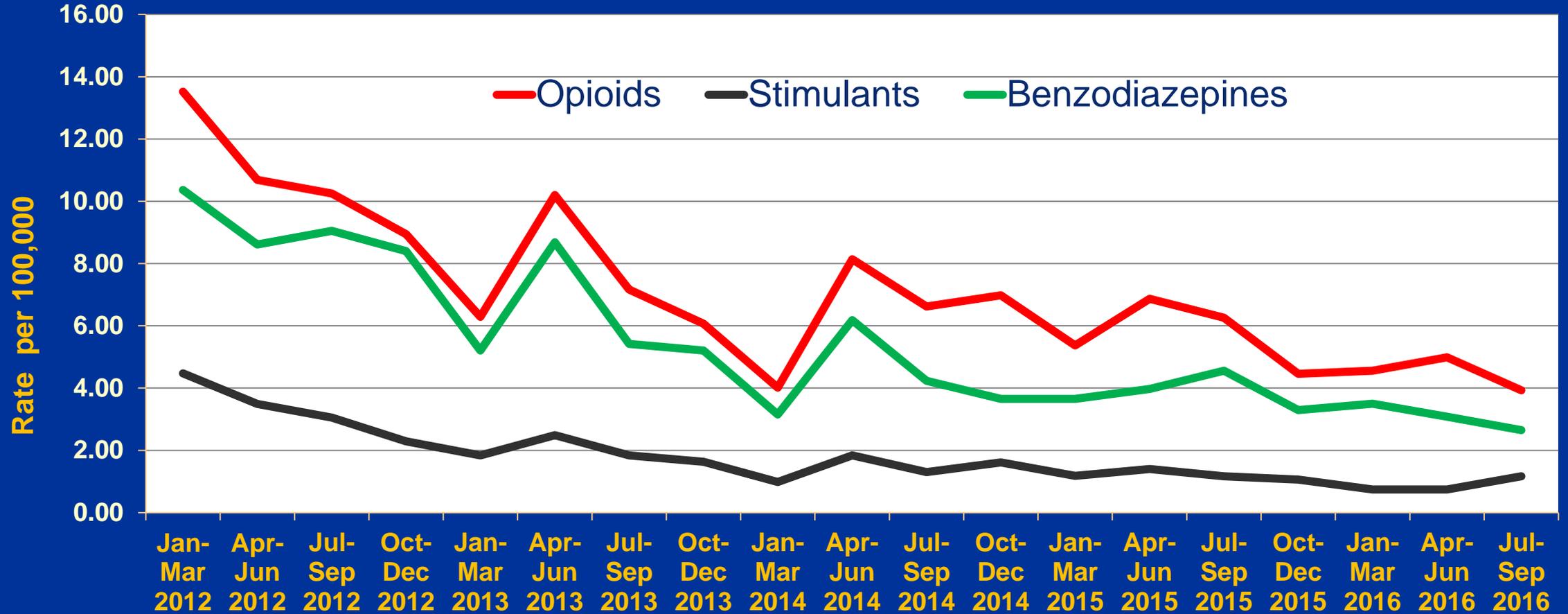
Source: Delaware PMP (Department of State) as provided by Brandeis University, Table 2.1

Percentage of days with overlapping prescriptions across opioid and benzodiazepine drug classes and across opioid release forms, Delaware, January 2012 - September 2016



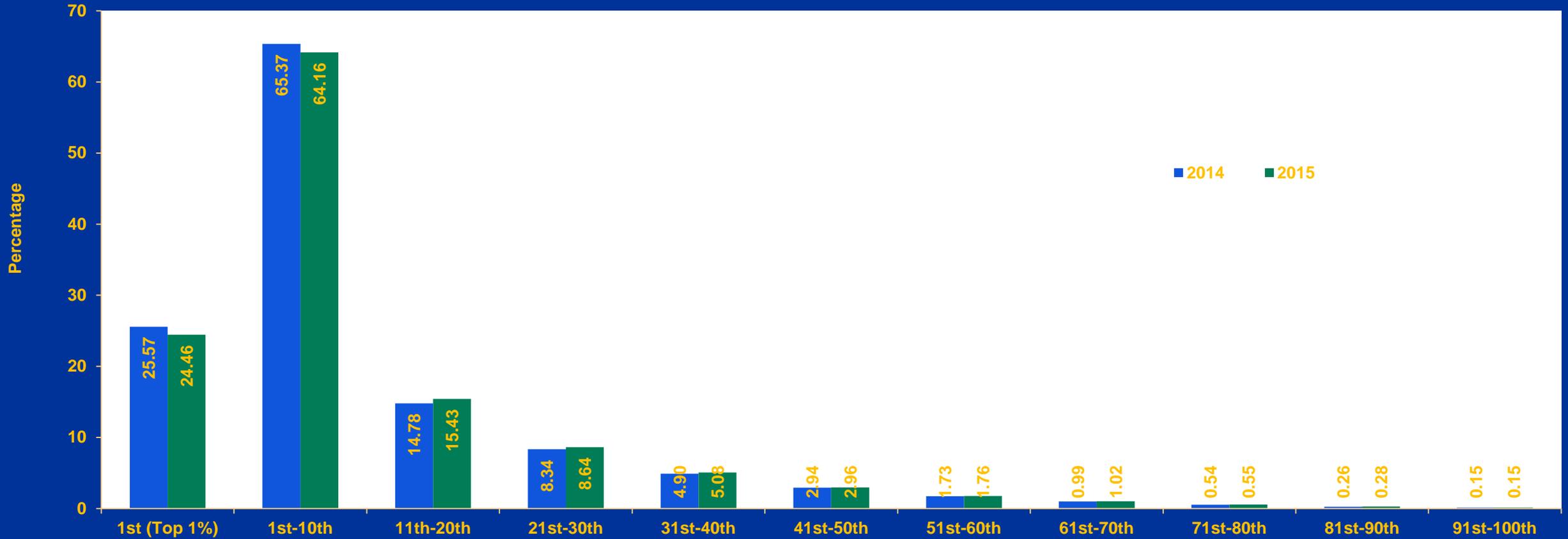
Source: Delaware PMP (Department of State) as provided by Brandeis University, Table 3.2

Multiple provider episode rates¹ per 100,000 residents by drug class, Delaware, January 2012 - September 2016



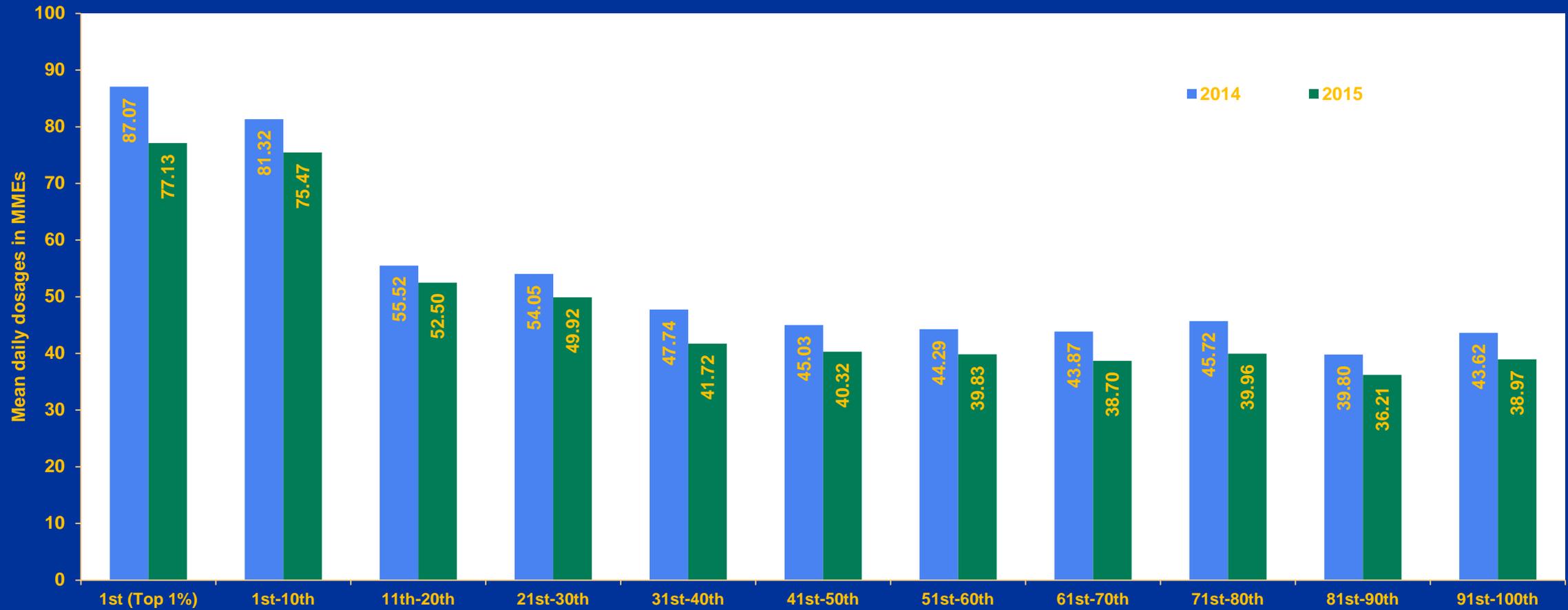
¹ Multiple provider episode rate is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current three months.

Percentage of opioid prescriptions by prescriber percentile ranking¹ based, Delaware, 2014-2015



¹ Percent refers to the percentage of all controlled substance prescriptions written per day per prescriber percentile rank.

Mean daily dosage for opioids in MMEs by prescriber percentile ranking, Delaware, 2014-2015



Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH, Tamara M. Haegerich, PhD, Roger Chou, MD

IMPORTANCE: Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.

OBJECTIVE: To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

DESIGN: The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.

EVIDENCE SYNTHESIS: Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (>1 year) benefit of opioids for chronic pain. **Opioids were associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.**

RECOMMENDATIONS: There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and revise prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

CONCLUSIONS AND RELEVANCE: The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

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- ✚ Editorials
- ✚ Author Audio Interview at jama.com
- ✚ Related articles and JAMA Patient Page
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JAMA: The Journal of American Medical Association

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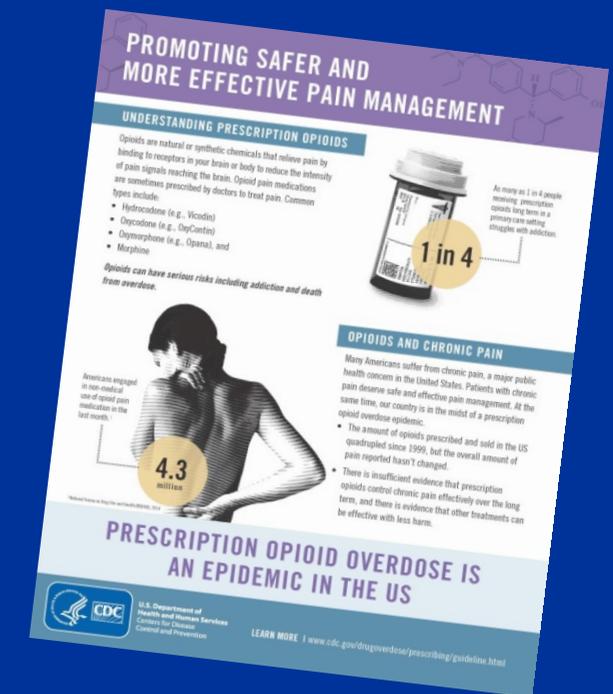
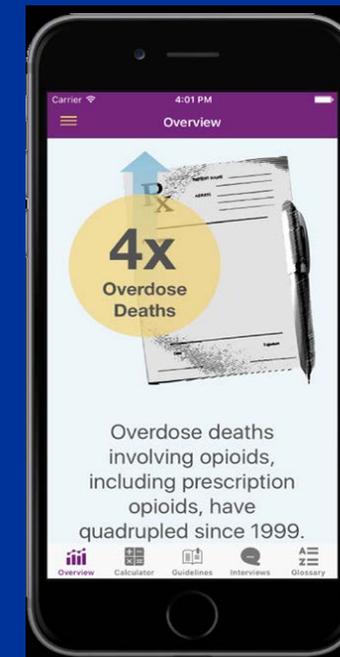
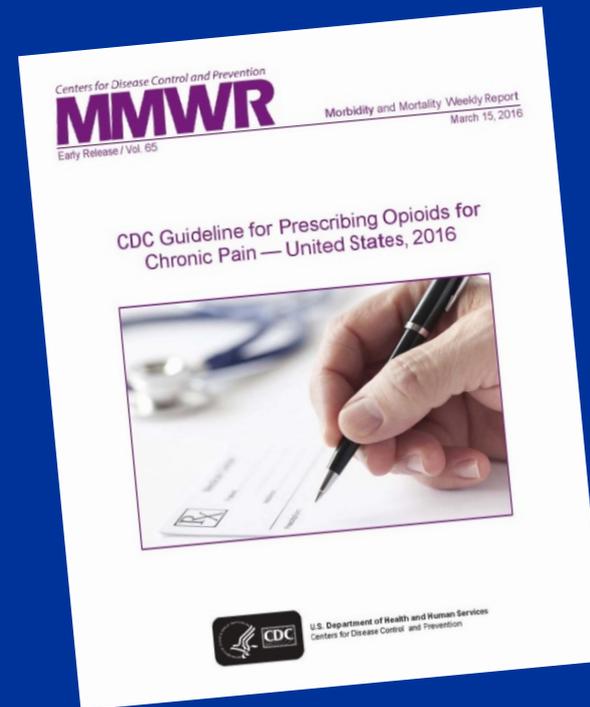
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JAMA[®]
The Journal of the American Medical Association

CDC's *Guidelines for Prescribing Opioids for Chronic Pain*

Available in several formats:

- a mobile app
- pocket guide
- fact sheets.



<http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>

Evidence reviews: opioids not first-line or routine therapy for chronic pain

- There is insufficient evidence to determine whether pain relief, function, or quality of life improves with long-term opioid therapy (most RCTs <6 weeks).
- Long-term opioid use can lead to abuse, dependence, and overdose.
- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.
- If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.



(Recommendation category A: Evidence type: 3)

Effective treatments for chronic pain

- **Non-pharmacologic therapies**
 - Rehabilitative services and physical therapy
 - Cognitive behavior therapy and relaxation techniques
 - Exercise and strength training
- **Non-opioid pharmacologic treatments**
 - Acetaminophen and NSAIDs
 - Serotonin and norepinephrine reuptake inhibitors (SNRIs); tricyclic antidepressants (TCAs)
 - Selected anticonvulsants (e.g., pregabalin, gabapentin)
- **Interventional approaches**
- **Multimodal and multidisciplinary therapies**



“Comparing” Effectiveness

PAIN TREATMENTS	EXTRAPOLATED BENEFITS FOR VARIED PAIN OUTCOMES
Opioids	<= 30%
Tricyclics/SNRIs	30%
Anticonvulsants	30%
Acupuncture	>= 10%
Cannabis	10-30%
CBT/Mindfulness	15-50%
Graded Exercise Therapy	Variable
Sleep Restoration	>= 40%
Hypnosis, Manipulation, Yoga	“+ effect”

- Many studies low GRADE quality of evidence
- Most studies <3 months
- Rarely do studies compare one treatment with another

See also: CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. JAMA 2016; 315 (15): 1624-1645



Pro Reg's new safe prescribing regulations

- Published in the Jan. 1, 2017 issue of the *Register of Regulations*
- Effective April 1, 2017
- Culmination of an 18-month formal rule-making process
- Establish basic standards for prescribing opiates safely
- Give new requirements for prescribing for acute episodes and chronic, long term pain management



<http://tinyurl.com/providerfacts>

Screen all patients for prescription drug abuse

PDAC recommended that medical practitioners screen all patients, not only “high risk” patients.

Provider resources

U.S. SAMHSA - Opioid Overdose Prevention Toolkit

<http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742>

CAGE Questionnaire to identify alcohol misuse:

http://www.integration.samhsa.gov/clinical-practice/sbirt/CAGE_questionnaire.pdf

For further information on SBIRT, including trainings, visit

<http://www.sbirtraining.com/>. For information on coding for reimbursement, visit <https://www.samhsa.gov/sbirt>.





One-stop website for Delaware with:

- Prevention information for physicians to talk with patients.
- For parents to talk with their children.
- For loved ones seeking treatment and recovery resources.

New CDC Prescription Drug Overdose Prevention Grant

Five-year grant (March 2016 – Aug. 31, 2020)

DPH awarded \$ 1,219,351

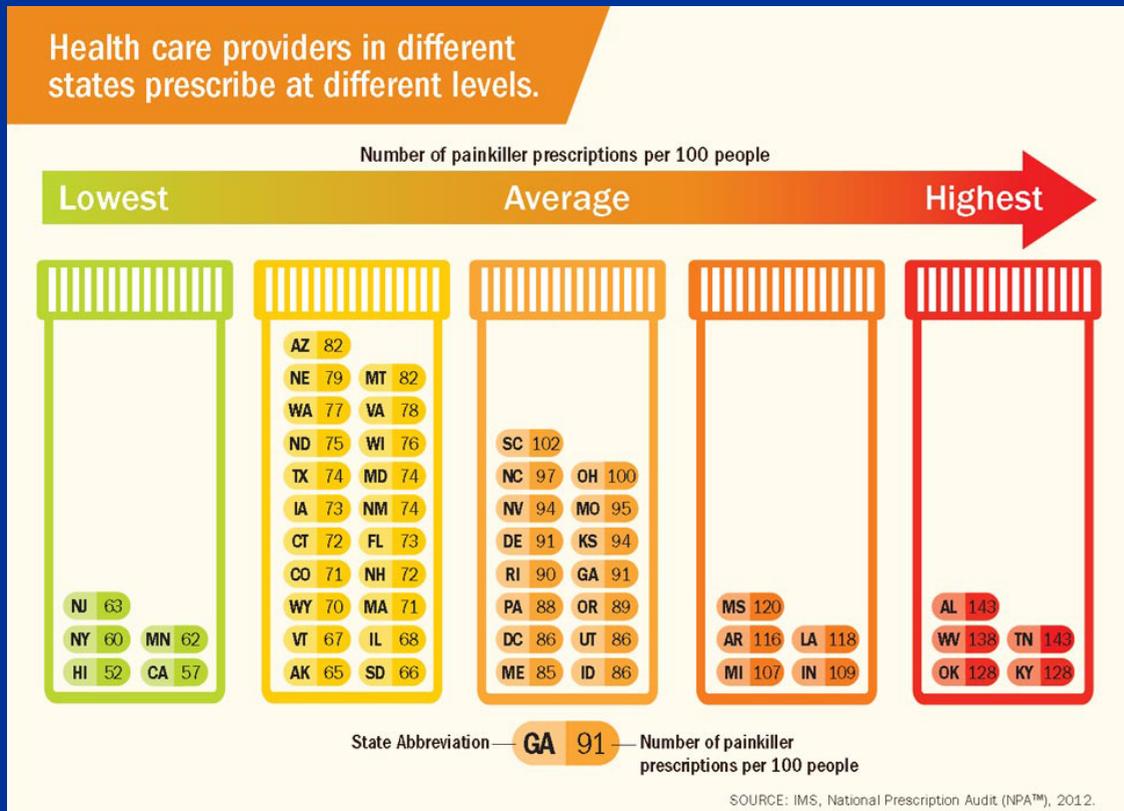


CDC

Priority Strategy #1: Enhance and Maximize the PMP

- Make the PMP easier to use and access
- Conduct Public Health surveillance with PMP data and disseminate

New CDC Prescription Drug Overdose Prevention Grant



CDC website; IMS, National Prescription Audit, 2012

Priority Strategy #2: Implement Community/Insurer Health System Interventions

- Enhance uptake of evidence-based opioid prescribing guidelines
- Use PMP data to identify “High Risk” prescribers and communities
- Develop prescriber report cards that detail individualized prescribing trends

Current Interventions: Primary Prevention (*cont.*)

- Public Education
- School education
- Drug take back



Addiction Campaign

**PARENTS CAN TALK ABOUT
SUBSTANCE ABUSE.** *We can help.*



HELP
is here.
PREVENT • TREAT • RECOVER

 DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

www.HelpsHereDE.com

Health Education in Schools

**Smart
Moves**
**Smart
Choices**

 Botvin
LifeSkills® Training



Current Interventions

Secondary Prevention

- Evolving and expanding Delaware treatment system
- Hero Help and Angel programs
- Drug Court



Statewide treatment centers opened to meet demand

The State of Delaware spent \$4.45 million in FY16 on these resources:

- Opened three 16-bed residential treatment program units and reconfigured Delaware City program (78 to 95 beds).
- Doubled sober living residential beds statewide (60 to 120 beds).
- Doubled the residential treatment beds for ages 18-25 recovering from addiction to opiates (16 to 32 beds).



Current Interventions

Tertiary Prevention

- Syringe Exchange Program
- Naloxone (“NARCAN”)
- Good Samaritan Law of 2013



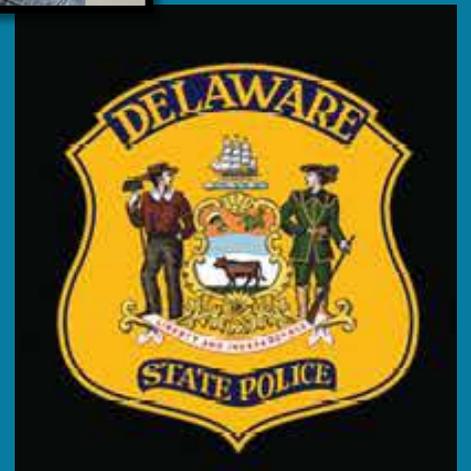
You **won't be arrested** when reporting an overdose.
Call 911.

atTAcK addiction Be a hero. Make the call.
www.atTAcKaddiction.com



Law Enforcement Interventions

- Drug Diversion Investigations
- Standardized continuing education of controlled substance related abuse and impairment
- Drug take-back
- Naloxone
- Fentanyl death – criminal penalty for dealer
- Drug Overdose Fatality Review Commission
- Hero Help and Angel Program
- HIDTA



Substance Exposure in Infants

The problem

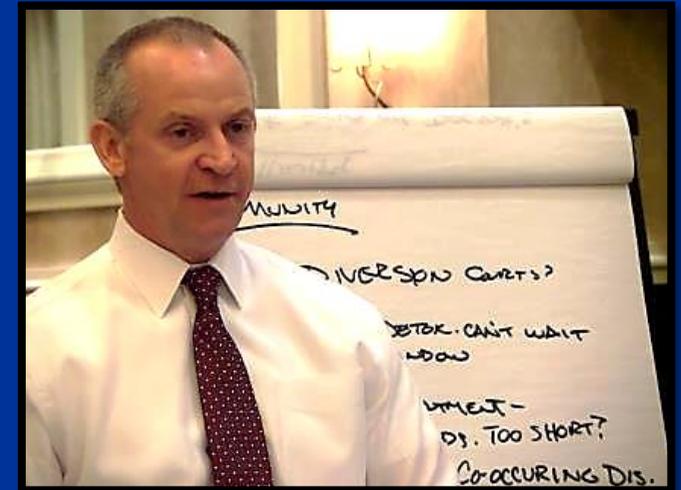
- Women struggling with opioid addiction: high rate of unplanned pregnancy
- Opioids are the second most common substance found at birth in DE
- At least 168 opioid SEI reported to Kids Dept in 2016. The number of SEI grown significantly in recent years.

The Response

- SAMHSA technical assistance
- Growing partnerships between state agencies, medical providers, and SA treatment
- Increased screening during prenatal care
- State law requires ob/gyns educate patients
- Increase access to LARCs

Much More to Do

- More support for health care providers around safe prescribing
- Reimbursement for non-opioid pain management
- Statewide implementation of an evidence-based curriculum in schools
- Access to SUD treatment services, including MAT
- Connecting individuals to treatment
- Correctional programs
- Access to Naloxone
- Better Surveillance



Thank You!



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health