

Welcome

Office for State, Tribal, Local and Territorial Support
presents . . .

CDC Vital Signs

Addressing the Current Heroin Abuse and Overdose Epidemic: The Role of States and Localities

July 14, 2015

2:00–3:00 pm (EDT)



Centers for Disease Control and Prevention
Office for State, Tribal, Local and Territorial Support

Agenda

- | | | |
|----------------|------------------------------------|---|
| 2:00 pm | Welcome & Introductions | Matthew Penn, JD, MLIS
Director, Public Health Law Program, Office for State, Tribal, Local and Territorial Support, CDC |
| 2:05 pm | Presentations | CDR Christopher Jones, PharmD, MPH
Senior Advisor, Office of Public Health Strategy and Analysis, Office of the Commissioner, US Food and Drug Administration

Gary M. Franklin, MD, MPH
Medical Director, Washington State Department of Labor and Industries

Barbara Cimaglio
Deputy Commissioner, Alcohol and Drug Abuse Programs, Vermont Department of Health

Alexander Y. Walley, MD, MSc
Assistant Professor of Medicine, Boston University School of Medicine |
| 2:30 pm | Q&A and Discussion | Matthew Penn, JD, MLIS |
| 2:55 pm | Wrap-up | |
| 3:00 pm | End of Call | |



CDC *Vital*signs™ Teleconference

To support STLT efforts and build momentum around the monthly release of CDC *Vital Signs*



Vital Signs: Demographic and Substance Use Trends Among Heroin Users—United States, 2002–2013

Christopher M. Jones, PharmD, MPH

CDR, USPHS

Senior Advisor

Office of the Commissioner

US Food and Drug Administration

CDC Vital Signs Town Hall

July 14, 2015

National Center for Injury Prevention and Control

Division of Unintentional Injury Prevention



Key Findings

- ❑ Heroin use increased among nearly all demographic groups in the past decade
- ❑ People using heroin also report abuse or dependence on other substances
- ❑ With this increase in use, there has been a corresponding increase in heroin-related overdose deaths

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 64

July 7, 2015

Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013

Christopher M. Jones, PharmD¹; Joseph Logan, PhD²; R. Matthew Gladden, PhD³; Michele K. Bohm, MPH³ (Author affiliations at end of text)

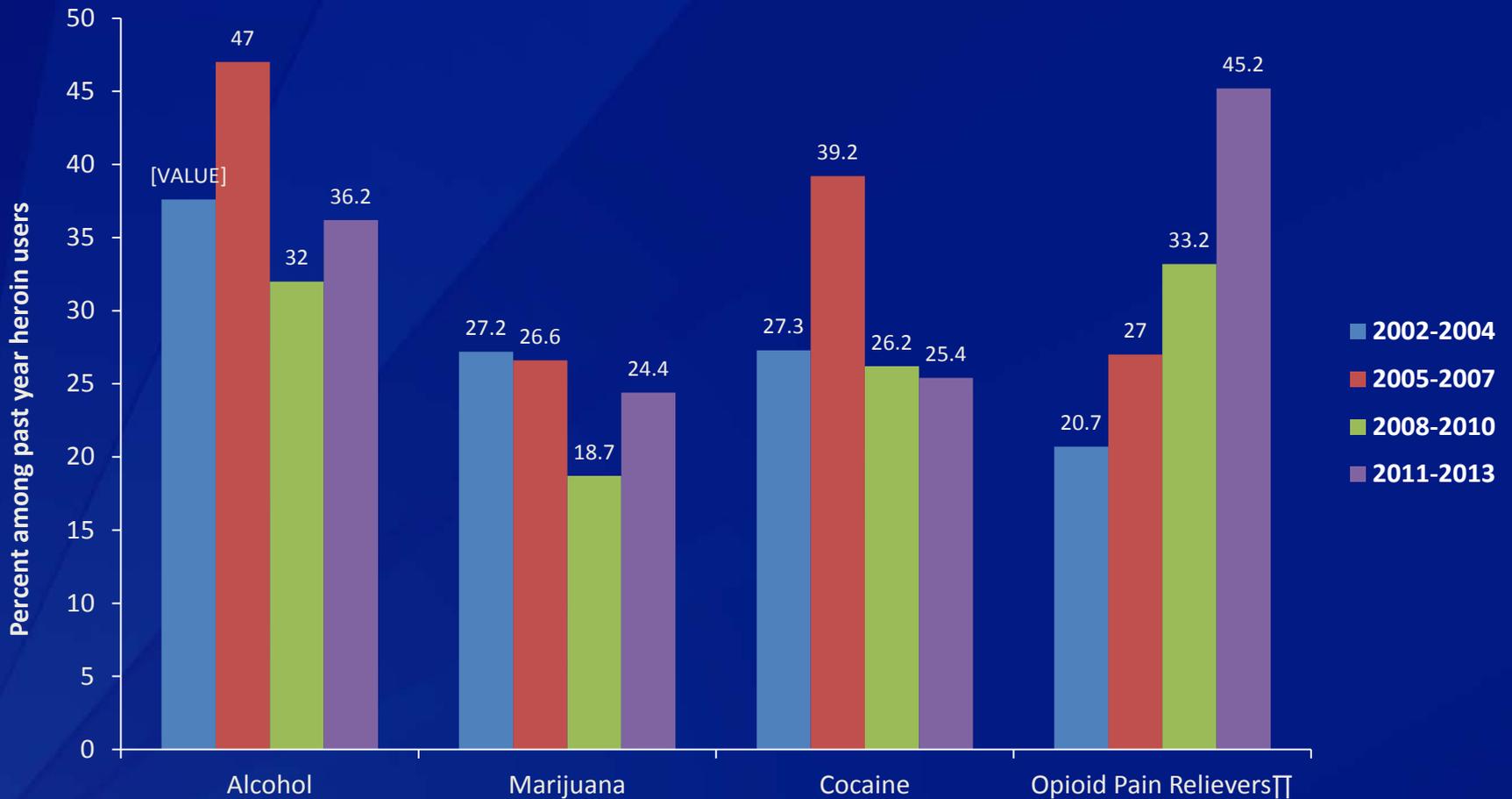
Changing Demographics of Heroin Use

Heroin Use Has INCREASED Among Most Demographic Groups

	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than \$20,000	3.4	5.5	62%
\$20,000-\$49,999	1.3	2.3	77%
\$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

*Annual average rate of heroin use (per 1,000 people in each group)

Substance Abuse or Dependence Among Past Year Heroin Users



Trends in Heroin Abuse or Dependence and Overdose Deaths



Groups at Increased Risk for Heroin Abuse or Dependence

Characteristic	Past-year heroin abuse or dependence	
	aOR	(95% CI)
Sex		
Male	2.1 ⁺⁺⁺	(1.4–3.0)
Female	1.0	
Age (yrs)		
12–17	0.3 ⁺⁺	(0.1–0.6)
18–25	1.0	
26	0.6 ⁺⁺	(0.4–0.9)
Race/Ethnicity		
Non-Hispanic white	3.1 ⁺⁺⁺	(1.8–5.1)
Other	1.0	
Geography		
Residing in CBSA with ≥1 million persons	2.4 ⁺⁺⁺	(1.5–3.6)
Residing in other area	1.0	
Household income (annual)		
<20,000	1.0	
\$20,000–\$49,999	0.5 ⁺⁺	(0.3–0.7)
≥\$50,000 or more	0.6 ⁺	(0.3–0.9)
Insurance coverage		
None	3.1 ⁺⁺⁺	(2.2–4.3)
Medicaid	3.2 ⁺⁺⁺	(1.9–5.4)
Private or other	1.0	
Past-year substance abuse or dependence⁵		
Alcohol	1.8 ⁺⁺	(1.2–2.9)
Marijuana	2.6 ⁺⁺	(1.5–4.6)
Cocaine	14.7 ⁺⁺⁺	(7.4–29.2)
Opioid pain relievers	40.0 ⁺⁺⁺	(24.6–65.3)
Other psychotherapeutics [¶]	1.6	(0.8–3.2)

- ❑ Men
- ❑ 18–25 year olds
- ❑ Non-Hispanic whites
- ❑ People living in large urban areas
- ❑ People with household income ≤ \$20,000 annually
- ❑ The uninsured
- ❑ People in Medicaid

Abbreviations: aOR = adjusted odds ratio; CBSA = core based statistical area; CI = confidence interval.

* Past-year heroin abuse or dependence is based on diagnostic criteria contained in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*.

⁺ Statistically significant finding; [†]p<0.05; ⁺⁺p<0.01; ⁺⁺⁺p<0.001.

⁵ Referent group is no past-year abuse or dependence.

[¶] Other psychotherapeutics includes tranquilizers, sedatives, and stimulants.

People With Other Substance Abuse or Dependence Also at Increased Risk

People with abuse or dependence on:

ALCOHOL

are

2x

MARIJUANA

are

3x

COCAINE

are

15x

Rx OPIOID PAINKILLERS

are

40x

More likely to have heroin abuse or dependence

The Public Health Response



PREVENT People From Starting Heroin

Reduce prescription opioid painkiller abuse.

Improve opioid painkiller prescribing practices and identify high-risk individuals early.



REDUCE Heroin Addiction

Ensure access to Medication-Assisted Treatment (MAT).

Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.



REVERSE Heroin Overdose

Expand the use of naloxone.

Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.

Thank you!



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E-mail: cdcinfo@cdc.gov Web: www.cdc.gov/injury

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the Food and Drug Administration. The presenter has no conflicts of interest to report.

National Center for Injury Prevention and Control

Division of Unintentional Injury Prevention





State-based Policy on Opioids for Chronic Pain

CDC *Vital Signs* Town Hall

July 14, 2015

Gary M. Franklin, MD, MPH
Research Professor

**Departments of Environmental Health,
Neurology, and Health Services**
University of Washington

Medical Director
**Washington State Department of
Labor and Industries**



The Worst Man-made Epidemic In Modern Medical History

- ❑ Over 140,000 deaths
- ❑ Many more hundreds of thousands of overdose admissions
- ❑ Millions addicted and/or dependent
 - ❑ Degenhardt *et al. Lancet Psychiatry* 2015; 2: 314–22; POINT prospective cohort: **29.4% any (mild, moderate, severe) opioid use disorder by DSM-V** (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)
- ❑ Spillover effect to heroin and to Social Security Disability Insurance (SSDI)

You Won't Alter Epidemic Effectively If You Don't Understand How Epidemic Began

- ❑ By late 1990s, at least 20 states had passed new laws, regulations, or policies that moved from near-prohibition of opioids to use without any dosing guidance
 - WA law: “No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.” (WAC 246-919-830, 12/1999)
- ❑ Laws were based on weak science and good experience with cancer pain
 - ❑ No ceiling on dose
 - ❑ Axiom: use more opioid if tolerance develops

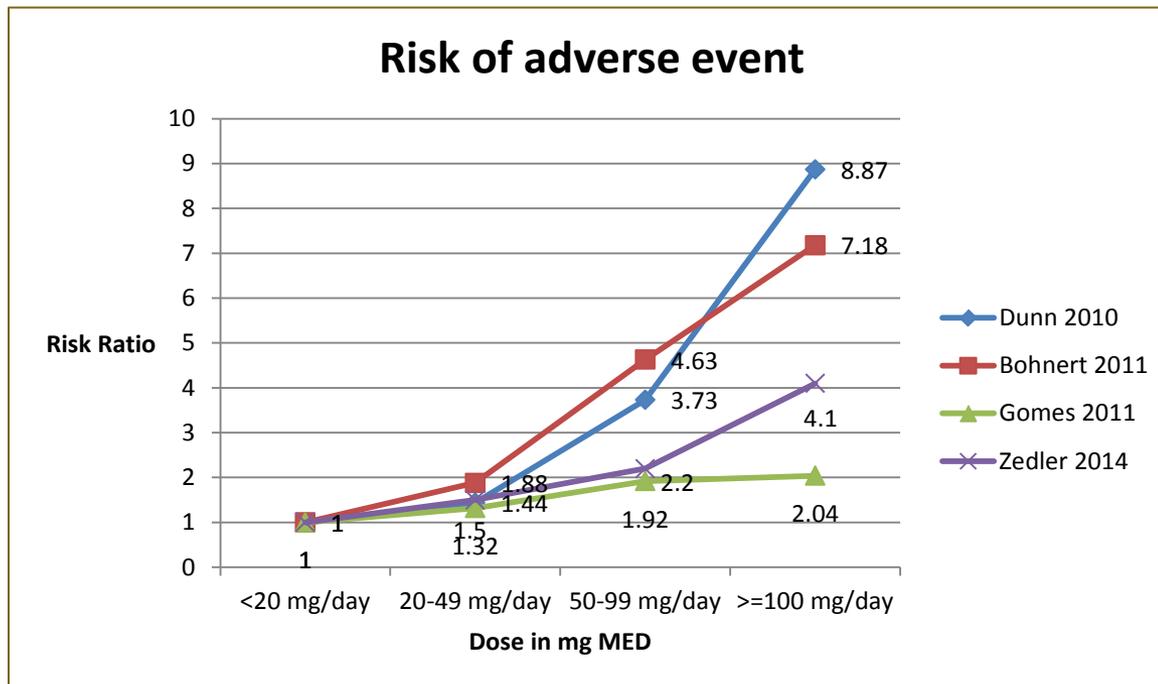




Evidence of Effectiveness of Chronic Opioid Analgesic Therapy (COAT)

The Agency for Healthcare Research and Quality's (AHRQ) recent draft report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," which focused on studies of effectiveness measured at > 1 year of COAT use, found **insufficient data on long-term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms."** (AHRQ 2014; Chou *et al.*, *Annals Int Med*, 13 Jan 2015).

Responding to the EVIDENCE: Morphine Equivalent Dose RELATED RISK



- Risk of adverse ± overdose event increases at >50 mg MED/day
- Risk increases greatly at ≥100 MED/day

2007: WA State AMDG initially recommends 120 MED threshold dose

2009: CDC recommends: 120 mg/day MED

2012: CT work comp: 90 mg/day MED

2013: OH State Medical Board: 80 mg/day MED

2013: Am College Occ. & Enviro. Med: 50 mg/day MED

2014: CA work comp: 80–120 mg/day MED

Dosing Policies Since 2007

- ❑ 2007: WA AMDG—consultation at **120** mg/day MED
- ❑ 2009: CDC—recommends **120** mg/day MED
- ❑ 2010: WA ESHB 2876—directs DOH boards and commissions to establish dosing guidance and best practices
- ❑ 2012: CT workers comp—**90** mg/day MED
- ❑ 2013: OH State Medical Board—**80** mg/day MED
<http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidelines.pdf>
- ❑ American College of Occ. & Enviro. Medicine—**50** mg/day MED
- ❑ 2013: Indiana—**60** mg/day MED threshold
http://www.in.gov/pla/files/Emergency_Rules_Adopted_10.24.2013.pdf
- ❑ 2014: CA Medical Board—physicians proceed cautiously (yellow flag warning) once the MED reaches **80** mg/day
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf
- ❑ 2014: CO Dept. of Regulatory Agencies—**120** mg/day MED
<http://1.usa.gov/1DNPaxT>

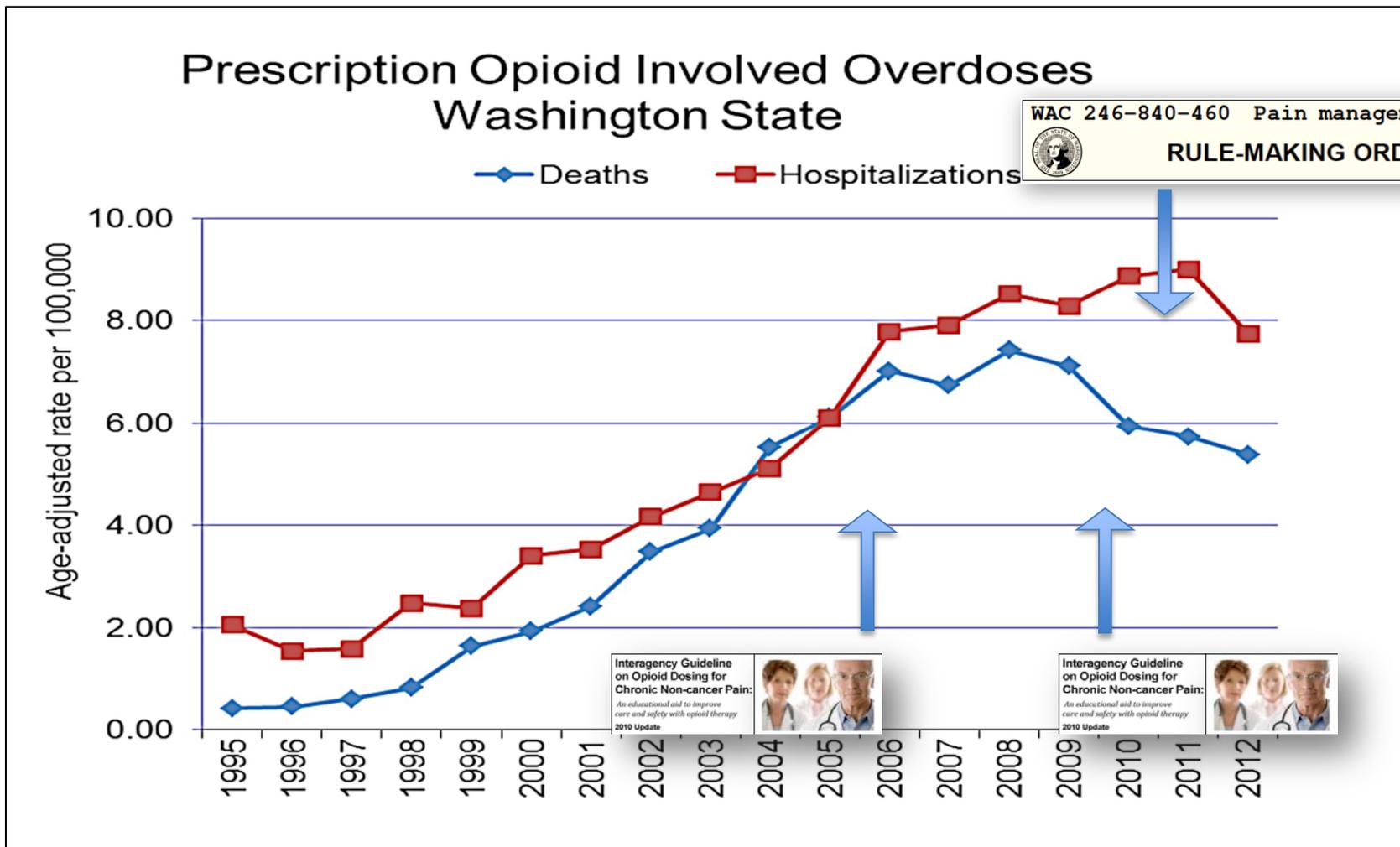


Concrete Policy Steps to Take

- ❑ Collaboration among state agencies at the highest levels
- ❑ Reverse permissive laws
- ❑ Set opioid dosing and best practice guidelines/rules for acute, subacute and chronic, non-cancer pain
- ❑ Establish metrics for tracking progress; track deaths and overdose ED visits and hospitalizations; track high MED and prescribers
- ❑ Implement an effective Rx monitoring program
- ❑ Encourage/incent use of best practices (web-based MED calculator, use of state PMPs)
- ❑ DO NOT pay for office-dispensed opioids
- ❑ ID high prescribers and offer assistance (e.g., academic detailing, free CME, ECHO)
- ❑ **Incent community-based Rx alternatives (activity coaching and graded exercise early, opioid taper/multidisciplinary Rx later)**
 - ❑ e.g., cognitive behavioral therapy has been found useful in systematic reviews of at least 8 different chronic pain conditions



“Bending the Curve” — WA State First in NATION with Decline in Opioid-Related Adverse Events



Source: Jennifer Sabel PhD, WA State Department of Health, 2014

Reduce the Development of Preventable Disability

- ❑ Decrease the proportion of injured workers on chronic opioids*

	Baseline: 2012	1Q 2013	2Q 2013	3Q 2013	4Q 2013
Percent of claims received with opioids 6–12 wks from injury	4.9%	4.6%	3.3%	1.4%	1.1%

*2013 opioid guideline for injured workers: <http://1.usa.gov/1nYlarL>



THANK YOU!

**For electronic copies
of this presentation,
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ljl2@uw.edu**

**For questions or feedback,
please email Gary Franklin
meddir@u.washington.edu**



Vermont Department of Health's Role in Addressing the Opiate Epidemic

Barbara Cimaglio, Deputy Commissioner,
Vermont Department of Health



24

Vermont's Approach

The public health approach –

Review data

Gain partner collaboration

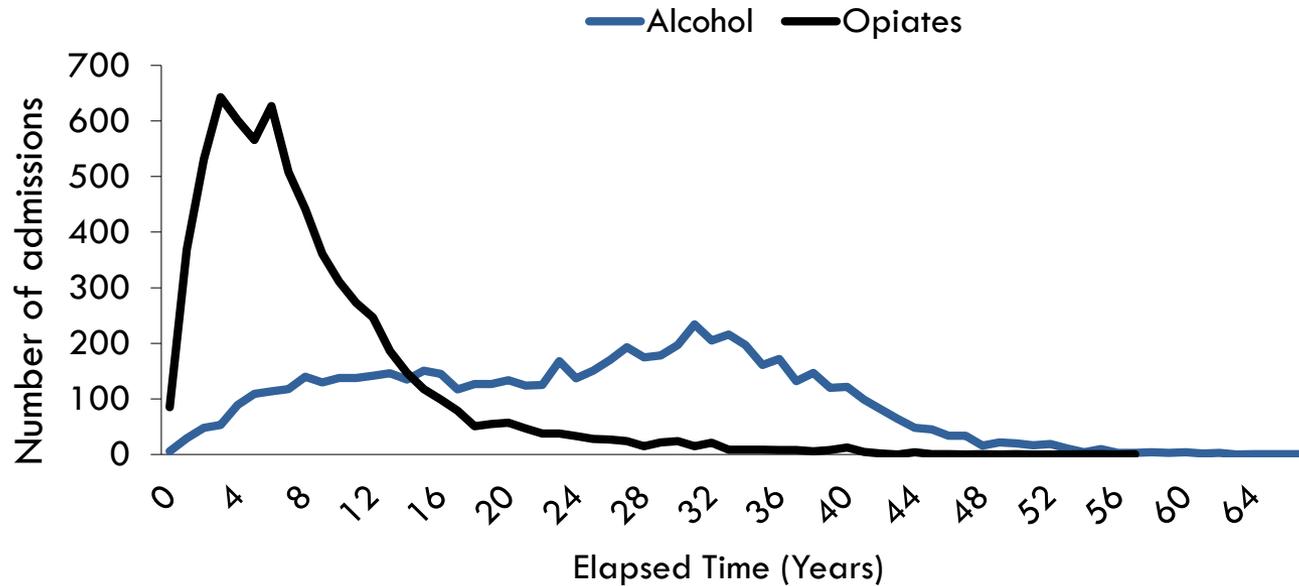
Develop policies

Implement program

Evaluate outcomes

People Seek Treatment For Opioid Addiction Much Sooner After First Use Than With Alcohol

Elapsed Time (Years) Between First Use and Treatment Admission for Daily Users of Opioid and Alcohol



	Opioids	Alcohol
Average Elapsed Time	8.2 +/- 7 years	24.8 +/- 12 years
Number of Admissions	6,776	6,207

Source: Alcohol and Drug Abuse Treatment Programs, admissions 2005–2011

Actions to Address Opioid Drug Abuse

Education

- Prescriber education
- Community education
- Naloxone distribution

Tracking and Monitoring

- Vermont Prescription Drug Monitoring System (VPMS)
- Prescribing Opiates for Pain Management Regulation

Enforcement

- Identification verification at pharmacies
- Law enforcement training on prescription drug misuse and diversion

Proper Medication Disposal

- Keeping medications safe at home
- Proper medication disposal guidelines consistent with FDA standards
- Community take-back programs

Treatment Options

- Care Alliance for Opioid Addiction Regional Treatment Centers
- Outpatient and residential treatment at state-funded treatment providers
- State regulation for programs and physicians who prescribe for addiction treatment



What is the Vermont Prescription Monitoring System?

The VPMS is a system in which controlled prescription drug data is collected in a database **to promote the appropriate use of controlled substances for legitimate medical purposes**, while deterring the misuse, abuse, and diversion of controlled substances.

<http://healthvermont.gov/adap/VPMS.aspx>



Unified Pain Management Council

- ❑ Medical Practice Board adopted pain management policy in Vermont
http://healthvermont.gov/hc/med_board/documents/opioid_pain_treatment_policy.pdf
- ❑ Working to improve use of Vermont Prescription Monitoring System
- ❑ Rule to govern prescribing opiates for chronic pain
http://healthvermont.gov/regs/documents/opioids_prescribing_for_chronic_pain_rule.pdf



Naloxone (opioid OD reversal drug)

- All EMTs can administer naloxone
- New legislation allows pharmacists to dispense OTC
- Training and resource materials are available on VDH website
- Good Samaritan Law passed; naloxone prescriptions can be written for a family member
- Training for law enforcement through Vermont State Police

<http://healthvermont.gov/adap/treatment/naloxone/index.aspx#kit>

“Hub and Spoke Model”

Goals

- + An established physician-led medical home
- + A single MAT prescriber
- + A pharmacy home
- + Access to existing Community Health Teams
- + Access to Hub or Spoke nurses and clinicians
- + Linkages between Hubs and primary care Spoke providers in their areas

Vermont Agency of Human Services
Oversight and Collaboration



Care Alliance for Opioid Addiction

Treatment Center Service Regions

Northwest Region

HowardCenter / Chittenden Center
c/o UHC Building
1 South Prospect St.
Burlington, VT 05401
802-488-6450

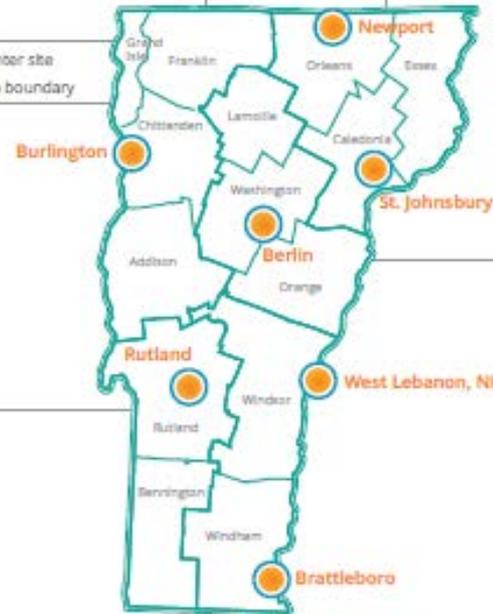
HowardCenter / Addiction Medicine
75 San Remo Dr.
South Burlington, VT
05403

Northeast Region *(projected 1/14)*

BAART Behavioral Health Services: Newport
475 Union St.
Newport, VT 05855
802-334-0110
baartprograms.com

BAART Behavioral Health Services: St. Johnsbury
445 Portland St.
St. Johnsbury, VT 05819
802-748-6166
baartprograms.com

Treatment Center site
 Service Region boundary



Southwest Region *(projected 10/13)*

West Ridge Center for Addiction Recovery
1 Scale Ave., Bldg. 10
Rutland, VT 05701
802-747-1857

Central Region

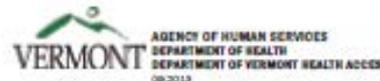
Central Vermont Addiction Medicine (BAART / CVSAS)
300 Granger Rd.
Berlin, VT 05602
802-223-2003

Southeast Region

Brattleboro Retreat
1 Anna Marsh Ln.
Brattleboro, VT 05302
802-258-3705
brattlebororetreat.org

Habit OPCO: Brattleboro
16 Town Crier Dr.
Brattleboro, VT 05301
802-258-4624
habitopco.com

Habit OPCO: West Lebanon
254 Plainfield Rd.,
West Lebanon, NH 03784
603-298-2146
habitopco.com





Vermont Department of Health

Website

<http://healthvermont.gov>

Substance Abuse Prevention/Treatment & Related Data

<http://healthvermont.gov/adap/adap.aspx>

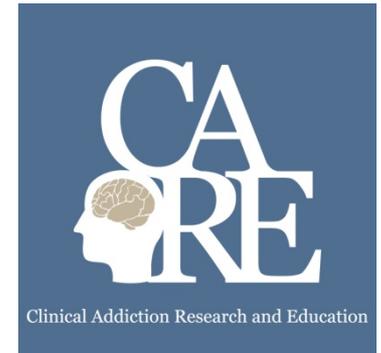
Naloxone

<http://www.healthvermont.gov/adap/treatment/naloxone/>

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Overdose Prevention and Naloxone Rescue Kits in Massachusetts

Alexander Y. Walley, MD, MSc

Assistant Professor of Medicine

Boston University School of Medicine

Medical Director

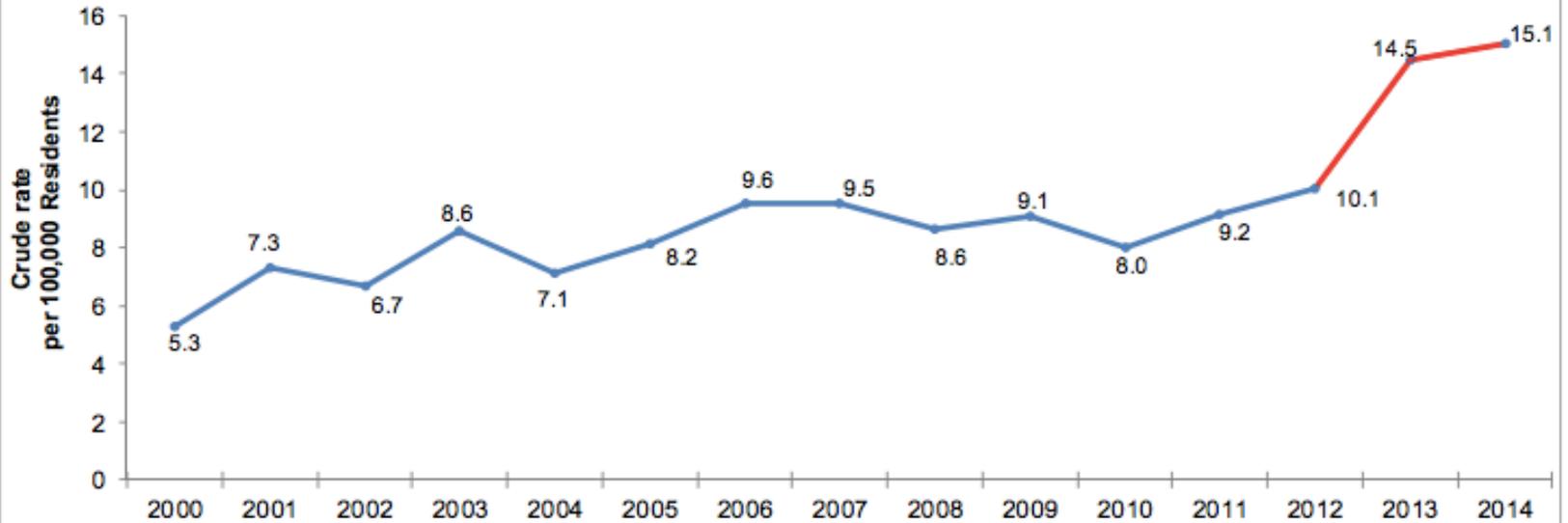
Opioid Overdose Prevention Pilot Program

Massachusetts Department of Public Health

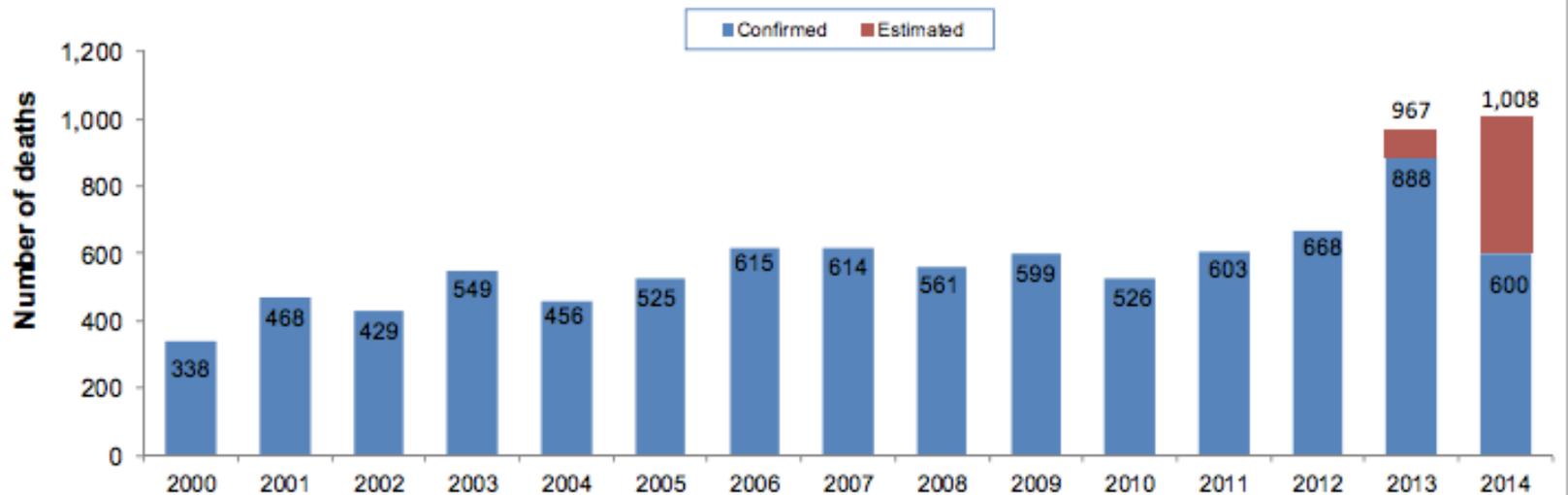
Addressing the Current Heroin Abuse and Overdose Epidemic: The
Role of States and Localities

CDC July 2015 *Vital Signs* Town Hall

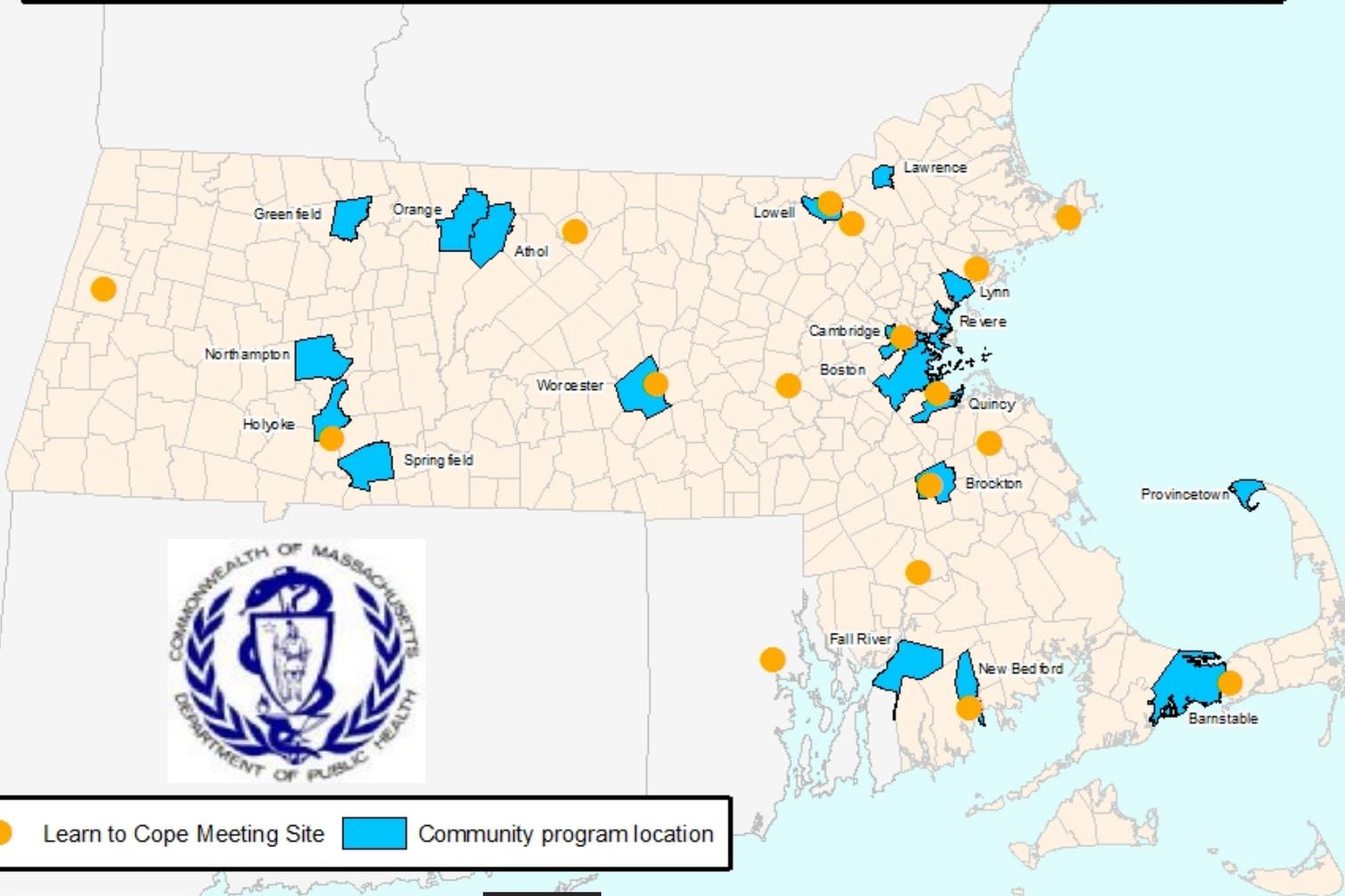
Rate of Unintentional¹ Opioid Overdose Deaths Massachusetts Residents: 2000-2014



Opioid-Related Deaths, Unintentional/Undetermined Massachusetts: 2000-2014



Massachusetts Department of Public Health Overdose Education and Naloxone Rescue Kit Program Locations, 2015

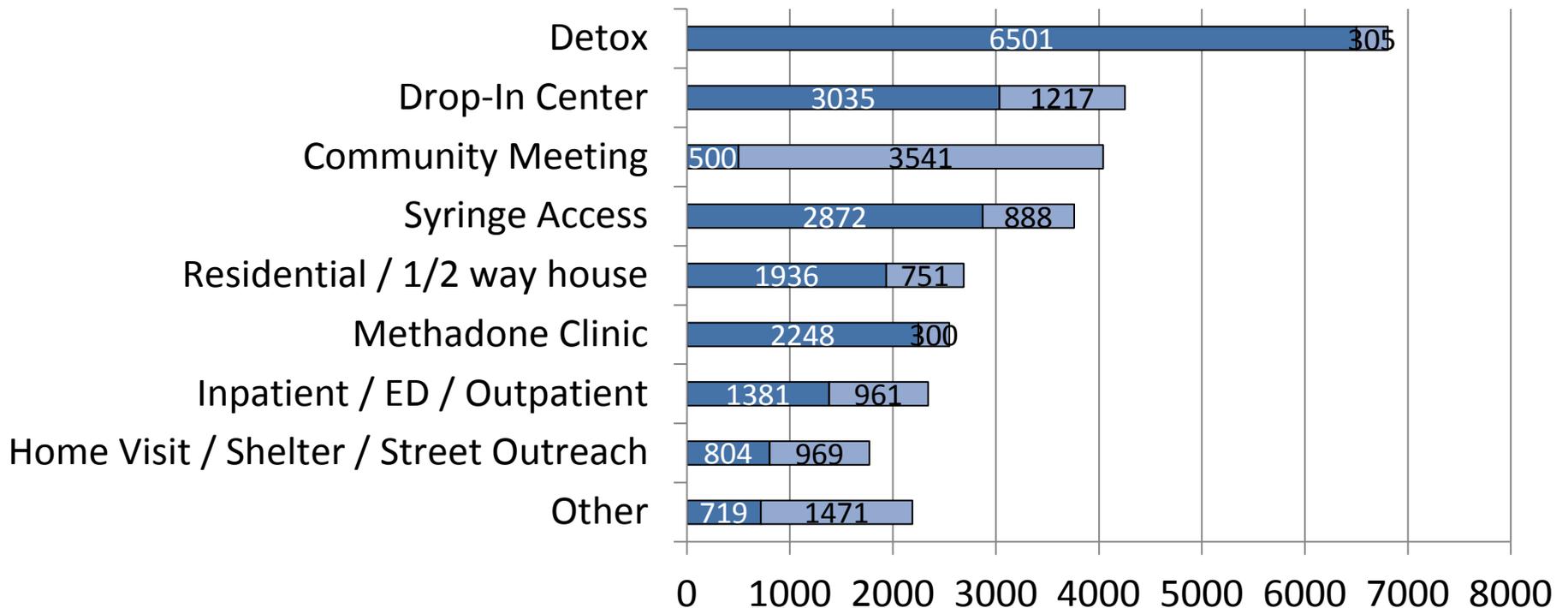


● Learn to Cope Meeting Site ■ Community program location



Enrollment locations 2008–2014

■ Using, In Treatment, or In Recovery ■ Non Users (family, friends, staff)



Program Data

Program data from people with location reported: Users: 20,012 Non-Users: 10,415

As of May 2015 > 33,000 enrollees (28 per day) and

> 4700 overdose rescues documented (5 per day)



Rate Ratios of Fatal Opioid Overdose by Levels of Nasal Naloxone Distribution Implementation in 19 Communities in Massachusetts, 2002–09

Cumulative enrollments per 100k	RR	ARR*	95% CI
Absolute model:			
No enrollment	Ref	Ref	Ref
Low implementation: 1-100	0.93	0.73	0.57-0.91
High implementation: > 100	0.82	0.54	0.39-0.76

* Adjusted Rate Ratios (ARR) All rate ratios adjusted for the city/town population rates of age under 18, male, race/ethnicity (Hispanic, white, black, other), below poverty level, medically supervised inpatient withdrawal treatment, methadone treatment, BSAS-funded buprenorphine treatment, prescriptions to doctor shoppers, and year

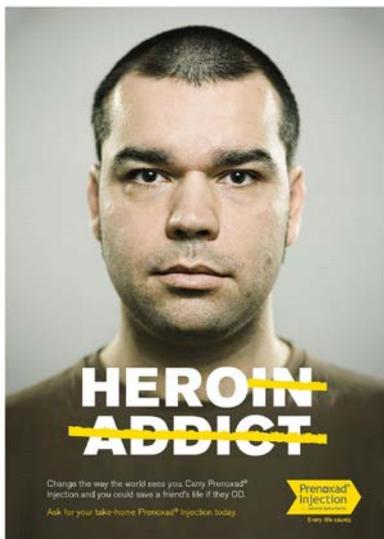
Walley et al. *BMJ* 2013; 346: f174.



Community Level Impact

- Naloxone rescue kits work, but they are not enough
- Build on what works
 - Medically managed withdrawal (detox)
 - Methadone maintenance
- Fill the gaps – Harm reduction and treatment across points of contact
- Populations and venues
 1. Active users
 - Syringe access programs
 - Detox programs
 - Methadone maintenance
 - Emergency Department*
 - Criminal justice-involved*
 - Pharmacy and primary care*
 2. Caregivers and social networks
 - Community meetings and support groups
 - Primary care providers
 - Pharmacy – Behind the counter, over the counter
 3. First responders
 - Public health-public safety partnership

*Venues and populations that warrant targeted research, program development, and implementation



1 IN 5

- Lack of breathing
- Blue lips/fingertips

- Administer Narcan



For more information visit www.bphc.org/ahope



Prescribe to Prevent:
Overdose Prevention and Naloxone Rescue Kits for Prescribers and Pharmacists

Go to prescribetoprevent.org

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The Network for Public Health Law

BOSTON UNIVERSITY
Boston University School of Medicine
Continuing Medical Education

LEARN to COPE

A peer-led support network for families dealing with addiction and recovery

Thank you – awalley@bu.edu

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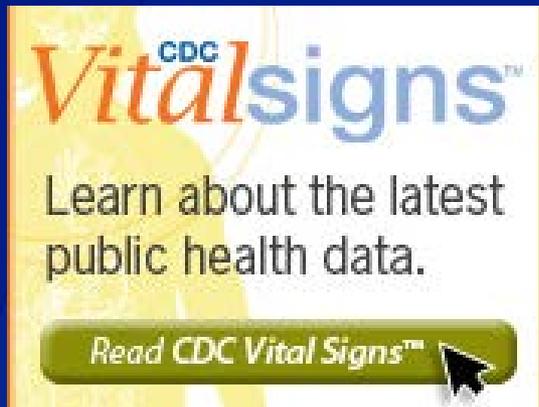
<http://tools.cdc.gov/syndication/search.aspx?searchURL=www.cdc.gov%2fvitalsigns>

Vital Signs interactive buttons and banners

<http://www.cdc.gov/socialmedia/tools/buttons/vitalsigns/index.html>

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OSTLTSFeedback@cdc.gov



Please mark your calendars for the next
Vital Signs Town Hall Teleconference

Tuesday, August 11, 2015

2:00–3:00 pm (EDT)

For more information, please contact Centers for Disease Control and Prevention.

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