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February 2015 Briefing Summary

Opioid Abuse in Wisconsin: *State Policy, Naloxone, and Prescribing Practices*

Briefing Materials are available at: http://uwphi.pophealth.wisc.edu/programs/health-policy/ebhpp/events/index.htm

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The use and misuse of opioids, and public policy responses

Jim Cleary from the Pain and Policy Studies Group (PPSG) at UW-Madison discussed the need for a drug control system that balances preventing diversion with ensuring adequate availability for medical use.

- Opioid sales, treatment admissions, and deaths in the US have more than tripled since 1999. Yet many people are living with pain, many of whom *need* these medications but do not receive them.
- Efforts to combat opioid addiction and misuse go back at least a century.
- There is not as much of a link between use and death as we might think. Some studies have found no link between use of morphine and morphine-related crime. Methadone accounts for 10 percent of opioid use, but over one-third of opioid-related deaths. Marketing may explain different rates between countries.
- 55 percent of people who abuse prescription painkillers get them free from a friend or relative; 17 percent have them prescribed for them by a physician.
- The most crucial strategy to combat misuse is education (for providers, patients, and the public). Lack of physician understanding of these medications is far too common.
- Too often, physicians see the "right number" of medications to dispense as the number it will take to prevent the patient calling after hours to get a refill. Allowing partial refills may help.

Aaron Gilson from the PPSG discussed strategies to stop diversion. Echoing the need for balance, he pointed out that many factors make the association between prescribing and deaths non-causal and non-linear.

- Diversion takes many forms: theft from manufacturers/distributors, providers, patients, and in transit; inappropriate prescribing; prescription forgery; pill mills; doctor shopping (and "pharmacy hopping"); internet sales without a prescription; gift or purchase from patients; and improper disposal.
- Recent responses by states to abuse and diversion include Prescription Drug Monitoring Programs (PDMPs); medication security measures; medication take-back measures and drop boxes; practitioner, patient, and public awareness campaigns; and joint efforts to investigate diversion.
- DEA take back days starting in 2010 were very successful, but the federal government now leaves such efforts up to the states. A 4-hour Dane County take-back event in 2011 collected over 14,000 dosage units. Medication drop boxes for passive collection help but are hard to find.

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Best practices in Prescription Drug Monitoring Programs (PDMPs)

Patrick Knue from the PDMP Training and Technical Assistance Center discussed trends and best practices in the operation of PDMPs—state programs that collect controlled substance prescription records statewide and provide data to authorized end-users for use in clinical care, law enforcement, professional regulation, and research.

- Providers can use PDMPs to guard against misuse and drug interactions. Law enforcement agencies (with a warrant, in Wisconsin) can monitor unlawful activities by providers, patients, and others.
- Recommended practices include: collecting data at the shortest possible intervals; collecting patient ID and method of payment (cash is associated with misuse); integrating reports with health information exchanges (workflow disruption is a key barrier to prescriber utilization); implementing interstate data sharing; and mandating enrollment and utilization of the system.
- Wisconsin's program is developing quickly (including integration with e-medical records), but it does not currently collect Patient ID or mandate enrollment or utilization, and its data collection interval is weekly.
- PDMPs have been shown to inform and impact physician prescribing decisions. They also reduce diversion, especially if they are proactive (law enforcement-oriented).

Attorney General's perspective

Brad Schimel, Wisconsin's new Attorney General, said that fighting opioid abuse is a priority for his DOJ.

- Balance in use is important, but there is too much of a medical focus on eliminating *all* pain.
- Wisconsin is a leader in drug take-back programs, and we plan to expand on them.
- Investigation needs to improve, but we cannot arrest our way out of this problem. We need more naloxone training, medication-assisted treatment in corrections facilities, and drug treatment courts, which are extremely cost-effective. However, these initiatives require more resources for our justice system.

Naloxone practice and policy

Cynthia Gaston from UW Health discussed the promise of naloxone and improved opioid management.

- At least 10 percent of the population has a genetic predilection to opioid addiction, and environmental and psychosocial factors also make someone's chance of addition harder to predict. People who first misuse these drugs at a young age face a greater risk, so early education is crucial.
- Naloxone rapidly reverses opioid effects. It requires a prescription, but has no potential for abuse and no effect on individuals who are not on opioids. The main danger is that, because its duration is shorter than that of opioids, repeat doses may be required for a single opioid overdose. Naloxone does not increase misuse, and in fact abusers are more likely to seek treatment for addiction after naloxone administration.
- Naloxone comes in several forms: The typical kit is cheap ($15-45) but difficult to use because needles are required. The Evzio auto-injector is easier to use, but expensive ($345) and may require many repeat doses. The FDA is still studying commercial products for intranasal syringes, but they show promise.
- Naloxone prescriptions should be given to anyone at risk of addiction and individuals likely to witness an overdose. More training, kit standardization, and distribution to underserved, rural areas will also help.

Anna Legreid Dopp from UW Health discussed naloxone access policies and the pharmacist's role.

- The cost effectiveness of naloxone is extremely high, and co-prescribing it with opioids decreases abuse.
- The federal government could help by making it an OTC or even "behind-the-counter" drug.
- Pharmacists can better help through broader use of 3rd-party prescriptions and standing orders, and through collaborative practice agreements. Legal authority to write their own orders would be best of all.
- Many challenges to distribution remain, including stigma (perceived by providers and patients), payment policies (many insurers don't cover many prescription and administration types), and caregiver fears.

Scott Stokes from AIDS Resource Center of WI (ARCW) discussed harm reduction (strategies embracing any incremental change to reduce negative drug use consequences and promote health) in the field.

- Goals of ARCW's harm reduction program include preventing disease, reducing mortality, and offering treatment for drug dependence. Its naloxone distribution program now produces over 1000 users trained and over 1000 peer saves each year (because 85% of all ODs are witnessed), as well as over 100 treatment referrals yearly. Demand for these services, as well as its needle exchange program, is rising, as the demographics of users skews younger and more middle-class.
- Naloxone access should be expanded to drug treatment facilities and jails/prisons, and made available through co-prescribing or OTC. Program funding and price gouging should be addressed, and the "Good Samaritan" law should be expanded to apply to the user as well (eliminating a deterrent to 911 calls).