

CDC *Vital Signs* Town Hall Teleconference

Addressing the Current Heroin Abuse and Overdose Epidemic:

The Role of States and Localities

Q&A

July 14, 2015

1:00 pm CT

Matthew Penn: So thank you so much for these excellent presentations. This is Matthew Penn again here, your facilitator. Remember you can get in the queue to ask a question of our presenters or make a comment by pressing star one. And please say your name when prompted. And the Operator will announce when it's your turn.

I encourage you to take advantage of this opportunity to share your own strategies, lessons learned, challenges, success stories, things like that. You can post questions to our presenters or to each other, in fact. We have quite a few states and organizations on the call so there's lots of folks, lots of expertise to draw upon. And this is really a forum for you to discuss, collaborate, and question different methods, practices, and experiences around the heroin epidemic and other opioid use, abuse, and misuse.

Operator, we are ready for questions. Is there anyone in the queue?

Coordinator: Yes, we do have a couple of questions. Our first question comes from Don Flattery with the Virginia Governor Task Force. Go ahead.

Don Flattery: Good afternoon. Thank you very much for organizing this conversation. These kinds of discussions to educate and inform are always welcome. I have basically three points to make and if need be I'll just turn the last point into a question for the gentleman who has an association with FDA.

First, I'd like to challenge a characterization made by Commander Jones and his remarks. He suggested three legs to needed prevention -- first reducing prescription painkiller abuse; second, access to MAT; and third, use of lifesaving measures such as naloxone. We're doing many of those things in the Virginia Governor's Task Force along the same lines and many of the things that were discussed by the excellent speakers as well.

But the issue that Commander Jones characterized - it's not just the matter of prescription painkiller abuse. There are two components. There's nonmedical use, which is abuse, and then there's medical use -- overuse of medically prescribed opioids. I think Dr. Franklin in his remarks and going through all the data just helped make that very important case.

According to research study by Kolodny, Courtwright, and others, the fastest growing age group of those who died of prescription opioid overdoses in 2014 was the age 45 to 54. These aren't young kids crushing and snorting oxy before a football game. They're likely people who became dependent and addicted to their medically prescribed opioids.

So we need to in the characterization of this issue stop limiting the cause to one of simply reducing abuse of painkillers. It's much bigger than that.

The second point I would like to make is that the curve of prescribed opioids in the US -- as all of you have seen -- has gone exponential over the last two decades. I think the last number I saw was a 2013 number with 259 million opioid prescriptions written in the US. Until we bend that curve of prescribed opioid drugs, we're going to continue to inject new addicted people into the pipeline. And we will spend massive state and federal resources fighting this issue, but we won't make a dent until fewer new patients are created.

And that leads me to my final point and will yield, and that is while CDC and HHS and ONDCP and many state governments and state governors and legislatures are onto this and recognizing that we've got an epidemic before us, the FDA continues to inexplicably approve new and more potent opioid products into the marketplace. And they're doing it with limited transparency. I'm not going to re-litigate the Zohydro case. They ignored their drug advisory panel.

They're characterizing these opioid drugs as safe if used as prescribed and I just challenge that. And then finally, they're using the enriched enrollment process for every opioid drug approved since 2006 that values speed of approval of these drugs. And if there's any drug that requires more considered and thoughtful review it's an opioid drug. And they're using that process which underrates risk.

So we need the FDA to stop working at cross purposes with many of us fighting this addiction. That has to change. So I apologize for taking too long but those are my remarks. So thank you very much.

Coordinator: Our next question comes from Judy Moseley with Ohio Department of Health. Go ahead.

Judy Moseley: Thank you. Excellent program. We were just wondering for the speaker from Massachusetts, how are you documenting your overdose reversals? We have a project DAWN program in Ohio -- the Deaths Avoided With Naloxone -- and we document the reversals by people coming back from refills. But we're interested in how you were documenting that with your program in Massachusetts. Thank you.

Dr. Alex Walley: Yes. The 4,700 reported overdose rescues is the same method I think you're using with project DAWN, which is essentially convenience. So when somebody comes back to the program usually where they were trained to use the naloxone and trained in overdose education often times to ask for more, we ask them what

happened. We have a form that is standardized form that we ask the details of what happened with the use of that naloxone.

So that's how we document our rescues. How we document the outcome in the study that we did was medical examiner data and looking at opioid overdose death rates at the town level, and compared towns for the study.

But for the program and documenting the number of rescues through the program, it's really convenience based on people who are coming back asking for more naloxone.

Judy Moseley: Thank you.

Coordinator: Our next question comes from Aaron Kochar from PorterStarke Services. Go ahead, please.

Aaron Kochar: Yes, Dr. Walley. I was wondering particularly with your next to last slide about the balance of distributing naloxone to those first responders as opposed to family and injected drug users themselves, especially considering the ever exponentially rising costs of naloxone.

And second, somewhat similar addendum would be - what balance in distributing to communities you have between permanent distribution sites as opposed to mobile distribution sites.

Dr. Alex Walley: Okay. So we have - naloxone's being distributed through first responders. And what I mean by that is police departments and fire departments. Quite broadly in the state as of the last eight months there's thirty-seven municipal agencies that are supported by the Department of Public Health to distribute where firefighters or

police officers are administering naloxone. And through that program we've had, I believe, over 700 rescues reported in the last six to seven months.

So that is a piece of the strategy and part of what the Department of Public Health is investing in. There's also departments that have done this on their own without support of the Department of Public Health and we don't have data on that.

And so these strategies of community-based distribution are not in competition in any way with first responders. In fact, I think that they're quite complimentary. So it raises the awareness throughout the community, equipping officers -- both police officers and firefighters -- with naloxone, really changes their role. It does bring and medicalizes them in some degree and brings them into the public health - not just public safety but also public health solution.

And then raising the awareness in the community - of the 33,000 plus people that we've trained in Massachusetts that are not police or fire but are in the community, about a third of them are active users; but another third are not people who are using opioids. They're the friends and family, which is made possible through third party prescribing legislation that we have in Massachusetts. So - and many other states have, by the way.

So that's - I don't - the cost of naloxone is an issue and, really, the cost of naloxone for public health is getting higher and higher. The cost of naloxone for the medical system - it's still a lot cheaper or competitive with an EpiPen. And so I think in the medical system, for a person who's at risk, I think it makes a lot of sense for insurance to cover it.

And so our strategy has been to try looking towards the future to try to move naloxone distribution into the insured medical system to the degree that we can. And that's why I brought up pharmacy based strategies.

As far as mobile units versus fixed sites, we have really benefitted from the local innovation of the community-based organizations who have adapted their - the venues that they use to distribute these kits and the education based on what the local needs are in the community. So you kind of got a sense of that as I went through the different venues where we're distributing.

We obviously think fixed sites like detoxes, drop-in centers, and needle exchanges or syringe access programs are very important, but community-based meetings are really more mobile. And then we have people who - trying to reach those who otherwise we can't reach through street outreach, and that's a very mobile way.

So I know you've got to pick and choose if you have limited resources. My guidance or my advice would be look at that combination of the place where - that's ready to do this with the other factor being those who have access to the highest risk people. So that's sort of how we prioritize in the beginning and then it's grown from there.

Dr. Gary Franklin: This is Gary Franklin. Could I ask Alexander Walley among the 4,700 saves what percent of those were heroin versus prescribed opioids? Do you know that?

Dr. Alex Walley) Yes. Over 90%. So we really - this program, I think, is - we designed it initially to get to people who were using injection drugs. We had an existing system really built around HIV prevention that had access to high risk people who are using injection drugs. And that's going to - in Massachusetts, we have a longer opioid - heroin has been the primary drug threat in New England and Massachusetts since the '70's.

So while prescription opioids has really opened up the pool of people who are using opioids in our state like lots of others, we already had a heroin problem before it all began. And so heroin, I think, remains the final common pathway for most people who have an opioid use disorder in Massachusetts. And so by the time they're

overdosing, most people are using heroin; which may make us different from some other state. But that's my best impression.

We don't have fantastic discrimination between heroin deaths and prescription opioid deaths at the level of the medical examiner in Massachusetts like other states do. So that's a lot of what I'm saying - is my best opinion, but we don't have great discrimination between, like I said, heroin and prescription opioid deaths in Massachusetts.

Barbara Cimaglio: This is Barbara Cimaglio in Vermont, and we're seeing the exact same thing. It's increasingly heroin and I think the reality is that we need to have a more responsive treatment system so that people can get treatment access as they are identified. And there can be a firmer link into ongoing treatment because for most of these individuals, unless they get into a long term treatment relationship with medication-assisted treatment, the likelihood is they're going to be back out on the street.

Matthew Penn: Well thank you so much to our presenters today for sharing their expertise and their experiences and points about the programs that they've been involved with. And of course, to Dr. Jones for sharing with us information about the *Vital Signs* that was published just recently. We are now just past the top of the hour, so I think we're going to close out now.

Before we close, please let us know how we can improve these teleconferences. You can email suggestions to ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback -- all one word -- at cdc.gov. And we certainly hope that you will be able to join us for next month's town hall on Tuesday, August 11 when we will focus on antibiotic resistance.

So thank you so much for joining us today and that ends today's call. Good-bye.

Coordinator: Thank you. That concludes today's conference. You may disconnect at this time.
Thank you.