The Opioid/Opiate Landscape in Arizona

Understanding the Problem and Finding Solutions
Putting it in Perspective

Reaching across Arizona to provide comprehensive quality health care for those in need
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22% increase just since 2015

- Around 64,000 people died from drug overdoses in the U.S. in 2016
- Peak car crash deaths (1972)
- Peak H.I.V. deaths (1995)
- Peak gun deaths (1993)
Drugs Involved in U.S. Overdose Deaths, 2000 to 2016

- Synthetic Opioids other than Methadone, 20,145
- Heroin, 15,446
- Natural and semi-synthetic opioids, 14,427
- Cocaine, 10,619
- Methamphetamine, 7,663
- Methadone, 3,314

Years: 1999 to 2016
The National Rx Opioid Influx

• A 4 fold increase in the quantity of Rx Opioids sold in the U.S.

• The U.S. makes up 4.6% of the world’s population, but consumes 80% of its Rx opioids
The Evolving Landscape

4 out of 5 new heroin users start by misusing prescription painkillers

DEA Issues Alert on Fentanyl-Laced Heroin as Overdose Deaths Surge Nationwide

March 19, 2015

Twin Plagues: Meth Rises in Shadow of Opioids

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A Look at the Numbers

91 people die each day from an opioid-related overdose.

$55 billion is spent in health and social costs linked to prescription opioid abuse each year.

75% of heroin users first started by misusing prescription opioids.

1 in 10 people with the disease of addiction receive the treatment they need when they need it.

Sources: CDC, NIDA, HHS
Number and age-adjusted rates of drug overdose deaths by state, US 2015

2015 Age-adjusted rate
- 2.8 to 11.0
- 11.1 to 13.5
- 13.6 to 16.0
- 16.1 to 18.5
- 18.6 to 21.0
- 21.0 to 41.5
More than 2 Arizonans die each day from an opioid overdose

4 out of 10 Arizona adults know someone addicted to prescription painkillers

431 MILLION opioid pills were prescribed in 2016 enough for every Arizonan to have a 2.5 week supply

Drug overdoses* take more lives than car crashes in Arizona

In the last 5 years, 86% of persons who died from an opioid related cause were using multiple substances

Opioid Deaths (including both ox and heroin)
Prescription Drugs Deaths

Heroin deaths have TRIPLED since 2012 in Arizona

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Opioid death counts among Arizona residents and non-residents in Arizona from 2007 to 2016.
Hotspots in Arizona

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The cost of all opioid-related encounters has increased 125% from 2009 to 2015.

* Cost for encounters are calculated by applying the annual cost-to-charges ratio (produced by the Agency for Healthcare Research and Quality, Healthcare Cost Utilization Project) to reported encounter charges. This will estimate the actual cost paid to the provider for the healthcare services of the encounter. For this report, 2015 costs were estimated using the 2010-2014 average cost-to-charges-ratio by facility since 2015 and 2016 ratios were not available. When facility-specific ratios were not provided, the group ratio was used, or the state average ratio. These estimated costs are reasonable estimates of actual cost, and are a more accurate measure than reported charges.
Neonatal Abstinence and Newborn Drug Exposure Rates per 1,000 Births

AHCCCS represented 51% of Arizona hospital births between 2008 and 2014, but was the payer for 79% of the NAS cases.
Disparities

• Medicaid patients are 2x more likely to be prescribed an opioid

• 6x more likely to die from an opioid overdose
High Risk Populations

- Criminal Justice population
  - 1 in 10 opioid overdose deaths – most within 24 hours of release

- American Indians
  - 3x more likely for drug related overdoses

- Veterans
  - 55% spike in OUD in the past 5 years

- High MEDDDs and Polypharm
  - Risk doubles at 50MEDDDs, 10x at 90MEDDDs
  - 4 in 10 Arizona deaths involve combo of opioids and benzos

- Trauma, depression, anxiety

AHCCCS
Arizona Health Care Cost Containment System
Elevated Misuse in MH Population (NSDUH, 2015)

Figure 15. Past Year Misuse of Prescription Psychotherapeutics among Adults Aged 18 or Older, by Drug Type and Past Year Mental Illness Status: Percentages, 2015

AMI = any mental illness; SMI = serious mental illness.

* Difference between this estimate and the estimate for adults with no past year mental illness is statistically significant at the .05 level.
Specifically Those with Depression…

Figure 16. Past Year Misuse of Prescription Psychotherapeutics among Adults Aged 18 or Older, by Drug Type and Past Year Major Depressive Episode (MDE) Status: Percentages, 2015

+ Difference between this estimate and the estimate for adults with no past year MDE is statistically significant at the .05 level.

Note: Adult respondents with unknown past year MDE data were excluded.
And, Suicidal Thoughts

Figure 18. Past Year Misuse of Prescription Psychotherapeutics among Adults Aged 18 or Older, by Drug Type and Past Year Suicidal Thoughts: Percentages, 2015

+ Difference between this estimate and the estimate for adults with no Past Year suicidal thoughts is statistically significant at the .05 level.

Note: Adult respondents with unknown suicide information were excluded.
The Role of Trauma and ACES

![ACE Score and Drug Abuse Chart]

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Arizona Youth w/Past 30 Day Opioid Misuse

• 2 out of 3 youth said they used to cope with stress or feelings of sadness

• 9 out of 10 had experienced 1 or more ACEs

• 1 out of 3 had experienced 4+ ACEs

• 1 out of 2 have lived with someone who had a substance abuse problem
What is Arizona Doing to Solve the Opioid Crisis?
At the Governor’s Office

- Goal Site Council Established in 2016
- Executive Order to Limit Rx Opioid Quantities
- State of Emergency in June, 2017
- Emergency Rules
- Mandatory CSPMP began 10/16/2017
- ADHS Opioid Recommendations to the GO
- Legislative Special Session on Opioids

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ADHS Dashboard

816 suspect opioid deaths
5,377 suspect opioid overdoses
530 neonatal abstinence syndrome
7,261 naloxone doses dispensed
3,500 naloxone doses administered

Figures from 01/19/2018 7:59PM

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What Have We Learned?

- 6.8 million opioid pills prescribed every week
- AHCCCS members are 1.5x more likely to be prescribed an opioid
- 16% of suspected overdose deaths had been hospitalized for an opioid event in the past year
- 41% of current suspected overdose deaths had been prescribed opioids and benzos
- 34% had 10+ prescribers in the past year
3 Groups to Target

1. Opioid-Naïve Individuals
2. The Chemically Dependent
3. Diverters
Arizona Strategies

- Naloxone
- Prescribing Practices and Policy Change
- Chronic Pain Management
- Patient Education
- Community-based prevention
- Law Enforcement – diversion and Tx navigation
- Access to effective OUD Tx
- Recovery Supports
Prescribing and Dispensing Action Items at AHCCCS

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WHY Opioid-Naïve Individuals?

Even low doses for longer than 3 months increases the rate of addiction by 15x!

CDC MMWR, March 2017
Why Target Polypharm?

BMJ, March 2017

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Sign Up and **USE** the CSPMP

- Ensure Patient Safety
- Limit Liability
- Now Easier than Ever with Delegate Option
Why Checking the CSPMP is So Critical

**IMPROVE THE CSPMP**
25% of prescribers that wrote a prescription for opioids checked the Controlled Substances Prescription Monitoring Program (CSPMP).

**DECREASE CSPMP EXEMPTIONS**
41% of overdoses with a prescription for opioids had 10 or more prescribers in the past year.
Identification and Care Coordination

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Facilitate Use of Best Practices

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF CHRONIC NON-TERMINAL PAIN (CNTP)

#1: A comprehensive medical and pain-related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.

#2: A goal-directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks. The patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive-behavioral therapy when these therapies are recommended and available.

#3: The provider should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.

#4: Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short-term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal-directed trial lasting 30–90 days should be the starting point. Continuing opioid treatment after the trial should be a deliberate decision that weighs the risks and benefits of chronic opioid treatment for that

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF ACUTE PAIN

The goal of these guidelines is to balance the appropriate treatment of pain with approaches to more safely prescribe opioids. Thoughtful opioid prescribing for acute and postoperative pain can improve safety, reduce harm, and prevent the unintended or inappropriate long-term use of opioid medications.

Note: These guidelines are not intended to apply to hospice or palliative care patients (as defined by the World Health Organization), patients at end of life, or cancer-related pain.

#1: Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice, and non-opioid pain medications or therapies will not provide adequate pain relief.

#2: When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the expected duration of pain severe enough to justify prescribing opioids for that condition.

#3: When opioid medications are prescribed for acute pain, the patient should be counseled on the following:

The abuse of prescription drugs is a serious social and health problem in the United States. Arizona is no exception to this problem. According to data from Arizona’s Prescription Drug Monitoring Program, there are approximately 10 million Class II-IV prescriptions written...
Pain Management Centers of Excellence

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Increase E-Prescribing

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Project ECHO

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Screening and Assessment

- Substance Use
- Mental Health
Integrated Models: Pain Management, PCPs and Behavioral Health

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Incentivize What We Want to See
Educate Patients
http://rethinkrx.org/

Pain Management
AGuide for Patients

You would do anything for your friends...

but when it comes to medicine, sharing isn’t caring!
Your meds are just for you.

Click here for Pain Management video

Parent talk kit
Tips for Talking and What to Say to Prevent Drug and Alcohol Abuse
Why Harm Reduction is Critical to Solving the Opioid Crisis
Again: The Evolving Landscape

**DEA Issues Alert on Fentanyl-Laced Heroin as Overdose Deaths Surge Nationwide**

BY JOIN TOGETHER STAFF

March 19th, 2015

Opioid death counts among Arizona residents and non-residents in Arizona from 2007 to 2016.

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Why Naloxone?

- It saves lives!
- Creates awareness
- Community distribution
  - Someone understands and cares
  - Access to additional services and resources
  - Pipeline to treatment referral
Statewide Standing Order

• As part of the State of Emergency, Dr. Christ from ADHS signed a statewide standing order for naloxone

• Anyone can go directly to a pharmacy and get naloxone – the SO is the prescription and insurance covers the cost
Co-Prescribing Naloxone

- >90 MEDDs
- Any combination of opioids with benzos, muscle relaxers and sleep medication
- Education and instructions key
By the Numbers

• Community (Jan-Dec 2017)
  o Total kits distributed = 28,476
  o Reported reversals = 2,450

• Pharmacy
  7,261
  Naloxone doses dispensed

• First Responders
  5,150
  Naloxone kits ordered for 52 law enforcement agencies
  3,500
  Naloxone doses administered

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Understand and Educate: Naloxone

Contact Haley Coles
hcoles@spwaz.org
Why MAT?

• Most clinically sound and cost-effective way to treat opioid addiction based on extensive clinical research (NIDA, ASAM and the U.S. Surgeon General).
  o Improves treatment retention
  o Decreases opioid use
  o Reduces risk of mortality

• Number of AHCCCS members with OUD?

• Success rates of other modalities?
Myths of MAT

**MAT JUST TRADES ONE ADDICTION FOR ANOTHER:** MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery. (10)

**MAT IS ONLY FOR THE SHORT TERM:** Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT. (11)

**MY PATIENT’S CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT:** MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient. (2)
More MAT Myths

MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (14)

PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT’S RECOVERY PROCESS: MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.

THERE ISN’T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE: MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment. (8)
Stigma and Access to Healthcare

• How we talk about things impacts the way we think about things and vice versa

• Improved understanding that opioid use disorder is a complex interplay of biology and environment will decrease stigma and increase access to healthcare
Opioid STR Grant

- Opioid Monitoring Initiative
- MAT education and outreach
- Increase peer support services
- MAT COE for 24/7 access to care
- Hospital and ED discharge projects
- Diversion and incarceration alternatives
- Early MAT ID for re-entry population
- Expand residential/recovery home services

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Going to the mat for MAT

- Aligning Title XIX policies with STR activities
- Opening MAT for Buprenorphine and Vivitrol on the acute side 01/01/2018
- Cap rate adjustments
- Opening codes
- Cross-sector partnerships
- Cohort study on efficacy of Tx modalities

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Pregnant, Parenting and NAS Members

• 3 key access points
  ▪ Prevention – Primary and Secondary
  ▪ Delivery
  ▪ Post-Partum

• Learning Collaborative

• Policy Change on CSPMP checks

• Pilot model system

• Increasing capacity – providers and options

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So, Now What?
Use What Works!
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The Voice of the Community

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Understand and Educate: MAT
Navigate People to Help

SAMHSA’s MAT APP

Reaching across Arizona to provide comprehensive quality health care for those in need
Understand and Educate: Naloxone

Contact Haley Coles
hcoles@spwaz.org
Peer Support in all High Impact Points

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Stop Diversion

http://azdhs.gov/gis/rx-drop-off-locations

You would do anything for your friends...

but when it comes to medicine, sharing isn’t caring!
Your meds are just for you.

Prescription Drug & Heroin Dealing is a CRIME
Text Anonymously to 847411 (tip411) use Keyword TIPDEA

report
FRAUD, WASTE, or ABUSE

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Educate. Educate. Educate!!!

http://rethinkRX.org

Click here for Pain Management video

Parent talk kit
Tips for Talking and What to Say to Prevent Drug and Alcohol Abuse
Take Home Message

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Thank You

Shana.Malone@azahcccs.gov