# Finding Solutions to the Prescription Opioid and Heroin Crisis: A Road Map for States

National Governors Association

# Acknowledgments

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# National Governors Association Opioid Road Map Executive Summary

## THE PROBLEM

Inappropriate opioid prescribing has fueled one of the deadliest drug epidemics in U.S. history. Though most opioid-related overdoses involve prescription opioids, an increasing number are linked to illicit opioids such as heroin and fentanyl.

## THE ROLE OF STATES

Governors are taking action to end the opioid epidemic with a range of public health and public safety strategies across the continuum from prevention and early identification to treatment and recovery.

## THE ROAD MAP

The road map is a tool to help states respond to the opioid crisis with effective health care and public safety strategies.

## KEY STATISTICS

Every day, **78 people** die from an overdose related to prescription opioids and heroin.

Medicaid is the most common payer of opioid-related hospitalizations, the cost of which **quadrupled** between 2002 – 2012.

In 2012, health care providers wrote enough opioid prescriptions for every American adult to have a bottle of pills.

Heroin seizures by U.S. law enforcement rose **81%** between 2010 – 2014.

**4 out of 5** heroin users reported misusing prescription opioids before moving to heroin.

**80% of people** with an opioid use disorder are not receiving treatment.

## STEP 1 Assess the Situation

IDENTIFY POLICY AND FINANCIAL LEVERS, AND CONDUCT HIGH-LEVEL DATA SCAN

IDENTIFY OR CREATE PRESCRIPTION OPIOID AND HEROIN TASK FORCE

ENSURE KEY DECISION MAKERS ARE INVOLVED

CONNECT WITH PRIORITY STAKEHOLDERS AND SET VISION

**KEY OUTPUTS:**

Overarching vision and goals

Comprehensive understanding of the state levers to reduce opioid misuse and overdose

## STEP 2 Develop and Select Policies

### PREVENTING OPIOID MISUSE AND OVERDOSE

#### HEALTH CARE STRATEGIES FOR PREVENTION AND EARLY IDENTIFICATION

- Develop and update guidelines for all opioid prescribers.
- Limit new opioid prescriptions for acute pain, with exceptions for certain patients.
- Adopt a comprehensive opioid management program in Medicaid and other state-run health programs.
- Remove methadone for managing pain from Medicaid preferred drug lists.
- Expand access to non-opioid therapies for pain management.
- Enhance education and training for all opioid prescribers.
- Maximize the use and effectiveness of state prescription drug monitoring programs.
- Use public health and law enforcement data to monitor trends and strengthen prevention efforts.
- Enact legislation that increases oversight of pain management clinics to reduce "pill mills."
- Raise public awareness about the dangers of prescription opioids and heroin.

#### PUBLIC SAFETY STRATEGIES FOR REDUCING ILLICIT SUPPLY

- Establish a collaborative information sharing environment across state agencies.
- Leverage assets from partner entities to improve data collection and intelligence sharing.
- Expand statutory tools for prosecuting major distributors.
- Expand law enforcement partnerships and data access to better target over-prescribers.
- Implement best practices and ensure intergovernmental cooperation in narcotics investigations.
- Establish and enhance stakeholder coalitions.

### RESPONDING TO OPIOID MISUSE AND OVERDOSE

#### HEALTH CARE STRATEGIES FOR TREATMENT AND RECOVERY

- Change payment policies to expand access to evidence-based MAT and recovery services.
- Increase access to naloxone.
- Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services.
- Create new linkages to evidence-based MAT and recovery services.
- Consider authorizing and providing support to syringe service programs.
- Reduce stigma by changing the public's understanding of substance use disorder.

#### PUBLIC SAFETY STRATEGIES FOR RESPONSE

- Empower, educate, and equip law enforcement personnel to prevent overdose deaths and facilitate access to treatment.
- Reinforce use of best practices in drug treatment courts.
- Ensure access to MAT in correctional facilities and upon reentry.
- Strengthen pre-trial drug diversion programs to offer individuals the opportunity to enter into substance use treatment.
- Ensure compliance with Good Samaritan laws.

## STEP 3 Finalize Policies, Implement & Evaluate

**DEVELOP WORK PLAN BASED ON POLICY PRIORITIES**

Develop a work plan or identify an existing vehicle, such as an existing statewide opioid plan, from which an actionable work plan can be developed to achieve defined objectives.

**IMPLEMENT POLICIES**

**CONTINUOUSLY MONITOR AND EVALUATE**

Implement rapid cycle performance monitoring, reporting and quality improvement strategies.

Make programmatic adjustments based on evaluation.

**IN THE APPENDIX:** • State Examples • State Approaches to Establishing Opioid Prescription Limits • Medication Assisted Treatment Overview • Sample Key Data Sources • Abbreviated Resource List • More Information About Evaluation

# Introduction

## How to Use the Road Map

The road map is a tool to help states respond to the growing crisis of opioid misuse and overdose. Used effectively, this tool will help states assess their current capacity to address the problem, select evidence-based and promising strategies and evaluate their work.

With many states already working to combat the epidemic, some steps may overlap with efforts currently underway. The road map is designed as a policy development tool, allowing a state to use all or portions of the road map as it applies to their unique situation. States could consider revisiting the tool as needed.

## What to Expect

Here is an overview of what states will find as they progress through the road map:

- Background on the problem and the factors driving the current prescription opioid misuse and heroin epidemic
- Steps to address the crisis, including how to assess the situation, select policies and evaluate initiatives
- A summary of evidence-based and promising health care and public safety strategies to reduce opioid misuse and overdose
- An appendix with state data sources and additional resources, including sample state plans

## How it Was Developed

The road map was developed through extensive research and consultation with senior state officials and other national experts in the fields of health and public safety. The National Governors Association (NGA) invited input from a broad array of stakeholders, including pain specialists, substance use disorder treatment providers, health care payers, law enforcement and criminal justice professionals. Numerous federal agencies shared resources and expertise. The road map also reflects insights from the work NGA has done with states since 2012 to reduce prescription opioid misuse and overdose.

For additional information about the road map, please contact Kelly Murphy at kmurphy@nga.org or Jeff McLeod at jmcleod@nga.org.

# Background

## Opioid use disorder and overdose are serious problems affecting millions of Americans.

In 2014, an estimated 1.9 million people in the United States suffered from substance use disorders related to prescription opioids and an estimated 586,000 people were addicted to heroin.[1] Overdose deaths have soared in recent years; between 2001 and 2014, there was a 200 percent increase in the rate of overdose deaths involving prescription opioids and heroin.[2] According to CDC, more Americans died of drug overdoses in 2014 than in any year on record. Opioids were involved in 61 percent (28,647) of the 47,055 drug overdose deaths that occurred that year in the United States.[3]

The rise in opioid use disorder and overdose has been fueled by inappropriate opioid prescribing. Sales of prescription opioid painkillers nearly quadrupled from 1999 to 2014, though the amount of pain reported by Americans remained relatively unchanged.[4] This shift in opioid prescribing practices began in the 1990s with changing attitudes about pain management—including the move to treat pain as the fifth vital sign—and the risks associated with prescription opioids. In 2012, health care providers wrote 259 million prescriptions for opioid painkillers, enough for every American to have a bottle of pills.[5]

Along with the increase in prescription opioid misuse, the United States has recently seen a related surge in heroin. Heroin overdose death rates more than tripled between 2010 and 2014.[6] Although surveys show that less than 4 percent of people who have misused prescription opioids start using heroin within five years, four out of five recent heroin initiates (79.5 percent) reported nonmedical use of prescription opioids.[7] With an increased supply of heroin and new methods for selling to a broader base of customers, illegal drug traffickers have become increasingly aggressive and sophisticated in their distribution methods. Adding to the problem, traffickers in some areas have begun supplementing heroin with illicit fentanyl, an inexpensive and powerful opioid that is up to 50 times more potent than heroin. The emergence of illicit fentanyl has led to a dramatic increase in overdose deaths in some states and poses unique challenges for health care and public safety professionals.

# Background

Having recognized the widespread and devastating nature of the opioid crisis, governors are taking action to stem the tide of opioid use disorder and overdose. States are uniquely positioned to do this work, because they play a central role in protecting public health and safety; regulating health care providers; establishing prescription drug monitoring programs (PDMPs); and paying for care through Medicaid, state employee benefits, corrections and other health programs. Current evidence suggests that the most effective way to end the opioid crisis is to take a public health approach focused on preventing and treating opioid use disorder as a chronic disease while strengthening law enforcement efforts to address illegal supply chain activity. This road map uses a public health intervention model to guide state activities in targeting the problem with health care and law enforcement strategies. A monitoring and evaluation component is included to help states assess the effectiveness of those efforts and inform future activities.

1 Sarra L. Hedden et al., Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (Rockville MD: Substance Abuse and Mental Health Services Administration, 2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf (accessed June 13, 2016).

2 Rose Rudd et al., "Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014," Morbidity and Mortality Weekly Report 64 no. 50 (January 1, 2016): 1378–1382, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm (accessed June 13, 2016).

3 Ibid.

4 Leonard J. Paulozzi et al., "Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999–2008," Morbidity and Mortality Weekly Report 60 no. 43 (November 1, 2011): 1487–1492, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm (accessed June 13, 2016); and H.Y. Chang et al., "Prevalence and Treatment of Pain in Emergency Departments in the United States, 2000–2010," American Journal of Emergency Medicine 32 no. 5 (May 2014): 421–423, http://www.ncbi.nlm.nih.gov/pubmed/24560834 (accessed June 13, 2016).

5 Centers for Disease Control and Prevention, "Vital Signs: Opioid Painkiller Prescribing: Where You Live Makes a Difference," Morbidity and Mortality Weekly Report (July 1, 2014).

6 R. Rudd, "Increases in Drug and Opioid Overdose Deaths."

7 Pradip K. Muhuri, Joseph C. Gfroerer, and M. Christine Davies, "Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States," Center for Behavioral Health Statistics and Quality Data Review (August 2013), http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm (accessed June 13, 2016).

# NGA's Work on Reducing Prescription Opioid Misuse

**Between 2012 and 2015, NGA worked with 13 states on statewide plans that combined health care and law enforcement strategies to target the problem of prescription opioid misuse. Major aspects of statewide plans are listed below and informed the development of this road map.**

### Optimizing PDMPs.

PDMPs are being used to greater effect in many states as a source of real-time information for health care providers, as a tool to interdict diversion of prescription opioids and as an analytical tool for examining trends and outcomes associated with state policies and programs.

### Enhancing enforcement by coordinating operations, providing specialized training and strengthening existing laws.

States are improving their law enforcement and regulatory oversight activities by ensuring a coordinated approach to investigating and prosecuting cases.

### Ensuring proper disposal of prescription drugs.

States are collaborating with local coalitions, pharmacies, health professional boards and the Drug Enforcement Administration (DEA) in take-back activities, such as hosting take-back events and identifying permanent locations where the public can safely dispose of unused prescription medications.

### Leveraging the state's role as regulator and purchaser of services.

States are working to improve prescribing practices by increasing educational opportunities and requirements for health care providers, and adopting guidelines on appropriate prescribing practices.

# NGA's Work on Reducing Prescription Opioid Misuse

### Increasing access to treatment.

States play an important role in ensuring Medicaid and private insurance coverage of medication-assisted treatment (MAT), behavioral health and wraparound services and recovery supports. States are working to increase access in rural areas by implementing telehealth initiatives and by integrating treatment into primary care settings. (See Appendix A on page 29 for an overview of U.S. Food and Drug Administration (FDA)–approved medications indicated for treating opioid use disorder and opioid overdose.)

### Building partnerships among key stakeholders.

Reducing prescription opioid misuse requires agencies, consumer groups, health care providers, industry and others who may not typically work together to partner to develop an effective and comprehensive strategy. Governors are promoting interagency collaboration by creating task forces or working groups through executive order.

### Using the bully pulpit to promote public education about prescription opioid misuse.

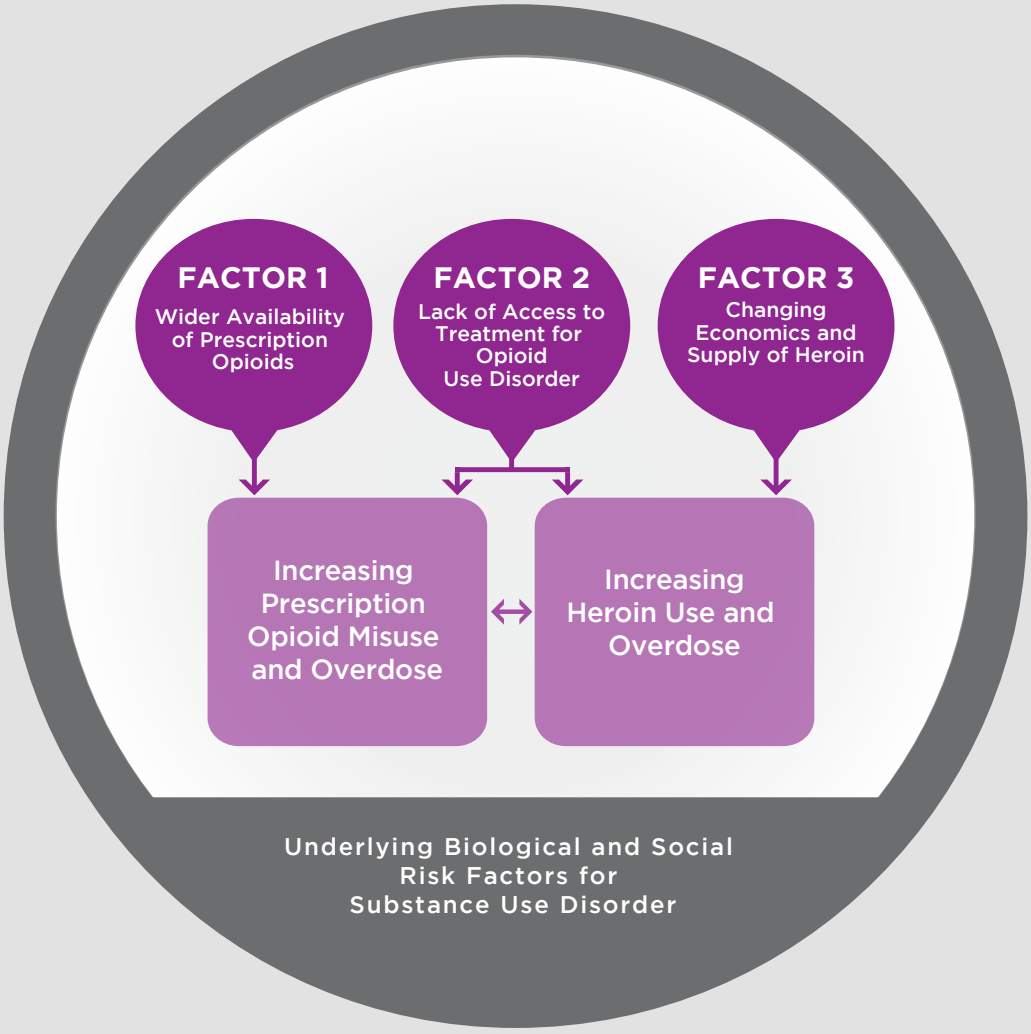
Governors are spearheading statewide public awareness campaigns to educate the public, providers, state policymakers and other public officials about the risks associated with prescription opioids, the scope of the problem and the need to destigmatize and raise awareness about treatment and recovery.

### Developing data strategies with metrics and evaluation plans to drive policy and practice.

To ensure that interventions have their intended effect, states are incorporating evaluation into their plans. Evaluation can help demonstrate the impact and value of policies and programs, ensure accountability for resources invested and inform the development of future policies and initiatives.

# Major Factors Driving the Prescription Opioid and Heroin Epidemic

## Understanding the factors that drive the interrelated problems of prescription opioid misuse, heroin use and opioid-related overdose is essential to developing effective strategies.



# Overview: Steps to Address Prescription Opioid Misuse and Heroin

# Step 1: Assess the Situation (2 –3 months)

**IDENTIFY POLICY AND FINANCIAL LEVERS, AND CONDUCT HIGH-LEVEL DATA SCAN**
Take initial inventory of existing state efforts, financial mechanisms, and high-level data to improve understanding of the problem and identify opportunities.

Identify staff to conduct initial review of:
- Existing state prescription opioid and heroin plans
- Medicaid and other contracting authorities
- Payment policies
- Financing mechanisms, including federal funding for health care and public safety
- High-level, publicly available state data, including health and public safety data

*See Appendix B on page 30 for a list of potential data sources and Appendix C on page 31 for an abbreviated resource list.

**IDENTIFY OR CREATE PRESCRIPTION OPIOID AND HEROIN TASK FORCE**
Designate a team ("Opioid Team") that owns development and execution of a strategic plan.

Compose or work with an existing Opioid Team with direct report to cabinet-level officials

Consider a team comprised of state officials and local academic experts to work in consultation with stakeholders

Identify a team lead (or co-leads) who is engaged with public health and safety, and who has:
- Visibility over all health and law enforcement efforts
- Ability to elevate key issues to ultimate decision makers

**ENSURE KEY DECISION MAKERS ARE INVOLVED**
Opioid Team identifies key decision makers to review and validate levers and provide preliminary high-level priorities for addressing the epidemic.

Identify and engage key decision makers to familiarize them with the problem and understand their high-level priorities

Key decision makers may include:
- "Drug czar"
- Behavioral health leads
- Medicaid director
- State health officials
- State corrections officials
- Attorney general
- State public safety officials
- State social services officials
- Sheriffs/police chiefs

*See Appendix D on page 32 for a list of key decision makers.

**CONNECT WITH PRIORITY STAKEHOLDERS AND SET VISION**
Opioid Team meets with priority stakeholders to assess the problem, identify potential challenges and establish vision.

Meet with priority stakeholders and trusted experts to:
- Identify health care and public safety priorities
- Interpret data and review evidence base
- Identify major state-specific challenges and opportunities related to political environment, cultural competency, etc.
- Develop a vision statement to guide priority setting within time horizons (1 year, 5–10 years, etc.)

*See Appendix D on page 32 for examples of priority stakeholders.

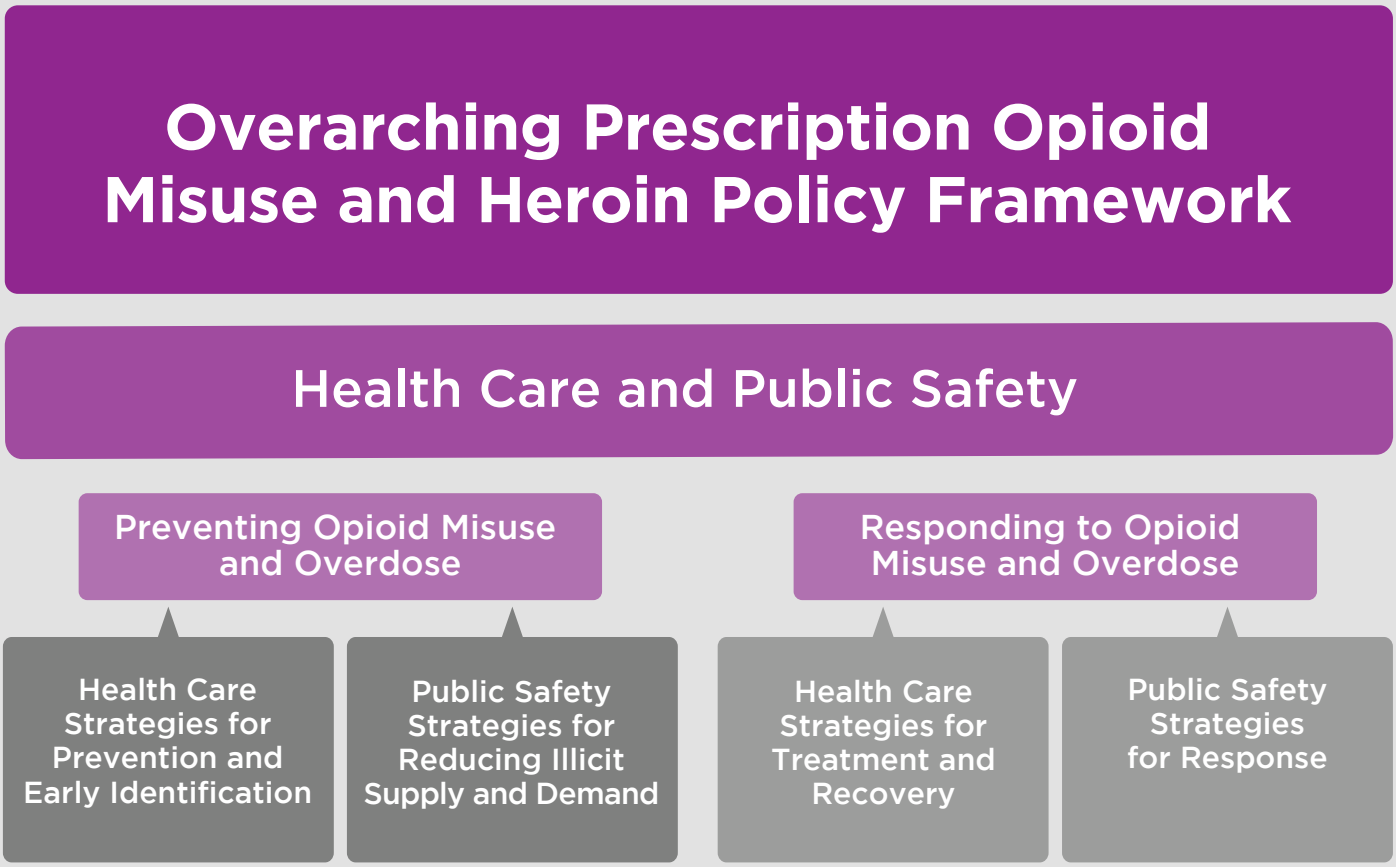
**KEY OUTPUTS:**

**1. OVERARCHING VISION AND GOALS**
- Informed by data and environmental scan
- Shaped by key decision makers and priority stakeholders
- Owned by the Opioid Team

**2. COMPREHENSIVE UNDERSTANDING OF THE STATE LEVERS TO REDUCE OPIOID MISUSE AND OVERDOSE**

# Step 2: Develop and Select Policies (3 months)

# Step 2: Establish a Policy Framework



# Step 2: Analyze Policy Strategies and Identify Policy Priorities

## How Strategies Were Selected

The following four pages include evidence-based and promising strategies for addressing prescription opioid misuse and heroin use within the general population. This section is not intended to be exhaustive; rather it highlights the most impactful policies and practices identified through research and consultation with states and other national experts. To build a comprehensive action plan, states may adopt some or all of these strategies, depending on the nature of the problem and other state-specific considerations. Notably, this road map does not include strategies for specific populations, such as pregnant women, veterans and rural communities, which will be addressed through future initiatives.

## Key Criteria for Selecting Strategies

### Evidence-based.

Is there strong evidence demonstrating the effectiveness of the strategy in achieving the desired outcome?

- Evidence-based programs and practices have been evaluated empirically and do not rely on traditional practice or anecdotal evidence.

### Promising.

For strategies that do not have a strong evidence base, how likely is it that the strategy will reduce the magnitude and severity of harm related to opioid misuse and use disorder or decrease opioid overdose deaths?

- How many people are likely to be affected?
- How important is the strategy to furthering a state's understanding of the problem and targeting future efforts?
- How likely is the strategy to result in unintended harm?
- Can the impact of the strategy be measured and tracked?

# Step 2: Health Care Strategies for Prevention and Early Identification

## Develop and update guidelines for all opioid prescribers.

- Work with state health professional licensing boards to develop or update opioid prescribing guidelines with recommended dosing and day limits.
- Consider adopting or using CDC's Guideline for Prescribing Opioids for Chronic Pain to inform state guidelines.

## Limit new opioid prescriptions for acute pain, with exceptions for certain patients.

- Partner with health care providers to establish dosage and day limits for new opioid prescriptions for acute pain, with exceptions for certain patients and flexibility for prescribers to use their clinical judgement in determining when higher doses or longer prescriptions are appropriate.
- Limits may be established in statute, regulations or guidelines (see Appendix E on page 33).

## Develop and adopt a comprehensive opioid management program in Medicaid and other state-run health programs.

- Programs may require a treatment plan between doctors and patients, a risk assessment signed by the patient, prior authorization for high-dose prescriptions or those exceeding a certain number of days and the use of a single prescriber and pharmacy for all opioid prescriptions.
- Encourage or require commercial plans to implement similar programs (e.g., Blue Cross Blue Shield Massachusetts' Prescription Pain Medication Safety Program).
- Authorize public payers, including Medicaid and Medicare, and commercial plans to review PDMP data applicable to their enrollees.

## Remove methadone for managing pain from Medicaid preferred drug lists.

- If methadone remains a preferred drug for managing pain, consider the use of step therapy, quantity limits and clinical criteria at the point of sale to limit its use to patients for whom the benefits outweigh the risks.

## Expand access to non-opioid therapies for pain management.

- In Medicaid and other state-run health programs, provide and consider increasing reimbursement for comprehensive pain management services that include non-opioid therapies for acute and chronic pain.
- Encourage or require commercial plans to implement similar reimbursement policies.

## Enhance education and training for all opioid prescribers.

- Work with institutions that educate and train opioid prescribers (e.g., medical schools and residency programs) to develop curricula on pain management, safe opioid prescribing and substance use disorder that incorporates opioid prescribing guidelines.

# Step 2: Health Care Strategies for Prevention and Early Identification

- As a condition of licensure, require all opioid prescribers to complete high-quality continuing medical education courses in pain management, safe opioid prescribing that incorporates opioid prescribing guidelines.

## Maximize the use and effectiveness of state PDMPs.

- Require providers to check the PDMP before prescribing Schedule II, III and IV controlled substances.
- Require pharmacists to report to the PDMP within 24 hours.
- Use PDMP data to provide proactive analyses and reporting to professional licensing boards and law enforcement.
- Make PDMPs easier to use by integrating PDMP data into electronic health records and health information systems and by allowing prescribers to establish delegate accounts.
- Ensure PDMP interoperability with other states.

## Use public health and law enforcement data to monitor trends and strengthen prevention efforts.

- Ensure access to key data sources (e.g., de-identified PDMP data and toxicology and drug seizure reports) to identify geographical hot spots and alert law enforcement, public health entities, community coalitions, substance abuse prevention and treatment agencies and the public.
- Authorize medical examiners to obtain PDMP data for death investigations.
- Establish multidisciplinary overdose fatality review teams to conduct confidential case reviews and inform state and local overdose prevention.

## Enact legislation that increases oversight of pain management clinics to reduce "pill mills."

- Define what constitutes a pain management clinic based on the volume and types of services provided.
- Require pain management clinics to register with the state or obtain a license or certificate from the state.
- Give the state health agency or licensing board authority to inspect pain management clinics and mandate unannounced inspections when receiving complaints of violations.
- Require pain management clinic owners and medical directors to meet training requirements and prohibit non-law-abiding or restricted licensees from becoming owners or employees.

## Raise public awareness about the dangers of prescription opioids and heroin.

- Use the bully pulpit to raise awareness about the risks associated with opioid use.
- Identify opportunities to require targeted education, such as middle and high-school health classes and annual safety trainings for student athletes and their parents.
- Work with community coalitions to provide evidence-based prevention programming to youth and other high-risk groups (e.g., Strengthening Families Program, PROPSER).
- Help publicize law enforcement-sponsored and pharmacy take-back programs as well as other opportunities for safe drug disposal.

# Step 2: Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids

## Establish a collaborative information sharing environment that breaks down silos across state agencies to better understand trends, target interventions and support a comprehensive state response.

- Increase law enforcement, human services, forensic labs and public health expert collaboration and understanding of state drug data trends, patterns, implications and threats (e.g., drug monitoring initiatives, see Appendix F on page 34).
- Embed public health professionals with state drug intelligence units, automate drug data collection processes for real-time alerts and share data on law enforcement and emergency services administration of naloxone to identify and map potential spikes in drug overdoses.
- Use de-identified PDMP data to pin-point communities with elevated levels of high-risk opioid and benzodiazepine prescribing as areas at potential high risk for heroin use.

## Leverage assets from partner entities to improve data collection and intelligence sharing to restrict the supply of illicit opioids.

- Where possible, designate High Intensity Drug Trafficking Areas (HIDTAs) as the central source for state drug intelligence and enter state opioid investigative activities into the HIDTA Case Explorer.
- Utilize the El Paso Intelligence Center as a national-level opioid intelligence repository for state law enforcement and non law enforcement partners, with HIDTAs providing and accessing data.
- Request criminal analyst and intelligence support from the National Guard Counterdrug Program for state law enforcement efforts.
- Harness the existing fusion center infrastructure to effectively communicate heroin supply intelligence within the state.
- Ensure that law enforcement data is shared with public health.

## Expand statutory tools for prosecuting major distributors.

- Establish or align legal definitions and criminal penalties for distribution of heroin and illicit fentanyl that results in fatal or nonfatal overdoses.
- Ensure state drug trafficking and conspiracy statutes are in place to target drug trafficking as part of an ongoing criminal enterprise.

## Expand law enforcement partnerships and data access to better target overprescribers.

- Investigate and prosecute opioid supply chain abuse, including high-risk providers, distributors and manufacturers.
- Work with medical and other health professional licensing boards to improve collaboration on investigations of high-risk providers.
- While maintaining privacy rights, grant safe and proper law enforcement access to PDMP data without a search warrant for open investigations involving bad acting prescribers and dealers within the prescription opioid trade. Ensure law enforcement investigators are tracked, trained and certified to access PDMP data.

# Step 2: Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids

## In narcotics investigations, implement best practices and ensure intergovernmental cooperation.

- Reduce heroin and illicit fentanyl supply through law enforcement interdiction efforts by local, state and federal law enforcement partners, such as targeting major distribution networks and actors (e.g., Mexican cartels).
- Implement state and local law enforcement best practices for narcotics investigations, such as collecting cell phones and pocket trash, interviewing family members and improving coordination with patients before discharge.
- Ensure cooperation and collaboration on heroin and illicit fentanyl intelligence and investigations from state and local law enforcement with correctional facilities, DEA Drug Task Forces, FBI field offices, fusion centers, regional HIDTAs and the National Guard Counterdrug Program.

## Establish and enhance stakeholder coalitions.

- Bring together public health, law enforcement and community leaders to create a comprehensive public messaging strategy that addresses the opioid epidemic and risk factors within the community (e.g., DEA's 360 Strategy).
- Establish, support and coordinate drug take-back days with stakeholder and community groups.

# Step 2: Health Care Strategies for Treatment and Recovery

## Change payment policies to expand access to evidence-based MAT and recovery services.

- Ensure that Medicaid and other state health programs adequately cover all FDA-approved MAT (methadone, buprenorphine, naltrexone) and evidence-based behavioral interventions. Encourage or require commercial health plans to adopt similar policies (see Appendix A on page 29).
- Provide reimbursement for components of comprehensive evidence-based treatment and recovery, including medication, office visits, behavioral interventions and wrap-around services.
- Review and remove barriers to MAT, such as fail first and inappropriate prior authorization protocols, and encourage generic substitution when appropriate.
- Work with the department of insurance to enforce federal parity laws designed to ensure equal access to behavioral health care and medical/surgical care.
- Use payment strategies (e.g., pay for performance, quality metrics and separating behavioral health from payment bundles) to increase access to evidence-based MAT and behavioral interventions and promote integration of behavioral health and primary care.

## Increase access to naloxone.

- Review and remove Medicaid barriers to naloxone, such as prior authorization, and consider placing naloxone on the preferred drug list.
- Pass "Good Samaritan" laws to protect prescribers, first responders and bystanders from liability when prescribing or administering naloxone.
- Enact legislation allowing naloxone dispensing via standing orders, collaborative practice agreements, statewide protocols or pharmacist prescriptive authority.
- Train first responders to recognize signs of opioid overdose and administer naloxone.
- Partner with professional associations to promote coprescribing of naloxone when clinically appropriate.
- Permit third party prescribing of naloxone.
- Create a centralized naloxone procurement and distribution process at the state level and consider negotiating with manufacturers to obtain a competitive pricing agreement.

## Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services.

- Require buprenorphine waiver training in primary care and other select medical residency programs.
- Establish a coordinated treatment system in which specialty treatment centers stabilize patients and refer to community providers for ongoing care (e.g., hub and spoke model).
- Provide ongoing education and support to primary care providers and other buprenorphine prescribers to expand MAT capacity (e.g., Project ECHO telehealth model).
- Increase the number of office- and community-based opioid treatment programs through collaboration with community health centers and new state funding.

# Step 2: Health Care Strategies for Treatment and Recovery

- Expand the reach of peer and family support organizations (e.g., Learn to Cope) through Medicaid and other state funding.

## Create new linkages to evidence-based MAT and recovery services.

- Begin MAT in emergency departments following an opioid overdose or related drug event, and ensure immediate linkages to behavioral services and community supports.
- Establish peer-based recovery programs in emergency departments to support individuals following an opioid overdose or related drug event.
- Train first responders to refer patients to high-quality MAT and harm reduction services following an overdose reversal.
- Provide information and assistance to help health care providers and the public identify treatment and recovery options in their communities (e.g., a call line).

## Consider authorizing and providing support to syringe service programs.

- Work with state health experts to assess the benefit of authorizing syringe service programs and providing state funding and technical assistance.
- Where syringe service programs are authorized, consider linking individuals accessing such programs to services such as human immunodeficiency virus (HIV) and hepatitis C testing, substance use disorder treatment, and overdose prevention.

## Reduce stigma by changing the public's understanding of substance use disorder.

- Develop targeted public awareness campaigns with messaging to help reframe substance use disorder as a chronic medical disease that requires ongoing treatment.
- Messaging should focus on MAT and behavioral health services as effective, evidence-based strategies for treating substance use disorder.

# Step 2: Public Safety Strategies for Responding to the Opioid Crisis

## Empower, educate and equip law enforcement personnel to prevent overdose deaths and facilitate access to treatment.

- Authorize and train law enforcement officers in overdose prevention and response, especially with illicit fentanyl, which may require multiple naloxone doses.
- Encourage law enforcement to partner with hospitals and health care systems to ensure individuals who overdose are connected to treatment and harm-reduction services.
- Educate law enforcement personnel on naloxone to avoid over- or under-dosing, relapse to overdose and seizures of naloxone.
- Where authorized, track naloxone rescues and ensure adequate budgeting for naloxone.
- Educate first responders and law enforcement on how to treat overdose response locations as potential crime scenes, preserving evidence for potential criminal prosecution of drug dealers supplying drugs to overdose victims.

## Reinforce use of best practices in drug treatment courts.

- Educate judges on the evidence-based research around MAT, as well as behavioral interventions and wrap-around services.
- Encourage evidence-based drug courts that provide access to MAT and do not force defendants to stop MAT as a condition of participation.
- Facilitate behavioral health specialist interaction with drug court judges to provide updates on the latest opioid use disorder research and integrate psychosocial, mental health and other support services, as well as drug test monitoring.
- Ensure that drug courts can access PDMP data to monitor defendants who may try to obtain prescription controlled substances outside of treatment programs.

## Ensure access to MAT in correctional facilities and upon reentry into the community.

- Increase access to MAT in prisons and correctional settings.
- Consider suspending, rather than terminating, Medicaid coverage during incarceration to facilitate access to treatment upon release.
- Provide sufficient substance use support and recovery units within state correctional substance use disorder programs.
- Ensure continued access to MAT for ex-offenders upon reentry into the community, and provide overdose education and naloxone for offenders during the re-entry process, when they are most vulnerable to overdose.
- Amend swift and certain sanction guidelines to include additional responses (e.g., deploying case managers) for individuals released on probation and parole whose offenses relate to a substance use disorder.

# Step 2: Public Safety Strategies for Responding to the Opioid Crisis

## Strengthen pre-trial drug diversion programs to offer individuals the opportunity to enter into substance use treatment.

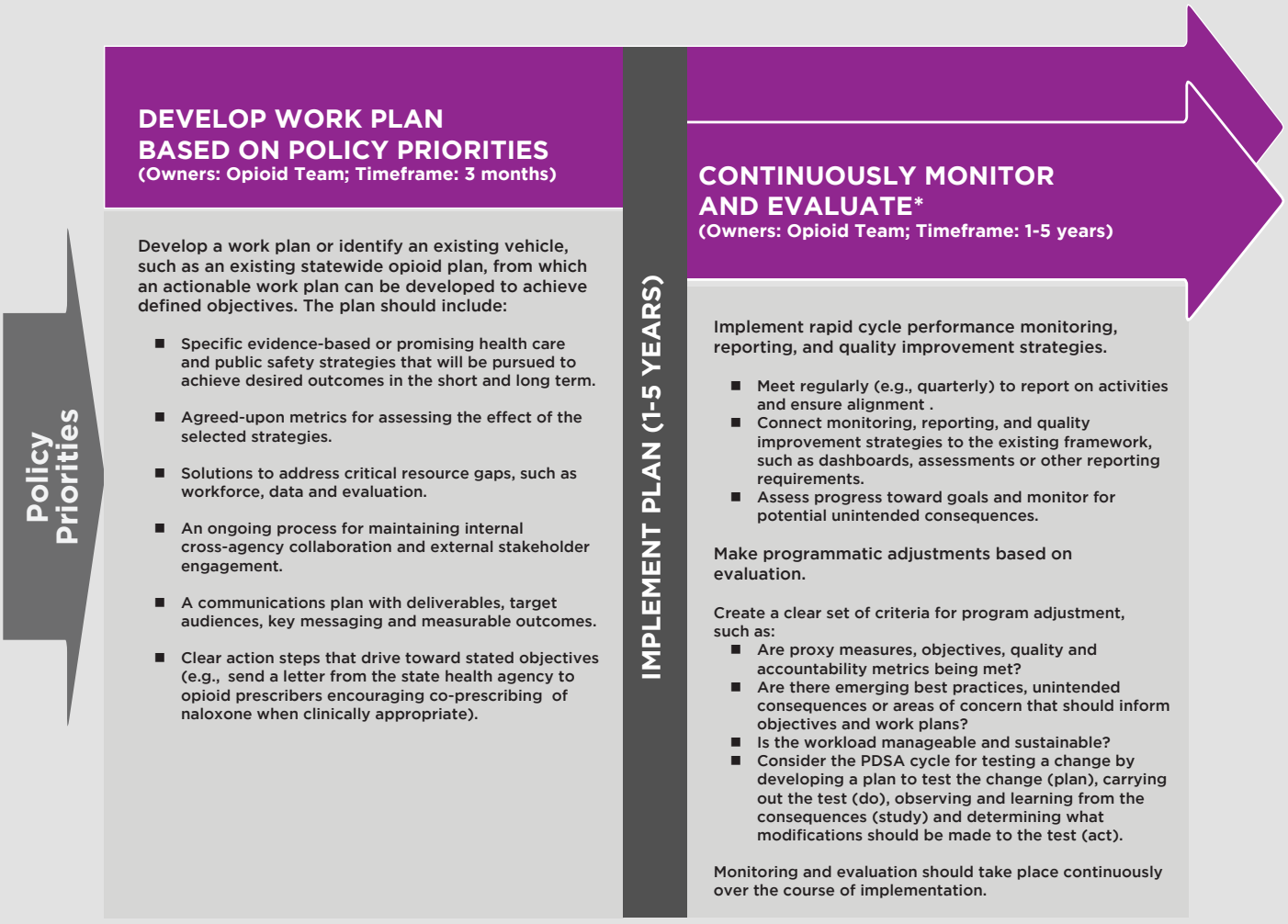
- Promote culture change within state and local law enforcement by improving understanding of substance use disorder and increasing collaboration with public health.
- Where possible, implement programs to divert individuals convicted of low-level drug offenses to community-based treatment and support services (e.g., Law Enforcement Assisted Diversion (LEAD), see Appendix F on page 34).
- Train law enforcement on referral to treatment following overdose intervention and build linkages to treatment through partnerships with community organizations (e.g., LEAD Policy Coordinating Group, see Appendix F on page 34).

## Ensure compliance with Good Samaritan laws.

- Raise awareness in key stakeholder communities (e.g., law enforcement, prosecutors, public health, hospitals and prescribers) regarding Good Samaritan laws that provide protections for naloxone prescribers and individuals who administer naloxone during an opioid overdose.
- Implement academy and in-service trainings for law enforcement personnel on applicable Good Samaritan laws.
- Encourage prosecutors to strengthen coordination and communication with law enforcement regarding application of the law.

# Step 3: Finalize Policies, Implement and Evaluate (6 months - 5 years)

# Step 3: Finalize Policies, Implement and Evaluate




*See Appendix F on page 35 for a plan example with metrics and Appendix G on page 38 for additional evaluation strategies..

# Appendix A: Medications Indicated for Treatment of Opioid Use Disorder and Overdose Reversal

## Methadone

Methadone is a slow-acting opioid agonist that acts as an opioid replacement for individuals in treatment for opioid use disorder. The drug prevents opioid withdrawal symptoms and blocks the effects of heroin and other opioids if given at higher doses. It is administered to patients once a day in pill, liquid and wafer forms. Methadone can be dispensed only at Substance Abuse and Mental Health Services Administration (SAMHSA)-certified outpatient opioid treatment programs (OTPs) or to a hospitalized patient in an emergency. Methadone has also been used as a treatment for chronic pain, though its use is limited because of serious risk of dependence and overdose.

## Buprenorphine

Buprenorphine is a partial agonist that suppresses opioid withdrawal symptoms for individuals in treatment for opioid use disorder. Although buprenorphine can produce opioid agonist effects, such as euphoria and respiratory depression, its effects are milder than full agonists like methadone. To prescribe this medication, physicians must complete a training course and receive a waiver granted by DEA, known as a DATA 2000 waiver. Unlike methadone, which can only be dispensed by an OTP, buprenorphine can be prescribed in an outpatient setting. It is most commonly taken via a pill or sublingual film. Buprenorphine is combined with naloxone to create Suboxone and its generic formulations, which make the drug more difficult to misuse. If injected or otherwise misused, the naloxone in Suboxone will cause the patient to enter opioid withdrawal. The first buprenorphine implant, Probuphine, received FDA approval in May 2016.

## Naltrexone

Naltrexone is a nonaddictive opioid antagonist used to treat opioid use disorder. Unlike methadone and buprenorphine, naltrexone is not an opioid replacement; the drug works by blocking the opioid receptors so they cannot be activated. If an individual who has taken naltrexone attempts to continue taking opioids, he or she will be unable to feel their effect. Naltrexone is administered in an injectable, long-acting formulation marketed under the brand name Vivitrol and administered once a month. Because naltrexone will not prevent withdrawal symptoms, it is recommended for patients who do not have opioids in their system.

## Naloxone

Naloxone is an opioid antagonist used to reverse opioid overdose. Naloxone has intravenous, intramuscular and intranasal formulations, with the latter two formulations considered safe for administration by laypersons. Naloxone works within minutes, and its effect persists up to an hour. Multiple doses may be required depending on the severity of respiratory depression. Naloxone, marketed under the brand name Narcan, does not produce tolerance or dependence and is not designated as a controlled substance.

## References:

Office of National Drug Control Policy, "Medication-Assisted Treatment for Opioid Addiction," Healthcare Brief (Washington, DC: Office of National Drug Control Policy, 2012), https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf (accessed June 14, 2016).

Substance Abuse and Mental Health Services Administration, "Medication and Counseling Treatment," http://www.samhsa.gov/medication-assisted-treatment/treatment (accessed June 14, 2016).

Substance Abuse and Mental Health Services Administration, "Naloxone," http://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone (accessed June 14, 2016).

# Appendix B: Sample Key Data Sources

## Types of Data

The following is a sample of key data sources states may consider reviewing to determine priorities for addressing prescription opioid misuse and heroin.

### Two macro-level surveys identifying prescription opioid misuse and heroin trends:

- The National Survey on Drug Use and Health (NSDUH)
- The National Epidemiological Survey on Alcohol and Related Conditions (NESARC)

### NGA's identified sources (mentioned here):

- PDMPs
- Morbidity and mortality data
- National Vital Statistics System (NVSS)
- State coroner/medical examiner data
- Birth certificate data
- Patient, provider and public surveys
- National Health and Nutrition Examination Survey (NHANES)
- Patient qualitative surveys
- Medicaid and other claims data
- Insurance provider data
- Behavioral health data
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavior Surveillance System (YRBSS)
- Harm reduction community/syringe exchange data

### Emergency department and hospitalization data

- Healthcare cost and utilization project (HCUP)
- State EMS data

### Law enforcement data

- National Drug Threat Assessment
- State forensic labs
- HIDTAs
- Drug seizures/lab results
- Shootings
- Gun recoveries
- Drug arrests
- Law enforcement naloxone deployments
- Emergency medical services naloxone deployment data
- Urinalysis results
- Automated Fingerprint Identification System
- State-administered Criminal Justice Information System

### Additional sources and measures used in studies of prescription opioid misuse and heroin:

- DEA Automation of Reports and Consolidated Orders System (ARCOS) [proprietary]
- Addiction Severity Index-Multimedia Version #1 (ASI-MV1) [proprietary]
- Prescription Behavior Surveillance System (PBSS)
- Poison control center data
- SAMHSA Treatment Episode Data Set (TEDS)
- SAMHSA National Survey of Substance Abuse Services (N-SSATS)
- IMS health data [proprietary]

# Appendix C: Abbreviated Resource List

## Federal Resources

- 2015 National Drug Control Strategy
- CDC Guideline for Prescribing Opioids for Chronic Pain
- CDC Report on Increases in Drug and Opioid Overdose Deaths
- CMCS Informational Bulletin on Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction
- DEA 2016 National Heroin Threat Assessment Summary
- HHS Opioid Resource Page
- SAMHSA Opioid Overdose Prevention Toolkit

## Academic Resources and Journal Articles/Blogs

- Brandeis University PDMP Training and Technical Assistance Center
- Health Affairs Blog Post on a Systems Approach to Addressing the Opioid Crisis
- Johns Hopkins School of Public Health Report on Taking an Evidence-Based Approach to the Opioid Epidemic:
- New England Journal of Medicine Article on the Relationship Between Nonmedical Prescription-Opioid Use and Heroin Use

## Professional Association/Other Organization Resources

- American Medical Association Call to Action to Physicians
- American Society of Addiction Medicine National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- National Association of Medicaid Directors Report on Interventions for Preventing Prescription Drug Abuse and Overdose
- National Association of State Alcohol and Drug Abuse Directors Overview of State Legislation to Increase Access to Treatment for Opioid Overdose
- National Safety Council Report on Key Actions States Can Take to Address the Opioid Epidemic
- Pew Charitable Trusts Prescription Drug Abuse Project

## Sample State Plans

- Colorado Plan to Reduce Prescription Drug Abuse
- Florida's Prescription Drug Diversion and Abuse Road Map
- Maryland Heroin and Opioid Emergency Task Force Final Report
- Massachusetts Governor's Opioid Working Group Recommendations
- Rhode Island Strategic Plan on Addiction and Overdose
- Virginia Heroin and Prescription Drug Abuse State Plan
- Washington State Interagency Opioid Working Plan

# Appendix D: Key Decision Makers and Examples of Priority Stakeholders

## Key Decision Makers

Governor, state legislators, "drug czar" and other key agency leads

## Examples of Priority Stakeholders

### State agencies/entities

Health and human services, public health, Medicaid, substance abuse services, behavioral health and mental health, health insurance exchange, public safety, corrections, attorney general, state police, judges, homeland security, poison control centers, state health professional licensing boards

### Federal agencies and programs

Centers for Disease Control and Prevention, Bureau of Justice Assistance, Drug Enforcement Administration, Federal Bureau of Investigation, High Intensity Drug Trafficking Areas Program, National Institute on Drug Abuse, Office of National Drug Control Policy, Substance Abuse and Mental Health Services Administration

### Municipal entities

Mayors and county leaders, city and county health departments, local police, drug courts, county drug and alcohol services coordinators, tribal authorities

### Other community stakeholders

Individuals and families affected by opioid misuse, faith leaders, colleges and universities, school districts, recovery high schools, syringe exchange programs and other harm reduction groups, peer support organizations, community drug prevention coalitions and task forces, supportive housing providers

### Professional associations and societies

Physicians, nurses, pharmacists, dentists, veterinarians, pain specialists, drug treatment and mental health services providers, police chiefs, prosecutors, public defenders, state and local judges

### Private and nonprofit sector entities

Drug manufacturers, drug distributors, insurance companies, pharmacy benefit managers, pharmacies, hospitals, health care systems, provider care collaboratives, employers

# Appendix E: Examples of State Approaches to Establishing Opioid Limits and Standards

As part of their comprehensive efforts to reduce opioid misuse and overdose, states are increasingly placing new limits on opioid prescriptions. As of June 23, 2016, four states (Connecticut, Massachusetts, Maine and New York) have established seven-day statutory limitations on opioid prescriptions in certain circumstances, with exceptions. Other states have less restrictive statutory limits on prescribing, or promote safe opioid prescribing and dispensing through regulations and guidelines. The following chart provides examples of several state approaches.

| State | Type | Prescription Limits | Dates |
|---|---|---|---|
| Connecticut | Statute | Seven-day limit for new opioid prescriptions for adults and all opioid prescriptions for minors. Permits documented exceptions for chronic and cancer pain, palliative care and clinical judgment. | Legislation enacted May 2016. |
| Illinois | Statute | Schedule II prescriptions limited to 30-day supply, with exceptions. Permits multiple prescriptions up to a 90-day supply if the prescriber meets specified conditions. | Legislation enacted September 2015. |
| Kentucky | Board rules required by statute | Forty-eight hour limit on dispensing of Schedule II and III controlled substances by physicians. No limit on opioid prescriptions. | Legislation enacted September 2012 requiring adoption of board rules by September 2012. |
| Massachusetts | Statute | Seven-day limit for new opioid prescriptions for adults and all opioid prescriptions for minors. Permits documented exceptions for chronic and cancer pain, palliative care and clinical judgment. | Legislation enacted March 2016. |
| Washington | Guideline and board rules required by statute | Pain specialist consultation required prior to prescribing daily morphine equivalent doses of 120 mg or greater, with exceptions. | Guideline developed April 2007 and revised most recently June 2015. Statute enacted January 2010 and board rules implemented between July 2011 and January 2012. |

# Appendix F: State Example: Massachusetts Governor's Opioid Working Group Recommendations

## Objective

Produce actionable recommendations to address the opioid epidemic in the Commonwealth of Massachusetts.

## Goals of the Plan

(1) Reduce the magnitude and severity of harm related to opioid misuse and use disorder.

(2) Decrease opioid overdose deaths.

## Focus Areas

Prevention, treatment, intervention, recovery

## Link to Plan

http://www.mass.gov/eohhs/docs/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf

## Key Strategies

1. Create new pathways to treatment.
2. Increase access to medication-assisted treatment.
3. Utilize data to identify hot spots and deploy appropriate resources.
4. Acknowledge substance use disorder as a chronic medical condition.
5. Reduce the stigma of substance use disorders.
6. Support substance use prevention education in schools.
7. Require all practitioners to receive training about substance use disorder and safe prescribing practices.
8. Improve the prescription monitoring program.
9. Require manufacturers and pharmacies to dispose of unused prescription medication.
10. Acknowledge that punishment is not the appropriate response to a substance use disorder.
11. Increase distribution of naloxone to prevent overdose deaths.
12. Eliminate insurance barriers to treatment.

## Recommendations

The working group report includes recommendations in 13 areas, including prescriber practices, neonatal abstinence syndrome, insurance and policing and correctional institutions. Recommendations in red are addressed in an action plan that tracks progress toward implementation. The working group report also includes a summary of short-term action items (six months to one year); mid-term action items (one year to three years); and long-term action items (three or more years).

# Appendix F: State Example: Rhode Island's Strategic Plan on Opioid Use Disorder and Overdose

### Goal of the Plan

Reduce opioid overdose deaths by one-third within three years.

### Key Strategies

Treatment, overdose rescue, prevention and recovery

### Link to Plan

http://www.health.ri.gov/news/temp/RhodeIslandsStrategicPlanOnAddictionAndOverdose.pdf

### Treatment Strategy: Every Door is the Right One

The core of this initiative recommends the development of a system of medication-assisted treatment at every location where opioid users are found, primarily: the medical system (emergency departments, hospitals, clinics, etc.), the criminal justice system, drug treatment programs and the community.

Proposed metric (monthly): Number of patients with opioid use disorder, number receiving medication-assisted treatment per year, retention in medication-assisted treatment, medication utilized.

### Rescue Strategy: Naloxone as Standard of Care

This initiative seeks to ensure a sustainable source of naloxone for community and first responder distribution and a high coverage of naloxone among populations at risk of overdose.

Proposed metric (monthly): Number of prescribers prescribing naloxone; number of naloxone prescriptions dispensed (overall) and to patients filling Schedule II opioid prescriptions or to patients filling opioid and benzodiazepine prescriptions.

### Prevention Strategy: Safer Prescribing and Dispensing

The main focus of this strategy is to use prescriber, prescription monitoring program and system-level efforts to reduce coprescription of benzodiazepines with opioids (for pain or opioid use disorder).

Proposed metric (monthly): Number of benzodiazepines and opioid prescriptions dispensed within 30 days for same patient; number of opioid treatment program patients also receiving prescribed benzodiazepine.

### Recovery Strategy: Expand Recovery Supports

This initiative recommends the large-scale expansion of recovery coach reach and capacity.

Proposed metric (monthly): Number of peer recovery coach encounters to emergency department, to hospital, to prison, in street outreach sessions; rate of referral and retention (one month) to treatment, to medication-assisted treatment, to recovery supports.

# Appendix F: Data Example: New Jersey's Drug Monitoring Initiative (DMI)

### Goal of the Plan

Establish a drug information sharing environment that enables law enforcement, human services and public health experts to better understand trends.

### Key Strategies

Data collection, production, training and outreach

### Collection Requirements

DMI establishes drug data collection and information sharing requirements based on the drug information needs of law enforcement, healthcare professionals and other constituents.

### Drug Data Collection and Use

- DMI collects data through formal data-sharing agreements and other structured arrangements with the following entities: state and county forensic laboratories, New Jersey Department of Health, county prosecutors' offices, state medical examiner's office, New Jersey Division of Mental Health and Addiction Services, Automated Fingerprint Information System and the PDMP. Where appropriate and necessary, data is de-identified prior to sharing to preserve patient confidentiality.
- Drug and related data sets collected include: forensic analysis of all drugs seized, deployments of naloxone by EMS (de-identified) and law enforcement, toxicology results from drug involved deaths, de-identified patient drug use data from treatment admissions, daily drug arrest data and daily crime arrest data.
- Data management processes are used to cleanse, normalize, geo-code, map and store drug data.
- Drug data and related analyses are used to provide investigative support, to support public health and human services constituents and to produce scheduled and ad hoc intelligence products.
- Real-time drug monitoring enables identification of new dangerous substances and assists in potential emergency scheduling of such substances, while also facilitating the production of timely alerts, warnings and notifications of emergent drug related incidents to law enforcement and public health partners.
- Strategic drug analysis supports various initiatives related to drug prevention, treatment and recovery.

### Training and Outreach

- Though the Basic Drug Recognition Course, DMI trains thousands of law enforcement, fire service, EMS and health partners in drug identification, current drug trends and reporting processes. DMI fosters a collaborative information sharing environment by participating in meetings, calls and symposiums with law enforcement, drug prevention coalitions, healthcare partners and other government entities.

# Appendix F: Connection to Treatment Example: Law Enforcement Assisted Diversion (LEAD)

## Goal of the Plan

Improve public safety and reduce recidivism for program participants.

## Key Strategies

Establish a pilot program to divert low-level drug crimes in areas of Seattle and King County, Washington

## Link to Plan

http://leadkingcounty.org/about/

## LEAD Program Design

- LEAD is a pre-booking diversion program that allows officers to redirect low-level offenders engaged in drugs to community-based services instead of courtrooms and prosecution.
- LEAD program participants begin working immediately with case managers to access services.

## LEAD Policy Coordinating Group

- LEAD is governed by a group of stakeholders that rule by consensus and utilize a memorandum of understanding.
- Membership of the policy coordinating group includes the mayor, county executive, city council, city attorney's office, county prosecutor, county sheriff, municipal police, state corrections department, community groups and advocates.

## Funding and Program Costs

- The program is funded through a collection of private foundations.
- After initial startup costs of $899 per month, the cost of the program declined to $522 per month by the end of the evaluation.

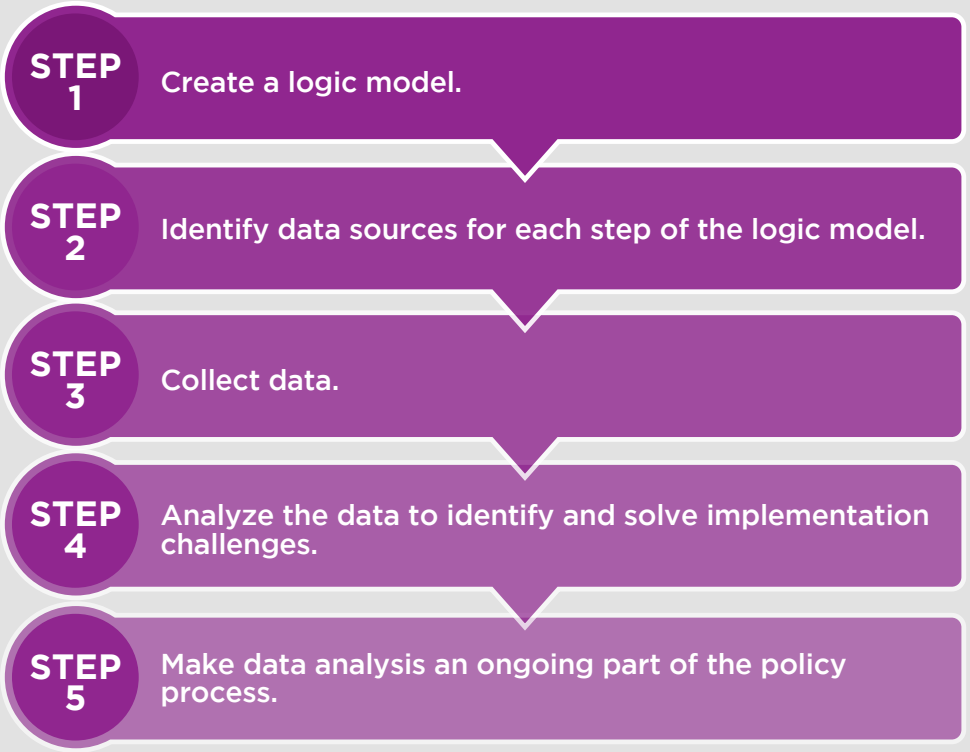
## Evaluation

- Studies so far have tested the relative effectiveness of the LEAD program in reducing criminal recidivism (i.e., arrests and charges).
- In 2015, participants in LEAD were 60 percent less likely than people in a control group to be arrested within the first six months of the evaluation.

# Appendix G: Evaluation Process

The following information comes from a forthcoming evaluation issue brief titled *Building Programs to Reduce Opioid Addiction: Utilizing Evaluation Science to Improve Success*, which provides guidance for governors and other state leaders on developing a comprehensive program to reduce opioid use disorder using best practices in evaluation science. It offers guidance on developing a logic model—the backbone of an effective evaluation plan. Further, it provides a step-by-step process for assimilating data into policy implementation and improvement.

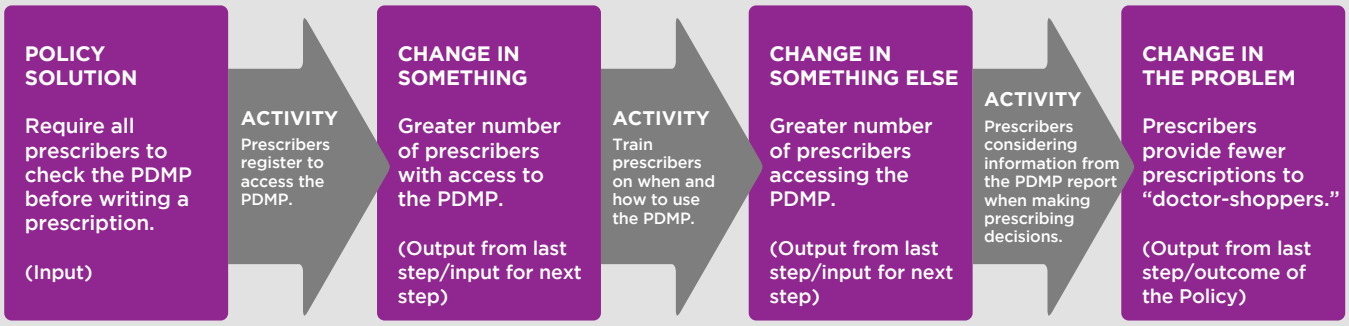
## Process for Utilizing Evaluation Science to Improve Success



# Appendix G: Evaluation Process

## Logic Model Example

A fully developed logic model is the core of any good evaluation effort. A logic model ensures a coherent and explicit connection between the policy and the desired results. Understanding those connections can be critical to the initial policy development process. Even if a logic model was not incorporated into initial policy development, one must still be created to monitor the performance of a specific policy. The logic model is the process for identifying and collecting data, and then evaluating and improving policy performance.



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