Preventing Prescription Drug Misuse, Abuse, and Diversion Across the Continuum

Association of State and Territorial Health Officials
Multistate Invitational Team Meeting
Emory Conference Center Hotel
Atlanta, Georgia

Summary Report

April 25-26, 2012

Project Overview

The project focuses on supporting state health officials, their leadership teams, and other partners in the development and implementation of a state action plan to address prescription drug misuse, abuse, and drug diversion using a coordinated approach to consider the issue along a continuum (i.e., prevention, monitoring and surveillance, enforcement, treatment and recovery). A central principle of this work is to help state health officials identify effective policy and legal strategies that are successful in reducing overdose deaths through collaboration with traditional and nontraditional partners. Activities are developed to build capacity for policy and programmatic approaches to preventing prescription drug misuse, abuse, and diversion toward the long-term improvement of health outcomes. This initiative serves as an opportunity for states to collaborate with other states facing similar challenges to identify the scope of the issue, justify political and resource barriers, assess partnerships, and determine how various systems can "fit" together using a public health approach.

On April 25-26, 2012, the Association of State and Territorial Health Officials (ASTHO) convened teams from six states to discuss the urgent problem of prescription drugs. The states represented were Kentucky, Ohio, Oklahoma, South Carolina, Tennessee, and West Virginia.

The meeting's goals were for each state team to: (1) agree on a set of priorities or action items that the team would pursue with other partners to strengthen or modify current efforts in the state related to preventing prescription opioid overdoses, and (2) identify opportunities for ongoing technical assistance provided by ASTHO.

State Team Participation

The strength of this meeting was the combined team approach, bringing together various efforts and state departments in the interest of integrated, comprehensive program and policy. The state teams were comprised of representatives that varied by state. Although several teams had multiple representatives from a single agency or entity, the following chart illustrates the diversity of the teams. Appendix I includes a full participant list.

	Kentucky	Ohio	Oklahoma	South Carolina	Tennessee	West Virginia
Public Health	X	X	X	X (OGC)	X	X
Mental Health/Behavioral Health/Substance Abuse		X	X	X	X	X
Targeted Populations (Older Adults, Maternal/Child)		X (Aging)				X (MCH)
Education						X
Law Enforcement	X	X	X			
Justice/Legal	X					
Legislative/Legislature			X		X	X
Inspector General	X					
Medical Licensing Board	X					
Pharmacy Board/Association			X			

Observations and Common Themes

Over the course of the meeting, participants learned more about epidemiological trends in drug abuse and overdose, as well as states' programmatic, legal, and policy initiatives to address prescription drug use. States also examined the importance of developing and sustaining partnerships. Each discussion area was examined in-depth, with each state providing an example for a specific topic of discussion. Descriptions of each presentation can be found in Section IV. General themes to emerge from the meeting included:

1. States with high burdens of prescription drug overdose and abuse are focused on addressing the issue, though the level and types of actions vary widely.

2. States welcome the opportunity to work together, as some have not had the opportunity to do so before the meeting.

3. High-level state leadership (e.g., from the legislature or the governor's office) helps greatly to address barriers and galvanize action in the state.

4. State laws are sometimes necessary to address barriers, particularly those related to aspects of their prescription drug monitoring programs (PDMPs), and these laws need to be evaluated for effectiveness and utility.

5. States will continue their efforts around provider education (prevention); improving the quality, reporting periods, and usability of their PDMPs (surveillance and monitoring); focusing on high-risk users, prescribers, and facilities to impede drug diversion (diversion and enforcement); and increasing and refining the focus on treatment and recovery support, including the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and medication-assisted treatment (MAT) modalities.

Expert Presentations and State Highlights

PRESCRIPTION OPIOIDS: USE, MISUSE, AND HEALTH CONSEQUENCES & POLICY OPTIONS FOR STATES
Len Paulozzi, MD, MPH; Chris Jones, PharmD, MPH; Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

Paulozzi and Jones delivered presentations related to the following areas: epidemiology (death rates, misuse, use, and examples of state work) and policy options (strategic focus areas and policy recommendations).

Paulozzi presented data on the prevailing trends for poisoning and drug poisoning, with the majority of the increases in fatalities attributed to the rise in drug-related poisoning. Although motor vehicle fatalities were the leading cause of injury-related mortality for many years, poisoning deaths have now surpassed motor vehicle crashes as a leading cause of death. Of these, opioid analgesics, cocaine, and heroin were the leading cause of drug overdose deaths, with opioid analgesics as the agent responsible for the greatest number of deaths. Paulozzi discussed the public health impact of opioid pain reliever use, indicating that, for every one overdose death in 2009, there were: nine substance abuse treatment

admissions, 30 emergency department visits for misuse or abuse, 118 people who met criteria for abuse or dependence on opioids, and 795 people aged 12 and older who reported nonmedical use in the past year. Paulozzi also presented maps that displayed state and regional information (e.g., overdose rates, nonmedical use, and oxycodone sales). Prior to the meeting, Paulozzi requested that the participating states count drug overdose deaths from the latest available vital records data that met specified criteria. During the meeting, he used this data in an exercise to make current comparisons between the states more practical.

Jones discussed CDC's strategic focus areas: enhancing surveillance, informing policy, and improving clinical practice. He provided additional information about prescribing trends and doctor shopping, and explained CDC's policy recommendations for addressing the epidemic. Those recommendations included: prescription drug monitoring programs (PDMPs); patient review and restriction programs; laws/regulations/policies; insurers and pharmacy benefit managers (PBM) mechanisms; clinical guidelines; improve access to substance abuse treatment. Jones conveyed the need to enhance treatment and recovery services, cautioning that this might lead to a rapid surge in treatment admissions—a scenario that the medical system is currently ill-prepared to address.

The presenters then invited questions from the participants, which included the following:

1. Two participants asked about the success rate for treatment programs. Paulozzi and Jones pointed out that success depends somewhat on the modality. Methadone treatment and maintenance has a high success rate, while other methods have lower rates of success and higher rates of relapse.
2. A participant asked about reasonable expectations for PDMP reporting times. There has been pushback from the industry on shortening reporting times. The presenters and other participants pointed out that industry *can* make the short reporting times happen, though sometimes it appears they may not wish to do so. In Oklahoma, the state went from 30-day reporting periods to 7-day, to 24 hours, and now to five minutes at the present time. There needs to be buy-in from doctors and other medical professionals.
3. A participant from the Ohio state team commented that a meeting was conducted with the state coroner's office to help them achieve better drug reporting data on drug overdoses in order to improve data collection and aggregation efforts. Kentucky recently passed a bill on how coroners must report overdose deaths.
4. A participant asked about how to better and more meaningfully disseminate data to drive action. In Tennessee, providers use a graphic (i.e., visual chart) so they can quickly appraise and compare their prescribing habits to their peers' and colleagues' (red/yellow/green). In Ohio, prescribers are given a risk score. The group discussed the need to better define the threshold for "abuse" and to determine the indicators for increased risk. For example, is the number of pharmacies visited by a person a proxy for abuse risk?

PANEL SESSION: STATE SYSTEMS APPROACHES

Ellen Benavides, MHA, Assistant Commissioner, Minnesota Department of Health; Christy Porucznik, PhD, MSPH, Assistant Professor, University of Utah School of Medicine; Division of Public Health (formerly of the Utah Department of Health); Steven Saxe, MHA, FACHE, Office Director, Health Professions and Facilities, Washington State Department of Health. Moderated by Paul Jarris, MD, MBA, Executive Director, ASTHO.

The group then turned to a panel comprised of state representatives to present specific model actions. Porucznik discussed Utah's progress, which stems from initially publishing data in 2007 and developing a strategic focus on reducing prescription drug abuse. Subsequently, prescription drug overdose death rates leveled off.

Utah has focused on this issue as a patient safety problem and has worked with the legislature to change confidentiality laws surrounding the state's controlled substances databases (maintained by the Utah Department of Commerce). Porucznik acknowledged that it would be ideal if the database could track prescribing by physician specialty area, physician group practices and mid-level practitioners, or create linkages to medical records to track diagnoses or other non-controlled substance prescriptions. With these data points, the state could better recognize true trends in drug use and abuse instead of focusing on legitimate prescribing patterns, and better direct action to "problematic" or criminal prescribers.

Porucznik and her colleagues continue to assert the importance of evaluating the effectiveness of specific guidelines, such as the impact of the "electronic medical record barrier." She pointed out that, if prompts or questions are not included in the electronic medical record, providers may not ask or do anything differently. There are opportunities for the delivery and exchange of relevant information.

Saxe discussed Washington state's strategies for addressing the prescription drug epidemic, largely centered on epidemiology and often referred to as model state practices. Washington created a broad-based interagency task force in 2008 with representatives from public health, mental health, regulators, and other state entities. The task force increased public and provider education, as well as diversion and surveillance efforts and evaluation of practice guidelines.

The task force currently encourages providers to consult the PDMP to review prescription history information and look for potential interactions. Following a change in legislation in 2007, which authorized the state to begin a prescription monitoring program, the program started data collection from all dispensers in October 2011 after it was delayed by insufficient funding. Practitioners and other authorized users were able to access data for the first time in January 2012.

The Washington Emergency Department Opioid Abuse Work Group, sponsored by the Washington State Department of Health (DOH), developed the Washington Emergency Department Opioid Prescribing Guidelines. The state's prescription monitoring program provides data on people who visit the emergency department frequently to provide dispensers with a tool to recognize when a patient may be obtaining prescription drugs for nonmedical use or with the intent to divert these substances. State and local officials have also conducted drug take-back programs across the state, involving environmental health advocates, as well as law enforcement and, in some cases, pharmacies.

Washington state also enacted a good Samaritan law. Under the measure, if an individual overdoses and someone else seeks assistance, that person cannot be prosecuted for drug possession, nor can the person overdosing. The law also allows people to use the opioid agonist naloxone, which counteracts the effects of opiate overdoses, if it is used to help prevent an overdose. Other Washington initiatives include an active needle exchange program and working with the state higher education system, specifically the University of Washington, to enhance rural provider education.

Benavides described two high-profile cases in Minnesota that focused attention on the prescription drug issue. As a result of two healthcare facility incidents, the state concentrated on drug diversion in those facilities. Controlled substance diversion by healthcare professionals is a serious issue that can lead to patient safety issues. In May 2011, the Minnesota Department of Health (MDH) and the Minnesota Hospital Association (MHA) invited a coalition of hospital, provider, law enforcement, licensing and other healthcare stakeholders to address this issue collaboratively. The group created the "Minnesota 'Controlled Substance Diversion Prevention' Roadmap of Best Practices," as well as final reports detailing enhanced safety components, to guide future action in Minnesota healthcare facilities.

The panel then invited questions from participants, which included the following:

1. A participant asked about the presence of veterinarians in the PDMP. In Washington state, the legislature recently passed a bill that exempts veterinarians from the current prescription monitoring program and requires the DOH, in collaboration with the Veterinary Board of Governors (VBOG), to establish alternative data reporting requirements for veterinarians. In Utah, there were concerns about prescriptions and patients' age until it was realized that there were animals in the database—possible grounds for the removal of veterinarian dispensers from the database. However, Porucznik remarked that the state only saw an incremental effect for veterinarians, even when they were separated out from the general database. In Tennessee, all prescribers are required to check the database because they have found that people are willing to take advantage of any available loophole.

2. A participant asked the panelists if they noted a rise in alcohol use and abuse in relation to prescription drugs, and inquired about the panelists' experiences with youth substance abuse prevention programs (i.e., whether it lowers the age of initiation). Washington is trying to track deaths also associated with alcohol. Using Utah's medical examiner data, the state has found that alcohol use is associated with about 20 percent of drug overdose deaths and authorities have not seen this percentage increase over the years. Per the question on youth programs, Porucznik discussed their lack of youth data (deaths are not necessarily being certified as drug-related), which makes it challenging to definitively illustrate youth drug use/abuse trends.

3. A question was asked about the effectiveness of using of high-profile cases to draw attention to the prescription drug problem. In Minnesota, these were moments when the community was galvanized around action because the incidents were very public. Officials in Minnesota used this opportunity to discuss how to work together well and it was a prime example of how to not be "turfy" and defensive.

4. A participant asked if there was *one* specific action in Utah that worked to decrease the use of prescription drugs. Jarris stated that a systems approach typically yields the greatest impact toward improvements in health outcomes.

5. Another participant asked about formal nursing education. The University of Washington is mostly targeting physicians, but also nursing and pharmacy students. Benavides emphasized the need to support rural practitioners.

The group commented on the need to tie together medical doctor and pharmacy training programs in school so they view one another as a prevention and treatment team. Others echoed the need for

Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs in multiple settings because this intervention reaches people *before* they are dependent and when it is still possible to get them to treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) is funding residency programs to teach SBIRT. Another participant commented on the need to reach out to the faith/religious community to address the cultural component. In Utah, religious affiliation was considered in some investigations and, often, people who died of overdose tended to be less engaged in their faith communities. People commonly report that they are religiously-adherent in Utah but, because drugs come from physicians, they are perceived as being more acceptable than alcohol or other substances (i.e., these usages are not accepted in the religious culture).

STATE POLICY TRENDS

Sharon Moffatt, RN, BSN, MSN; Chief, Health Promotion and Disease Prevention, ASTHO.

States have been increasingly interested in addressing prescription drug abuse, with many states introducing legislation across the broad continuum of action. Moffatt emphasized that it will be crucial to capture and share information related to implementation of these wide-ranging legislative efforts and policies. She also encouraged attendees to consider special populations, including youth, Medicaid recipients, military personnel, maternal and child populations, and older adults, and to consider what available levers exist to help these populations mediate legitimate access to opioid pain relievers while discouraging inappropriate use.

PRESCRIPTION DRUG OVERDOSE PREVENTION: SELECTED LEGAL STRATEGIES

Len Paulozzi, MD, MPH; Division of Unintentional Injury Prevention, NCIPC, CDC; and Stacie Kershner, JD, and Carla Chen, JD; Public Health Law Program, Office for State, Tribal, Local, and Territorial Support, CDC.

Kershner detailed laws, statutes, and regulations (not the rules of medical boards or the guidelines of state agencies) enacted before August 2010, explaining that, as new laws are adopted, CDC will update their analyses to reflect real-time changes. In this analysis, CDC compiled a sample of laws related to each strategy. Common elements from each statute or regulation were identified for each strategy, and these elements were combined to form the case definitions.

Promising legal strategies include:

- Prescription drug monitoring programs.
- Requiring physical examinations before prescribing.
- Requiring tamper-resistant prescription forms.
- Regulating pain management clinics.
- Setting prescription drug limits.
- Prohibiting “doctor shopping”/fraud.
- Requiring identification before dispensing.
- Providing immunity from prosecution/mitigation at sentencing (“good Samaritan”).

The framework presented was primarily for discussion—many laws appear to fall into the above categories, but may not be applicable (i.e., yield the same outcomes) in every state.

The Robert Wood Johnson Foundation (RWJF) is funding ongoing research at the University of North Carolina Chapel Hill and at the University of Utah. The studies at these institutions will reassess the effectiveness of PDMPs and evaluate the impact of three regulations on prescribing patterns, respectively. Additionally, CDC continues to track and monitor progress of states' prescription drug laws. In response to a question about evaluation of legal interventions, Kershner commented that RWJF and CDC would be good resources, but there are no best practices for legal evaluations at this point. However, RWJF does fund evaluation studies.

WORKING ACROSS SECTORS: FORGING AND SUSTAINING PARTNERSHIPS
(State Highlight: Ohio)

Ohio described three tiers of partnership in Ohio: within state government (cabinet-level team); five major work groups (enforcement, professional education, public education, recovery, and treatment); and 23 community-based opiate task forces throughout Ohio at the local level.

SOLACE (Surviving Our Loss and Continuing Everyday) is a statewide family engagement network that seeks to support individuals and families affected by addiction, advocate for policy changes, and mobilize other communities to affect their own change. It is expected that 20 new family support groups will soon begin. Ohio shared how the state embedded this work at the state and local levels through legislation, coalitions, and relationship-building, and how the concept of "*data driving action*" (e.g., mapping) illustrated the number of opiates being dispensed in Ohio, attracting the attention of the governor and providing the necessary momentum.

Ohio posed three questions to the group:

1. Can CDC develop a set of national guidelines for opioid and other controlled substance use in emergency departments that includes guidance around the use of opiates for chronic pain conditions?
2. Should we set a national standard for maximum morphine equivalent dose (MED) to be prescribed daily for the treatment of chronic pain conditions?
3. Should we define optimal treatment strategies to enhance the use and effectiveness of medication-assisted treatment (MAT) regimens?

A participant asked about the state's use of evidence-based recommendations related to the standardization of methadone and Suboxone prescribing. Ohio is planning to contract with the National Institute on Drug Abuse (NIDA) to evaluate their recommendations. Ohio hypothesized that lowering the prescribed dosages would also decrease costs and reduce diversion. The state is evaluating its formative guidelines at one pilot site and, if successful, Ohio will initiate a rules process to require their use for treatment services reimbursed through Medicaid. The Ohio team is willing to share these guidelines with the meeting participants as they become available.

STRENGTHENING OPPORTUNITIES FOR PREVENTION: AN ASSESSMENT OF CROSS-SYSTEMS PLANNING AND ACTION
(State Highlight: West Virginia)

West Virginia spoke to designing a strategy for comprehensively assessing prevalence, gaps, and need across the substance abuse continuum statewide. An intensive needs assessment resulted in reshaping

the state's entire prevention structure. West Virginia summarized three essential components to the state's success: executive leadership, action, and teamwork. West Virginia described an extensive list of outcomes and successes, namely the passage of a comprehensive substance abuse bill (SB 437), increased physician engagement initiatives, public/private partnerships between state agencies (e.g., the West Virginia Perinatal Partnership and the Claude Worthington Benedum Foundation), interstate prescription drug alliance, and SBIRT in schools, regional prisons, and Veterans Affairs offices. West Virginia's "lessons learned" included:

- System-wide assessment involving multiple partners is key—take your time and be patient.
- Establishing and continuing relationships with partners statewide is critical.
- A top down-bottom up approach was central to West Virginia's success.
- Data-informed decision making must guide the process.
- Funding is one part of success—grassroots efforts and collaborations are impactful and cost-effective.
- Be flexible and develop strategies that are flexible.
- Keep the end always in focus—people's lives depend on it.
- Get started and build your system over time.

IMPROVED PRESCRIPTION MONITORING AND SURVEILLANCE
(State Highlight: Oklahoma)

Oklahoma was well-positioned to speak to the state's regulatory environment and the subsequent impact on prescription monitoring. The Oklahoma PMP was enacted into law by Oklahoma's Anti-Drug Diversion Act. Dispensers are required to submit controlled substance prescription information directly to the system every 24 hours. As of January 2012, prescriptions must be reported to the PMP within five minutes of being delivered to the ultimate user or their designee. An advisory board was created comprised of professionals from chain and independent pharmacies, pharmaceutical companies, regulatory agencies, trade organizations, the pharmaceutical software industry, Indian Health Services, and law enforcement agencies. The advisory board's goal was to create the framework for moving Oklahoma's PMP to a real-time collection system that would take into account all stakeholders' concerns.

Director of the Oklahoma Bureau of Narcotics Darrell Weaver described Oklahoma's PMP, which was built in-house to the state's specifications after a 108 percent increase in drug overdose deaths, 81 percent of which were related to prescription drugs.

All overdose deaths in the state are reported to law enforcement. Law enforcement also receives reports of nonfatal overdoses, which are considered "in-progress" crimes. They receive data every day from hospitals through the state PMP. The PMP has a secure portal that takes about 10 seconds to operate and is open to every doctor and veterinarian in the state. Weaver reported an estimated 75 percent compliance rate with 17,000 registrants. Chain pharmacies quickly joined with the PMP and 85 percent of these pharmacies use one software platform. The number of prescriptions leaving the emergency room has decreased as a result of the real-time PMP. The cost to Oklahoma to implement this system was fairly minimal. Weaver pointed out that, the closer to real time the system can be, the more useful it is and the more confidence people have in the system itself.

Oklahoma also has an active prescription drug take-back program, with 120 boxes in secure locations around the state. The programs have collected approximately 8,000 pounds of unwanted, unused prescription drugs and the state is working with a refuse company to recycle the drugs into clean energy. Officials are unable to separate the drugs into schedules or classes to weigh each separately, but they are planning to conduct spot audits to determine the exact types of drugs received in each box.

REDUCING DRUG DIVERSION THROUGH ENFORCEMENT STRATEGIES
(State Highlight: Kentucky)

The state has sought to maximize its limited resources. Jennifer Carpenter from the Office of the Kentucky Attorney General explained that it had previously assigned just four law enforcement officers to pursue prescription drug cases, but has since partnered with local law enforcement to work together as a state unit. As a result, there are now eight officers available to work cases across the state, with local officers able to cross county lines to investigate cases.

The state's Kentucky All Schedule Prescription Electronic Reporting (KASPER) system has helped reduce the number of doctor shopping cases in Kentucky, but Carpenter reported the rising trend of online doctor shopping, as well as an increased number of cases from out-of-state. Kentucky enacted laws that prohibit out-of-state doctors from prescribing to Kentucky residents after observing an increased number of prescriptions that originated in Florida. The Kentucky team members represented at the meeting also work closely with Appalachian high intensity drug trafficking areas' (HITDA) offices and related initiatives, which have served as a great intelligence unit, to identify trends from Florida. Kentucky likened these prescribing and doctor shopping trends to those of an organized crime ring to demonstrate how the state has leveraged resources to increase enforcement in the state. In addition, Kentucky addressed three questions:

How have the judicial and public health sectors worked together? How have the two "cultures" merged and to what extent do they support each other?
The Office of Drug Control Policy in Kentucky is located within the Justice and Public Safety Cabinet and has strong connections to the criminal justice community and a close working relationship with public health, the treatment and recovery community, and the prevention/education community.

Do you have specific protocols for interacting?
Although no explicit protocol is followed, the representatives from Kentucky serve on numerous boards together and collaborate on projects of mutual interest.

What are your top three "lessons learned?"

1. Kentucky is blessed to have employees and agencies all across the government that care about addressing our substance abuse issues.
2. Almost all agencies are willing to collaborate and work together, you just have to ask.
3. We can accomplish much more when we combine resources, especially in these lean economic times.

ENHANCING TREATMENT AND RECOVERY SUPPORT
(State Highlight: Tennessee)

Co-presentation with Nicholas Reuter, MPH; Division of Pharmacologic Therapy, Center for Substance Abuse Treatment, SAMHSA.

First, Reuter discussed the Substance Abuse and Mental Health Services Administration's (SAMHSA) priorities in preventing and treating prescription drug abuse, including increasing and supporting the use of PDMPs, increasing funding capacity for treatment, and increasing training to providers. He discussed the benefits of SBIRT, as well. Reuter addressed some challenges of treatment and recovery, such as denial. He also discussed the long periods between the first exposure and admission for treatment. Four out of 10 individuals who report a prescription drug dependency have co-occurring mental health disorders. There are also capacity issues related to the demand for treatment services. Treatment continues to be difficult to tailor for each person, as there is no "one-size-fits-all" approach for everyone addicted to prescription drugs. Other challenges pertinent to states included:

- Continuing stigma against methadone treatment.
- Funding and resource shortages.
- Need to interface with criminal justice system.
- Need to integrate treatment interventions/referrals into overdose prevention.
- Lack of special attention to adolescents/young adults.
- Lack of evidence and research to guide states on the effectiveness of strategies.

SAMHSA is providing training on medication-assisted treatment. There are regional differences in terms of the types of medication-assisted treatment modalities used. SAMHSA supports the National Registry of Evidence-Based Programs and Practices (NREPP), which includes evidence-based programs for practitioners in the field to consider. SAMHSA also developed an opioid overdose prevention toolkit, in conjunction with ASTHO, which includes information about Naloxone administration, recovery, and "do's/don'ts" when responding to an overdose.

Reuter discussed the collaboration between CDC, the National Institutes of Health, and FDA focused on making naloxone more readily available to nonmedical users. FDA is determining if intranasal naloxone can be made available over-the-counter, as there is generally support (e.g., from first responders/EMS) for this route of administration.

SAMHSA is studying local interventions to increase prevention, treatment, and recovery supports and looking to turn enforcement and compliance into educational opportunities for law enforcement and physicians. Reuter referenced the example of Project Lazarus, a public health model from Wilkes County, North Carolina that is based on the premises that drug overdose deaths are preventable and that all communities are ultimately responsible for their own health. The Lazarus Project showed some successful outcomes, including a 69 percent reduction in overdose deaths between 2009 and 2011.

During the Q&A session, Reuter stated that SAMHSA will continue to emphasize the use of multiformulation combination opioid medications, as there is less abuse with these products based on the pattern of withdrawal associated with these products. The market continues to innovate with new delivery mechanisms for opioid detoxification, such as subcutaneous rods, but SAMHSA is not funding

these types of studies at this time. Recently, a new transdermal patch designed with analgesic release properties was introduced to the market, but additional research is needed on other modalities. NIDA is funding much of this research. A participant asked about harm reduction strategies that Reuter said have been studied in Canada, but not as rigorously in the United States.

Tennessee Department of Health Commissioner **John Dreyzehner, MD, MPH, FACOEM,** spoke of Tennessee's efforts to support treatment and recovery services. The state continues to work on enhancing its PMP and, at the time of the meeting, was waiting on news of a bill expected to pass through the legislature that would address many aspects of the prescription drug continuum. The Tennessee Prescription Safety Act of 2012 was signed into law by Governor Bill Haslam on May 11, 2012. Tennessee's efforts will focus on implementing the law and addressing the market forces that inform and influence the prescription drug trends. Tennessee also addressed three questions and offered an expanded description of the state's approach to tackling the epidemic:

How do substance abuse treatment and recovery support services complement or reinforce other state efforts?
These services are reflected by the formation of Governor's Public Safety Subcabinet Working Group (i.e., Department of Safety & Homeland Security, Department of Mental Health, Department of Health). Participants from Tennessee noted that it is the nature of governor's state plan to include multiple strategies and different units of interventions.

How have these efforts informed other prevention initiatives or programs?
Dreyzehner referred to a core messaging principle: "Anyone, Anywhere, Anytime."
The susceptibility message: Capture stories to dispel public preconceptions of diversion and drug misuse. Mortality rates are the tip of the proverbial iceberg.
The severity message: The human, service, and economic costs of near-misses and continuous treatment. Profiling costs elevates new potential governmental partners.
The prevention message: The mortality profile indicates this is a workforce and economic development issue.

What are your top three "lessons learned?"

1. Making laws, rules, and regulations is not for the faint of heart and requires persistence.
2. Different governmental interests bound together strengthen the case and long-term commitment.
3. Leveraging the mortality and diversion arguments pave the way for prevention and treatment messages.

State-Specific Planned Actions

State teams spent the majority of the meeting time engaged in an in-depth analysis of current work, gaps, and future plans across the continuum. Prior to the meeting, ASTHO staff created a master set of nationally accepted recommendations rendered from the White House Office of National Drug Control Policy's (ONDCP) 2011 Prescription Drug Abuse Prevention Plan and CDC. This combined set of recommendations was intended to provide guidance (evidence-based, when available) for state-level action to meaningfully and effectively reduce prescription abuse and drug overdose mortality rates. Using materials submitted by each state prior to the conference, as well as publicly available documents

and tools, ASTHO staff provided each state team with an analysis of current actions in each stage of the comprehensive continuum: prevention; surveillance and monitoring; diversion; and treatment and recovery. The state teams then used this tool to analyze each state's respective investments and actions, as well as identify and prioritize areas in which little or no action had been undertaken. The states prioritized these actions based on perceived commitment, effort, and cost. An abridged version of the gap analysis worksheet and each state's policy analysis is provided in Table 1. After one-and-a-half days of discussion, the states agreed on actions to pursue in the days and weeks following the meeting. These areas are summarized in the chart below:

State	Actions
Kentucky	Kentucky will work on increasing access to treatment services through Operation UNITE, in addition to maintaining the treatment hotline, and will look for ways to expand these efforts statewide. Kentucky will also work to reduce stigma and barriers to treatment and recovery. In the days following the meeting, a stakeholder meeting would convene to discuss raising money to expand the treatment hotline. The Kentucky Cabinet for Health and Family Services will conduct meetings with medical licensing boards.
Ohio	Ohio will establish prescribing thresholds for physicians and develop prescribing guidelines for use in emergency departments and acute care facilities. Ohio will use the state's PDMP (the Ohio Automated Rx Reporting System [OARRS]) to monitor for consulting thresholds for prescribers and collaborate on interstate diversion initiatives. Ohio will also standardize approaches for medication-assisted treatment/buprenorphine methods and will introduce guidelines in the near future.
Oklahoma	Oklahoma state team members will engage new partners and formally create a new state task force. Oklahoma will work collaboratively on specific measures identified in prevention, treatment and recovery, improving the use of the PMP, and targeting long-term care and hospice facilities for future action.
South Carolina	Representatives from South Carolina stated that they need to establish more groundwork. South Carolina stressed the need to develop relationships to get the attention of staff and principal stakeholders.
Tennessee	Tennessee will meet with a media and grassroots stakeholder groups to talk about prevention messaging. The team also plans to present information about SBIRT to the Tennessee Department of Health within a month of the meeting. Tennessee expected that the state legislature would pass a bill that would address several areas of prescription drug abuse, and members of the team were committed to implementation. Tennessee will evaluate its current laws, using a stakeholder input process to develop the methodology. Tennessee will monitor the state budget to determine if there is funding to hire staff to improve coordination between state/local law enforcement on investigations related to prescription fraud and diversion. A pharmaceutical company has also indicated its willingness to provide Tennessee with funds for the purchase of 5,000 doses of Naloxone. The state will carefully assess the proposal and weigh conflict of interest.

State	Actions
West Virginia	West Virginia will be challenged with implementing SB 437, a comprehensive substance abuse plan. West Virginia will focus on healthcare provider education, SBIRT expansion, PDMP utilization, stakeholder engagement, evaluation of current infrastructure and services, and addressing workforce goals for treatment and recovery services by engaging medical schools.

TABLE 1: GAP ANALYSIS—INITIAL RESULTS

The following charts are an abridged summary of the compiled recommendations, interfaced with the states' current activities in each area, as determined by ASTHO staff who materials submitted by the state prior to the meeting.

The gap analysis was intended to help states visualize their current investments and commitments, and to identify areas for future growth and activity. States reported additional activities that were not captured in these broad categories.

	Strengthening Opportunities for Prevention				
	KY	**OH**	**OK**	**TN**	**WV**
Healthcare Provider Education					
Training on responsible prescribing				X	X
Curricular requirements for training (pre-service) in schools of medicine, dentistry, pharmacy, etc.		Future plans indicated		X	
Continuing education in pain management		X			X
Evidence-based clinical guidelines for ED prescribing		X			
Parent, Youth, and Patient Education					
Public awareness campaigns	X	X	X	X	X
Educational materials on use and disposal of opioids	X	X			
Community and Healthcare Settings					
Epidemiological studies	X		X		X
SBIRT					X
Proper Medication Disposal					
Coordinate disposal efforts across the state		X	X	X	

	Improved Prescription Monitoring and Surveillance				
	KY	OH	OK	TN	WV
Prescription Monitoring Programs					
Focus on high-risk patients	X	X			
Link to EHRs	X				
Improve linkages to other state data systems (Medicaid)	X	X		X	X
Leverage state health information exchanges	X		X		
Incentives to providers checking PMPs		X		X	
Incorporate new technologies into SBIRT programs					
Improve PDMP inter-operability across states	X			X	X
Patient Review and Restriction (PRR) Programs					
Evaluate PRR programs	X			X	
Coordination between state program, workers' comp. to monitor script claims					

	Reducing Drug Diversion Through Enforcement Strategies				
	KY	OH	OK	TN	WV
Healthcare Provider Accountability					
Use of evidence-based guidelines	X	X			
Institute regulatory action (e.g., by state medical board) against providers who prescribe outside normal limits	X	X		X	
Model pain clinic regulation laws		X		X	
Use PMP data to identify "problem prescribers" and clinics		X	X		
Use PDMP to identify doctor shoppers		X	X		
Laws to Prevent Abuse and Diversion					
Enact and enforce laws to prevent abuse (e.g., photo ID for prescription pickup)				X	X
Evaluate laws for effectiveness					
Promote law enforcement collaboration		X			
Promote coordination of investigations					
Develop partnerships through HIDTAs		X			X

	Enhancing Treatment and Recovery Support				
	KY	OH	OK	TN	WV
Improve Substance Abuse Treatment					
Facilitate better access to effective treatment services	X	X		X	
Address under-treatment of substance abuse, increase parity				X	
Evaluate overdose prevention programs to train and distribute naloxone to non-medical users		X			
Reduce stigma and barriers to care (e.g., from methadone clinics to office-based buprenorphine treatment)		X			X
Leverage resources to improve service delivery	X	X			X
Identify performance indicators and outcome targets for opioid treatment services					

Conclusion

Although these states have made great strides in addressing prescription drug misuse, abuse, and diversion, much work remains to be done. Future efforts will be strengthened by a coordinated approach that addresses all aspects of the continuum.

Appendix I: Full Participant List

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Preventing Prescription Drug Misuse, Abuse, and Diversion
April 25-26, 2012

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