OREGON PRESCRIPTION DRUG OVERDOSE, MISUSE, AND DEPENDENCY PREVENTION PLAN

November 18, 2015

Oregon Health Authority

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Oregon Health Authority
Public Health Division
Injury and Violence Prevention Program
http://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=10
Technical Contact: Matthew.Laidler@state.or.us
Program Contact: Lisa.M.Millet@state.or.us
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Acknowledgements

Public Health Division Staff:

Laura Chisholm, MPH, Chronic Disease Self-Management Coordinator, Health Promotion and Chronic Disease Section

Adrienne Greene, MBA, Injury and Violence Prevention Section Grant Manager

Katrina Hedberg, MD, MPH, Health Officer and State Epidemiologist

Matt Laidler, MPH, MA, Injury and Violence Prevention Section Epidemiologist

Lisa Millet, MSH, Injury and Violence Prevention Section Manager

Heidi Murphy, MPH, Prescription Drug Monitoring Program Research Analyst

Lisa Shields, MPH, Prescription Drug Overdose Project Coordinator

Josh Van Otterloo, MPH, Prescription Drug Monitoring Program Research Analyst

Xun Shen, MD, MPH, Violence Epidemiologist

Michael Tynan, Policy Director

Stephanie Vesik, Prescription Drug Monitoring Program Operations Lead

Dagan Wright, PhD, MSPH, Emergency Medical Services and Trauma Data Manager

Injury Community Planning Group Members

Kathleen Carlson, PhD, Portland Veteran's Administration

Elizabeth Eckstrom, MD, Oregon Health Sciences University

Dwight Holton, JD, Lines for Life

Paul Lewis, MD, MPH, Health Officer, Multnomah, Washington and Clackamas Counties

Dennis McCarty, PhD, Oregon Health Sciences University

Gary McConahay, PhD, Clinical Director, Columbia Care Services

Cherryl Ramirez, Executive Director, Association of Community Mental Health Program Directors

Kimberly Repp, PhD, MPH, Epidemiologist, Washington County Public Health

Jim Shames, MD, Jackson County Health and Human Services

Kim Toevs, Senior Manager, Multnomah County Health Department

Haven Wheelock, Outside In

Rob Bovett, JD, Association of Oregon Counties

Oregon Health Authority Staff

Health Systems Division:

- Kim Wentz, MD, MPH, Medicaid Medical Director
- John Mcilveen, PhD, LMHC, State Opioid Treatment Authority
- Karen Wheeler, Administrator, Operations Support
- Roger Citron, RPh, Manager, Oregon Pharmacy and Therapeutics Committee, Drug Use Research and Management, and Oregon College of Pharmacy, Oregon State University
- Ted Williams, RPh, Oregon Pharmacy and Therapeutics Committee, DURM, and Oregon College of Pharmacy, OSU
- Dennis Eberhardt, Tribal Medical Contract Liaison
- Trevor Douglass, DC, Manager Provider Clinical Support Unit

Health Policy and Analytics Division:

- Lori Coyner, Manager, Health Analytics
- Jon Collins, PhD, Health Analytics
- Lisa Bui, MBA, Quality Director
- Cat Livingston, MD, MPH, Health Evidence Review Commission
- Denise Taray, RN, Coordinator Oregon Pain Management Commission

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Executive Summary

In Oregon in 2013, more drug overdose deaths involved prescription opioids than any other type of drug, including methamphetamines, heroin, cocaine, and alcohol. Since the 1990's, , there has been a dramatic increase in prescription controlled substance sales, use, misuse, dependency, and overdose due to opioids in Oregon. New data from Oregon's Prescription Drug Monitoring Program (PDMP) shows that prescribed opioid use is pervasive among Oregonians. In 2013, almost 1 in 4 Oregonians received a prescription for opioid medications[1], and in a recent national survey[2], Oregon ranked 2nd among all states in non-medical use of pain relievers (i.e. prescription pain medication).

Reducing prescription drug poisonings ("overdoses") is a complex problem that will require coordinated implementation of a comprehensive set of solutions. The following strategies are part of the framework to reduce prescription opioid overdose, misuse and dependency:

- Reduce problematic prescribing practices:
    - Develop and implement Opioid Prescribing Guidelines for Pain Management that address treatment of acute pain, chronic pain, and co-prescribing in various provider settings (e.g. primary care, emergency departments, dental offices, prenatal care, tribal clinics, Federally Qualified Health Centers, etc.)

    - Use the Prescription Drug Monitoring Program (PDMP) to assess high risk behavior, prescribing thresholds, and dangerous co-prescribing, and use of multiple prescribers and pharmacies. Develop the PDMP to allow for notifications to providers regarding at-risk patients (e.g. four or more providers providing painkiller prescriptions, > 120 mg Morphine Equivalent Dose (MED), etc.). Explore statutory change needed to integrate PDMP access into existing electronic health record systems (e.g. EDIE in Emergency Departments).

    - Provide reimbursement for non-opioid pain treatment therapies for chronic pain and increase access to the Chronic Pain Management Center model, including services such as nutrition, PT, chiropracty, massage, acupuncture, Cognitive

[1] http://www.orpdmp.com/orpdmpfiles/PDF_Files/Reports/Statewide2013.pdf

[2] http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm

Behavioral Therapy, graded exercise; as well as Medication Assisted Treatment and substance use disorder treatment.

  - Implement pharmacy opioid management strategies including: prior authorization for opioids, including clinical assessment of comorbidity, risk factors; preferred/non-preferred drug lists; dispensing limits for MED, quantity of pills, number of refills, and early refills; implement lock-in programs through pharmacy management-programs

- Improve safe drug storage and unused medication disposal
  - Explore statutory changes needed to require routine drug take-back at pharmacies.

- Increase and improve the infrastructure for naloxone rescue, and naloxone co-prescribing
  - Co-prescribe naloxone when prescribing opioids for at-risk patients
  - Allow naloxone prescribing and dispensing to third parties of patient (e.g. spouse, parent, partner, etc.)
  - Explore statutory changes needed to allow for naloxone to be prescribed and dispensed by directly by pharmacists.
  - Improve infrastructure for law enforcement and EMTs to administer naloxone to patients who have overdosed on opiates
  - Promote knowledge of the "Good Samaritan law" to the general public
  - Promote access to naloxone trainings for the public, at pharmacies, etc.

- Provide medication assisted treatment (MAT) for opioid use disorder
  - Ensure that Coordinated Care Organizations (CCOs) provide (MAT) for opioid use disorder.
  - Improve access to MAT services for patients throughout the state, including tribal populations (both urban and on reservations)
  - Increase the number of buprenorphine waivered physicians in practice in Oregon

- Implement routine collection, analysis and reporting of opioid overdose, misuse, and dependency data.
  - Evaluate the public health impact of implementation of the opioid prevention plan
  - Report data on overdose deaths, hospitalizations, percent of population with prescriptions for daily MED >120 mg, opioid use disorder treatment by: demographic characteristics and geographic location in the state, with a focus on disparities, including by socio-economic status, homelessness, veteran status, race-ethnicity.

- Provide education and training of the public, providers, health systems, policy-makers on the issues related to opioid overdose, misuse and dependency
    - Promote education of the public, providers, health systems regarding risks of opioid medications and reasonable expectations of chronic pain treatment and availability of non-pharmacologic pain treatment
    - Provide training to providers for challenging situations such as drug tapering, MAT, Substance Use Disorder treatment, pregnancy, and neonatal abstinence syndrome.

- Collaborate with federal and state entities to support the work of the initiative – including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Medicaid Medical Directors Network, and states such as Washington, New York, and Massachusetts who have implemented effective strategies.

A variety of state and local initiatives are under way to support the implementation of the strategies in this plan. Coordinated Care Organizations (CCOs) began work on an opioid prescribing Performance Improvement Project (PIP); the Public Health Division (PHD) received a grant from CDC to implement several of the strategies outlined in this plan in five regions of Oregon over four years; the Oregon Coalition for the Responsible Use of Meds (OrCRM) received a grant from the Oregon Department of Justice that will support local implementation of the strategies in this plan. Oregon will participate in a National Association of Medicaid Directors project to reduce misuse of, overdose and death from prescription opioids. Several regions in Oregon have developed opioid prescribing guidelines, and Jackson County CCOs and Western Oregon Health CCO have pioneered work to change prescribing practices of their providers.

To guide the coordination of this work, the Oregon Health Authority has chartered an Opioid Initiative Task Force that will meet monthly to monitor progress and plan ongoing work across the Authority and among state agencies.

Prescription Drug Poisoning/Overdose: Overview

The goal

Reduce deaths from prescription drug overdose/poisonings (PDO).

The target

Reduce opioid poisoning deaths (unintentional and undetermined intent)[3] to fewer than 2.5 deaths per 100,000 persons per year, or approximately fewer than 75 deaths per year, by December 31, 2020. (The peak in 2006 was 238 deaths—a rate of 6.5 per 100,000).

Reduce methadone-related poisoning deaths to fewer than 30 per year by Dec 31, 2020. (The peak number in 2006 was 140 deaths).

National Healthy People 2020 Objectives

- Prevent an increase in poisoning deaths among all persons
- Prevent an increase in poisoning deaths among persons 35 to 54 years of age.

The problem

In Oregon in 2013, more drug poisoning deaths involved prescription opioids than any other type of drug, including methamphetamines, heroin, cocaine, and alcohol. Since 1999, statistics show a dramatic increase in prescription controlled substance sales, illicit and prescribed drug use, misuse, dependency, and overdose due to drugs of all types in Oregon. New data from Oregon's Prescription Drug Monitoring Program (PDMP) shows that prescribed opioid use is endemic among Oregonians. In 2013, almost 1 in 4 Oregonians received a prescription for opioid medications, and in a recent national survey[4], Oregon ranked 2nd among all states in non-medical use of pain relievers (i.e. prescription pain medication).

[3] The overdose data and focus of overdose prevention is primarily unintentional and undetermined overdoses. Prevention activities that reduce the volume of opioids in the general population may also impact suicide attempts by overdose.

[4] http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm

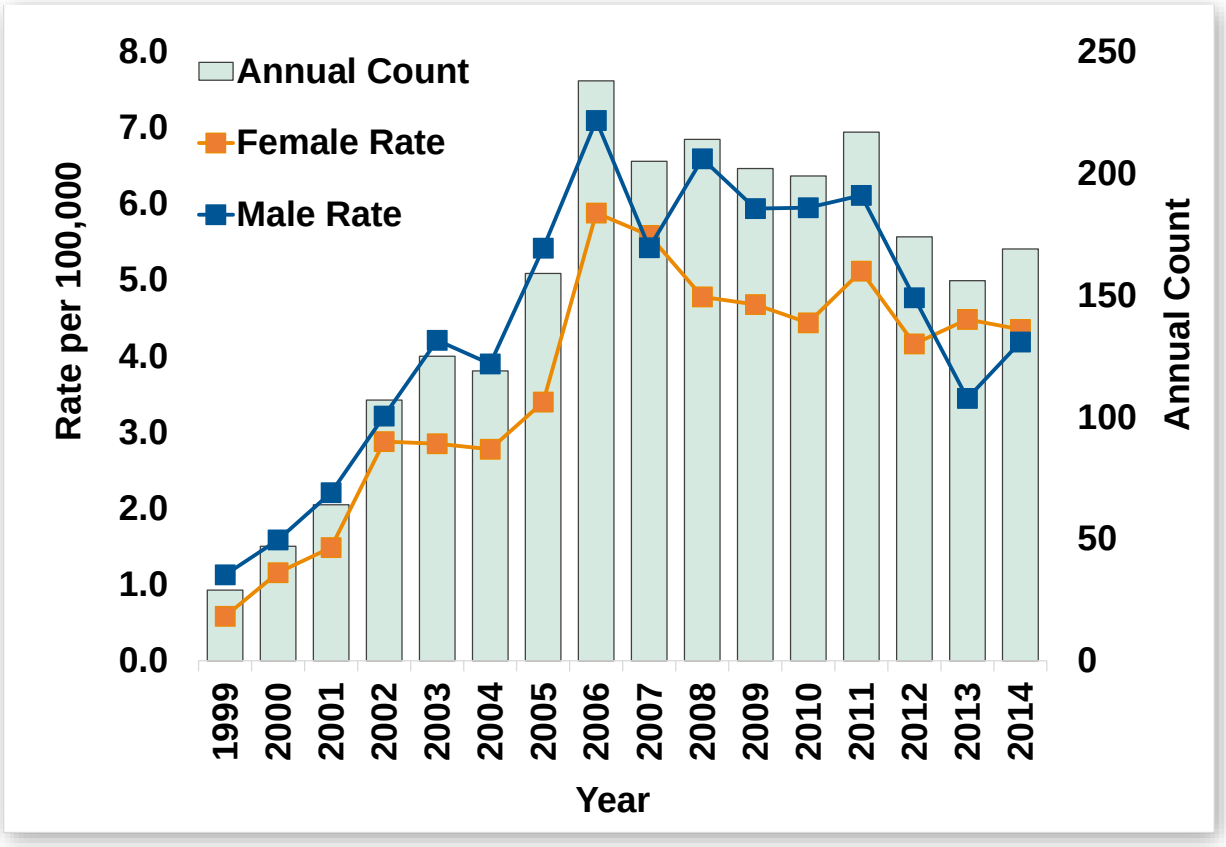
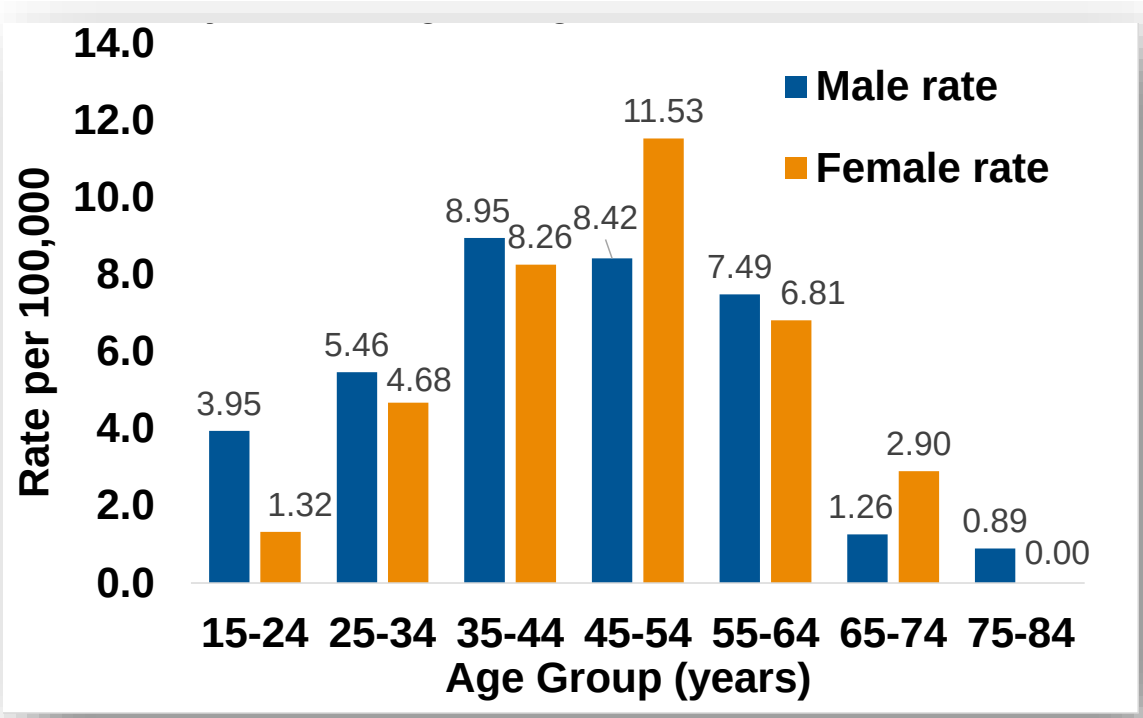


Figure 1. Unintentional and undetermined prescription opioid poisoning deaths and death rates, Oregon, 1999-2014.

While many drugs and medicines have potential for overdose, the use of both prescription opioids and heroin (often taken in combination with other medicines and drugs) has increased since 1999. With increased use of opioids, communities have seen increases in overdose hospitalizations and deaths, and need for treatment. Data on the sales of legally prescribed medicines (opioids in particular) and data on overdose hospitalizations and deaths can be used to illustrate the progression of an epidemic of overdose hospitalizations and deaths in Oregon.

Public health, behavioral health, health systems, academic institutions, policy makers, and law enforcement officials are working to reduce this problem. The etiology and prevention of drug overdose is a complex issue, as it involves individuals, businesses, health care systems and prescribers, law enforcement, public health, and behavioral health programs.

Figure 2. Unintentional and undetermined prescription opioid poisoning, average annual rates of mortality by age (years) and sex, Oregon, 2011-2013.



Oregonians use a wide variety of medications and drugs to both treat medical/psychiatric conditions and for recreation. Medicine and drug use is highly regulated by the federal and state governments, and many safety measures are in place to protect people from harm. These include:

- Regulations require pharmaceutical companies to place warnings on packaging of over the counter and prescribed medicines.
- Federal and state regulations control who can prescribe medicines that have a high risk for abuse.
- Medical training institutions teach students to prescribe controlled substances and over the counter medicines safely.
- Schools of pharmacy teach pharmacists to dispense medicines safely.
- Pharmaceutical boards regulate the practice of dispensing medicines.
- Most states require prescriber education on pain and the use of pharmaceutical medicines to control pain.

- Federal and state laws establish penalties to control and punish infractions of laws and regulations by individuals (patients, prescribers, and pharmacists), institutions, corporations, and criminal organizations that promote and control drug trade.

Nonetheless, these laws and regulations have not prevented misuse, abuse, addiction, and overdose due to the use of prescription opioids. In fact, CDC estimates that in 2012, providers in the US prescribed enough opioid painkillers for every American to have a bottle of pills.

Some basic facts about prescription opioid poisoning in Oregon:

- From 2000 through 2014, 2,226 people in Oregon died due to prescription opioid overdose.
- Unintentional and undetermined prescription opioid overdose death rates appear to have peaked in 2006 at 6.5 per 100,000 and declined to 4.0 per 100,000 in 2013. Preliminary data for 2014 indicates that this trend of decrease continues. Nonetheless, the overdose death rate in 2013 remains 2.8 times higher than in 2000.
- The use of prescription opioids is widespread in Oregon. An analysis of 2013 PDMP data showed that over 918,000 Oregonians (24% of Oregon's population) received a prescription for an opioid in one year.
- In 2013, one prescription drug overdose death occurred for every: 1,900 methadone prescriptions dispensed; 20,300 opioid prescriptions dispensed (excluding methadone); 125,000 benzodiazepine prescriptions dispensed.
- The mortality rates due to heroin overdose increased from 0.8 per 100,000 in 2000 to 3.2 per 100,000 in 2012. Although there is some concern that heroin overdoses generally rise as prescription opioid overdoses wane, heroin overdose deaths have remained relatively static since 2007.
- Deaths due to methadone (which is frequently prescribed for pain) overdose peaked in 2006 (3.8 per 100,000) and declined to 1.6 per 100,000 in 2013. Nonetheless, the methadone overdose death rate is still more than two times higher than the rate in 2000.
- In 2006, methadone accounted for 52% of all prescription opioid overdose deaths in Oregon. In 2013, methadone accounted for 40% of all prescription opioid overdose deaths.
- The rate of overdose death due to prescription opioids averages 1.7 times higher among males when compared to females, and the highest rates for both males and females are among persons 35-54 years of age.
- The highest rates of deaths due to drug overdose occurred among Caucasian and non-Hispanic Oregonians for every type of drug.

Although many drugs cause overdose deaths and hospitalizations in Oregon, prescription opioids have been the focus of prevention for the past decade, mainly due to the dramatic increase in prescription opioid deaths between 2000 and 2006. This dramatic increase was observed throughout the US, and has remained unabated in many states.

Although the cited numbers are daunting in consideration of prevention, the good news is that prescription opioid poisoning has already decreased dramatically in Oregon. Although the rate of PDO increased 364% between 2000 and 2006 (1.4 per 100,000 to 6.5 per 100,000), the rate has declined 38% between 2006 and 2013 (to 4.0 per 100,000). The rate of death associated with methadone poisoning decreased 58% between 2006 and 2013, from 3.8 to 1.6 per 100,000.

The true burden of the prescription opioid epidemic is more penetrating than mortality alone. CDC estimates[5] that for each death there are:

- 10 treatment admissions for abuse;
- 32 emergency department visits for misuse or abuse;
- 130 who abuse or are dependent;
- 825 non-medical users.

What OHA/PHD has done to reduce PDO

Unlike nearly every state that has experienced a surge in prescription opioid deaths, the mortality rate in Oregon has begun to decrease. The state Legislature enacted legislation to establish a Prescription Drug Monitoring Program (PDMP) in 2009, and the PDMP was operational by 2011. Oregon's PDMP is housed in the Public Health Division, and is focused on helping health care providers assess the controlled substances prescription history of their patients, and to identify concerning behaviors (e.g. multiple prescriptions from multiple providers and pharmacies, high doses of opioids or opioids for extended periods of time, etc.) that lead to substance misuse or overdose.

In 2013, the legislature passed a law that allowed the establishment of medically-supervised lay-person (non-medical professional) naloxone rescue, which has been shown to prevent deaths among people who have already overdosed. The legislature also adjusted Oregon PDMP statute to allow delegates of healthcare providers and pharmacists to use the PDMP. Additionally, local public health authorities and Coordinated Care Organizations have organized a prescriber group in Jackson County (Jackson County/southern Oregon Pain Guidance Group)

[5] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. 2014. Policy Impact: Prescription Painkiller Overdoses. http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf

to improve health care practice around opioid prescribing, increase patient safety, and coordinate efforts across systems of care. This practice model is being adopted by other prescribers.

The State Pharmacy Program removed methadone as a “preferred” pain treatment drug from the state Medicaid preferred drug list or formulary, effective January 1, 2014, which affects non-CCO members of Oregon Health Plan (2.5% of the OR population or less). Non-preferred drugs (the new designation for methadone when used for pain) require a provider to ensure the drug is being prescribed for a Medicaid funded condition and does not exceed the dosing threshold of 120 MED (morphine equivalents daily). In addition, prescribers are asked to consider switching to a preferred drug.

The Oregon Health Systems Division is expanding the use of a brief screening and intervention tool known as Screening Brief Intervention, Referral and Treatment statewide (SBIRT).

Members of Oregon’s academic community and medical researchers are engaged in activities to develop new knowledge and disseminate knowledge about drug overdose, pain care, drug and alcohol abuse and dependency, and drug policy.

The Governor’s office sent a team to the National Governor’s Association Policy Academy on Prescription Drug Abuse. The team developed a policy paper to guide policy development in Oregon on overdose prevention. This team formed Oregon Coalition for the Responsible Use of Meds to work on policy issues statewide.

The Oregon Health Authority and medical directors of the Coordinated Care Organizations (CCO) agreed in 2015 to designate opioid management as the Performance Improvement Project for two years.

Since 2008, through dissemination of overdose data and analysis, the Injury Violence Prevention Program has educated policy-makers and stakeholders regarding the problem of prescription opioid overdose, especially around methadone overdose.

In addition, many efforts to reduce prescription opioid overdose, too numerous to mention here, to at are underway in counties across the state. Some examples include the establishment of a pain guidance group (PGG) in Jackson County, and the development of prescribing guidelines in Multnomah County.

Strategies for prevention

Although progress has been made in the effort to reduce prescription drug-related deaths, much remains to be done. Reducing prescription drug poisonings is a complex social and public health problem that will require a coordinated implementation of a comprehensive set of solutions. A key element for identifying prescription opioid misuse is in place in Oregon—the PDMP. The key to assuring the effectiveness of the PDMP is in promoting PDMP use, improving access, and utilizing PDMP data to inform policy. In addition, community-level interventions aimed at curbing inappropriate prescription opioid use will address the problem at the local level.

The following strategies are part of the framework to reduce prescription opioid overdose, misuse and dependency:

- Reduce problematic prescribing practices:
    - Implement Opioid Prescribing Guidelines for Pain Management
        - Develop and implement statewide Opioid prescribing guidelines that address treatment of acute pain, chronic pain, and co-prescribing; and various provider settings (e.g. primary care, emergency departments, dental offices, prenatal care, tribal clinics, Federally Qualified Health Centers, etc.)
        - Encourage CCOs to adopt Prescribing Guidelines similar to those used by the Southern Oregon's Pain Guidance Group.
        - Promote development of prescriber groups (e.g. the Southern Oregon Pain Guidance Group) by local public health authorities and CCOs to improve practice, increase patient safety, and coordinate efforts across health care systems.
        - Leverage federal support for using Patient Centered Medical Homes to develop and implement an opioid policy for all staff.
        - Leverage federal and state support to enforce compliance by providers with safe prescribing practices via provider enrollment/disenrollment, and monitoring
        - Utilize professional boards or peer review to work with high opioid prescribing physicians.
        - Support guidelines requiring assessment of comorbidity using tools such as SBIRT

    - Use the Prescription Drug Monitoring Program to Assess
        - Use PDMP data to create routine reports to help prescribers track high risk behavior, prescribing thresholds, and dangerous co-prescribing, and use of multiple prescribers and pharmacies.

        - Automate PDMP prescriber alert notifications that identify when medicines dispensed to patients might endanger patient safety and health.
        - Establish best practice recommendations for the use of the PDMP.
        - Monitor overdose by producing annual reports and special reports using PDMP data.
        - Develop the PDMP to allow for notifications to providers regarding at-risk patients (e.g. four or more providers providing painkiller prescriptions, > 120 mg Morphine Equivalent Dose, etc.).
        - Explore statutory change needed to integrate PDMP access into existing electronic health record systems (e.g. EDIE in Emergency Departments).
        - Leverage federal support to develop national PDMP and cross-coverage with bordering states

    - Provide reimbursement for non-opioid pain treatment therapies
        - Implement recommendations of the Health Evidence Review Commission's evaluation of evidence-based practices for non-opioid treatment of chronic lower back pain.
        - Require insurers to pay for non-pharmacological care for chronic non-cancer pain treatment.
        - Encourage Coordinated Care Organizations (CCOs) and other prescribers to increase the use of non-opioid pain management.
        - Develop funding and reimbursement for, and access to the Chronic Pain Management Center model, including services such as nutrition, PT, chiropracty, massage, acupuncture, Cognitive Behavioral Therapy, graded exercise; as well as Medication Assisted Treatment and substance use disorder treatment.
        - Leverage federal requirement of parity in mental health care to increase provision of services for chronic pain patients.

    - Implement pharmacy opioid management strategies including:
        - Prior authorization for opioids, including clinical assessment of comorbidity, risk factors
        - Preferred/Non-preferred Drug Lists
        - Dispensing limits for Morphine Equivalent Dose, quantity of pills, number of refills, and early refills
        - Provide feedback from pharmacists to prescribing providers
        - Implement lock-in programs through pharmacy management-programs
        - Encourage use of PDMP at point of service

        - Utilize Pharmacy Board to work with outliers

- Improve safe drug storage and unused medication disposal
    - Explore statutory changes needed to require routine drug take-back at pharmacies.

- Increase and improve the infrastructure for naloxone rescue.
    - Co-prescribe naloxone when prescribing opioids for at-risk patients
    - Allow naloxone prescribing and dispensing to third parties of patient (e.g. spouse, parent, partner, etc.)
    - Explore statutory changes needed to allow for naloxone to be prescribed and dispensed by directly by pharmacists.
    - Improve infrastructure for law enforcement and EMTs to administer naloxone to patients who have overdosed on opiates
    - Promote knowledge of the "Good Samaritan law" to the general public
    - Promote access to naloxone trainings for the public, at pharmacies, etc.

- Provide medication assisted treatment for opioid use disorder
    - Ensure that Coordinated Care Organizations (CCOs) provide medication assisted therapy (MAT) for opioid use disorder.
    - Improve access to MAT services for patients throughout the state, including tribal populations (both urban and on reservations)
    - Educate providers and stakeholders on the value of increased MAT utilization, and partnering on innovative ways to serve Oregon's opioid dependent population.
    - Increase the number of buprenorphine waivered physicians in practice in Oregon
    - Leverage federal support for parity in treating mental health and Substance Use Disorders

- Implement routine collection, analysis and reporting of opioid overdose, misuse, and dependency data.
    - Evaluate the public health impact of implementing of the opioid prevention plan
    - Report data on overdose deaths, hospitalizations, percent of population with prescriptions for daily MED >120 mg, opioid disorder treatment by: demographic characteristics and geographic location in the state. Include a focus on disparities, including by Socio-economic status, homelessness; veteran status, race-ethnicity, etc.

- Provide education and training of the public, providers, health systems, policy-makers on the issues related to opioid overdose, misuse and dependency

    - Promote education of the public, providers, health systems regarding risks of opioid medications and reasonable expectations of chronic pain treatment and availability of non-pharmacologic pain treatment
    - Provide training to providers for challenging situations such as weaning, MAT, Substance Use Disorder treatment, pregnancy, and neonatal abstinence syndrome.

- Work with federal and out of state entities to support the work of the initiative – e.g. the MED project, the Medicaid Medical Directors Network, the National Association of Medicaid Directors, CMS, CDC, including states such as Washington and New York and Massachusetts who have implemented effective strategies.

Evaluation and performance metrics.

Outcome metrics:

Goal: 1.1. Reduce the prescription drug overdose mortality rate.					
	Metric Benchmark: 3.9 per 100,000 in 2014.				
Objective:	2016	2017	2018	2019	2020
1.1.A. Reduce the rate of unintentional and undetermined prescription opioid deaths to less than 3.0 per 100,000 by 2020 (2014 benchmark: 3.9 per 100,000)					
	Metric Benchmark: 47 deaths in 2013.				
	2016	2017	2018	2019	2020
1.1.B. Reduce the number of methadone-associated PDO deaths to <30 annually (2014 benchmark: 47 deaths).					

Implementation plan

Project Period: August 1, 2016 - July 31, 2020.

Sub-Objectives	Goals and Objective(s) that this action supports	Lead and Partners	Supported by injury program core component(s)*
1.1.a. By October, 2016, The Oregon Public Health Division will convene an opioid initiative task force.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: OHA Public Health Division leadership, IVPP	4, 5, 6
1.1.b. By September, 2016, engage PHD policy office in collaboration to develop policies that require CCOs and insurers to adopt PDO prevention as a health systems improvement project.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP; partners: ICPG, PHD Policy Office, HSD, QHOC, OHA Chief Medical Officer, State Health Officer, OR-CRM	3, 4
1.1.c. By September of 2016, engage PHD policy office in collaboration to remove methadone as a preferred pain treatment drug from CCO and private insurer prescription formularies.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP; partners: ICPG, PHD Policy Office, HSD, State Health Officer	3, 4, 5
1.1.d. By January, 2017, develop a grant application toolkit to aid local health departments in applying for US DOJ Harold Rogers PDO intervention grants.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP, PDMP	3, 4, 5, 6
1.1.e. By January, 2017, develop a grant application toolkit to aid local law enforcement agencies in applying for US DOJ naloxone rescue program development grants.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP, PDMP	3, 4, 5, 6

Sub-Objectives	Goals and Objective(s) that this action supports	Lead and Partners	Supported by injury program core component(s)*
1.1.f. By January of 2017, evaluate the impact that removal of methadone from the state Medicaid preferred drug list or formulary had on prescribing behavior.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP; partners: OHSU	2, 5
1.1.g. Update the state prescription drug overdose report by January 2019 (current report from 2014 to be updated on 5-year cycle) to inform stakeholders and PDO prevention partners.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP	2, 5
1.1.h. By December, 2016, begin abstracting medical examiner records from unintentional and undetermined drug overdose deaths, and collect detailed data on these deaths with the NVDRS system module.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP	2
1.1.i. By September, 2019, complete implementation of community-based PDO prevention in 13 of 36 counties (72% of the Oregon population). The community-level interventions will involve convening regional pain guidance groups (PGGs), and interdisciplinary action teams (IATs) made up of health systems, behavioral health, public safety, prescribers, and local health departments in these 13 high-burden (PDO) counties. PGGs and IATs will focus on adopting opioid prescribing guidelines, expanding naloxone rescue programs,	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP	4

Sub-Objectives	Goals and Objective(s) that this action supports	Lead and Partners	Supported by injury program core component(s)*
increasing availability of medically-assisted therapy, and implementing health systems-level policies that prevent PDO.			
1.1.j. By September, 2019, PDMP enrollment in community intervention project sites will reach 95% of top prescribers of controlled substances (23% of prescribers who write 81% of all controlled substance prescriptions).	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: regional PDO prevention coordinators, IVPP	1, 2, 4
1.1.k. By September 30, 2016, the PDMP will be easier to use and access by accelerating the sign up process during the license renewal process.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: IVPP	1, 2, 4
1.1.l. By August, 2019, increase to 16 the number of CCOs that have adopted PDMP use guidelines.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: local health departments, PHD policy office, regional PDO prevention coordinators, IVPP	4, 5
1.1.m. By August, 2019, increase the number of CCOs that adopt model opioid prescribing guidelines for non-cancer chronic pain	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: local health departments, PHD policy office, regional PDO prevention coordinators, IVPP	4, 5

Sub-Objectives	Goals and Objective(s) that this action supports	Lead and Partners	Supported by injury program core component(s)*
1.1.n. By December, 2016, develop a framework for measuring the availability of medication assisted treatment for opioid dependence. Track and disseminate MAT availability as a metric.	Goal 1.1, Objectives 1.1.A, 1.1.B	Lead: state opioid authority, local health departments, regional PDO prevention coordinators, IVPP	2, 4, 5

Performance metrics

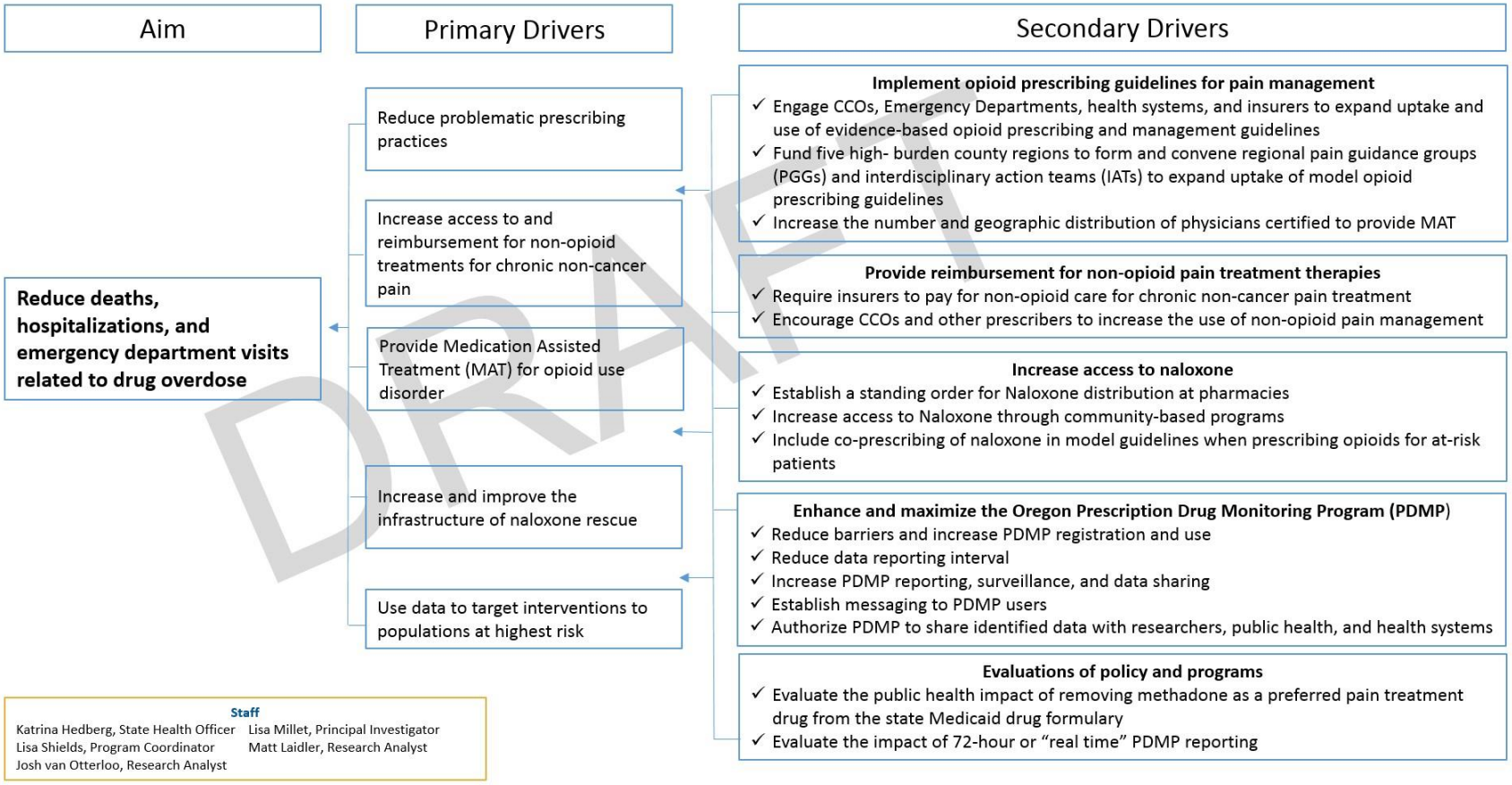
Key evaluation questions for Goal 1.1:

1. Were any new policies created that address CCO adoption of PDO prevention?
2. Was PHD policy office engaged in collaboration to remove methadone as a preferred pain treatment drug from insurer prescription formularies?
3. Was a grant toolkit created for counties to support them in applying for BJA intervention grants?
    1. If yes, how many counties used the toolkit?
    2. If used, how many counties obtain grants?
4. Was an evaluation conducted of the impact of removal of methadone from the state Medicaid preferred drug list or formulary?
5. Was the state prescription drug overdose report updated?
6. Were medical examiner records from unintentional and undetermined drug overdose deaths abstracted, and were detailed data on these deaths entered in the NVDS system module?
    a. Were those data used to inform prevention policies?

Oregon Opioid Initiative Logic Model

Goals	Partners	Outputs	Outcomes - Impact		
		Activities	*Short*	*Medium*	*Long*
Reduce prescription drug overdose deaths **Reduce prescription drug overdose hospitalizations** **Reduce emergency department visits for drug overdose and drug seeking** • Strengthen statutes • Reduce opioid prescriptions for chronic non-cancer pain • Increase access to naloxone rescue and co-prescribing • Increase access and provision of evidence based substance abuse disorder treatment • Improve pain management for chronic non-cancer pain • Improve coordination of care across health systems and community organizations for patients with complex chronic non-cancer pain (e.g. hotspots)	**State Agencies:** • OHA: Public Health and Health Systems Divisions; Policy Office; Health Systems Transformation Center; Health Analytics; Injury Prevention prescription drug overdose program, Prescription Drug Monitoring Program, Emergency Medical Services, surveillance and data analysis, opioid use disorder treatment, Substance use prevention program; Data systems access. • Department of Justice, High Intensity Drug Trafficking Agency • Oregon Department of Veterans Affairs **Health systems**; Oregon Health Leadership Council, CCOs **Healthcare licensure boards, associations & commissions** **Community based organizations**: local public health, local behavioral health; pain treatment centers, Oregon Pain Guidance (Jim Shames), Multnomah Naloxone Rescue (Paul Lewis), Oregon Pain Advisors **Oregon Coalition for Responsible Use of Meds:** Lines for Life (Dwight Holton) **Federal:** CDC, SAMHSA, & DOJ funds, technical assistance; VA **Public Safety**: State Medical Examiner, State Police; Department of Justice, Salem Police, EMS **Evaluation**: Portland State University, Acumentra Health, Program Design and Evaluation Services **Academic Support and Training:** OHSU, NW Addictions Technology Transfer Center	**Policy** • Authorize PDMP to share identified data w researchers, public health, & health systems • Establish PDMP messaging • Address naloxone gaps in statue **Enhance the PDMP** • Increase registration & use. • Increase ease of use & access. • Implement messaging. **Health system interventions** • Engage CCOs, Health Systems, and insurers to change policy to reduce problematic prescribing. • Implement opioid prescribing guidelines. • Co-prescribe naloxone • Establish Medication Assisted Treatment • Establish non-opioid pain management clinics **Community-level interventions** • Convene regional pain guidance groups and action teams to norm prescribing, advance health-system adoption of opioid prescribing guidelines, Substance Use Disorder treatment, MAT, non-opioid pain treatment & identify overdose hot spots. • Naloxone rescue, naloxone for offenders at release & patients completing substance abuse treatment **Evaluation** • Evaluate the change in preferred drug list or formulary policy on methadone prescribing and outcomes & the impact of 72-hour PDMP data reporting	**Enhance PDMP** • Reduce barriers to access & use • Reduce data collection interval • Data sharing with researchers, LHDs, & health medical directors • Establish messaging to PDMP users • Increased use of standard reports for surveillance • Integrate PDMP data into EDIE **Implement opioid prescribing guidelines** Expanded use of guidelines **Increase access to opioid disorder Rx** • Increased MAT in health systems **Increase access to Naloxone rescue** • Naloxone distributed to released offenders, patients completing opioid use Tx, & pregnant women w opioid disorder • Community lay naloxone rescue & co-prescribing **Improve non-opioid pain Rx** • Establish alternative pain care for complex chronic non-cancer pain Regional pain guidance teams review data & plan training & advocacy for evidence based practice, & identify hot spots	Increased registration and use of PDMP Decreased rate of high dose) opioid prescribing Decreased rate of methadone pain treatment among public and private insurers. Increased use of non-opioid pain therapies Reduce problematic co-prescribing of opioid/benzodiazepines Decreased use of multiple prescribers for opioids Decreased rate of high dose opioid Rx Increased use of claims reviews to identify high-risk prescribing Intervene in hot spots	Decreased rates of opioid abuse Increased opioid use disorder treatment & MAT treatment Decreased rate of ED visits related to opioids overdose and drug seeking Decreased drug overdose death rate, including both opioid and heroin death rates Improved health outcomes in state "hot spots"

Driver Diagram: Prescription Drug Overdose, Misuse, and Dependency Prevention, 2015 - 2019



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Oregon Health Authority, Public Health Division, Injury and Violence Prevention Program. Prescription Drug Monitoring Program factsheets and prescription overdose fact sheets: http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/index.aspx

Oregon Pain Guidance Group (OPG): http://opioidprescribersgroup.com/

Oregon Pain Guidance Group's Opioid Prescribers Guidelines: http://www.southernoregonopioidmanagement.org/opioid-prescribing-guidelines/introduction/

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Other Resources

Injury and Violence Prevention Program, Oregon Health Authority, Public Health Division: http://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=10

Oregon Chapter of the American College of Emergency Physicians Emergency Department Prescribing Guidelines: http://ocep.org/

Oregon Pain Guidance website includes model prescribing guidelines and resources for healthcare providers and patients: http://www.oregonpainguidance.com/

Oregon Prescription Drug Monitoring Program web portal: http://www.orpdmp.com/

Oregon Naloxone Training Protocol: https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/Naloxone-Training-Protocol.aspx

Oregon Substance abuse treatment: http://www.oregon.gov/oha/amh/pages/gethelp.aspx

Medication Assisted Treatment and Recovery in Oregon: http://www.oregon.gov/oha/amh/Pages/umatr.aspx

Oregon Coalition for the Responsible Use of Meds: http://orcrm.org/

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: www.cdc.gov/ncipc/

National Institute of Drugs and Alcohol Naloxone Brief: http://www.drugabuse.gov/about-nida/noras-blog/2014/02/naloxone-potential-lifesaver

Substance Abuse and Mental Health Services: Guidelines for Prescribing Buprenorphine and Buprenorphine Products http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf http://buprenorphine.samhsa.gov/products.html

SAMHSA Opioid Overdose Toolkit: Five Essential Steps for First Responders: http://store.samhsa.gov/shin/content//SMA14-4742/Toolkit_FirstResponders.pdf

Oregon Pain Advisors: http://www.painadvisors.com/

Progressive Rehabilitation Associates Pain Management Center: http://www.progrehab.com/pain-management.html

Data Sources / Analysis

Death data: Mortality data are obtained from the Center for Health Statistics, Public Health Division, OHA.

Hospitalizations: Hospitalization data are obtained from the Oregon Association of Hospitals for all non-federal acute-care inpatient facilities. Hospitalization data do not contain personal identifiers, and may include multiple admissions, re-admissions, and transfers for one individual. Hospitalization data do not contain information about persons treated in emergency departments and released. Hospitalization data rely on the International Classification of Diseases version 9 (ICD-9). In 1999, a change occurred in the way the causes of death are coded, from the International Classification for Diseases (ICD) version 9 to ICD version 10. Therefore, mortality data collected prior to 1999 are not directly comparable to data from 1999 and thereafter.

Prescription Drug Monitoring Program: -- The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies. Pharmacies submit prescription data to the PDMP system for all Schedules II, III and IV controlled substances dispensed to Oregon residents. The protected health information is collected and stored securely.

Oregon-licensed healthcare providers and pharmacists and their staff may be authorized for an account to access information from the PDMP system. Bordering state licensed healthcare providers may also be authorized for access accounts. By law their access is limited to patients under their care.

The program was started to support the appropriate use of prescription drugs. The information is intended to help people work with their healthcare providers and pharmacists to determine what medications are best for them.

Population data: Between census years, population estimates are used as denominators for rates. Denominators for this report are based on national center for Health Statistics intercensal estimates.

Rates: Unless otherwise noted, all rates presented in this document are crude rates. Age-adjusted rates are weighted by a standard population so that the rate in question can be compared to rates from other locations or groups (the Oregon rate of suicide compared to the national rate of suicide, for instance). Crude rates show the actual number of events in the population in question (i.e. population of Oregon), although crude rates do not account for

differences in population structures between populations that might explain differences between the rates.

Behavioral Risk Factor Surveillance System (BRFSS): The BRFSS, administered and supported by the Behavioral Surveillance Branch (BSB) of the CDC, is an on-going data collection program designed to measure behavioral risk factors in the adult population 18 years of age or over living in households. See: www.dhs.state.or.us/dhs/ph/chs/brfs/index.shtml

Oregon Healthy Teens Survey: OHT monitors risk behaviors and other factors that influence the health and well-being of Oregon's children and adolescents. See: www.dhs.state.or.us/dhs/ph/chs/youthsurvey/index.shtml

Web-based Injury Statistics Query and Reporting System (WISQARS): Available online from the centers for Disease Control and Prevention, WISQARS is in interactive database system that provides customized reports of injury data at the national and state level: www.cdc.gov/ncipc/wisqars/