SUBSTANCE ABUSE WORKING GROUP

NOTICE OF PUBLIC MEETING

DATE: **Wednesday, October 5, 2016**

TIME: **10:00 A.M.**

LOCATIONS: Office of the Attorney General
Mock Courtroom
100 N. Carson Street
Carson City, Nevada 89701

VIDEOCONFERENCE TO:

Office of the Attorney General
Conference Room #4500
555 East Washington Avenue
Las Vegas, Nevada 89101

AGENDA

Please note: The Substance Abuse Working Group may 1) take agenda items out of order; 2) combine two or more items for consideration; or 3) remove an item from the agenda or delay discussion related to an item at any time. Reasonable efforts will be made to assist and accommodate individuals with disabilities who wish to attend the meeting. Please contact Michele Smaltz at (775) 684-1195 (msmaltz@ag.nv.gov), in advance, so that arrangements can be made.

1. Call to order and roll call of working group members.

2. Public comment. (Discussion Only) Action may not be taken on any matter brought up under public comment until scheduled on an agenda for action at a later meeting.

3. Discussion and possible action on approval of June 8, 2016, meeting minutes. **Attachment A.**

4. Discussion on High Intensity Drug Trafficking Area (HIDTA) Report from Colorado. *See* "*The Legalization of Marijuana in Colorado*." Volume 4. On-Line link: http://www.rmhidta.org/html/2016%20FINAL%20Legalization%20of%20Marijuana%20in%20Colorado%20The%20Impact.pdf. **Mark Jackson, Douglas County District Attorney**.

5. Discussion and update on possible substance abuse awareness campaigns from **Dr. Stephanie Woodward, Dept. of Health and Human Services**.

6. Discussion on AB 453 (2015 Session) Dextramethorphan; Preventing Teen Cough Medicine Abuse. **Attachment B. Carlos Gutierrez, Consumer Healthcare Products Association**.

7. Report on recreational marijuana legalization and its impact on the state. **Attachment C. Honorable Pat Hickey, Nevadans for Responsible Drug Policy**.

8. Report regarding findings from the Nevada Dispensary Association delegation trip to Colorado. **David Marlon, Solutions Recovery.**

9. Discussion on the National Safety Council's "*Prescription Nation 2016: Addressing America's Drug Epidemic."* **Attachment D. Linda Lang.**

10. Discussion of legislative proposals by the working group. **Wes Duncan, First Assistant Attorney General**.

11. Discussion and possible action on incinerators and the formation of a working group studying incinerators in the state of Nevada. **Wes Duncan, First Assistant Attorney General**.

12. Public comment. (Discussion Only) Action may not be taken on any matter brought up under public comment until scheduled on an agenda for action at a later meeting.

13. Adjournment.

Supporting material for this meeting may be requested from Michele Smaltz at (775) 684.1195 (msmaltz@ag.nv.gov), and is available at the Office of the Attorney General, 100 N. Carson Street, Carson City, Nevada 89701.

In accordance with NRS 241.020, this public notice and agenda was posted on or before September 27, 2016 on the Office of the Attorney Website, http://ag.nv.gov/, the State of Nevada's Public Notice Website, https://notice.nv.gov, and in the following locations:

Office of the Attorney General 100 N. Carson Street Carson City, Nevada 89701-4717 Office of the Attorney General 555 E. Washington Avenue, #3900 Las Vegas, Nevada 89101 Nevada State Capitol 101 N. Carson Street Carson City, Nevada 89701 Legislative Counsel Bureau Nevada Legislature Building 401 S. Carson Street Carson City, Nevada 89701	Office of the Attorney General 5420 Kietzke Lane, #202 Reno, Nevada 89511 Nevada State Library 100 N. Carson Street Carson City, Nevada 89701 Grant Sawyer Office Building 555 E. Washington Avenue Las Vegas, Nevada 89101

Attachment A

To

Agenda

Substance Abuse Working Group

October 5, 2016

Draft Meeting Minutes of June 8, 2016 Meeting

(Agenda Item 3)

STATE OF NEVADA SUBSTANCE ABUSE WORKING GROUP

MINUTES OF MEETING

June 8, 2016

Location of Meeting:

Office of the Attorney General
Mock Courtroom
100 N. Carson Street
Carson City, NV 89701

Videoconference To:

Office of the Attorney General
Grant Sawyer Building
555 E. Washington Ave., Room 4500
Las Vegas, NV 89101

1. Call to order and roll call of members.

Attorney General (AG) Laxalt called meeting to order at 10 a.m. Board Counsel Raelene Palmer, DAG called the roll.

Members Present:
Adam P. Laxalt, Attorney General – Chair
Wesley Duncan, First Assistant Attorney General – Vice Chair
Mark Jackson, Douglas Co. District Attorney
David Marlon, President Solutions Recovery, Inc.
Linda Lang, Ex. Director Nevada Statewide Coalition Partnership
Richard Whitley, Director Dept. of Health & Human Services
Chuck Callaway, LVMPD Director of Intergovernmental Services
Hon. Pat Hickey, Member Nevada State Board of Education
Dr. Miriam Adelson, Adelson Clinic

Members Absent
Dr. Larry Pinson, Executive Secretary Nevada State Board of Pharmacy

Others Present
Michele Smaltz, Executive Assistant to AG Laxalt
Barbara Cozens, Legal Secretary II, Office of the Attorney General
Stacy Ward
Liz MacMenamin, V.P. Retail Association of Nevada
Elyse Monroy
Jeanette Belk
Fred Olmstead

Dave Wubsy
Stephanie Woodard
Shelly Capurro
Chris Ferlani
Liz Greb
Monty Williams
Michael Hillerby
Nita Schmidt
Kendara Shultz
Fred Meyer
Perry Olshan
Brian Evans
Margaret Pickard
Kimberly Arguello
Jamie Ross
Mary Cannizzaro
Dan Neill
Trey Delap
Lesley Dickson, MD.
Loretta Moses
Susan Fisher[1]

2. Public Comments

None

3. Discussion and possible action on approval of March 29, 2016, meeting minutes.

It was moved by Wes Duncan to approve the minutes as written. The motion was seconded by Dr. Adelson. Motion approved. Mark Jackson abstained from voting. Minutes approved as written.

4. Discussion, nomination, and election of Working Group vice president and secretary. (For possible action)

Wes Duncan was nominated as Vice Chair by AG Laxalt. David Marlon volunteered to be appointed Secretary.

It was moved by Chuck Callaway and seconded by Dr. Adelson to appoint Wes Duncan as Vice Chair and David Marlon as Secretary. Motion approved.

[1] Additional members of the public were in attendance; however, they did not sign in.

5. Report on Clark County drug courts (Ms. Margaret Pickard, Esq., Specialty Court Manager, 8th Judicial District Court – for discussion only).

Ms. Pickard's presentation focused on the Clark County Specialty Courts and various programs associated with those Courts (handout).

AG Laxalt requested further information from Ms. Pickard regarding how the AG's office can help with any of the specialty court/programs. Ms. Pickard indicated that the AG's office can help in three ways: (1) Mentoring Programs; (2) Community Support (funding); and (3) Researchers.

Mark Jackson had further comments regarding the data that was presented on the true success rate for drug court. More specifically, he is interested in Nevada statistics, not national statistics. Mr. Jackson suggested some further tracking take place to obtain better statistics regarding the actual success rate of the drug court system/program. Ms. Pickard provided further explanation on her presentation with regard to Mr. Jackson's comments and what the drug courts are doing to track Nevada's data and the success rate.

Dr. Adelson requested information from Ms. Pickard regarding the number of individuals who started a treatment program and successfully finished. Ms. Pickard provided information and data about the felony DUI program. Dr. Adelson and Ms. Pickard further discussed treatment programs and obtaining additional data concerning Nevada statistics.

David Marlon requested information from the doctor [name of doctor unknown] who was attending with Ms. Pickard about the use of the Naltrexone Implant and/or other FDA approved implant devices for addiction treatment. The doctor could not provide any information regarding implantable devices at this time.

6. Report on how Clark County jails issue Methadone to inmates (Chuck Callaway, Police Director, LVMPD Office of Intergovernmental Services – for discussion only).

Chuck Callaway provided follow up information regarding a discussion at the last meeting (March 29, 2016) concerning Methadone use in the Clark County Detention Center (CCDC) and whether Methadone is given and if so, how.

Captain Fred Meyer, CCDC, provided further information concerning the CCDC and operation of the detention center. In 2015, 56,611 individuals were processed through the CCDC. Captain Meyer provided information about the dissemination of Methadone to individuals while in the CCDC. For example, if a pregnant female comes into the detention center and is using Methadone, the detention center will provide that individual with Methadone in order to avoid detox of the fetus. This is an accreditation standard. If individuals come into the facility and they are actively compliant within a

treatment program, the detention center will contact the specific facility so Methadone can be brought into the facility for these individuals.

Additional comments and discussion was had regarding what percentages of individuals come into the CCDC who are using Methadone. Kendra Shultz, Health Services Administrator, provided information concerning what types of substances were being tracked based on health records that were contained in the CCDC data base.

7. Report on "Take Back Day" (Liz MacMenamin, Retail Association of Nevada – for discussion only).

Liz MacMenamin's presentation centered on Northern Nevada's Take Back Day and the participation of the Retail Association of Nevada (RAN).

Ms. MacMenamin is a volunteer with The Take Back Program. She provided information regarding expanding Nevada's Take Back Program to include Southern Nevada. She recently met with Chuck Callaway and LV Metro to establish the program in Southern Nevada. She is very excited that Metro is coming on board to implement this program and will work with the DEA as well. RAN will be setting up dates to strategize set-up of the program in Southern Nevada. RAN has been in contact with several retail establishments to work as drop off locations.

It is noted that AG Laxalt discussed Agenda Item No. 9 out of order.

9. Report on RX Abuse (Stacy Ward, Drug Abuse Coordinator, Reno Police Dept. – for discussion only) - [taken out of order].

The first prescription drug Take Back Day for Washoe County was held in October 2009. Over 39,000 pills were collected at the first event. Collection sites are set up at various retail establishments. Since the first take back day, 15 take back events have occurred, in which 1.9 million pills have been collected. During the Northern Nevada take back day, pills are categorized into the various types. This is a unique component to the Northern Nevada collection, as the DEA deals in the weight of the pills. The Northern Nevada team wanted to determine what types of drugs were collected. 14% of the total pills collected are categorized as drugs of abuse.

After collection of the drugs, the DEA helps incinerate the pills. Prior to the DEA's assistance with incineration, pills were incinerated just as evidentiary pills. At this time, the DEA bears the cost of the incineration of pills collected during take back days.

On April 30, 2016, 242,000 pills were collected in Northern Nevada. The amount is still trending up for pill collection. The need for this event is still great.

8. Report on "Take Back Day (Mike Lewis and, DEA, Los Angeles Field Division and Daniel Neill, DEA, Las Vegas District Office – for discussion only).

Daniel Neill presented on the 11th National Take Back Day. Nationwide, a total of 4,000 law enforcement participated. Nine agencies participated in Nevada. There were over 5,000 collection sites nationwide, with 26 sites in Nevada. A total weight of 447 tons of Rx drugs were collected nationwide, with 3,776 lbs. collected in Nevada. Nevada has Take Back Days every day, so Nevada numbers may be lower than the national average.

Take Back Day is also a tool that is used to get the word out to the public about Rx drug abuse. More media play is given to get the public involved to get drugs out of their medicine cabinets.

Discussion was made about the incineration of the pills. Nevada does not have an incinerator. Incineration is contracted out to a company in Utah. AG Laxalt suggested the group look into getting a local incinerator; however, the cost may be prohibitive at this time.

10. Presentation on the Division of Public and Behavioral Health activities in Nevada (including treatment) (Julia Peek, Deputy Administrator, Nevada Division of Public and Behavioral Health and Stephanie Woodard, Psy.D., Licensed Clinical Psychologist, Nevada Division of Public and Behavioral Health Bureau of Behavioral Health, Prevention, and Wellness) – for discussion only).

A very detailed presentation was given from Julia Peek and Stephanie Woodard regarding opioid prevention and treatment efforts in Nevada. Ms. Peek provided vast amounts of data concerning the health epidemic that surrounds Rx drug abuse. (See handout.) Ms. Peek spoke to Nevada's average as to the amount of prescriptions written per capita – 94 out of 100. She provided additional information regarding high school students' use of Rx drugs – 1 in 5 self-reported they had used Rx drugs that were not written specifically for them.

Data was also presented regarding hospital related opiate dependence visits, as well as opiate related deaths in Nevada. Further discussion was made about tracking whether Naloxone was used during hospital visits and/or used by EMT's as support in Rx drug related visits/calls.

Ms. Peek informed the group that recently Nevada received a large grant from the CDC relating to prevention/intervention efforts. 1 million dollars will be received through 2019, with the possibility of an additional $500,000/yr. This grant will help gather data from various systems throughout Nevada agencies to help with prevention/intervention. HHS is looking to develop a program that will gather information across systems for individual persons and provide services tailored to that individual.

Additional questions arose as to providing Naloxone to the public, family members, and possibly EMT's to assist with individuals who have an opioid dependence. Additionally, it was asked if any programs are in place for this or any future programs anticipated. Ms. Peek advised HHS is working on getting a program started. They are looking at opportunities to assist with education and access to Naloxone. Dr. Adelson questioned whether Methadone treatment was being looked at as a treatment option. Dr. Woodard clarified that all types of FDA approved treatment are being looked at as possible options.

Dr. Woodard presented information regarding prevention, intervention, treatment, and recovery. Additional data was provided regarding addiction. Dr. Woodard covered the definition and progression of addiction as well as access to addiction treatment. 10,600 discharges from state funded treatment facilities in 2012, and in 2015 that number decreased to 4,700 discharges. HHS is looking to expand opportunities for screening, interventions, and further expansion of medication assisted treatment.

Additional discussion occurred regarding gathering more robust data concerning treatment.

11. Report on Prescription Drug Abuse efforts in Nevada (Linda Lang, NV Statewide Coalition Partnership – for discussion only).

Linda Lang reported on what the coalition efforts are throughout Nevada regarding drug abuse education in the Nevada communities, provider education, and criminal justice intervention.

It is noted that AG Laxalt discussed Agenda Item No. 13 out of order.

13. Report on outreach to other Attorneys General Offices (Wes Duncan, Assistant Attorney General, Attorney General's Office – for discussion only). [taken out of order]

Wes Duncan presented information regarding other state AG offices' approach to combatting opioid abuse, specifically information from Indiana, Massachusetts, and Montana.

AG Laxalt concluded the presentation discussing what legislation West Virginia and Wisconsin are proposing to combat Rx drug use/abuse.

12. Establish goals for the Working Group (for discussion and possible action).

AG Laxalt provided an update about working with the White House head of substance abuse. His office is still working on getting in touch with them; however, the White House is continuing to work with state AG offices on awareness campaigns and PSA's. AG Laxalt will continue efforts to pursue working with the White House on this front.

AG Laxalt requested group discussion on what the group would like to focus on as a whole.

Hon. Pat Hickey initiated discussion concerning IP1, now Question 2 – legalization/commercialization of Marijuana – and the implications it may have on law enforcement and/or government. Hon. Hickey proposed that further discussion/presentations be made at the next meeting.

Dave Marlon proposed giving additional information regarding a team that is going to Colorado to discuss prevention, education, awareness, treatment, and how the legalization of marijuana has affected Colorado. Dave Marlon will be attending with this team, and volunteered to give a presentation of the findings from this meeting.

Margaret Pickard initiated discussion about working with the AG's office to acquire a researcher/research to collect data from one source instead of gathering it from various areas. UCLA Criminal Justice could be a possible connection for a researcher/research. AG Laxalt suggested that Ms. Pickard work with the AG's office and then present something to the group as a possible project.

Mark Jackson requested the current HIDTA (High Intensity Drug Trafficking Areas) report (Report #3 – Nov 2015) be made available to members of the group so they can be educated and possibly provide questions for the individuals of the group that will be travelling to Colorado.

AG Laxalt will provide additional information/presentation at the October meeting. AG Laxalt further proposed if Question 2 is passed, that the group head up a project to get ahead of the repercussions of the legalization of marijuana and the issues that come along with the legalization of marijuana.

Wes Duncan suggested the group put forth some effort to establish best practices for prescribers along the lines of what West Virginia has put forth. Richard Whitley offered the assistance from the new Nevada HHS Health Officer, Dr. John Dimuro, to provide assistance with setting up this effort. It was moved by Wes Duncan, seconded by Dave Marlon to have the group focus on setting up best practices regarding Rx drug use/abuse. Motion approved.

AG Laxalt opened additional discussion regarding an awareness campaign. Dave Marlon provided comments about a PSA video contest the prior group had put together. Richard Whitely provided information about PSAs and what tends to work. For example, getting announcements out to individuals about where to go to get treatment and/or service is beneficial. The group should do research regarding what the target market is and where the issues are that could reach the target market. Need to target individuals that want to change and make the information available to those individuals. Mr. Whitely opined that being ready to respond is helpful. Mr. Whitley also mentioned the Wisconsin model of broadcasting to health providers is very useful. Nevada has the same type of system which could be used to broadcast to physicians. A system could

be set up to get information out about issues in the community and then broadcast to heath care providers. Additionally, a program could put together information regarding what treatment is available and what insurance (i.e. Medicaid) will cover, i.e. treatment, etc.

AG Laxalt suggested that the group move forward with an awareness campaign focusing on treatment and the stigma of treatment. AG Laxalt requested input from the group on who could help gather the information for this campaign. Richard Whitley offered Dr. Woodard and additional staff from their office to be a part of the team to research what types of campaigns to run.

AG Laxalt introduced discussion regarding sponsoring a bill regarding law enforcement notifications to doctors of stolen drugs/overdoses. Chuck Callaway provided discussion regarding mandatory reporting and issues regarding this complicated issue. AG Laxalt suggested that his office would put together a bill similar to the Wisconsin HOPE legislation and present it to the group at the next meeting. If the group would like to sponsor the proposed bill, they could vote on it then.

Dave Marlon provided information regarding a meeting he attended from the National Association of Recovery Schools. A committee has been formed to look at creating a recovery high school in Southern Nevada for high school students returning after having received treatment. Dave Marlon will update the group regarding this committee at the next meeting.

14. Public comment. (Discussion Only) Action may not be taken on any matter brought up under public comment until scheduled on an agenda for action at a later meeting.

No public comment from Las Vegas or Carson City.

15. Adjournment.

Motion to adjourn by Wes Duncan, seconded by Dave Marlon. Motion approved. Meeting adjourned at 12:13 p.m.

Attachment B

To

Agenda

Substance Abuse Working Group

October 5, 2016

Assembly Bill No. 453

(Agenda Item 6)

ASSEMBLY BILL NO. 453–COMMITTEE ON COMMERCE AND LABOR

MARCH 23, 2015

Referred to Committee on Commerce and Labor

SUMMARY—Provides for the regulation of the sale of dextromethorphan. (BDR 40-392)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

EXPLANATION – Matter in *bolded italics* is new; matter between brackets [omitted material] is material to be omitted.

AN ACT relating to drugs; prohibiting a person from selling, distributing, bartering, dispensing or offering to sell a material, compound, mixture or preparation containing dextromethorphan to a minor under certain circumstances; prohibiting a minor from purchasing, receiving or otherwise acquiring any material, compound, mixture or preparation containing dextromethorphan under certain circumstances; establishing a civil penalty for certain violations; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the sale of any drug, medicine, remedy, poison or chemical that is not otherwise restricted by grocers and dealers without restriction when prepared and sold in original and unbroken packages and, if poisonous, labeled and sold in accordance with the requirements of federal law. (NRS 639.270) This bill prohibits a person from selling, distributing, bartering, dispensing or offering to sell any material, compound, mixture or preparation containing dextromethorphan to a person under 18 years of age without a prescription. This bill also prohibits any person under 18 years of age from purchasing, receiving or otherwise acquiring any material, compound, mixture or preparation containing dextromethorphan. This bill also provides that a person or owner of a retail establishment who takes certain steps to prevent the sale of a material, compound, mixture or preparation containing dextromethorphan to a person under 18 years of age shall be deemed to be in compliance with these provisions. Finally, this bill requires any person who sells, distributes, barters, dispenses or offers to sell a material, compound, mixture or preparation containing

dextromethorphan in violation of these provisions to: (1) for a first offense, receive a warning; and (2) for a second or subsequent offense, be assessed a civil penalty.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 453 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as provided in subsection 2:

(a) A person shall not sell, distribute, barter, dispense or offer to sell any material, compound, mixture or preparation containing dextromethorphan to a minor under the age of 18 years.

(b) A minor shall not knowingly purchase, receive or otherwise acquire any material, compound, mixture or preparation containing dextromethorphan.

2. If a minor has a valid prescription for a material, compound, mixture or preparation containing dextromethorphan:

(a) A person may sell, distribute, barter, dispense or offer to sell the material, compound, mixture or preparation containing dextromethorphan for which the minor has a valid prescription; and

(b) The minor may purchase, receive or otherwise acquire the material, compound, mixture or preparation containing dextromethorphan for which he or she has a valid prescription.

3. A person shall be deemed to be in compliance with the provisions of paragraph (a) of subsection 1 if:

(a) The person reasonably assumes, based on the appearance of a person to whom a material, compound, mixture or preparation containing dextromethorphan is sold, distributed, bartered, dispensed or offered for sale, that the person is 25 years of age or older.

(b) Before the person sells, distributes, barters, dispenses or offers to sell any material, compound, mixture or preparation containing dextromethorphan to another person, the person:

(1) Demands that the other person present a valid driver's license or other written or documentary evidence which indicates that the other person is 18 years of age or older;

(2) Is presented a valid driver's license or other written or documentary evidence which indicates that the other person is 18 years of age or older; and

(3) Reasonably relies upon the driver's license or other written or documentary evidence presented by the other person.

4. With respect to any sale made by an employee of a retail establishment, the owner of the retail establishment shall be

deemed to be in compliance with the provisions of paragraph (a) of subsection 1 if the owner:

(a) Had no actual knowledge of the sale; and

(b) Establishes and carries out a continuing program of training for employees which is reasonably designed to prevent violations of paragraph (a) of subsection 1.

5. A person who violates paragraph (a) of subsection 1 shall:

(a) For the first violation, receive a warning in writing; and

(b) For each subsequent violation, be assessed a civil penalty of $50. This penalty must be recovered in a civil action, brought in the name of the State of Nevada by the Attorney General or by any district attorney in a court of competent jurisdiction.

6. As used in this section, "minor" means a person under the age of 18 years.

Sec. 2. NRS 639.270 is hereby amended to read as follows:

639.270 Any drug, medicine, remedy, poison or chemical, the sale of which is not otherwise restricted as provided by this chapter ~~[,]~~ ***or section 1 of this act,*** and any patent or proprietary medicine, may be sold by grocers and dealers generally without restriction when prepared and sold in original and unbroken packages and, if poisonous, labeled with the official poison labels and sold in accordance with the requirements of the Federal Food, Drug and Cosmetic Act.

H

Attachment C

To

Agenda

Substance Abuse Working Group

October 5, 2016

Issues Nevada Policymakers Should Consider

(Agenda Item 7)

Issues Nevada policymakers should consider before legalizing recreational marijuana (Question 2)

1. "I tell others governors that we are not making any extra revenue beyond regulating that industry and then finding money to educate kids on the dangers of the new strains [higher THC potency] of pot...Why not wait and see how things work out in Colorado?"

   Gov. Hickenlooper, CNN

2. "Criminals are still selling on the black market...we have plenty of cartel activity in Colorado [and] plenty of illegal activity that has not increased at all."

   CO Attorney General Cynthia Hoffman

3. "I tell this to every state official who asks about how difficult it will be to set up a system to regulate and tax marijuana in their state...It will be ***more difficult*** than you think, it will take ***more time*** than you think, and it will definitely be ***more costly*** than yo think."

   CO Director of Taxation

4. Colorado took **12 years** to go from legalizing medical marijuana to recreational. In that period they set up the infrastructure to begin regulating and implementing a process for state government in CO to oversee the marijuana industry. In Nevada--Question 2 would require the same process to take place in **just two year's** time. With all the problems that still exist with regulating and implementing *medical marijuana* legislation--is Nevada ready to go headlong into legalizing "recreational?"

5. Under provisions of an initiative petition (**Question 2**), if passed by voters this November--Nevada lawmakers cannot "substantially change" the 13-page initiative for three years, under Nevada law. In Colorado, this resulted in the following legislative session--71 bills being introduced to attempt to "clean up" the voter-passed amendment. Tick Segerblom has already promised the 2017 Session will be the "marijuana session."

6. Under **Question 2**--the Dept. of Taxation will be required to create a regulatory bureaucracy unparalleled in State of Nevada governance.

Attachment D

To

Agenda

Substance Abuse Working Group

October 5, 2016

Prescription Nation 2016

(Agenda Item 9)

PRESCRIPTION NATION 2016

ADDRESSING AMERICA'S **DRUG EPIDEMIC**

making our world safer

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This is the most fatal drug crisis on record in United States history, and too many families and communities are left to suffer in its path. These highly addictive medicines have been incorrectly marketed as the most effective method for treating pain and, subsequently, liberally prescribed. Prescription opioids also serve as gateway drugs to heroin, which has a nearly identical chemical makeup and is cheaper and sometimes easier to obtain.

The facts are clear:

- ✓ More than 259 million opioid prescriptions were written in 2012
- ✓ 1.9 million Americans are addicted to opioid painkillers
- ✓ The U.S. makes up 4.6 percent of the world's populations but consumes 81 percent of the world supply of oxycodone
- ✓ 4.3 million adolescents and adults reported non-medical use of prescription opioids in 2014
- ✓ 4 out of 5 heroin users started on prescription opioids

The National Safety Council is committed to ending unintentional injuries and death in our lifetime and has been fighting this drug epidemic for years. State governments also play a significant role in this fight, with state legislators, Governors, and public health officials dictating the strategy.

This report identifies four key actions states can take that could have immediate and sustained impact:

- ✓ Require and expand prescriber education
- ✓ Develop and implement prescriber guidelines
- ✓ Increase access to naloxone, an overdose antidote
- ✓ Expand access to treatment

Prescription opioid overdoses kill 52 people every day.

In 2014, the most recent annual statistics available, 18,893 people died as a result of a prescription opioid overdose.

4 Key Actions:

- ➤ Require and expand prescriber education
- ➤ Develop and implement prescriber guidelines
- ➤ Increase access to naloxone, an overdose antidote
- ➤ Expand access to treatment

Some states have made significant progress. Others have much more to do while each day people suffer from addiction and die from this epidemic. States were given a rating of "Making Progress", "Lagging Behind" or "Failing" based on careful evaluation of efforts in six key indicators:

6 KEY INDICATORS

1. Mandatory Prescriber Education

Mandatory prescriber education helps providers make well-informed decisions on medical treatment based on best practice and the latest research, carefully weighing the benefits and risks of opioids and their alternatives. The Centers for Disease Control and Prevention (CDC) has shown that the increase in opioid prescribing has resulted in increased admissions for treatment of opioid use disorder and overdose deaths, despite a lack of a corresponding decrease in reported pain. Additionally, physicians report receiving limited education on pain treatment.

2. Opioid Prescribing Guidelines

Sound, evidence-based prescribing guidelines encourage physicians to incorporate alternative, non-opioid treatments for pain and provide the lowest effective doses and the fewest number of pills when prescribing dangerous opioid medications. The recently released CDC guideline on opioid treatment for chronic pain should be adopted as the state prescribing guideline, but states should also consider the risks for acute pain patients. If followed, NSC believes guidelines that address acute and chronic pain could reduce the number of opioid overdose deaths in the United States.

3. Eliminating Pill Mills

"Pill mills" are a doctor's office, clinic or health care facility that routinely prescribes controlled substances outside the scope of standard medical practice and often in violation of state laws and greatly increases the risk of abuse and overdose. States should pass legislation that regulates pain clinics and pain management services, requiring such actions as following prescribing guidelines, defining ownership, restricting dispensing of controlled substances and requiring use of state prescription drug monitoring programs.

6 KEY INDICATORS

4. Prescription Drug Monitoring Programs (PDMPs)

PDMPs play an important role in any effective approach to the prescription opioid epidemic. Doctor shopping, or going to multiple providers for prescriptions, and providers who prescribe controlled substances outside the scope of standard medical practice will continue to fuel the opioid epidemic. PDMPs directly address these issues. Nearly every state has an operating PDMP, and states should take steps to simplify registration and utilization, improve reporting response times and upgrade technology to allow data integration into clinical workflows.

5. Increased Access to Naloxone

Naloxone is an opioid antagonist that saves lives by reversing an opioid overdose, with no negative side effects. Naloxone is not a controlled substance and has no abuse potential. States should ensure that naloxone is widely available without a prescription under standing orders and covered by insurance plans, both public and private.

6. Availability of Opioid Use Disorder (OUD) Treatment

Access to treatment is key to helping those with a substance use disorder. In order to increase this access, states must expand capacity for treatment, including medication-assisted treatments and require both public and private health insurers to cover medication-assisted treatment and remove caps on duration of treatment.

States were evaluated on each of these indicators which are critical to effectively and comprehensively fighting this growing epidemic.

This report provides a roadmap for strengthening laws and regulations. NSC is prepared to assist states with implementation of these evidence-based strategies which can save thousands of lives every year.

A ROADMAP FOR **STRENGTHENING LAWS & REGULATIONS**

47 STATES NEED TO IMPROVE!

28 STATES are "FAILING"

4 STATES are "MAKING PROGRESS"

FAILING

MEET ZERO INDICATORS

THREE HAVE MET ZERO INDICATORS.

Michigan
Missouri
Nebraska

3 STATES

MEETS 1 INDICATOR

Alaska
District of Columbia
Hawaii
Idaho
Kansas
Montana
Wyoming

MEETS 2 INDICATORS

Arizona
Connecticut
Florida
Georgia
Illinois
Iowa
Maine
Maryland
Mississippi
Nevada
New Jersey
New York
North Dakota
Oklahoma
Oregon
South Carolina
South Dakota
Virginia

LAGGING BEHIND

MEETS 3 INDICATORS

Arkansas
Colorado
Delaware
Louisiana
Massachusetts
Minnesota
Pennsylvania
Texas
Utah
Washington

MEETS 4 INDICATORS

Alabama
California
Indiana
New Hampshire
North Carolina
Ohio
Rhode Island
West Virginia
Wisconsin

MAKING PROGRESS

MEETS 5 INDICATORS

Kentucky
New Mexico
Tennessee
Vermont

MEETS 6 INDICATORS

ZERO HAVE MET ALL 6 INDICATORS.

NO STATES

DEADLIEST DRUG EPIDEMIC ON RECORD IN OUR NATION'S HISTORY

The United States is confronting the deadliest drug crisis on record. *(CENTERS FOR DISEASE CONTROL & PREVENTION, 2016)* Drug overdoses, mostly caused by opioids, end far too many lives too soon. More than 47,055 families lost loved ones in 2014 to a drug overdose. Opioid pain medications like Vicodin (hydrocodone), OxyContin (oxycodone) or Fentanyl accounted for 18,893 deaths. *(CDC NATIONAL CENTER FOR HEALTH STATISTICS, 2015)*

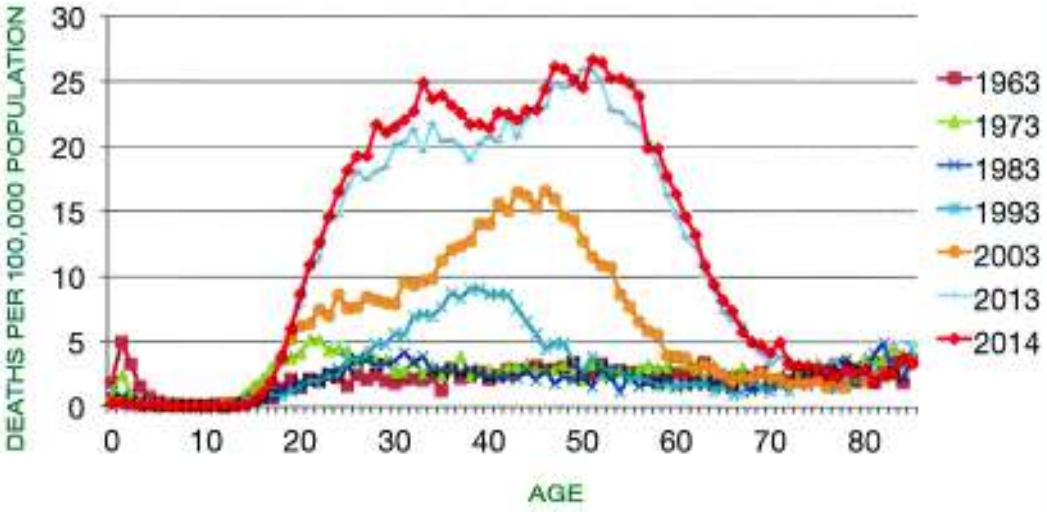
According to the CDC, the increase in opioid-related fatalities and treatment admissions parallels the increase in sales of opioid pain relievers. *(PAULOZZI, JONES, MACK, & RUDD, 2011)* Opioid prescribing remains high, with more than 259 million prescriptions written in 2012. *(PAULOZZI, MACK, & HOCKENBERRY, VITAL SIGNS: VARIATION AMONG STATES IN PRESCRIBING OF OPIOID PAIN RELIEVERS AND BENZODIAZEPINES—UNITED STATES, 2012, 2014)*

Opioid pain medications, if taken too long or at a high daily dose, can have deadly and life-changing consequences even when used under the care of a medical professional.

The drug problems of past decades pale when compared to the current opioid epidemic which has killed 165,000 Americans from 2000 to 2014.

Poisoning Death Rates by Age

This graphic shows the rate of poisoning deaths has changed in the past fifty years. In 1963, poisoning deaths peaked in early childhood causing 5 deaths per every 100,000 people.



Today, there has been a **550 percent increase** in the age-adjusted death rate of Americans killed by poisoning. These deaths, primarily from an overdose of an opioid pain medication or heroin, peak around age 50 with a secondary peak around age 30. Especially troubling is that these deaths span from ages 20-70 as it shows an increase in the rate of poisoning death for nearly all working adults.

FACT

From 1963 to 2014 the age adjusted **death rate for poisoning increased 550%** from 2.0 to 13.0.

AMERICANS ARE AT GREATER RISK FOR ADDICTION THAN THEY REALIZE

Opioid pain medications have a number of side effects and the risk of addiction may be the most serious. However, it is clear most people do not understand this risk. A 2015 National Safety Council public opinion poll found nearly 90 percent of opioid users were not worried about addiction, even though 60 percent of respondents reported having an addiction risk factor such as personal or family history of alcoholism, depression, use of psychiatric medications, or a history of physical, mental or sexual abuse. More education is needed about who is at risk for addiction from opioid pain medication use.

More than 1.9 million Americans are addicted to opioid painkillers. *(SAMHSA, 2015)* For some people, their first prescription of an opioid pain medication began an addiction that was never intended or expected. More than 4.3 million people have misused[1] an opioid painkiller in the past month. *(SAMHSA, 2015)* Seventy percent of people gain access to opioids from people they know. *(SAMHSA, 2015)* Tragically, about four percent of those who misuse opioid painkillers will transition to heroin. *(JONES, 2013)*

STARTED MISUSING
an opioid pain medication for the first time
TODAY!

Risk Factors for Opioid Addiction

- Having depression, anxiety or other mental health illness
- A personal and/or family history of alcohol or substance abuse
- A history of physical, mental or sexual abuse
- Long term use of opioid pain medications

[1] *"Misuse" includes use without a prescription or taking the drug for the feeling or "high" it causes. Examples of misuse include using another person's prescription or using "saved" medications from a previous medical condition or surgery.*

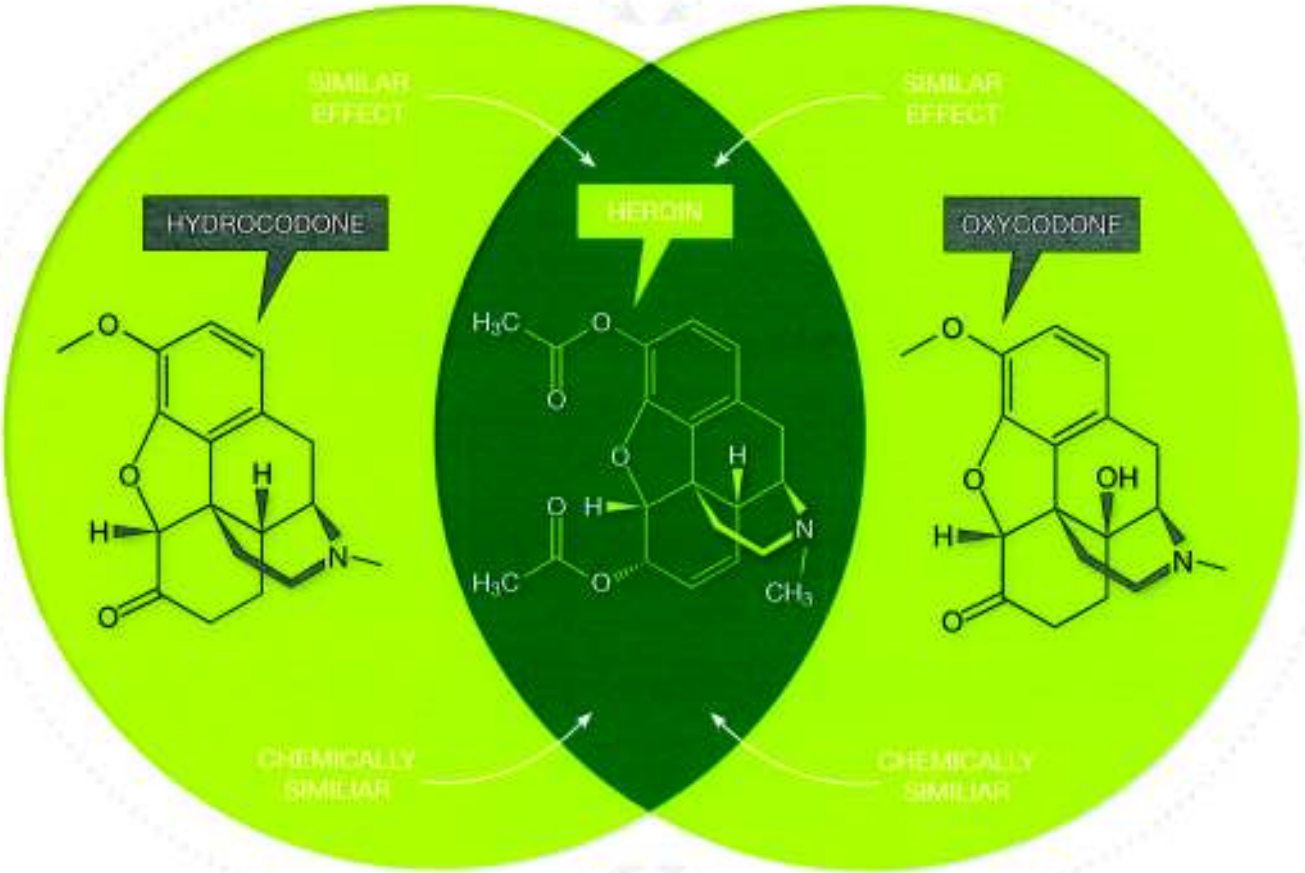
THE TRANSITION TO HEROIN

Opioid pain medications, like hydrocodone and oxycodone, are chemically similar to heroin and have a similar effect on our minds and bodies.

As opioid pain medication use dramatically increased, the United States also experienced an increase in heroin use and deaths. More than 900,000 people reported heroin use in 2014, a 153 percent increase since 2007. *(COMPTON, JONES, & BALDWIN, 2016)* Tragically, heroin deaths tripled in the 5 year period from 2010 to 2014, increasing from 3,300 to more than 10,000 deaths. *(CENTERS FOR DISEASE CONTROL & PREVENTION, 2016)*

These facts clearly show heroin use patterns have changed. In the 1960's, 80 percent of heroin users reported heroin was the first opioid they used. Today, of the 600 people who begin using heroin, *(SAMHSA, 2015)* four out of five report that they started with opioid pain relievers. *(JONES, HEROIN USE AND HEROIN USE RISK BEHAVIORS AMONG NONMEDICAL USERS OF PRESCRIPTION OPIOID PAIN RELIEVERS – UNITED STATES, 2002-2004 AND 2008-2010, 2013)*

Opioid Pain Medications and Heroin
are Chemically Similar and just as Addictive



In fact, nonmedical users of opioid pain medications were 19 times more likely to use heroin than people reporting no misuse of opioids. *(MUHURI, GFROERER, & DAVIES, 2013)*

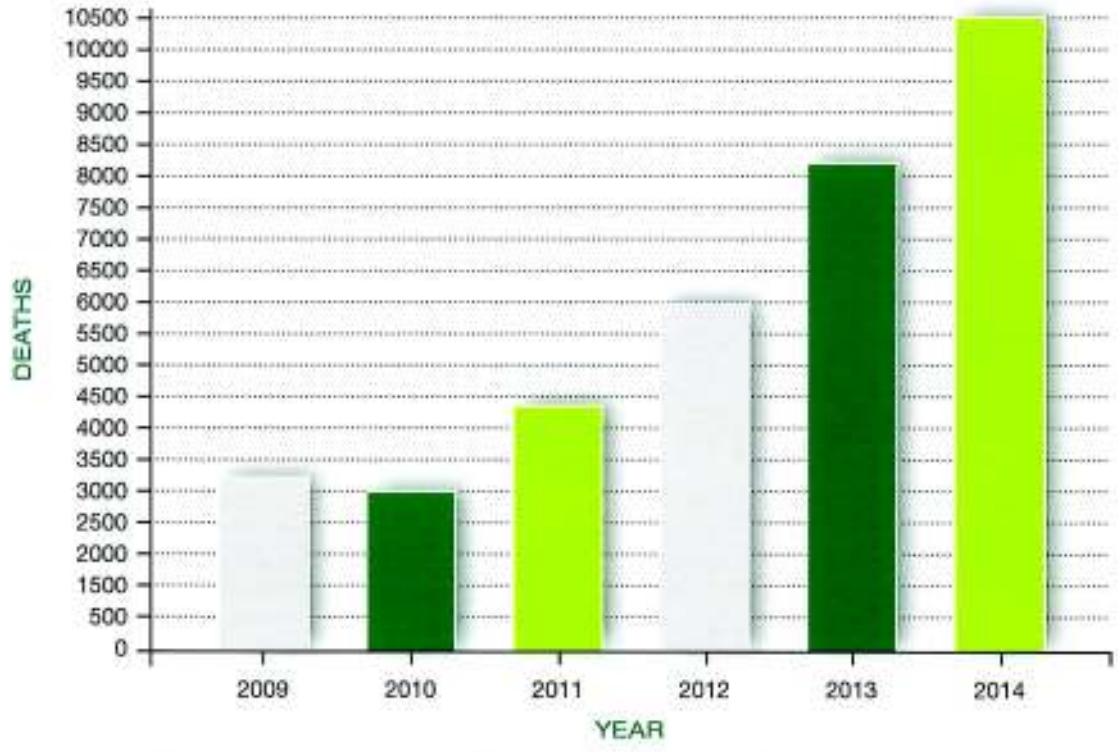
More research is needed to fully understand what prompts a person misusing opioid pain medications to transition to heroin. However, it is widely believed the transition to heroin happens as users turn to dealers for their daily supply of opioids, heroin is offered as a cost saving measure.

Nonmedical users of opioid pain medications were **19 times more likely** to use heroin

States with the **highest heroin fatality rates.**

OVERALL RANK	STATE	AGE-ADJUSTED HEROIN DEATH RATE PER 100,000
1	Ohio	11.1
2	West Virginia	9.8
3	Connecticut	8.9
4	New Hampshire	8.1
5	Massachusetts	7.2
6	New Mexico	7.2
7	Rhode Island	6.8
8	Delaware	6.3
9	Vermont	5.8
10	Missouri	5.8

FIGURE 1: Heroin Deaths by Year, United States, 2009-2014



DEADLY EMERGENCE OF FENTANYL

Fentanyl, a synthetic opioid, is 50 times more potent than heroin and 100 times more potent than morphine. *(CDC, 2016)* It is commonly prescribed to manage pain for advanced stage cancer patients.

However, fentanyl, when added to heroin, can create a lethal combination and is often added by drug dealers without the end user's knowledge. The Drug Enforcement Administration (DEA) has documented the import of illegally manufactured fentanyl into parts of the U.S. *(U.S. DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT ADMINISTRATION, 2015)* DEA National Forensic Laboratory Information System (NFLIS) found fentanyl reports increased 300 percent from the second half of 2013 to the first half of 2014. The DEA issued a health advisory in March 2015 after documenting a surge of fentanyl drug seizures and deaths. *(U.S. DRUG ENFORCEMENT ADMINISTRATION, 2015)*

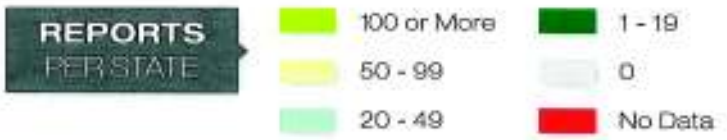
The maps below show the extent to which fentanyl reports have grown since 2009, when 35 states reported analyzing fentanyl. That same year, no state had more than 49 fentanyl reports. By 2014, 46 states reported fentanyl, with six states having 100 or more reports. *(U.S. DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT ADMINISTRATION, 2015)*

In only a 72-hour period in Chicago, 74 people died from an overdose of fentanyl laced heroin in October 2015.

(CORNER NEWSAL & SOCL, 2015)

FIGURE 2:
2009 Fentanyl Reports in NFLIS by State,
January - June 2009

FIGURE 3:
2014 Fentanyl Reports in NFLIS by State,
January - June 2014



In 21 states, more than
25 percent
of overdose death certificates did not specify the drugs involved in the death.

Critical Collection

Improved data collection is vital to fully understand the scope of the epidemic.

A March 2015 DEA National Threat Assessment Summary noted the true number of fentanyl-related deaths is most likely higher because "many coroners' offices and state crime laboratories do not test for fentanyl or its analogs unless given a specific reason to do so." *(U. S. DRUG ENFORCEMENT ADMINISTRATION, 2015)* Better mortality data is needed to accurately track the involvement of fentanyl and other drugs in opioid-related deaths. A 2013 study documented variation in how states certify manner of death, including toxicology, and found that death certificates often do not specify the drugs involved in overdose deaths. For example, in 21 states, more than 25 percent of overdose death certificates did not specify the drugs involved in the death. *(WARNER, PAULOZZI, NOLTE, DAVIS, & NELSON, 2013)*

A CDC Health Advisory Network (HAN) alert recommends that medical examiners and coroners screen for fentanyl in suspected opioid overdose cases, especially in areas reporting increases in fentanyl seizures or unusually high spikes in heroin or unspecified drug overdose fatalities. *(CENTERS FOR DISEASE CONTROL AND PREVENTION, 2015)* The HAN alert further recommends that coroners and medical examiners use Substance Abuse Mental Health Safety Administration *(SAMHSA)* consensus recommendations to report opioid-related deaths. *(GOLDBERGER, MAXWELL, CAMPBELL, & WILDFORD, 2013)*

The National Safety Council urges states to adopt these recommendations. Improved data collection is vital to fully understand the scope of the epidemic.

STATE PROGRESS

Multiple actions will be needed to end this drug epidemic and reduce the loss of life. It is only with concentrated state focus and efforts to reduce opioid overprescribing and to improve the ability to identify and offer help to those at risk. By ensuring that effective and coordinated substance abuse treatment is readily available to those with opioid use disorder, we can end the loss of life in the current drug crisis.

The National Safety Council examined state progress on six key indicators:

1. Mandatory Prescriber Education
2. Opioid Prescribing Guidelines
3. Eliminating Pill Mills
4. Prescription Drug Monitoring Programs (PDMPs)
5. Increased Access to Naloxone
6. Availability of Opioid Use Disorder (OUD) Treatment

1.	Requires Mandatory Prescriber Education	**17 states** meet this indicator: CA, CT, DE, IA, KY, MA, NV, NH, NM, NC, OR, RI, SC, TN, VT, WI, WV
2.	Adopted Opioid Prescribing Guidelines	**22 states** meet this indicator: AL, AZ, AR, CA, CO, HI, IN, KY, MA, MN, NH, NM, NC, OH, OK, PA, RI, TN, UT, VT, WA, WV
3.	Eliminating Pill Mills	**12 states** meet this indicator: AL, FL, GA, IN, KY, LA, MS, OH, TN, TX, WI, WV
4.	Allows Physician and Pharmacy delegates to PDMPs	**40 states** meet this indicator: AL, AR, AZ, CA, CO, CT, DE, DC, ID, IL, IN, IA, KS, KY, LA, MD, MA, MN, MT, NH, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY
5.	Allows Naloxone to be prescribed with a standing order	**35 states** meet this indicator: AK, AL, AR, CA, CO, DE, FL, GA, IL, IN, KY, LA, MD, ME, MN, MS, NC, ND, NV, NH, NJ, NM, NY, OH, OK, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI
6.	Availability of Opioid Use Disorder (OUD)Treatment	**3 states** meet this indicator: ME, NM, VT

STATE PROGRESS

STATE	REQUIRES MANDATORY PRESCRIBER EDUCATION	ADOPTS OPIOID PRESCRIBING GUIDELINES	ELIMINATES PILL MILLS	ALLOWS PHYSICIAN DELEGATES TO ACCESS PDMPs	ALLOWS NALOXONE STANDING ORDER	MEETS NEED FOR OUD TREATMENT
Alabama		✔	✔	✔	✔	
Alaska					✔	
Arizona		✔		✔		
Arkansas		✔		✔	✔	
California	✔	✔		✔	✔	
Colorado		✔		✔	✔	
Connecticut	✔			✔		
Delaware	✔			✔	✔	
District of Columbia				✔		
Florida			✔		✔	
Georgia			✔		✔	
Hawaii		✔				
Idaho				✔		
Illinois				✔	✔	
Indiana		✔	✔	✔	✔	
Iowa	✔			✔		
Kansas				✔		
Kentucky	✔	✔	✔	✔	✔	
Louisiana			✔	✔	✔	
Maine					✔	✔
Maryland				✔	✔	
Massachusetts	✔	✔		✔		
Michigan						
Minnesota		✔		✔	✔	
Mississippi			✔		✔	
Missouri						

State ranking were based on best available data at time of publication.

STATE PROGRESS

STATE	REQUIRES MANDATORY PRESCRIBER EDUCATION	ADOPTS OPIOID PRESCRIBING GUIDELINES	ELIMINATES PILL MILLS	ALLOWS PHYSICIAN DELEGATES TO ACCESS PDMPs	ALLOWS NALOXONE STANDING ORDER	MEETS NEED FOR OUD TREATMENT
Montana				✔		
Nebraska						
Nevada	✔				✔	
New Hampshire	✔	✔		✔	✔	
New Jersey				✔	✔	
New Mexico	✔	✔		✔	✔	✔
New York				✔	✔	
North Carolina	✔	✔		✔	✔	
North Dakota				✔	✔	
Ohio		✔	✔	✔	✔	
Oklahoma		✔			✔	
Oregon	✔			✔		
Pennsylvania		✔		✔	✔	
Rhode Island	✔	✔		✔	✔	
South Carolina	✔			✔		
South Dakota				✔	✔	
Tennessee	✔	✔	✔	✔	✔	
Texas			✔	✔	✔	
Utah		✔		✔	✔	
Vermont	✔	✔		✔	✔	✔
Virginia				✔	✔	
Washington		✔		✔	✔	
West Virginia	✔	✔	✔	✔		
Wisconsin	✔		✔	✔	✔	
Wyoming				✔		

State ranking were based on best available data at time of publication.

MANDATORY PRESCRIBER EDUCATION

The medical community is an important and vital partner in addressing the opioid epidemic. An Institute of Medicine report recommends that all healthcare providers keep their knowledge of pain management current through continuing medical education (CME). *(NATIONAL RESEARCH COUNCIL, 2011)* Licensure, certification and recertification examinations should include assessments of providers' pain education. Unfortunately, research has shown that practicing physicians received fewer than 12 hours of pain management education in medical school. *(MEZEI & MURINSON, 2011)* Another study found that 60 percent of physicians surveyed did not "receive training on identifying prescription drug abuse and addiction" in medical school. *(THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE, 2005)*

Addressing this knowledge gap is necessary to reduce dangerous prescribing practices and improve treatment of pain. **NSC recommends that states require CMEs on pain management for prescribers of controlled substances.** Seventeen states currently require education for physicians and other professionals who prescribe controlled substances to treat pain. *(FEDERATION OF STATE MEDICAL BOARDS, 2015)* For example, Kentucky doctors are required to take 4.5 hours of activity related to KASPER (Kentucky All Schedule Prescription Electronic Reporting), pain management or addiction disorders. In New Mexico, prescribers who are registered with the DEA must complete a 5 hour CME class about pain and addiction. Following implementation of New Mexico's CME requirement, the amount of opioids per prescription declined and prescribers issued fewer high-dose prescriptions. *(KATZMAN, ET AL., 2014)*

NSC Calls for Federal Educational Standards on Pain Management

Based on the successes seen by states like New Mexico in changing prescribing patterns as a result of the requirement for CME classes, **the National Safety Council recommends that the DEA require CME for all prescribers who apply for a new or renewed registration under the Controlled Substances Act of 1970.**[1]

The proposed CME should include the following topics:

- ✓ Relative efficacy and risks of medications used to treat acute and chronic pain
- ✓ Responsible prescribing, including the use of tools such as state Prescription Drug Monitoring Programs
- ✓ Linkage to treatment for those with addiction

Not all prescribers are required to register with the DEA—only those who will prescribe controlled substances such as opioid pain medications. Therefore, DEA controlled substance registration and renewal provides a targeted opportunity to address this knowledge gap.

State requires medical education for prescribers on pain management

17 states meet this indicator:

California, Connecticut, Delaware, Iowa, Kentucky, Massachusetts, Nevada, New Hampshire, New Mexico, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Vermont, West Virginia and Wisconsin

(FEDERATION OF STATE MEDICAL BOARDS, 2015)

[1] *The Controlled Substances Act of 1970 established that some medications require additional screening and oversight by the Drug Enforcement Agency (DEA) when prescribed, including most opioid pain medications.*

OPIOID PRESCRIBING GUIDELINES

Opioid prescribing guidelines helps medical providers make informed choices about pain treatment. Guidelines consist of recommendations for pain treatment based on the current knowledge of the risks and benefits of opioid use, as well as the risks and benefits of alternative non-opioid treatments. A number of medical professional organizations, state licensing agencies, state medical boards and, most recently, the CDC have published opioid prescribing guidelines. When states have developed guidelines, both regulatory and voluntary approaches have been used to develop and implement a guideline. States have developed opioid prescribing guidelines for a variety of clinical settings, including chronic pain, emergency medicine and workers compensation.

Washington, Kentucky, Ohio, Vermont and Indiana are among the states that have taken a regulatory approach by changing controlled substance regulations and establishing interagency and prescriber workgroups to develop a prescribing guideline.

Utah, in 2009, convened a steering committee and workgroups to develop their guideline, *Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain*. Arizona and North Carolina used a similar process, convening workgroups comprised of prescribers and medical associations to develop a guideline for hospital emergency departments regarding the prescribing of opioid pain relievers for patients with non-cancer pain.

Types of Opioid Guidelines

Chronic Pain

Chronic pain guidelines comprise recommendations on the use of opioids in treating pain lasting longer than three months or past the time of normal tissue healing. Twenty-two states have developed prescribing guidelines for chronic pain.

In March 2016, CDC issued an *Opioid Prescribing Guideline for Chronic Pain*. This guideline is intended to inform pain treatment decisions of primary care providers treating chronic, non-cancer pain.

The CDC guideline includes:

- ✓ Lower dosage recommendations. Higher opioid doses are associated with higher risk of overdose and death—even relatively low doses (20-50 morphine milligram equivalents (MME) per day) increase risk
- ✓ Risk assessment criteria for all patients. Previous guidelines focused safety precautions on "high risk patients," however, opioids pose risk to all patients, and currently available tools cannot rule out risk for abuse or other serious harm
- ✓ More specific recommendations compared to previous guidelines on monitoring and discontinuing opioids when risks and harms outweigh benefits

State or state medical board has issued an opioid prescribing guideline

22 states meet this indicator:

Alabama, Arizona, Arkansas, California, Colorado, Hawaii, Indiana, Kentucky, Massachusetts, Minnesota, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington and West Virginia

(NATIONAL SAFETY COUNCIL, 2016)

OPIOID PRESCRIBING GUIDELINES (CONTINUED)

Emergency Medicine

Nine states have adopted guidelines developed by the American College of Emergency Physicians (ACEP) to inform the use of opioids in hospital emergency departments. **Key elements of the ACEP guideline include:**

- ✓ Use of short-acting, instead of long-acting, opioids
- ✓ Prescriptions for no more than a seven-day supply. States like Ohio have specified that no more than a three-day supply of opioid pain medications should be prescribed for acute pain in emergency room settings

Workers' Compensation

Three states have developed a guideline for the use of opioid pain medications in the treatment of occupational injuries covered by state workers' compensation programs. Following the 2007 implementation of the opioid dosing guideline, Washington workers' compensation system examined detailed billing data to learn about changes in opioid prescribing to workers receiving disability compensation. The introduction in Washington of an opioid dosing guideline appears to be associated with a decline in the mean dose for long-acting opioids, percent of claimants receiving opioid doses ≥120 mg morphine equivalent dose per day, and number of opioid-related deaths among injured workers. *(FRANKLIN, MAI, TURNER, SULLIVAN, WICKIZER, & FULTON-KEHOE, 2012)*

Guideline development is critical as opioids, even when prescribed at low doses, carry significant risks. States like Washington which have implemented a prescribing guideline, reduced opioid prescribing and reduced opioid overdose fatalities. As a result, **the National Safety Council recommends that all states adopt an opioid prescribing guideline.** At a minimum, the guideline should address:

- ✓ When initiation of opioid treatment is appropriate
- ✓ Guidance on maximum dose and duration of opioid treatment
- ✓ Information on how to monitor treatment to ensure patient safety

Washington State Case Study

Washington has seen success in reducing overdose deaths and opioid prescribing rates through the implementation of a prescribing guideline. In 2007, voluntary guidelines were introduced in Washington to guide physicians on responsible opioid prescribing for non-cancer pain. Following introduction of the guideline, prescribers reported increases in awareness of safer opioid prescribing practices, and the State realized subsequent decreases in overdose deaths. In 2010, Washington required all licensing boards to establish rules and adopt one evidence-based prescribing guideline. The State developed a number of tools and resources to support responsible opioid prescribing practices. In addition, it increased training and support for prescribers to recognize substance abuse and make referrals to treatment. These efforts have resulted in a 29 percent reduction in drug overdose death rate since 2008.

ELIMINATING PILL MILLS

"Pill mills" are a doctor's office, clinic or health care facility that routinely prescribes controlled substances outside the scope of standard medical practice and often in violation of state laws. Frequently advertised as "pain management" clinics, pill mills can operate within medical practices that treat a variety of legitimate medical issues. Typical characteristics of pill mills include non-individualized care, lack of referrals to specialists or use of diagnostic tests and repetitive combinations of medications that do not vary from patient to patient.

NSC recommends continued state policy development that stops the establishment and/or operation of pill mills that function outside guidelines for licensed, qualified physicians and whose primary treatment is prescribing opioids. State policy should include requirements for acceptable standards of medical care including:

- ✓ Following prescribing guidelines in accordance with standards established by state licensing authorities and prevailing best practice standards
- ✓ Defining ownership requirements to ensure that clinic owners can be held accountable by state licensing authorities
- ✓ Restricting the dispensing of controlled substances
- ✓ Requiring use of state prescription drug monitoring programs by pain clinics
- ✓ Requiring an appropriate medical evaluation including adequate patient history and physical examination
- ✓ Conducting an appropriate risk assessment at each visit

Ten states have adopted pain clinic requirements to target activities consistent with these practices. Two additional states–Alabama and Indiana–have enacted regulations for prescribers related to specific prescribing activities rather than regulations limited to pain clinics. This trend may allow for a greater variety of enforcement options and address pill mills operating within other medical specialties or practice settings. *(NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS, 2014)*

The State has a law or laws that regulate pain clinics or pain management services

12 states meet this indicator:

Alabama, Florida, Georgia, Indiana, Kentucky, Louisiana, Mississippi, Ohio, Tennessee, Texas, West Virginia and Wisconsin

(NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS, 2014)

Florida State Case Study

By 2009, Florida was known as the epicenter of the nation's pill mill activity. DEA's Automation of Reports and Consolidated Orders System (ARCOS) reported that 98 of the top 100 oxycodone dispensing physicians in the nation were located in Florida. *(FLORIDA OFFICE OF THE ATTORNEY GENERAL)* Starting in 2010, in an effort to address this growing public health threat, Florida began requiring pain clinic registrations and inspections and enacted a number of laws to curb high-volume prescribing. **These included:**

- Bans on physician dispensing
- Establishment of a PDMP
- Tougher penalties for illegal prescribing

As a result of these new requirements, opioid prescribing rates decreased and overdose deaths declined by 23 percent between 2010 and 2012. *(JOHNSON, PAULOZZI, PORUCZNIK, MACK, & HERTER, 2014)* After the 2010 law, Florida experienced a significant decrease in the amount of opioids prescribed - equal to 500,000 fewer 5-mg hydrocodone tablets. *(RUTKOW, CHANG, DAUBRESSE, WEBSTER, STUART, & ALEXANDER, 2015)* Another study found the death rate from prescription painkiller overdoses in Florida was 7 percent lower than expected. In 2011, the rate was 20 percent lower and in 2012, 34.5 percent lower. *(KENNEDY-HENDRICKS, RICHEY, MCGINTY, STUART, BARRY, & WEBSTER, 2016)*

Today, none of the top 100 opioid dispensing physicians reside in Florida.

PRESCRIPTION DRUG MONITORING PROGRAMS

Patients who obtain opioid painkillers from four or more doctors or pharmacies are at an increased risk of overdose. Therefore, state Prescription Drug Monitoring Programs (PDMPs) can be a valuable tool to help prescribers make informed clinical decisions and avoid costly or fatal errors. PDMPs serve as an early warning system, alerting prescribers and state officials about high-risk patients seeking prescriptions from multiple doctors and risky prescribing practices and allowing them to intervene when necessary to protect patients and the community.

Unfortunately, PDMPs are underutilized by prescribers. A 2015 study of primary care prescribers found that while a majority reported having obtained data from their PDMP at some point in time, prescribers consulted PDMP data in fewer than one-quarter of instances when they prescribed opioids to patients. *(RUTKOW, TURNER, LUCAS, HWANG, & ALEXANDER, 2015)* In states with voluntary PDMP use, prescribers verified patient history only 14 percent of the time before prescribing an opioid. *(SHATTERPROOF, 2016)*

In a Johns Hopkins survey, family practice physicians reported they did not use the PDMP because it was time-consuming process and data was not reported in an easy to use format. Other issues identified include physician perception that data was needed only for a few patients. *(RUTKOW, TURNER, LUCAS, HWANG, & ALEXANDER, 2015)*

State action remains necessary to ensure widespread adoption and utilization of PDMPs by prescribers and pharmacists. Fourteen states require prescribers to access the PDMP prior to prescribing a schedule II, III or IV controlled substances. The number is based on how it is defined. *(PDMP CENTER OF EXCELLENCE BRANDEIS UNIVERSITY, 2016)* In Kentucky, New York and Tennessee–three of the first states to mandate prescriber use of the PDMP–increased PDMP utilization has resulted in reductions in opioid prescriptions and in patients visiting multiple providers–75 and 36 percent reductions respectively in doctor shopping in New York and Tennessee.

However, the rapid implementation of these mandates has not been without challenges. A Brandeis Center of Excellence report recommends that states establish stakeholder groups to build consensus and offer feedback to better integration of PDMP data in clinical decisions. *(PDMP CENTER OF EXCELLENCE BRANDEIS UNIVERSITY, 2016)* CDC has provided funding to states to develop universal registration and use, making PDMPs easier to use and the data more timely. *(CENTERS FOR DISEASE CONTROL AND PREVENTION, 2016)*

State PDMP allows prescriber and dispenser delegates

40 states meet this indicator:

Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming

(NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS, 2014)

PRESCRIPTION DRUG MONITORING PROGRAMS (CONTINUED)

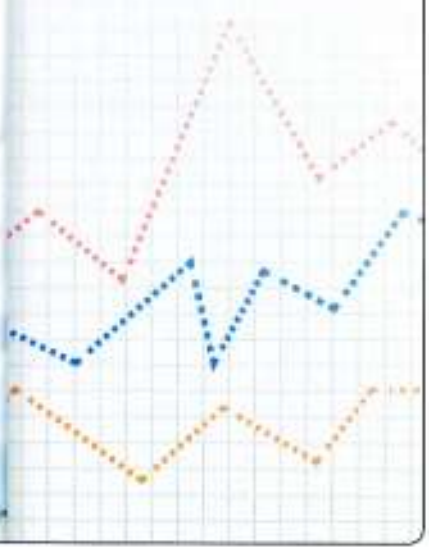
Forty states allow physicians and dispensers to appoint delegates or staff from their practice to access PDMP data, making it easier to integrate into clinical workflow. Institutional accounts are another PDMP innovation that makes it easier for clinicians, hospitals or universities to manage and supervise a delegate's PDMP utilization. To increase the effective use of PDMPs, **NSC recommends that State PDMPs allow prescriber and physician delegates and the creation of institutional accounts.**

Another hurdle to PDMP utilization is complicated multi-step application and verification processes. **NSC recommends that states simplify the PDMP registration process, integrating and automating when possible with other licensing processes.** Prescribers and pharmacists need easy-to-use reports with real-time information. Oklahoma's PDMP was the first to offer real-time data reports to pharmacists and physicians to assist them in making timely clinical decisions whether to issue a prescription or dispense medication to a patient. Since then, 27 state PDMPs now collect prescription information from pharmacies within 24 hours of dispensing controlled substances. The remaining state PDMPs collect this data within 72 hours or weekly. **NSC recommends that all states collect prescription data within 24 hours.**

NSC also recommends that States improve reporting response times and upgrade PDMP technology to facilitate data transfer into clinical workflows. The Kentucky PDMP processes the majority of PDMP queries within 15 seconds or less, and a number of states are currently working on pilot programs to integrate PDMP date into physician and hospital electronic health record systems.

Making Changes

PRESCRIBERS and PHARMACISTS NEED EASY-TO-USE REPORTS with REAL-TIME INFORMATION



INCREASED ACCESS TO NALOXONE

Opioid overdoses are reversible with the timely administration of naloxone. Naloxone, available by prescription, can be administered as an injection or nasal spray. It is not a controlled substance and has no abuse potential.

Physicians can provide a prescription for naloxone to a person at risk of overdose, similar to prescribing an EpiPen for people with severe allergies. However, unlike some types of allergic reactions, an opioid overdose renders the victim unable to self-administer this medication. Making naloxone available to family members and friends of those suffering from addiction, as well as first responders, will save lives.

Some states have increased access to and use of naloxone by amending medical practice laws and regulations to allow a licensed healthcare professional to prescribe naloxone for use by a third-party such as a family member. For example, Massachusetts allows community programs to provide naloxone to trained individuals with a standing order from the health department.

Community overdose education and prevention programs distribute naloxone overdose prevention kits and provide training. Education includes how to recognize the signs of an overdose, when and how to administer naloxone and the importance of rescue breathing until 9-1-1 first responders arrive.

Use of naloxone has increased greatly. From 1996 through June 2014, laypersons reported using naloxone in 26,463 overdose reversals. In 2013 alone, nearly 40,000 laypersons with 93 organizations reported 8,032 overdose reversals—lives that may not have been saved without laws allowing increased naloxone access. *(WHEELER, JONES, GILBERT, & DAVIDSON, 2015)*

State allows
a standing order
for naloxone

35 states meet
this indicator:

Alabama, Alaska, Arkansas, California, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington and Wisconsin

(NETWORK FOR PUBLIC HEALTH LAW, 2016)

INCREASED ACCESS TO NALOXONE (CONTINUED)

Thirty-five states permit naloxone to be prescribed with a standing order.[1] *(NETWORK FOR PUBLIC HEALTH LAW, 2016)* More recently, Connecticut, Idaho, North Dakota and New Mexico started allowing naloxone to be dispensed by pharmacists. About a dozen states permit pharmacists to establish collaborative practice agreements with a physician to dispense naloxone. Other states allow the pharmacy board to establish standards that permit naloxone to be dispensed.

However, while this progress is encouraging, more work is needed to ensure that naloxone remains affordable. **Therefore, NSC recommends that states, insurers, and other relevant payers work to ensure that naloxone is covered by all insurance plans, including public plans.**

Good Samaritan Provisions

Opioid overdose often happen when the victim is with friends or family members. Witnesses or bystanders to an overdose may be in the best position to save a life by administering naloxone. However, some overdose bystanders sometimes fail to summon medical assistance for fear of police involvement. *(TOBIN, DAVEY, & LATKIN, 2005)*

"Good Samaritan" laws provide protection from negative consequences associated with calling for help. Opioid overdose bystanders can become "Good Samaritans" by calling emergency responders without fear of arrest or other negative legal consequences.

Thirty-four states and the District of Columbia have enacted Good Samaritan provisions. **NSC recommends that all states enact Good Samaritan laws to remove any barriers to seeking help for a drug overdose.**

Sal's Story

Patty DiRenzo, of Blackwood, NJ lost her son Sal to a fatal overdose. His death could have been prevented if the people with whom he was using drugs had called 9-1-1 for help. They didn't, most likely afraid of legal consequences. Instead of saving a life by seeking help, Sal was left alone to die, without the medical help he needed. Patty lost her son, and her grandson lost his father, because someone was afraid to call 9-1-1.

Patty believes with proper treatment Sal could have beaten his addiction, but this opportunity was lost forever with his passing. The majority of overdose victims do not die until one to three hours after they have initially taken a drug, and most of these deaths occur in the presence of others. This leaves a significant amount of time for witnesses to intervene and call for medical help, but the fear of arrest and prosecution prevents many from making that call. Good Samaritan laws remove these legal barriers, so that calling 9-1-1 is never a crime.

Patty believes "Saving a life is far more important than punishing those who seek help."

[1] *A standing order allows a drug to be dispensed by a pharmacy or other programs to any person who meets specific criteria and without the prescriber or patient ever meeting.*

AVAILABILITY OF OPIOID USE DISORDER TREATMENT

Opioid use disorder (OUD), occurs when the recurrent use of opioid pain relievers or heroin cause significant clinical problems including health issues, disability, and the failure to meet major responsibilities at work, school or home. OUD is a brain disease and a serious chronic health condition like heart disease or diabetes. And like these conditions, medication and support to make lifestyle changes may be required to effectively treat an OUD. **As a chronic disease, if left untreated, OUD will worsen, often resulting in death.** In 2014, more than 2.4 million people had an opioid use disorder related to use of opioid pain relievers or heroin. *(SAMHSA, 2015)*

Medication assisted treatment (MAT) with buprenorphine or methadone is the most effective treatment for OUD. *(WORLD HEALTH ORGANIZATION, 2009)* A third medication, Naltrexone, can also be used to treat OUD. However, it is less effective in sustaining long-term recovery. *(COUSINS, RADFAR, CRÈVECOEUR-MACPHAIL, ANG, DARFLER, & RAWSON, 2016)*

Methadone is provided in a clinic setting at opioid treatment programs (OTP). OTPs are federally regulated clinics that dispense methadone, usually as a liquid, daily to patients. Barriers to methadone include waiting lists for treatment, relatively few locations in most states, insurance coverage limits and requirements for daily clinic visits. In 2012, nearly all state OTPs operated at greater than 80 percent capacity, and OTPs in 12 states reported 100 percent capacity. *(JONES, CAMPOPIANO, BALDWIN, & MCCANCE-KATZ, 2015)*

With most state OTPs operating at capacity, buprenorphine which can be prescribed in office-based settings, offers the most viable way to expand access for MAT. Buprenorphine is prescribed by SAMHSA certified physicians who receive specialized training. Patient caseloads for buprenorphine prescribers are capped at 30 individuals in the first year. *(SAMHSA, 2016)* After the first year, physicians can expand their caseload to 100 patients, but many physicians do not apply for this extension. If all physicians provide buprenorphine at the maximum level, 1,093,150 people can receive treatment in the US, which is less than the number needed. *(JONES, CAMPOPIANO, BALDWIN, & MCCANCE-KATZ, 2015)*

State has sufficient buprenorphine treatment
capacity to treat residents with opioid dependence

3 states meet this indicator:

Maine,
New Mexico
and Vermont

(JONES, CAMPOPIANO, BALDWIN & MCCANCE-KATZ, 2015)

AVAILABILITY OF OPIOID USE DISORDER TREATMENT (CONTINUED)

Treatment capacity in the United States lags behind the need for opioid treatment. An analysis of national and state treatment capacity found that rates of opioid abuse or dependence (891.8 per 1,000,000 people) far exceeded the maximum buprenorphine treatment capacity (420.3) and numbers of people receiving methadone (119.9) at an OTP. Most states had opioid dependence rates higher than their buprenorphine treatment capacity. Only three states—Maine, New Mexico and Vermont had maximum buprenorphine treatment capacity sufficient to meet the treatment need in their state. *(JONES, CAMPOPIANO, BALDWIN, & MCCANCE-KATZ, 2015)*

States must close the treatment gap. **NSC recommends that physician patient caseload limits be raised for buprenorphine wavered physicians and that advanced practice nurses are allowed to obtain DATA-2000 waivers to prescribe buprenorphine. NSC also recommends that federal and state-funded substance abuse services offer MAT, the most effective methods of opioid dependence treatment.** Care should be coordinated and MAT provided in conjunction with counseling and recovery support services. Vermont and Massachusetts have developed innovative care models to expand buprenorphine treatment capacity in their states, and this treatment should also be affordable. **NSC recommends that States require public and private health insurers to cover medication assisted treatment.** All three options for medication-assisted treatment should be available to all patients as unique patient characteristics may mean one form of medication assisted treatment is more effective. Also caps on the length and duration of MAT should be eliminated.

Reality Check

RATES OF OPIOID ABUSE/ DEPENDENCY FAR EXCEED the maximum buprenorphine/ methadone **TREATMENT CAPACITY** in nearly all states

Vermont: Effective and Coordinated Opioid Treatment

Through a unique partnership between the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs and the Department of Vermont Health Access's Blueprint for Health, the Care Alliance was formed. The Care Alliance for Opioid Addiction is a statewide partnership of clinicians and treatment centers that provide MAT to Vermonters addicted to opioids.

How it Works

The Care Alliance uses a Hub & Spoke model to ensure that each person's care is effective, coordinated and supported. People can access care by requesting services at a regional opioid treatment center (Hub), or their primary care provider (Spoke), or by dialing 2-1-1, a statewide, free, confidential information and help service. Five regional opioid treatment centers in 8 locations in Vermont serve as treatment hubs. Regional opioid treatment centers treat patients with complex needs with medication assisted treatment, either methadone or buprenorphine. In the Spokes, community physicians lead a team of nurses and clinicians to treat patients with medication assisted therapy, using buprenorphine. Patient care is coordinated and supported and supervised by a physician. Nurses and counselors connect patients with community-based support services. Support services may include mental health and substance abuse treatment, pain management, life skills and family support, job development and recovery support.

Highlights of Vermont's Opioid Treatment System to Date:

- In 2015, more than 4,800 people received MAT in Vermont, up from 2,867 in January 2013
- The 90-day retention rate among Vermont Medicaid-eligible individuals served by the Hub and Spoke system is 77 percent and greater than the national average of 70 percent and is increasing
- Vermonters who stay in treatment in Hubs longer than 90 days show improved overall functioning at discharge than those who left treatment earlier

RECOMMENDATIONS

NSC believes that if the following recommendations are implemented by state leaders, we can begin to reverse this epidemic and save lives.

1. Establish State requirements for medical education on effective pain management
2. Require CME for prescribers who apply for a new or renewed registration under the Controlled Substances Act of 1970. CME should be pertinent to the classes of controlled substances prescribed by the provider. The proposed CME should include the following topics:
   - ✓ Relative efficacy and risks of medications used to treat acute and chronic pain
   - ✓ Responsible prescribing, including the use of tools such as state Prescription Drug Monitoring Programs (PDMPs)
   - ✓ Linkage to treatment for those with addiction
3. Adopt state opioid prescribing guideline. At a minimum, the guideline should address:
   - ✓ When initiation of opioid treatment is appropriate, provide guidance on maximum dose and duration of opioid treatment
   - ✓ Monitor treatment to ensure patient safety
4. Develop or strengthen state policy that stops the establishment and/or operation of pill mills that function outside prescribing standards for licensed, qualified physicians and whose primary treatment is prescribing opioids. State policy should include requirements for acceptable standards of medical care including:
   - ✓ Following prescribing guideline in accordance with standards established by state licensing authorities and prevailing best practice standards
   - ✓ Defining ownership requirements to ensure that clinic owners can be held accountable by state licensing authorities
   - ✓ Restricting the distribution of controlled substances
   - ✓ Requiring use of state prescription drug monitoring programs by pain clinics
   - ✓ Requiring an appropriate medical evaluation including adequate patient history and physical examination
   - ✓ Conducting an appropriate risk assessment at each visit
5. Make PDMPs easy to use:
   - ✓ Require the collection of prescription data within 24 hours
   - ✓ Simplify the PDMP registration process, integrating and automating when possible with other medical professional licensing processes
   - ✓ Improve reporting response times and facilitate data transfer into clinical workflows
6. Improve reporting of drugs involved in drug overdose fatalities:
   - ✓ Encourage medical examiners and coroners to screen for fentanyl for suspected opioid overdose cases
   - ✓ Require coroners and medical examiners use SAMHSA consensus recommendations to report opioid-related deaths
7. Expand access to naloxone and remove barriers to its purchase and use
   - ✓ Enact laws allowing standing orders for naloxone
   - ✓ Require insurers, and other relevant payers to ensure that naloxone is covered by insurance plans, including public plans
   - ✓ Enact laws to enact "Good Samaritan" laws to remove any barriers to seeking help for a drug overdose
8. Increase patient caseload caps for buprenorphine wavered physicians
9. Allow advanced practice nurses to obtain waiver to prescribe buprenorphine. Expand use of medication assisted treatment, ensure it is offered and available at state-funded treatment providers
10. Require public and private health insurers to cover medication assisted treatment
11. Remove caps on the duration of medication-assisted treatment

ABOUT THE NATIONAL SAFETY COUNCIL

Founded in 1913 and chartered by Congress, the National Safety Council, **nsc.org**, is a nonprofit organization whose mission is to save lives by preventing injuries and deaths at work, in homes and communities, and on the roads through leadership, research, education and advocacy. NSC advances this mission by partnering with businesses, government agencies, elected officials and the public in areas where we can make the most impact—distracted driving, teen driving, workplace safety, prescription drug overdoses and Safe Communities.

Visit **nsc.org** to learn more.

WORKS CITED

Centers for Disease Control and Prevention. (2016, March 14). *Fentanyl Overdose Data.* Retrieved March 31, 2016, from Centers for Disease Control and Prevention: http://www.cdc.gov/drugoverdose/data/fentanyl.html

Centers for Disease Control and Prevention. National Center for Health Statistics. (2015). *Multiple Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015.* Retrieved December 14, 2015, from Centers for Disease Control and Prevention: http://wonder.cdc.gov/mcd-icd10.html

Centers for Disease Control & Prevention. (2016, March 14). *Data Overview.* Retrieved April 5, 2016, from Centers for Disease Control & Prevention: http://www.cdc.gov/drugoverdose/data/

Centers for Disease Control and Prevention. (2012, September). *Menu of Pain Management Clinic Regulation.* Retrieved March 1, 2016, from Centers for Disease Control and Prevention: http://www.cdc.gov/phlp/docs/menu-pmcr.pdf

Centers for Disease Control and Prevention. (2015, October 26). *Increases in Fentanyl Drug Confiscations and Fentanyl-related Overdose Fatalities.* Retrieved March 1, 2016, from Emergency Preparedness and Response: http://emergency.cdc.gov/han/han00384.asp

Centers for Disease Control and Prevention. (2016, March 15). *Prevention for States.* Retrieved April 5, 2016, from Centers for Disease Control and Prevention: http://www.cdc.gov/drugoverdose/states/state_prevention.html

Compton, W. M., Jones, C. E., & Baldwin, G. T. (2016). Relationship between Nonmedical Prescription-Opioid Use and Heroin Use. *New England Journal of Medicine,* DOI: 10.1056/NEJMra1508490.

Cousins, S. J., Radfar, S. R., Crèvecoeur-MacPhail, D., Ang, A., Darfler, K., & Rawson, R. A. (2016). Predictors of Continued Use of Extended-Released Naltrexone (XR-NTX) for Opioid-Dependence: An Analysis of Heroin and Non-Heroin Opioid Users in Los Angeles County. *Journal of Substance Abuse Treatment,* 66–71.

Federation of State Medical Boards. (2015). *Continuing Medical Education Board by Board Overview.* Retrieved March 1, 2016, from Federation of State Medical Boards: http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_CME_Overview_by_State.pdf

Florida Office of the Attorney General. (n.d.). *Pill Mill Initiative.* Retrieved March 1, 2106, from Florida Attorney General: http://myfloridalegal.com/pages.nsf/Main/AA7AAF5CAA22638D8525791B006A30C8

Goldberger, B. A., Maxwell, J. C., Campbell, A., & Wildford, B. B. (2013). Uniform Standards and Case Definitions for Classifying Opioid-Related Deaths: Recommendations by a SAMHSA Consensus Panel. *Journal of Addictive Diseases,* 32:231–243.

Gorner, J., Nickeas, P., & Sobol, R. R. (2015, October 2). *74 overdoses in 72 hours: Laced heroin may be to blame.* Retrieved March 1, 2016, from Chicago Tribune: http://www.chicagotribune.com/news/local/breaking/ct-heroin-overdoses-met-20151002-story.html

Johnson, H., Paulozzi, L., Porucznik, C., Mack, K., & Herter, B. (2014, July 4). *Decline in Drug Overdose Deaths After State Policy Changes—Florida, 2010–2012.* Retrieved March 1, 2016, from Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm

Jones, C. M. (2013). Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002–2004 and 2008–2010. *Drug and Alcohol Dependence,* 95-100.

Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment. *American Journal of Public Health,* e55-e63.

Kennedy-Hendricks, A., Richey, M., McGinty, E. E., Stuart, E. A., Barry, C. L., & Webster, D. W. (2016). Opioid Overdose Deaths and Florida's Crackdown on Pill Mills. *American Journal of Public Health,* Vol. 106, No. 2, pp. 291-297. doi: 10.2105/AJPH.2015.302953.

Mezei, L., & Murinson, B. (2011). Pain Education in North American Medical Schools. *Journal of Pain,* 1199-1208.

Muhuri, P. K., Gfroerer, J. C., & Davies, M. C. (2013, August). *Associations of nonmedical pain reliever use and initiation of heroin use in the United States.* Retrieved March 31, 2016, from CBHSQ Data Review: http://archive.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf

National Alliance for Model State Drug Laws. (2014, April). *Prescription Drug Abuse, Addiction and Diversion: Overview of State Legislative and Policy Initiatives Part 2: State Regulation of Pain Clinics.* Retrieved March 1, 2016, from National Alliance for Model State Drug Laws: http://namsdl.org/library/7C4C8B13-1C23-D4F9-74DC1E8E771E451A/

National Alliance for Model State Drug Laws. (2015, September). 2015 Annual Review of Prescription Monitoring Programs. Retrieved May 2016, from National Alliance of Model State Drug Laws: http://www.namsdl.org/library/E89878EA-E597-4B32-B83391F57B2275A7/

National Research Council. (2011). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington DC: National Academies Press.

Network for Public Health Law. (2016, April 15). *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws.* Retrieved May 6, 2016, from Network for Public Health Law: https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf

Paulozzi, L. J., Jones, C. M., Mack, K. A., & Rudd, R. A. (2011, November 4). *Vital Signs: Overdoses of Prescription Opioid Pain Relievers,* United States, 1999 - 2008. *MMWR: Morbidity & Mortality Weekly Report, 60(43),* pp. 1487-1492.

Paulozzi, L. J., Mack, K. A., & Hockenberry, J. M. (2014, July 4). Vital Signs: *Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines—United States, 2012.* Retrieved January 7, 2016, from Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm

WORKS CITED

PDMP Center of Excellence Brandeis Univeristy. (2016, May). *PDMP Prescriber Use Mandates: Characteristics, Current Status, and Outcomes in Selected States.* Retrieved April 5, 2016, from PDMP Center of Excellence Brandeis Univeristy: http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%203rd%20revision.pdf

Rutkow, L., Chang, H.-Y., Daubresse, M., Webster, D. W., Stuart, E. A., & Alexander, G. C. (2015). Effect of Florida's Prescription Drug Monitoring Program and Pill Mill Laws on Opioid Prescribing and Use. *JAMA Internal Medicine,* 175(10):1642-1649. doi:10.1001/jamainternmed.2015.3931.

Rutkow, L., Turner, L., Lucas, E., Hwang, C., & Alexander, G. C. (2015). Many primary care physicians are aware of prescription drug monitoring programs, but many find the data difficult to access. *Health Affairs,* 484-492.

SAMHSA. (2015). *Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2016, April 12). *Buprenorphine Waiver Management.* Retrieved April 20, 2016, from SAMHSA: http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management

Shatterproof. (2016, March). *Prescription Drug Monitoring Programs: Critical Elements of Effective State Legislation.* Retrieved April 5, 2016, from Shatterproof: https://secure.shatterproof.org/page/-/Shatterproof_WP_FINAL.pdf?_ga=1.228326110.217109100.1461943552

Syed, Y., & Keating, G. (2013). Extended-release intramuscular naltrexone (VIVITROL): A review of its use in the prevention of relapse to opioid dependence in detoxified patients. *CNS Drugs,* 27(10):851-861 doi:10.1007/s40263-013-0110-x.

The National Center on Addiction and Substance Abuse. (2005). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the US.* New York: Columbia University.

Tobin, K. E., Davey, M. A., & Latkin, C. A. (2005). Calling emergency medical services during drug overdose: an examination of individual, social and setting correlates. *Addiction,* 100(3):397-404.

U. S. Drug Enforcement Administration. (2015, April). *National Heroin Threat Assessment.* Retrieved March 1, 2015, from Drug Enforcement Administration: http://www.dea.gov/divisions/hq/2015/hq052215_National_Heroin_Threat_Assessment_Summary.pdf

U.S. Department of Justice, Drug Enforcement Administration. (2015). *Special Report: Opiates and Related Drugs reported in NFLIS, 2009-2014.* Springfield VA: U.S. Drug Enforcement Administration.

U.S. Drug Enforcement Administration. (2015, March 18). *DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety.* Retrieved March 1, 2016, from http://www.dea.gov/divisions/hq/2015/hq031815.shtml Warner, M., Paulozzi, L. J., Nolte, K. B., Davis, G. G., & Nelson, L. S. (2013). State Variation in Certifying Manner of Death and Drugs Involved in Drug Intoxification Deaths. American Forensic Pathology, 231-236.

Warner, M., Paulozzi, L. J., Nolte, K. B., Davis, G. G., & Nelson, L. S. (2013). State Variation in Certifying Manner of Death and Drugs Involved in Drug Intoxification Deaths. *American Forensic Pathology,* 231-236.

Wheeler, E., Jones, T. S., Gilbert, M. K., & Davidson, P. J. (2015, June 19). *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014.* Retrieved March 1, 2016, from Morbidity and Mortality Weekly Report (MMWR): http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm?s_cid=mm6423a2_e

World Health Organization. (2009). *Treatment of Opioid Dependence.* Retrieved April 15, 2014, from Guidelines for the PsychosocialyAssisted Pharmacological Treatment of Opioid Dependence: http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

nsc.org/rxreport

0616 900008929