Update on Opioid Response Activities, September – December 2017

Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths in Arizona on June 5, 2017. The requirements under the emergency declaration included:

- Providing consultation to the Governor on identifying and recommending necessary elements for an Enhanced Surveillance Advisory
- Initiating emergency rule making with the Arizona Attorney General's Office to develop rules for opioid prescribing and treatment within health care institutions
- Developing guidelines to educate healthcare providers on responsible prescribing practices
- Developing and providing training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations; and
- Providing a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.

A summary of activities related to the emergency declaration follows.

Enhanced Surveillance/Reporting of Opioid-Related Data

- Governor Ducey issued an executive order on June 15, 2017 to increase the reporting of opioid-related data, allowing state health officials to have information within 24-hours of specific events. This was a first step toward understanding the current burden in Arizona and build recommendations to better target prevention and intervention. The specific health conditions in the enhanced surveillance included suspected opioid overdoses, suspected opioid deaths, naloxone doses administered in response to either condition, naloxone doses dispensed, and neonatal abstinence syndrome.
- This Executive Order was revised and renewed on August 10, 2017, under the Governor's Executive Order 2017-05 Enhanced Surveillance Advisory.
- On October 9, 2017, emergency rules went into effect to continue opioid-related reporting on an on-going basis. The timeline for reporting was extended from 24 hours to 5 business days. ADHS is currently conducting regular rulemaking to adopt rules for opioid poisoning-related reporting.
- A summary of data reported through the required surveillance program is attached in Appendix A.

Emergency rulemaking for opioid prescribing and treatment within health care institutions

- Emergency rules for licensed health care institutions went into effect on June 28, 2017. These rules focus on health and safety; provide regulatory consistency for all health care institutions; establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment; include specific processes related to opioids in a health care institution's quality management program, and notify the Department of a death of a patient from an opioid overdose.
- ADHS is currently conducting regular rulemaking and has gathered input on how the rules could be improved through several stakeholder workgroup meetings and surveys in September and October.
- An oral proceeding was held on December 18, 2017. Written comments were accepted through December 18, 2017.

Developing guidelines to educate healthcare providers on responsible prescribing practices

- ADHS utilized the Arizona Prescription Drug Initiative Health Care Advisory Team, which has been in place since 2015, to review and update the Arizona Opioid Prescribing Guidelines published in 2014.
- The Rx Initiative Health Care Advisory Team, made up of professional health care associations, practicing clinicians, and subject matter experts, met nine times since June 2017 to review and update the guidelines.
- The content of the guidelines was finalized in December 2017, and the final draft is posted at www.azhealth.gov/opioidprescribing/
- The Guidelines are a voluntary, consensus document that promotes patient safety and best practices if prescribing opioids for acute and chronic pain.
- Current updates reflect:
    - Incorporation of the most recent evidence, national guidelines (including the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, 2017* and *CDC Guideline for Prescribing Opioids for Chronic Pain, 2016*), best practices from other states, and Arizona data.
    - A shift in pain care that avoids unnecessary exposure to opioids in order to reduce the risk of adverse outcomes. Previous guidelines focused on the "safe prescribing" of opioid therapy, while these guidelines aim to prevent initiating unnecessary opioid therapy while addressing patients' pain from a whole-person perspective.
    - Emphasis on non-stigmatizing language. Health care providers can counter stigma by using accurate, nonjudgmental language. These guidelines employ person-first language ("Patients with substance use disorder" instead of "addicts"), nonjudgmental terminology ("negative urine drug test" instead of "dirty") and supportive terms ("recovery" instead of "no cure").

  - Increased focus on prevention, recognition, and treatment of opioid use disorder in patients receiving long-term opioid therapy for chronic pain, given the high risk of developing opioid use disorder in this population.
  - Integration into clinical workflow (operationalization). A key element of success of guideline implementation is how seamlessly it can be incorporated into a clinician's normal activities. This revised version includes specific operationalization actions under each guideline.

Developing and providing training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations

- ADHS has free naloxone kits available for law enforcement agencies and first responders who are unable to bill for naloxone. Agencies can request naloxone by completing the request form on the ADHS website.
- ADHS has provided 5,150 naloxone kits for 52 law enforcement agencies since June 2017.
- Over 1200 first responders have received training since June 2017.
- ADHS received a SAMHSA grant to help support training of first responders in naloxone administration and conducting screening, brief intervention, and referral to treatment. AzPOST and the University of Arizona are partnering with ADHS to implement grant activities.
- 85% of people experiencing non-fatal overdoses received naloxone pre-hospital.
- Law enforcement officers have administered naloxone approximately 200 times since June.

Providing a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017

- ADHS submitted the Opioid Action Plan to Governor Ducey on September 5, 2017. The Opioid Action Plan includes 12 major recommendations with over 50 actions slotted for completion by June 30, 2018.

Update: Opioid Emergency Declaration & Action Plan Implementation

Update on Opioid Action Plan

Goal	Recommendations	Progress to Date (Dec. 2017)
Reduce Opioid Deaths	Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment.	ADHS conducted a survey to gather stakeholder input on initial legislative recommendations. Survey results and written comments have been provided to legislative policy staff. (Appendix B)
Improve Prescribing & Dispensing Practices	Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues.	ADHS convened the first meeting of the Regulatory Board work group on Dec. 19
	Establish a taskforce to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP).	The Arizona Board of Pharmacy convened the taskforce and identified a set of initial improvements regarding registration of prescribers and improved outreach, technical assistance, and education. (Appendix C)
Reduce Illicit Acquisition & Diversion of Opioids	Meet with leaders of law enforcement and first responder agencies to expand Angel Initiative and other OUD diversion programs and assist the DEA with filling vacancies in the DEA Tactical Diversion Squad.	ADHS and Homeland Security leadership met with law enforcement leadership in September. (Appendix D & E) Two law enforcement agencies are participating in the Angel Initiative with 85 individuals enrolled.
Improve Access to Treatment	Require all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum.	ADHS has invited academic partners to participate in a workgroup to develop curriculum basics. First meeting is scheduled for January 10.
	Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder.	Contracting process to establish call-in resource is in progress.
	Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services.	AHCCCS has convened the peer support work group.
	Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the state.	Insurance Parity Task Force was convened December 12. The Task Force will begin by conducting a survey of current insurance coverage related to pain management and opioid use disorder treatment.

Update: Opioid Emergency Declaration & Action Plan Implementation

Goal	Recommendations	Progress to Date (Dec. 2017)
Improve Access to Treatment	Engage the federal government outlining necessary federal changes to assist Arizona with our response to the opioid epidemic.	ADHS is working with Governor's Office on communication plan.
	Increase access to naloxone and Vivitrol for individuals leaving state and county correctional institutions and increase access to MAT therapy for individuals with opioid use disorder while incarcerated.	ADHS leadership met with the Goal Council 4 Recidivism Breakthrough Project to discuss employment center involvement. (See Appendix F) ADHS surveyed correctional facilities to determine interest in having naloxone program and completed analysis of formerly incarcerated individuals who overdosed after release. (See Appendix G)
Prevent Opioid Use Disorder/ Increase Patient Awareness	Utilize Public Service Announcements (PSAs) to educate patients, providers, and the public regarding opioid use and naloxone.	The Governor's Office of Youth, Faith, and Family developed new PSAs that began airing in December and are scheduled to continue through 2018. See www.RethinkRxabuse.org
	Create a youth prevention taskforce to identify and implement evidence-based, emerging and best practice substance abuse prevention/early identification curriculum, expand after-school opportunities, and identify resource needs.	The Governor's Office of Youth, Faith, and Family held the first meeting of the youth prevention taskforce on December 15.

Additional Opioid-Related Activities:

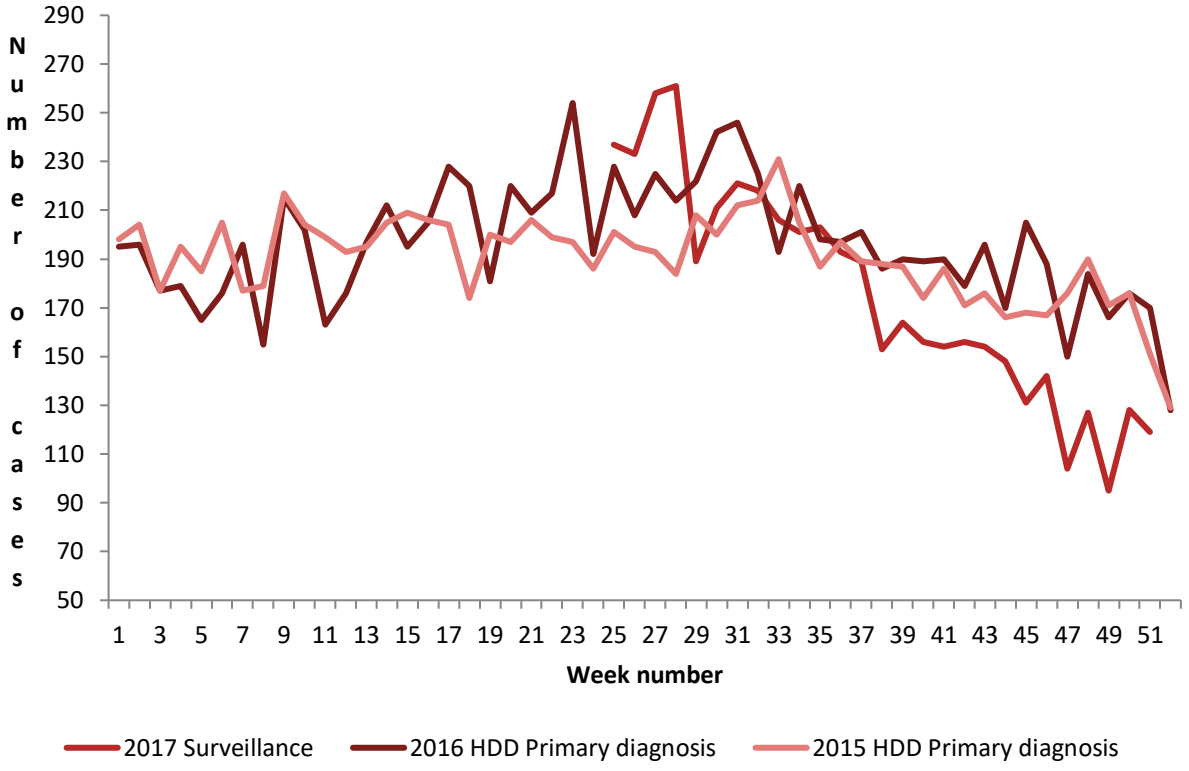
- The Arizona Department of Health Services (ADHS) held the first meeting of the state Drug Overdose Fatality Review Team on November 28, 2017. The program was established in law during the 2017 legislative session. The team will conduct analysis of the incidence and causes of drug overdose fatalities and make recommendations to reduce preventable overdoses in the future.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded ADHS $3.1 million for a comprehensive First Responder opioid/naloxone program in partnership with the University of Arizona and the Arizona Police Officer Standards and Training board. This initiative expands efforts to provide access to naloxone and opioid overdose recognition and naloxone administration training for first responders, and implement an Opioid Screening, Brief Intervention, and Referral to Treatment curriculum for first responders. Grant funds will provide approximately $785,000 per year for the next four years.
- The Arizona Health Care Cost Containment System (AHCCCS) is expanding access to opioid treatment programs throughout the state using grant funds from SAMHSA. The first of five, 24-hour centers for opioid treatment, including two medication-assisted treatment (MAT) centers and three crises centers, opened in October 2017 to address the growing need for access to opioid use disorder treatment.

Appendix A – Highlighted Opioid Data

Appendix A

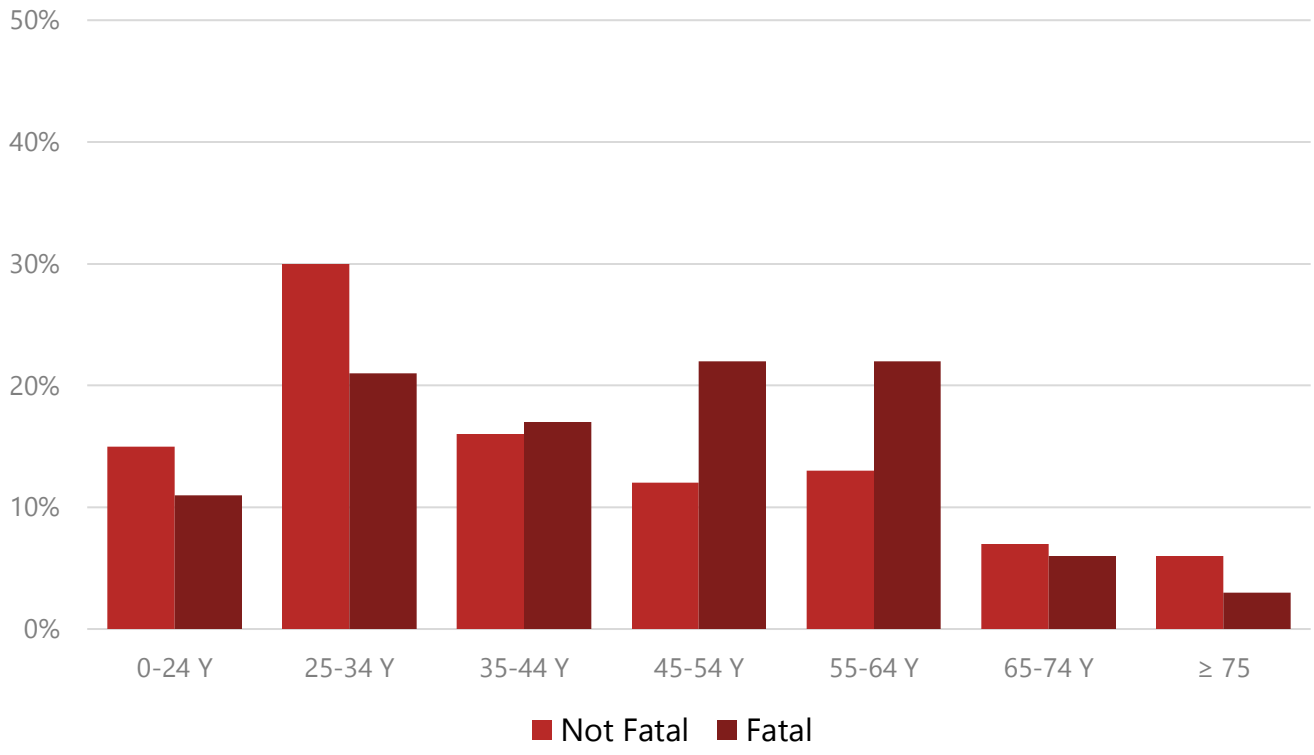
Highlighted Opioid Data: June 15 – December 31, 2017

Figure 1: Year on Year Comparison by Week: 2015-2017



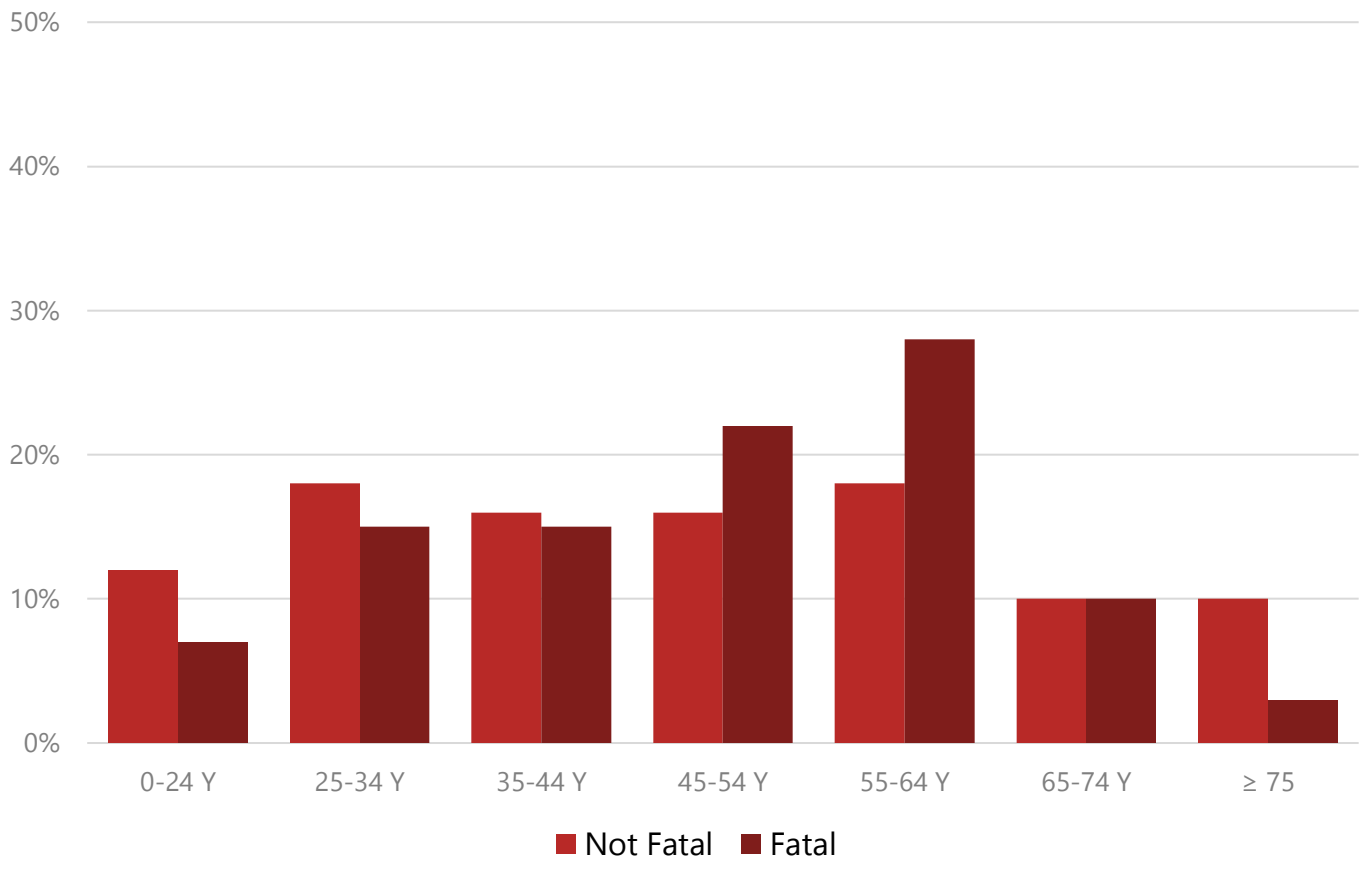
- Real-time opioid overdose surveillance data began being reported to ADHS on June 15, 2017.
- Hospital discharge data (HDD) is emergency room and inpatient information reported to ADHS by hospitals
- Week to week comparison of opioid overdoses reported through the surveillance system with HDD data from 2015 and 2016 shows that overdoses in Arizona rise in the spring, peak in the summer and decline in the fall
- Because real-time opioid overdose reporting is new it is not yet as complete as HDD, but efforts are being made to improve it as the system matures

Figure 2: Verified Fatal & Not Fatal Opioid Overdoses by Age: Males June 15, 2017-December 31, 2017



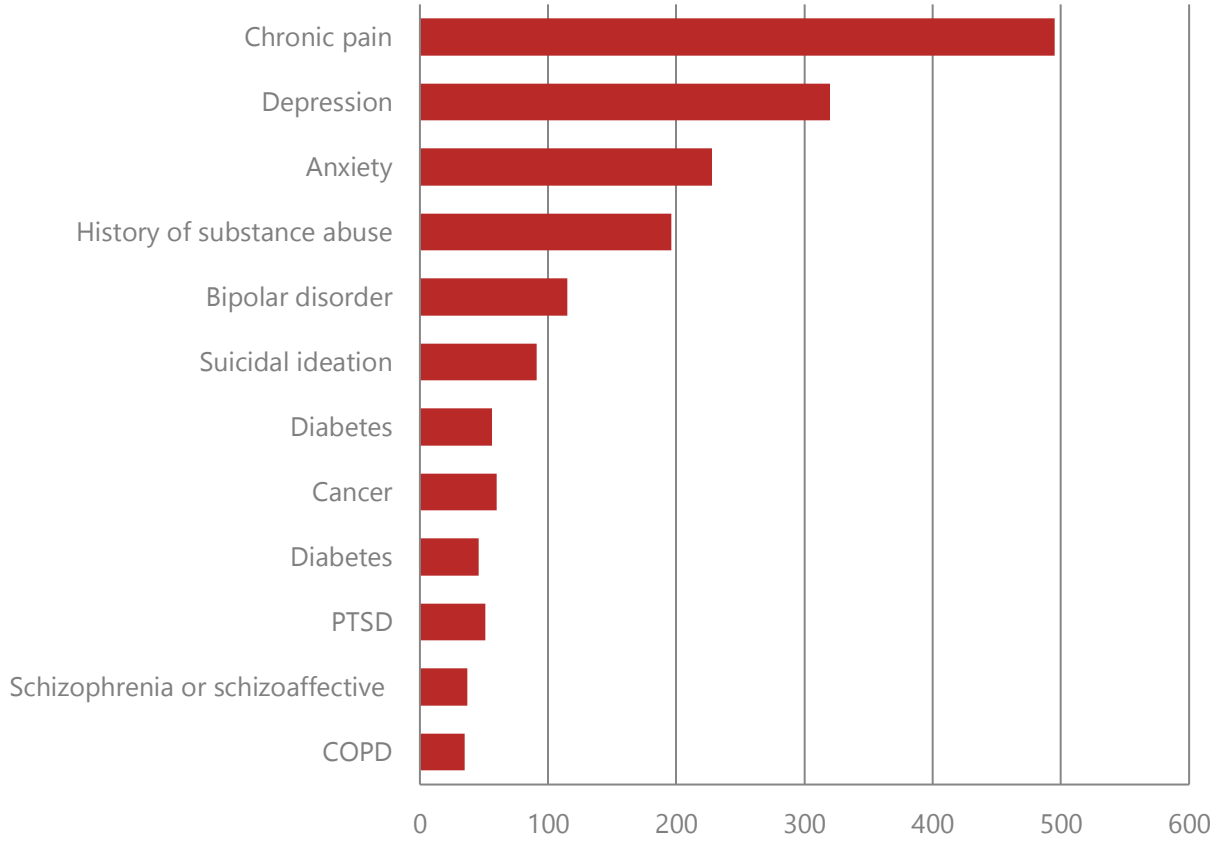
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- Men 34 years old and younger have more non-fatal verified opioid overdoses than older men
- Men 35 years and older are more likely to have a fatal verified opioid overdose than other age groups

Figure 3: Verified Fatal & Not Fatal Opioid Overdoses by Age: Females June 15, 2017-December 31, 2017



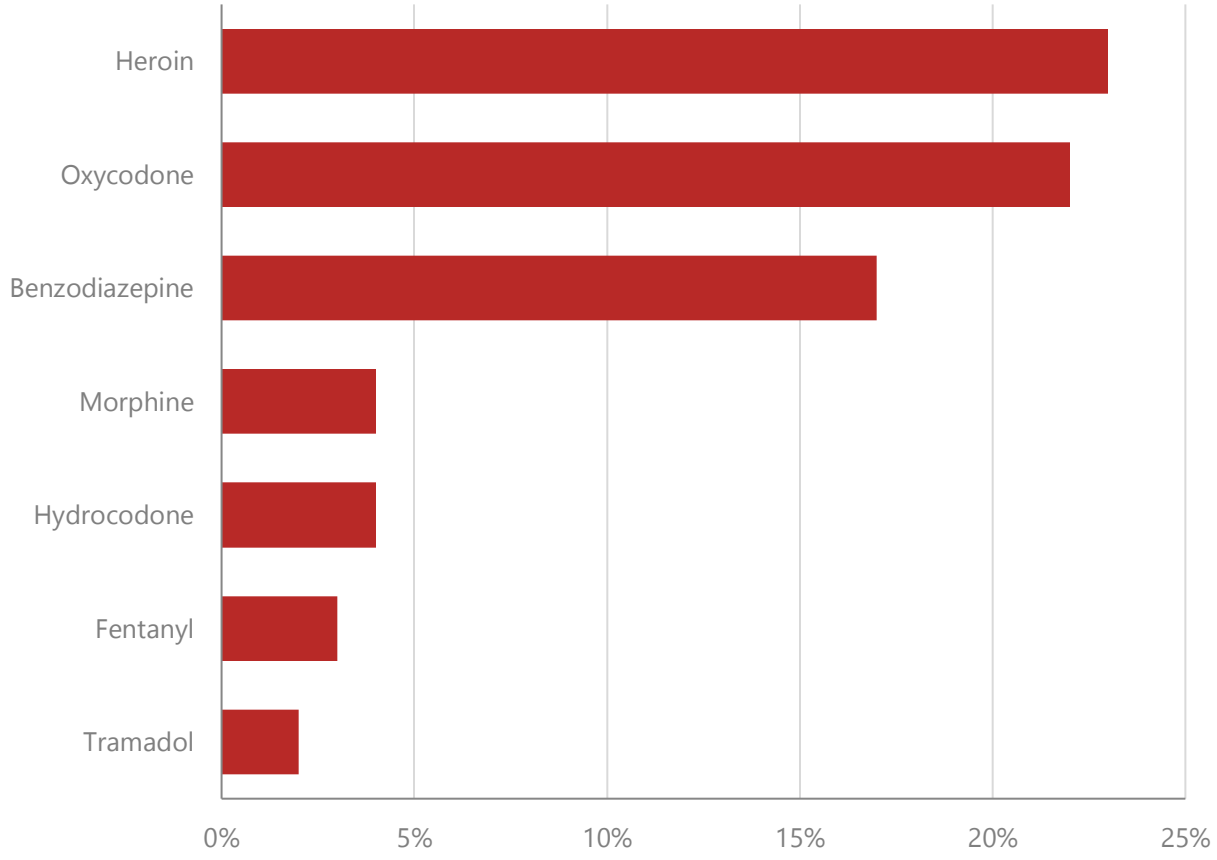
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- Women 44 years old and younger have more non-fatal verified opioid overdoses than older women
- Women 45-64 years old are more likely to have a fatal verified opioid overdose than other age groups

Figure 4: Reported Pre-Existing Conditions for Verified Opioid Overdoses: June 15, 2017-December 31, 2017



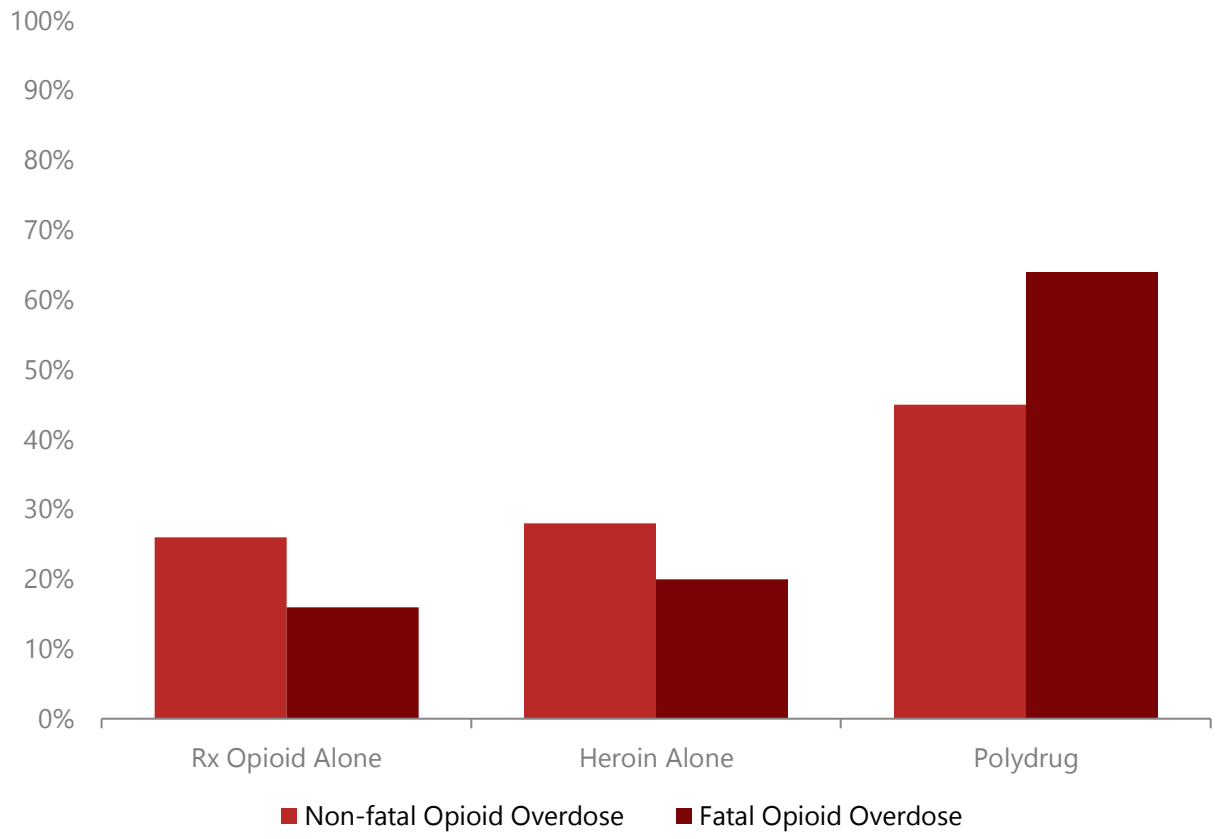
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- Chronic pain (e.g. lower back pain, joint pain, arthritis) is the most common pre-existing physical condition reported for those who had a verified opioid overdose
- Depression and anxiety are the most common pre-existing behavioral health conditions reported for those who had a verified opioid overdose

Figure 5: Drug Type Involved in Verified Opioid Overdoses: June 15, 2017-December 31, 2017



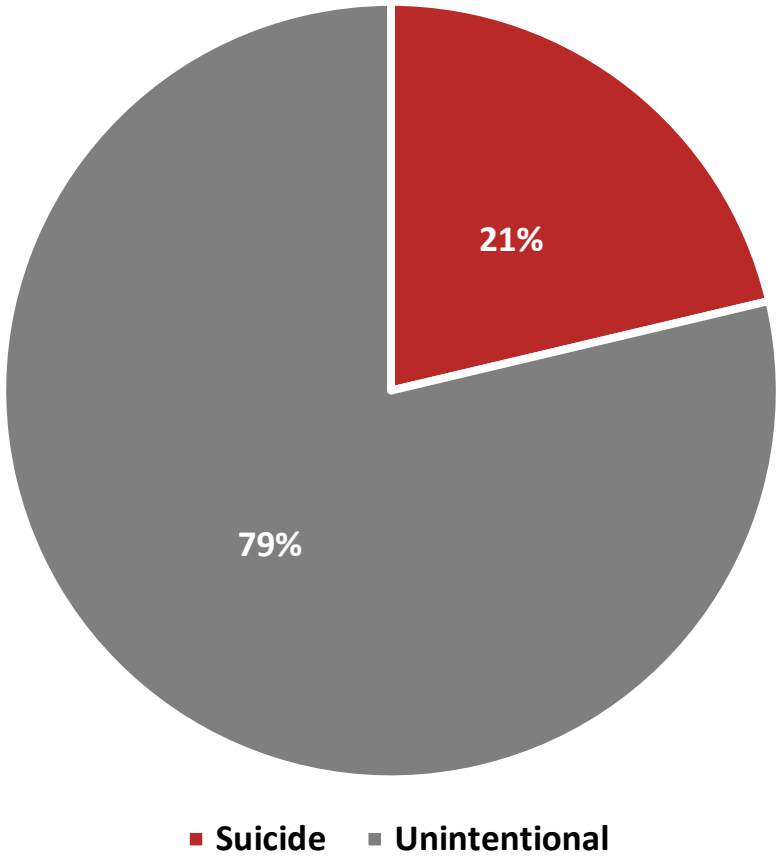
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- Heroin, alone or in combination with other drugs, was reported to be involved in 23% of verified opioid overdoses
- Oxycodone, morphine, and hydrocodone, alone or in combination with other drugs, were involved in 30% of verified opioid overdoses

Figure 6: Prescription Drug, Heroin, and Poly-drug Use in Verified Opioid Overdoses June 15, 2017-December 31, 2017



- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- 64% of verified *fatal* opioid overdoses and 45% of *non-fatal* opioid overdoses involved polydrug use of at least one opioid and at least one other type of drug

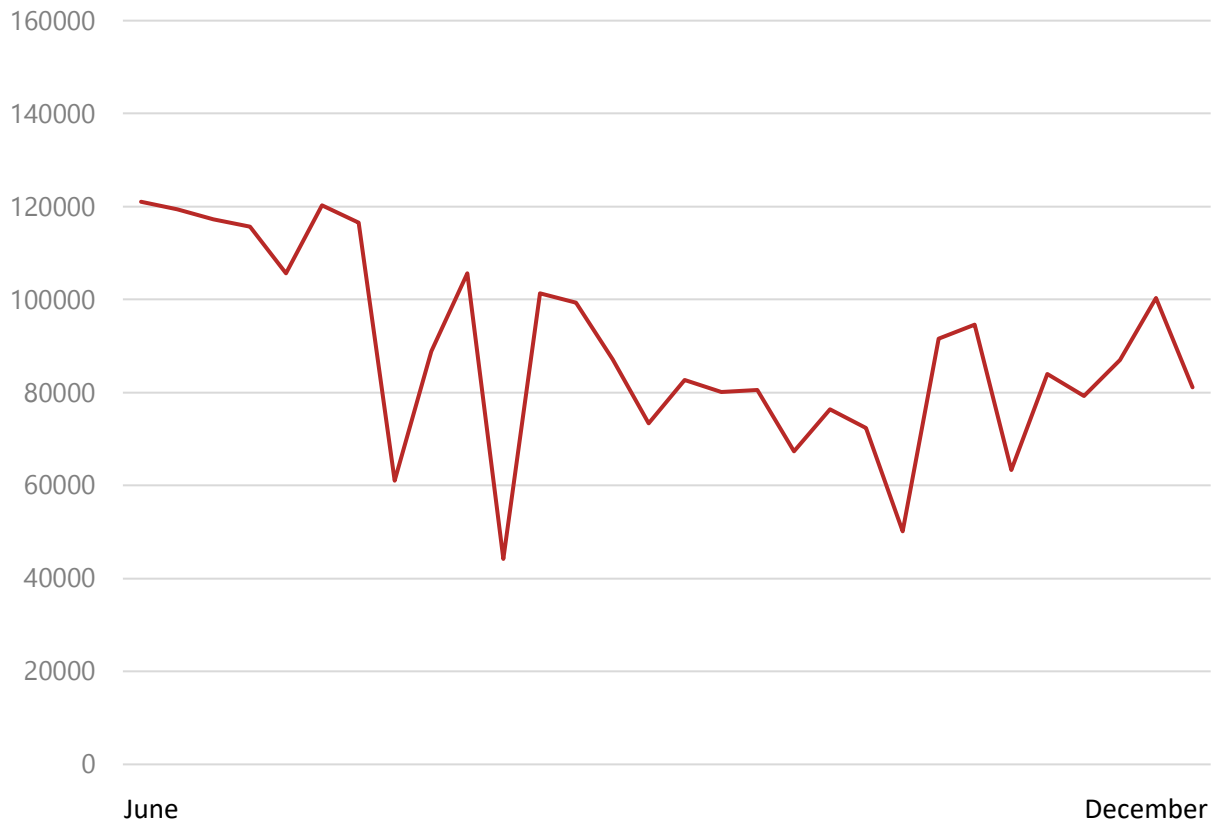
Figure 7: Intent of Verified Overdose: June 15, 2017-December 31, 2017



176 (12%) of cases did not have information about suicide available.

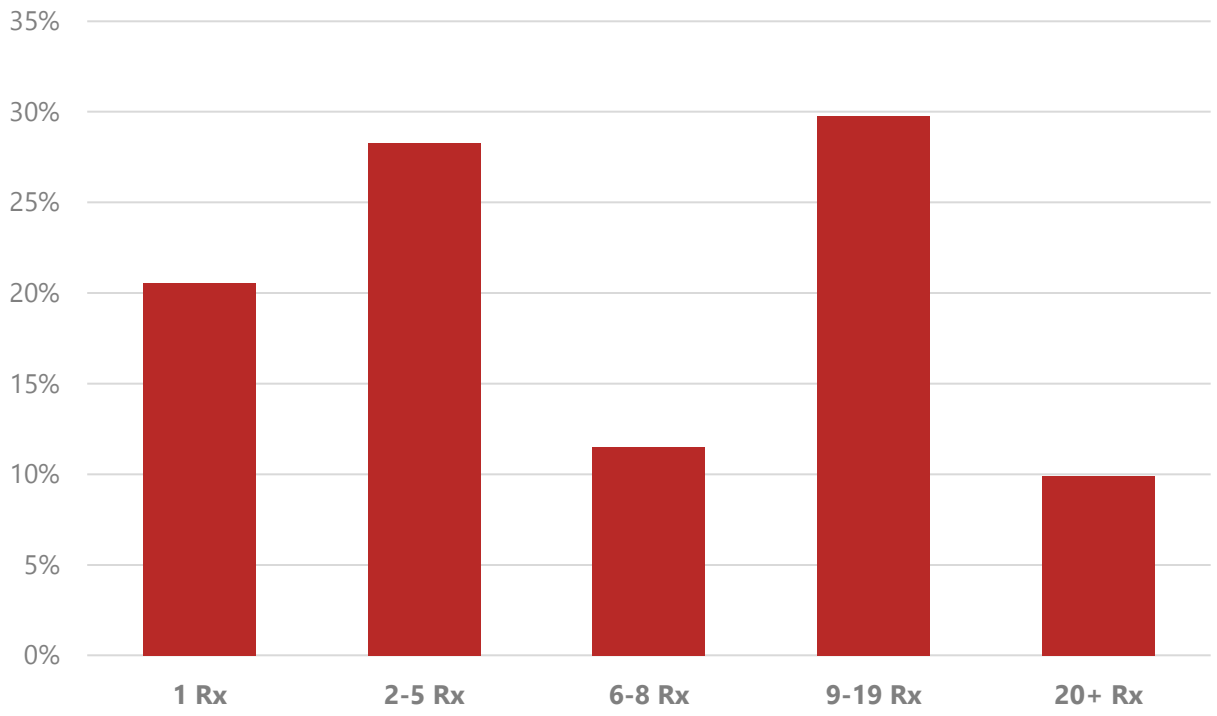
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- The majority of verified opioid overdoses were not intentional

Figure 8: Opioid Prescriptions per Week: June 15, 2017-December 31, 2017



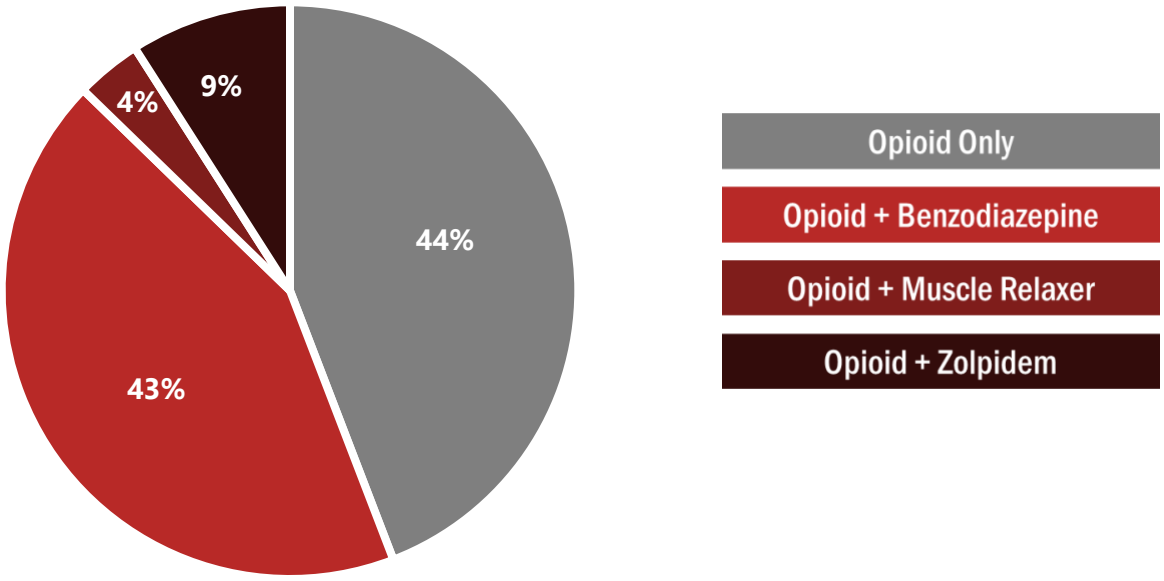
- Data from the Arizona Controlled Substances Prescription Monitoring Programs shows that the number of opioid prescriptions filled per week in Arizona has declined since June 15, 2017

Figure 9: Number of Opioid Prescriptions Filled January 1, 2017- December 31, 2017 by People who had a Suspected Opioid Overdose June 15, 2017-December, 31, 2017



- Approximately 80% of the people who had a suspected opioid overdose between June 15, 2017 and December 31, 2017 had two or more prescriptions filled between January 1, 2017 and December 31, 2017

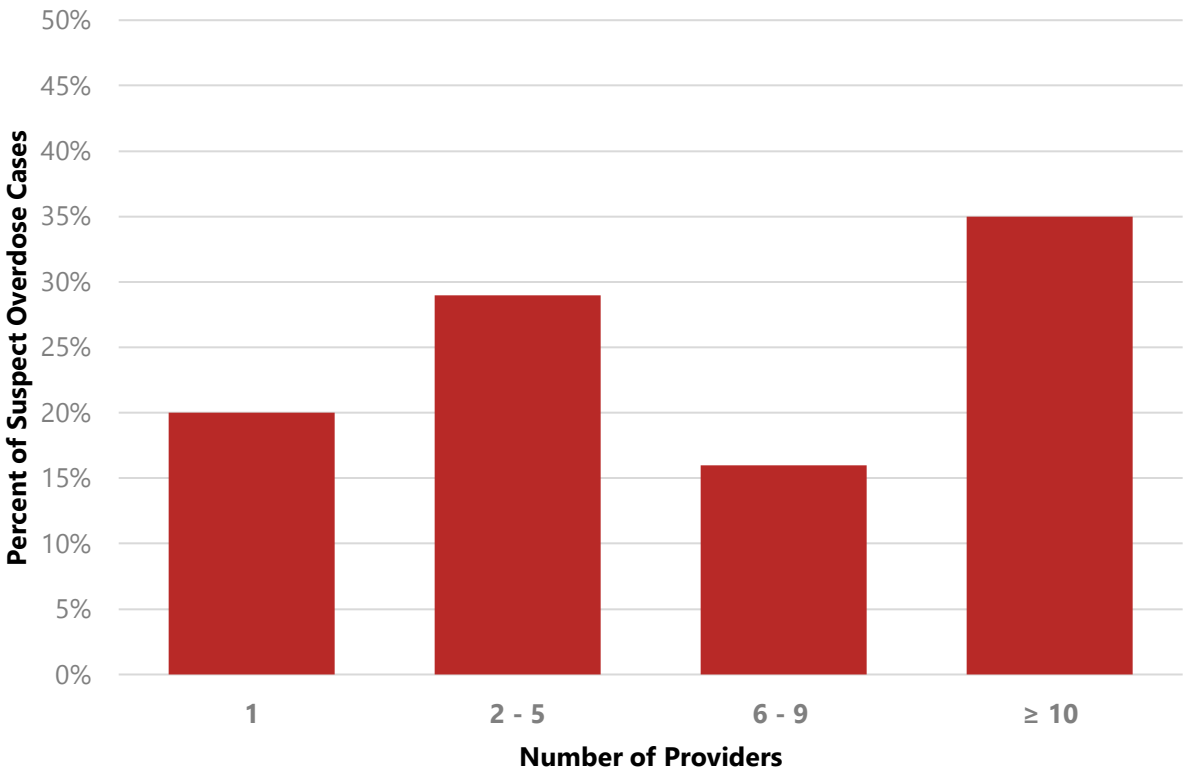
Figure 10: Drug Combinations Prescribed to People Who Had a Suspect Opioid Overdose between June 15, 2017-December 31, 2017



Prescription Drug Monitoring Program (PDMP) data from January 1, 2017 – December 31, 2017

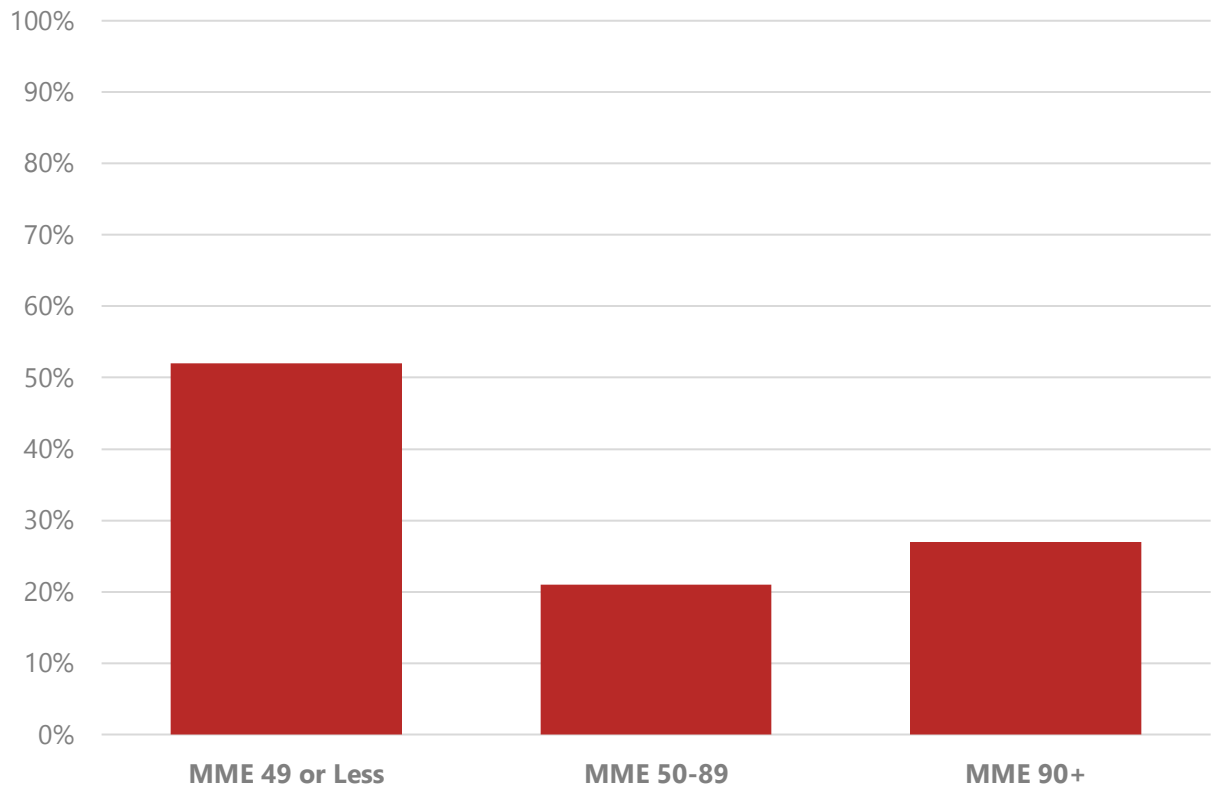
- Taking opioids with certain other drugs increases the chance of overdosing
- 43% of people who had a suspected opioid overdose were prescribed opioids and benzodiazepines

Figure 11: Number of Opioid Prescribing Providers per Suspect Overdose Case June 15, 2017-December 31, 2017



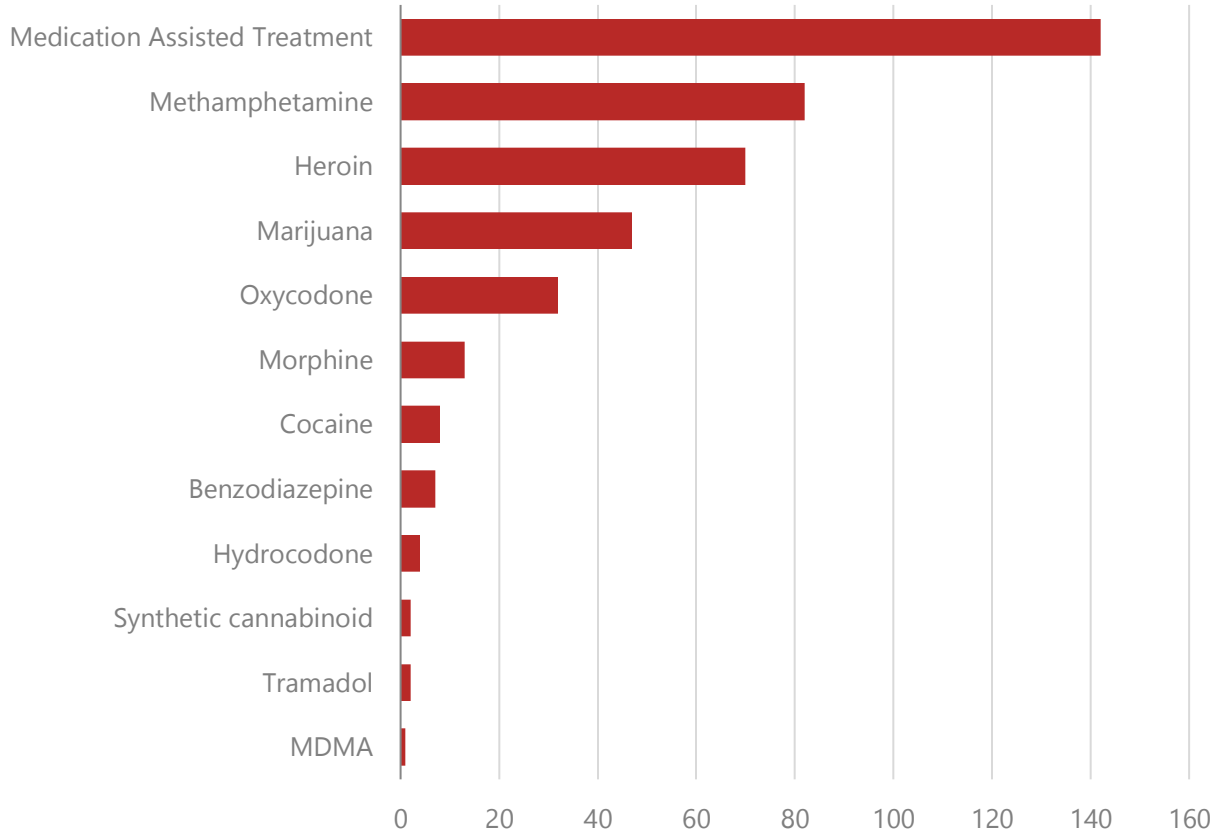
- 80% of people who had a suspected opioid overdose were prescribed opioids by more than one provider
- 35% were prescribed opioids by 10 or more providers

Figure 12: Morphine Milligram Equivalents (MME) for Prescriptions Filled January 1, 2017-December 31, 2017 by People Who Had Verified Opioid Overdoses June 15, 2017-December 31, 2017



- MME is a measure of the strength of a patients daily opioid dose
- Approximately 50% of people with verified opioid overdoses had prescriptions for doses of 50 or more MME filled prior to their overdose

Figure 13: Drugs Used by Women Who Gave Birth to Infants Who Developed Neonatal Abstinence Syndrome June 15, 2017-December 31, 2017



- Numerous drugs can cause neonatal abstinence syndrome
- The majority of women were reported to have received medically assisted treatment during their pregnancies
- Methamphetamine and heroin were the most common drugs used without medical supervision

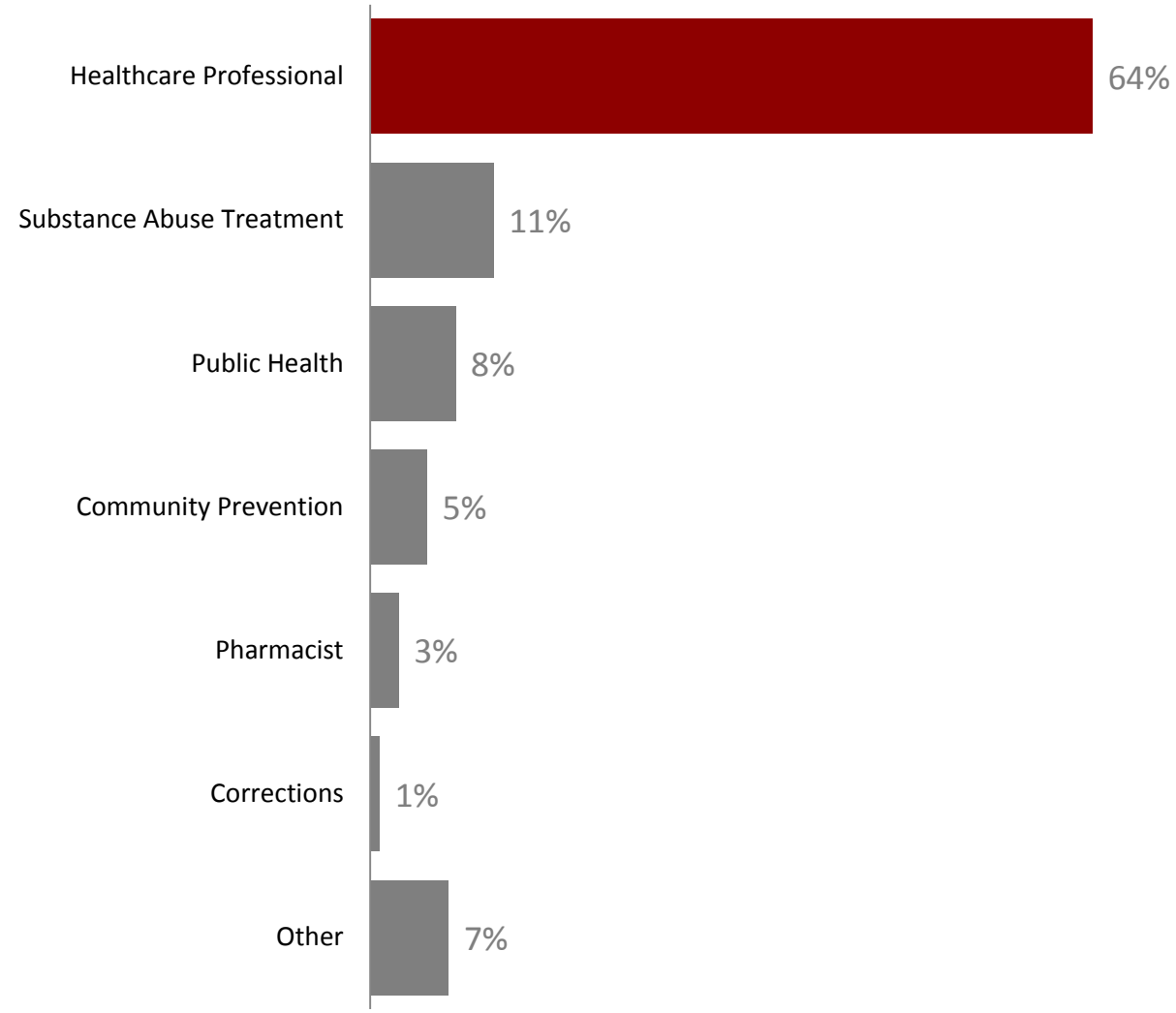
For more data and bi-weekly updates, visit www.azhealth.gov/opioids

Appendix B – Summary of Results of Legislative Recommendations Survey

Feedback: Opioid Legislative Recommendations Brief

From November 21, 2017 through December 1, 2017, partners, stakeholders, and Goal Council 3 subgroup members were invited to provide feedback on the preliminary ideas in the Arizona Opioid Action Plan proposed to enact legislative solutions to impact the ongoing opioid emergency. A total of 118 individuals and organizations responded through the online survey.

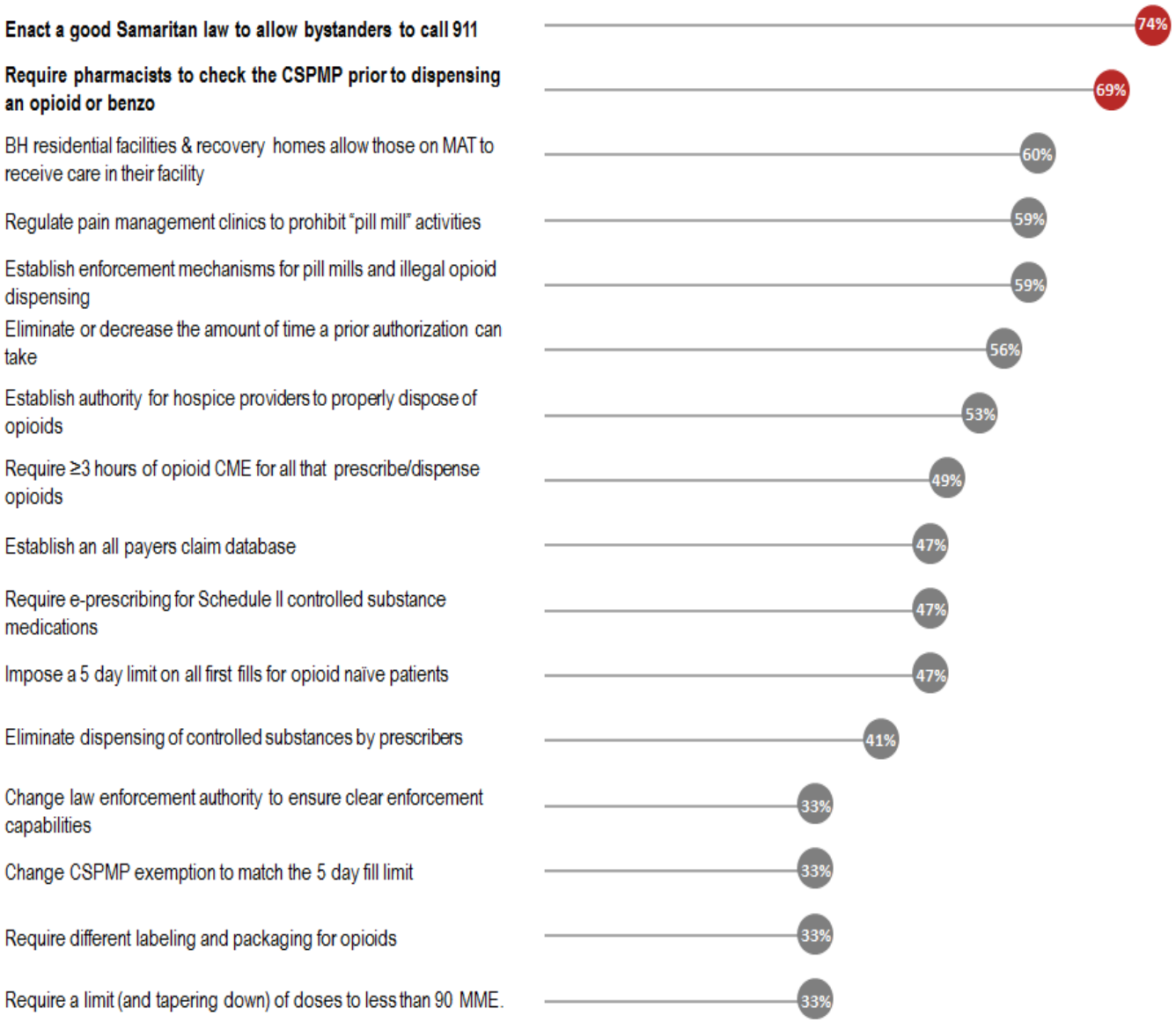
The majority of survey respondents were **healthcare professionals**, including physicians, nurses, nurse practitioners and physician assistants.



Feedback: Opioid Legislative Recommendations Brief

A total of 16 legislative proposals were included in the Opioid Action Plan. Respondents were asked to identify which of these proposals they viewed as being effective at addressing the opioid crisis in Arizona and what suggestions they had to improve each of the 16 proposals.

Legislative proposals respondents most frequently identified as being effective at addressing the opioid crisis were **enacting a Good Samaritan law** and **requiring pharmacists to check the CSPMP before dispensing**.



Feedback: Opioid Legislative Recommendations Brief

Summary of suggested improvements to legislative proposals:

Proposal	Theme	Selected Examples
Impose a 5 day limit on all first fills for opioid naïve patients for all payers	Allow exceptions to the limit for certain situations (n=15)	We ask that provision be made for appropriate, evidence based exceptions for certain surgical procedures that allow up to 7 days supply.
		We must develop a comprehensive list of exemptions for conditions and situations. Some examples include hospice and palliative care, oncology, post-surgical discharge, neonatal abstinence syndrome patients and patients with limited ability to receive follow-up care.
		Restrict this limitation to ER visits and Acute non-surgical pain (inpatient or outpatient)
		The postoperative exemption needs to be flexible enough to say five days for less painful surgery but longer more painful surgery
	General increase to the day limit (n=6)	We believe that a national standard would be better in order to not confuse part year residents. We would suggest a 7 day limit.
		The 10 day limit seems sufficient
	General decrease to the day limit (n=2)	Impose a 3 day limit
	Eliminate this requirement (n=8)	The day limit needs to be removed, you cannot create a hard and fast rule on a complex issue like pain management.
	Exceptions for access to care issues (n=3)	We want to be careful that we don't create an access to care issue for patients who have had traumas, recent surgeries or who have legitimate pain and are not able to see or contact their prescriber during office hours
Require a limit (and tapering down) of doses to less than 90 MME. (Taper down would occur over years, exemptions for specific situations would be made in statute)	Eliminate the requirement (n=17)	It is virtually impossible to specifically legislate an appropriate taper
		Determination of appropriate dosages and tapering recommendations should be left to clinicians and be based on the clinical nature of the patients condition
	Offer exceptions (n=16)	Some patients with chronic pain may need to have dosages over the 90mg of mme.
		Must make an exception for buprenorphine products. A dose of 8 mg BID is 480 MMEs.
	Taper down over years is too long (n=6)	This taper down needs to change from over years to over a set months span for instance 9-10 months.

Feedback: Opioid Legislative Recommendations Brief

	Include more provider education (n=4)	For those of us who are trying to get people weaned down sometimes it is difficult because of comfort levels with tapering schedules so possibly having some sort of guideline would be helpful to follow.
Require e-prescribing for Schedule II controlled substance medications	Expand or restrict the impacted substances (n=4)	We believe that e-prescribing should be required for all controlled substance medications
		Schedule 2 drugs that are not opiates should not be included, particularly stimulants used for ADHD.
	Consider exemptions for rural areas (n=4)	We are concerned about the inconsistent availability of this technology through the different vendors to all physicians, especially in rural areas.
Require different labeling and packaging for opioids ("red caps")	Alternatives to red cap (n=4)	Bubble pack card; different colors for higher schedules of drugs; child proof caps; black box warning on bottle
	Increases risk of theft/diversion (n=16)	This will allow kids and abusers to know the first thing to grab or steal from medicine cabinets or strangers.
		The different color caps only alerts people who would steal, abuse, or divert medication as to which medicines they should target.
Eliminate dispensing of controlled substances by prescribers	Allow exceptions to prevent access to care issues (n=6)	We must avoid unintended consequences of prohibiting dispensing in remote rural communities, home visits to vulnerable patients, or other special circumstances where dispensing a medication is the most viable option for the patients with limited or no mobility.
		Schedule 2 drugs that are not opiates should not be included, particularly stimulants used for ADHD.
	Allow exceptions for certain procedures or class of medication (n=6)	Exceptions for schedule 3, 4 and 5
		Be specific if this does not apply to Methadone.
		Allow dispensing of 1 day supply out of urgent care clinics
Require pharmacists to check the CSPMP prior to dispensing an opioid or benzodiazepine	Provide clarity about pharmacists' next steps after checking the CSPMP (n=4)	What would be their responsibility for action, if they see multiple prescriptions, or prescribing patterns that seem problematic?

Feedback: Opioid Legislative Recommendations Brief

Require at least 3 hours of opioid-related CME for all professions that prescribe/dispense opioids	Increase or decrease required number of hours (n=14)	Our members request that flexibility be allowed in specifying the number of hours of mandatory CME related to Opioid education.
		Perhaps consider 'tiering' specific populations that engage in opioid prescribing to longer CME requirements.
		would require more than this other states require 8 hours annually
	Include or exempt certain categories of professionals (n=6)	It is unnecessary and unfair to impose this mandate on physicians who do not have a DEA registration or have never prescribed Schedule II medications and should be exempt
		This should be reserved for prescribers that are not pain fellowship trained and board certified.
	Include specific topics in the continuing educations (n=6)	also teach alternative pain treatment.
		3 hr of substance use disorder and harm reduction for CMEs not just anything to do with opioids
	Consider a sunset date or review period (n=3)	We recommend a policy like this have a sunset date so its need can be reevaluated in the future and modified if necessary.
Establish an all payers claim database	No specific improvement themes noted	
Regulate pain management clinics to prohibit “pill mill” activities	Ensure clear definitions (n=6)	It is important that any criteria used to subject physicians to additional regulations is carefully designed so responsible physicians, who by virtue of the type of medicine they practice treat higher numbers of patients who suffer from pain, are not unduly and unnecessarily impacted.
Change CSPMP exemption to match the 5 day fill limit; exempt for prescriptions of 5 days or less.	Check CSMP for all prescriptions (n=5)	There should be no limit, any prescribing of controlled substances should require a check
Change law enforcement authority to ensure clear enforcement capabilities	No specific improvement themes noted	

Feedback: Opioid Legislative Recommendations Brief

Establish authority for hospice providers to properly dispose of opioids to prevent diversion	No specific improvement themes noted	
Eliminate or decrease the amount of time a prior authorization can take	No specific improvement themes noted	
Establish enforcement mechanisms for pill mills and illegal opioid dispensing	No specific improvement themes noted	
Enact a good Samaritan law to allow bystanders to call 911 for a potential opioid overdose	Include other substances in addition to opioids (n=4)	Include all substances in this good Samaritan law not just opioids.
	Allow the affected person to call 911 without fear of reprisal (n=3)	Always allow bystanders and please allow the people themselves to call 911 without fear of reprisal if they are dying.
	Add syringe access (n=5)	Include a recommendation to enact a law that would decriminalize the distribution of needles for SUD persons.
Require licensed BH residential facilities and recovery homes to develop policies & procedures that allow individuals on MAT to continue to receive care in their facilities	No specific improvement themes noted	

Appendix C – Summary of CSPMP Improvement Recommendations

Controlled Substance

Prescription Monitoring Program

Task Force Committee

Summary of Initial Recommendations

11-30-2017

Mission of the Task Force:

Establish a task force of healthcare professionals, licensing boards, Board of Pharmacy, Arizona Department of Health Services, and law enforcement agencies to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). Considerations should include but are not limited to:

i. Potential need for grant funding and/or technical assistance to assist health care providers to link their electronic health records to the CSPMP
ii. Additions to CSPMP to flag patients at higher risk of overdose
iii. Additions to CSPMP to flag patients who exhibit drug diverting behaviors
iv. Addition of veterinarians to reporting into and checking the CSPMP
v. Assessment of exemptions from mandate to check the CSPMP
vi. Improvement to prescriber report cards
vii. Use of CSPMP as a public health surveillance tool

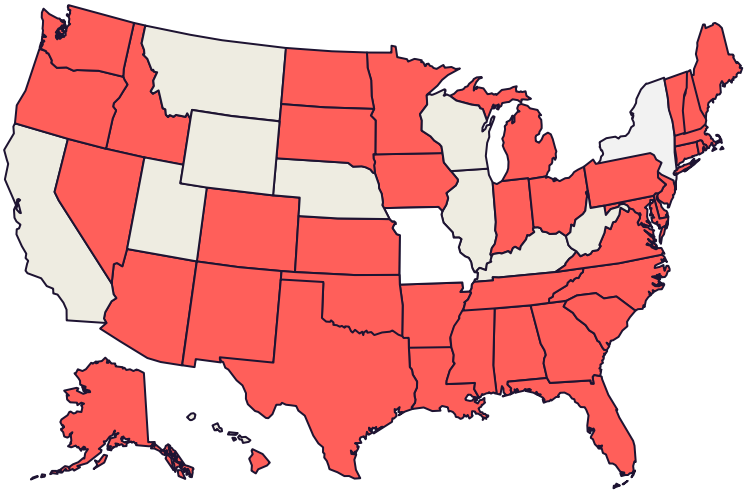
(highlighted in yellow was not discussed and will be addressed in a future meeting)

Task Force Members:

Task Force Members:	
Board of Pharmacy	Tom Van Hassel (Chair)
Medical Board	Pat Mcsorley
Osteopathic Board	Jenna Jones
AZ Medical Association	Pele Peacock
AHCCCS	Shana Malone
ADHS	Sheila Sjolander
Arizona Pain Society	Stephen Borowsky
Attorney General's office	Mary McGray
Attorney General's office	Travis Williams / Ron Davis
DEA	Julie Antilla
Arizona Pharmacist Association	Kelly Fine
Board of Pharmacy	Kam Gandhi
Board of Pharmacy	Douglas Skvarla
Hospital Associations	Jennifer Carusetta
Hospital Associations	Debbie Johnston
Arizona Pain Society leadership	Dr. Julian Grove
Arizona Society of Interventional Pain Physicians	Dr. Bill Thompson
Arizona Association of Health Plans	Deb Gullet
Arizona Osteopathic Association	Pete Wertheim

Current Database – APPRISS

- 42 prescription drug monitoring programs now use Appriss Health to operate their platforms nationwide.
- The most responsive, scalable, cost effective PDMP platform in the market
- Highly configurable to meet states' diverse needs
- Delivers information, insights, and tools to research, public health professionals, clinicians, and law enforcement



Recommendations:

1. Improve registration process (Bill needed)

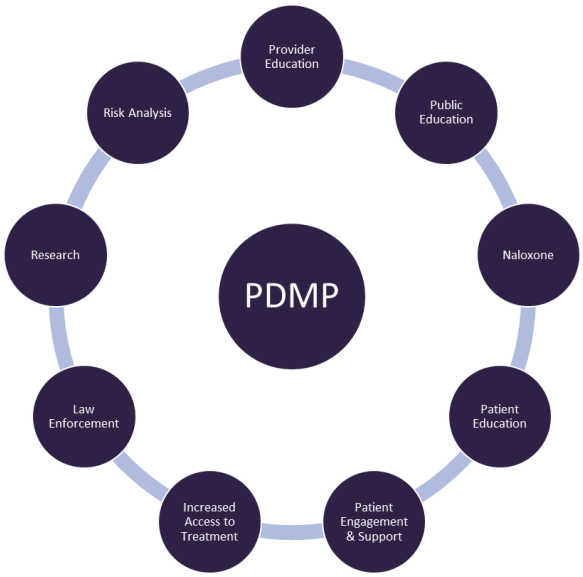
During the last legislative session, Arizona Board of Pharmacy (ASBP) modified the Controlled Substance Prescription Monitoring Program language to streamline the registration process. The ASBP further learned that interlinking with the other Health Boards could further improve registration. As the process to interlink with the Health Board was underway, it was quickly identified that though the process became somewhat easier, we could improve this process by having collected data that was uniform with what is required to register for the CSPMP. Below is a spreadsheet identifying the variability in data being collected by the Health Boards. A standard collection of data by all health board would help smoothen the registration process with the CSPMP.

		Data Collected by Health Boards							
	Board of Pharmacy	Medical Board	Dental Board	Naturopathic Board	Podiatry Board	Nursing Board	Osteopathic Board	Optometry Board	Physican Assistant
DEA #	X			X	X	X			
DEA Suffix # (Medical Residents Only)	X								
NPI #	X								
Exact Professional License #	X	X	X	X	X	X	X	X	X
License Type (MD/DO/DDS/DMD)	X	X	X	X	X	X	X		X
Email Address Belonging ONLY to Prescriber	X	X		SOME	X			X	X
First Name	X	X	X	X	X	X	X	X	X
Last Name	X	X	X	X	X	X	X	X	X
Date of Birth	X	X	X	X	X	X	X	X	X
Last 4 digits of SSN	X	X	X	X	X	X	X	X	X
Healthcare Specialty	X	X	X	X	X	X	X	X	X
Primary Contact Phone Number	X	X	X	X	X	X	X	X	X
Primary Work Location	X	X		X	X	X	X	X	X
Employer Name	X	X		X	X	X		X	X
Employer Address	X	X		X	X	X		X	X
Employer City	X	X		X	X	X		X	X
Employer State	X	X		X	X	X		X	X
Employer Zip Code	X	X		X	X	X		X	X
Employer Phone Number	X	X		X	X	X		X	X

2. **Implement CSPMP Add-on** (Funds needed approximately $500,000)
   - **CSPMP Add-on** provides **discrete SUD/PDMP data for incorporation into native EHR displays and decision support and includes:**
     i. **Use scores, risk scores, plain text alerts, and more**
   - **CSPMP Add-on** that is a **substance use disorder prevention and management platform that leverages the PDMP's status into a full suite of SUD functionality.**

- **CSPMP Add-on** that is a **care coordination platform that allows for person to person messaging, care notes, referrals – supporting the care of our highest at-risk individuals.**

Putting the PDMP at the Center of the Solution



Additional data sources

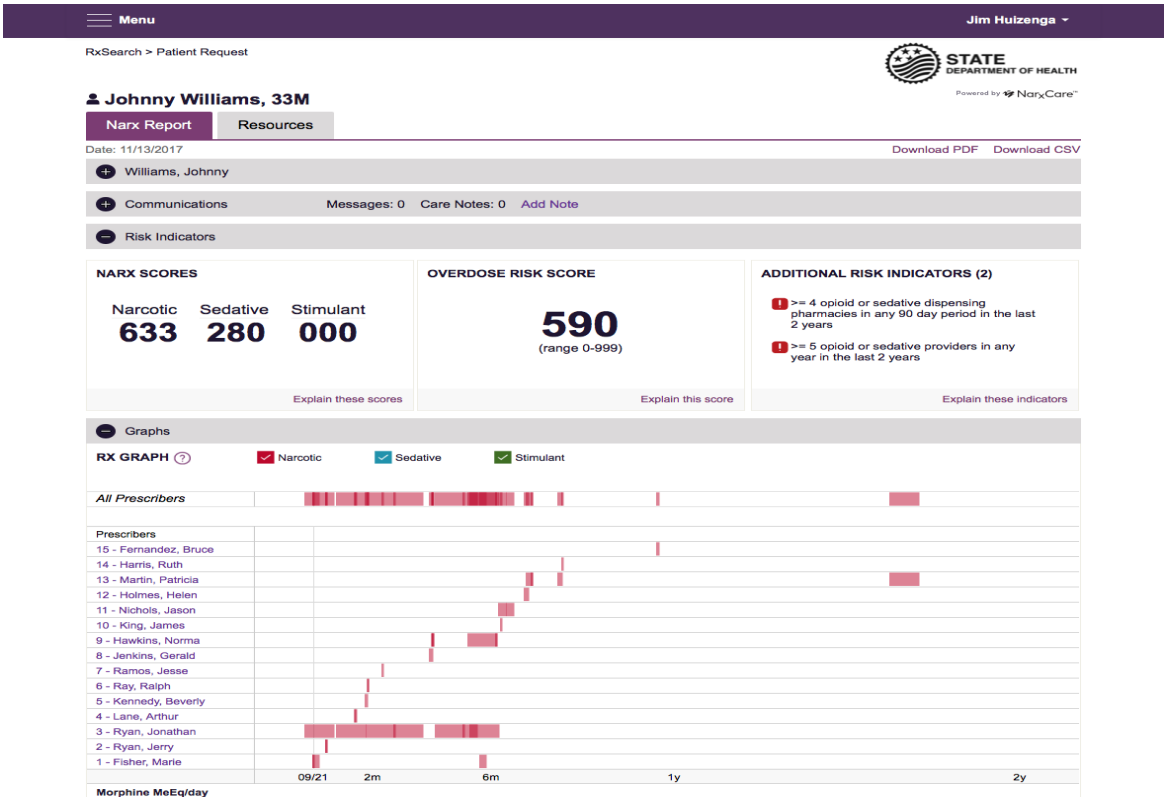
Visualizations

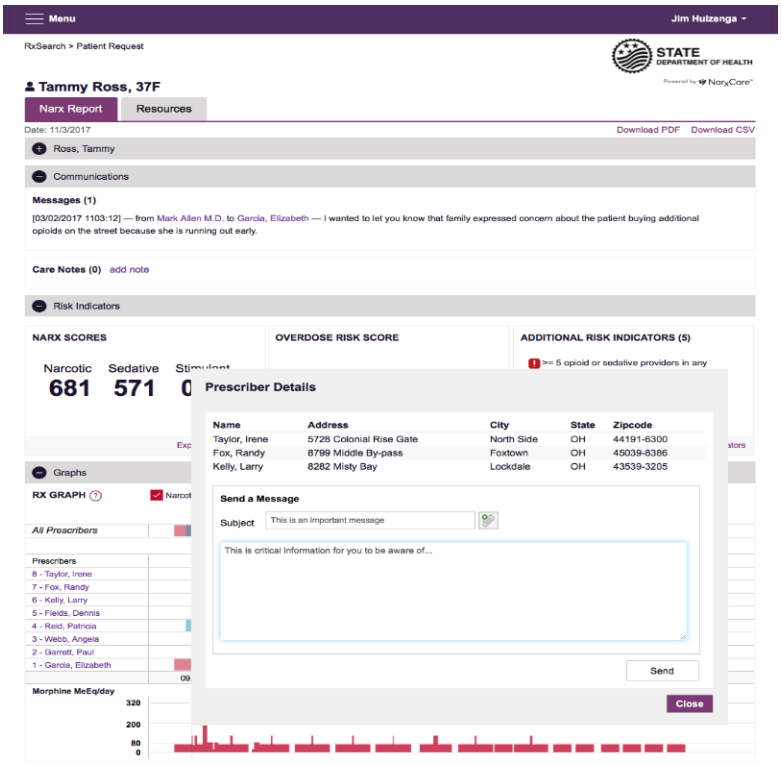
Analytics and predictive modeling

Provider and patient education and support

Care coordination

Sample of a Narxcare report:





Goal is to increase care coordination for those most at risk.

Simply click on any provider's name (or several of them), compose and send your message

3. Enhance Communication:
   Arizona State Board of Pharmacy has been tasked to implement a PDMP database that is cutting edge and the best in the country. As the Arizona State Board of Pharmacy moves in that direction, there has to be one communication/message lead by one entity. The task force feels that this entity to be the Arizona State Board of Pharmacy. The task force, has agreed that communication will be distributed to all the practitioners and dispensers via their respective Board and Association. This will result in a more improved process of sharing one message/communication. Further discussion and plan of action will be discussed at future task force meetings.

4. Enhance marketing/training:
   The Arizona State Board of Pharmacy has moved quickly to upgrade the database to be the best in the industry. As we evolved to fight the opioid epidemic, we now need to bring the users up to speed and to leverage the tools available at their fingertips to make a difference. The Arizona State Board of Pharmacy is ready to share with the database users of this state how valuable and useful this tool is and how it will play a KEY role in saving lives.

5. Enhance staff support to optimize use of the CSPMP
   Additional staff support is needed to:
   - Provide robust data analysis to evaluate trends and patterns and present findings to the public or policy makers;
   - Perform a variety of complex administrative tasks; and
   - Provide training and technical assistance on the CSPMP throughout Arizona.

Appendix D – Call to Action Law Enforcement

ARIZONA OPIOID EPIDEMIC

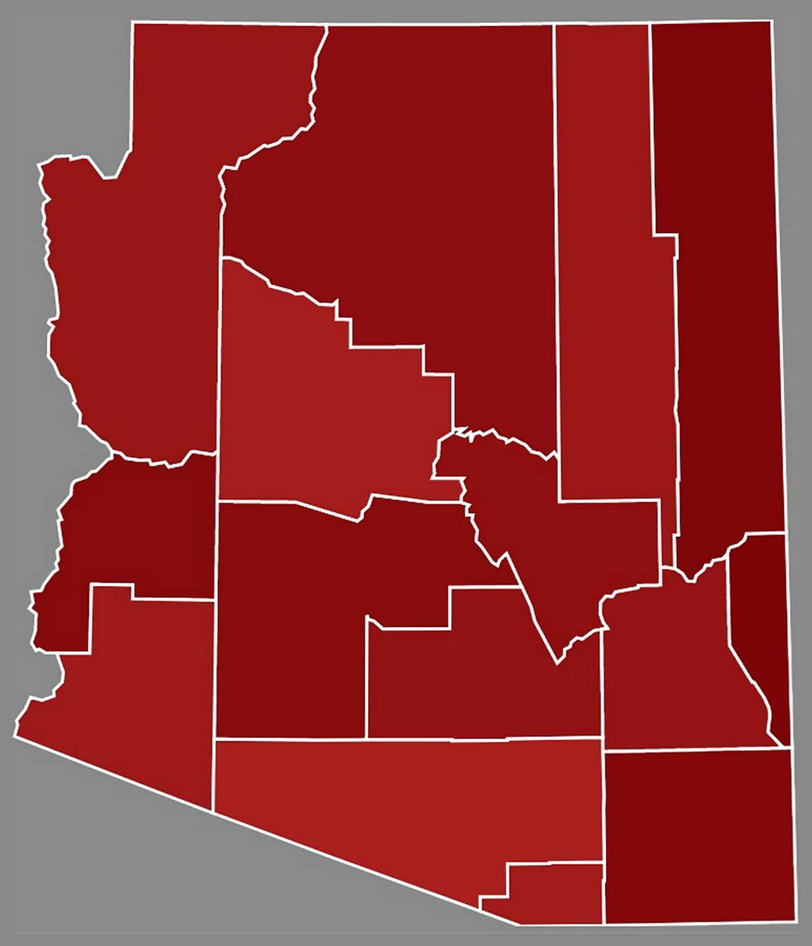
CALL TO ACTION

LAW ENFORCEMENT

Assist citizens to seek treatment.
Reduce the illicit supply of opioids.

1. Expand the Arizona Angel Initiative

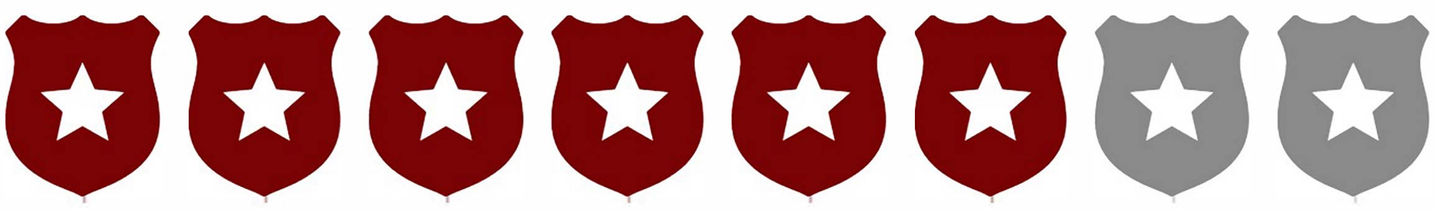
- The Arizona Angel Initiative allows citizens to walk into a police precinct, turn in their drugs and request treatment without fear of prosecution. Angels are also able to help parents secure safe placement for their child(ren) while they are in treatment in lieu of placing their child(ren) in the foster care system.
- Some law enforcement agencies nationally have implemented programs that attempt to reduce obstacles to accessing treatment, including through “deflection”, in which police serve as a point of contact for individuals seeking treatment.



2. Identify Additional Diversion Programs

- Identify additional opportunities for substance abuse disorder (SUD) Opioid Use Disorder (OUD) diversion programs in Arizona
- Increase the number of non-traditional intake sites individuals with SUD/OUD can access (ie. Safe Stations a fire department based program, additional law enforcement agencies)
- Use the existing 211 hotline to link to treatment services/resources

3. Fill vacant positions on the DEA Tactical Diversion Squad



ARIZONA DEPARTMENT OF HEALTH SERVICES

DEA Tactical Diversion Squad (TDS)

Arizona has **8 TDS vacancies** (6 in Phoenix and 2 in Tucson) that need to be filled by local law enforcement to assist in preventing illegal supply and diversion activities

azhealth.gov/opioid

Appendix E – Call to Action First Responders

ARIZONA OPIOID EPIDEMIC

CALL TO ACTION

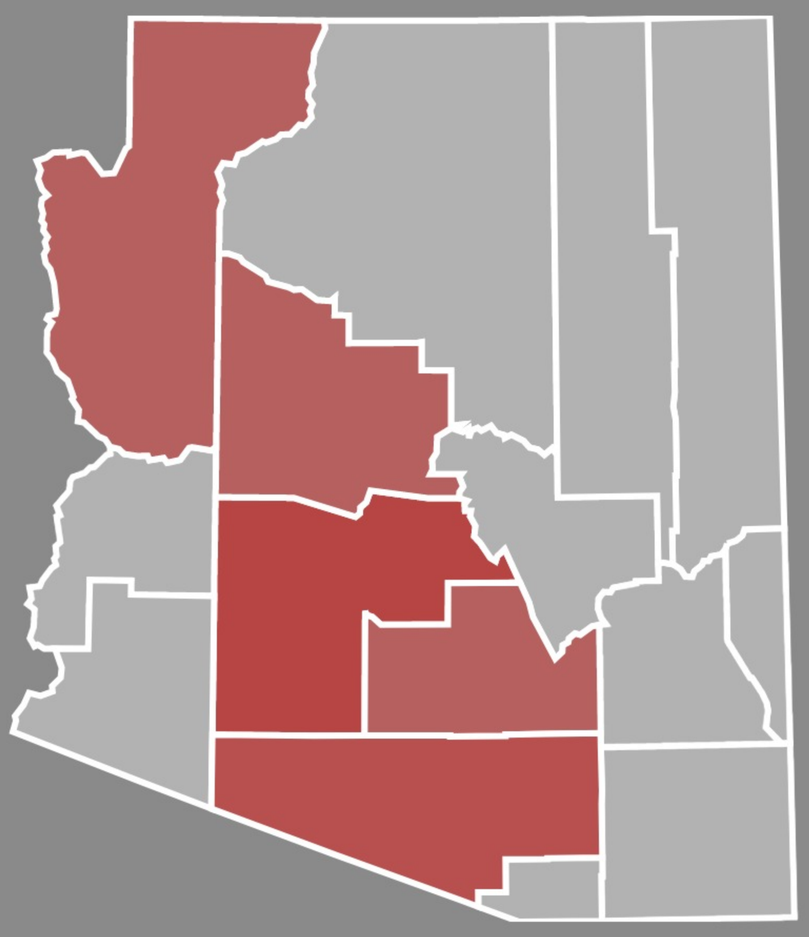
RECOMMENDATIONS FOR FIRST RESPONDERS

Assist citizens to seek treatment.
Reduce the illicit supply of opioids.

1. Save Lives with Naloxone

- Law enforcement officers are often the first to arrive on scene to an overdose
- Naloxone can reverse the effects of an opioid overdose and save a life
- Trained law enforcement agencies can receive free naloxone through the **ADHS naloxone voucher program** at azhealth.gov/opioid

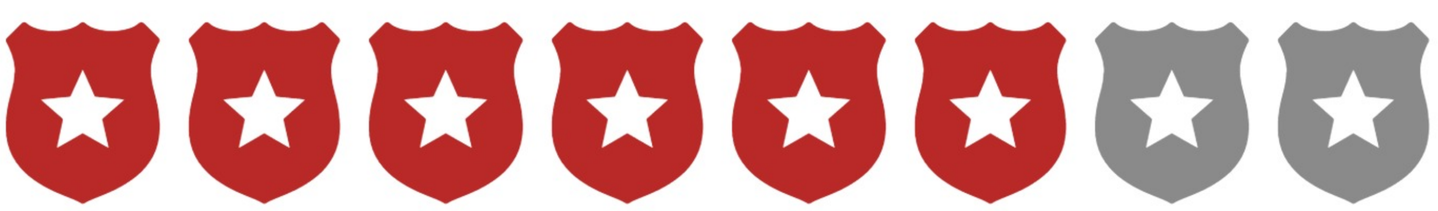
Excluding deaths, 85% of overdoses received naloxone pre-hospital



2. Utilize Diversion Programs

- Expand the **Arizona Angel Initiative** which allows citizens to walk into a police precinct, turn in their drugs and request treatment without fear of prosecution
- Identify additional opportunities for substance abuse diversion programs
- Increase the number of non-traditional intake sites individuals can access (ie. **Safe Stations** - a fire department based program)
- Implement programs to reduce obstacles to accessing treatment
- Use existing 211 hotline to link to treatment services/resources

3. Fill Vacant Positions on the DEA Tactical Diversion Squad



Arizona has **8 vacancies** (6 in Phoenix and 2 in Tucson) that need to be filled by local law enforcement in order for the TDS to be able to assist in preventing illegal supply and diversion activities

azhealth.gov/opioid

ARIZONA DEPARTMENT OF HEALTH SERVICES

Appendix F – Call to Action Correctional Facilities

ARIZONA OPIOID EPIDEMIC

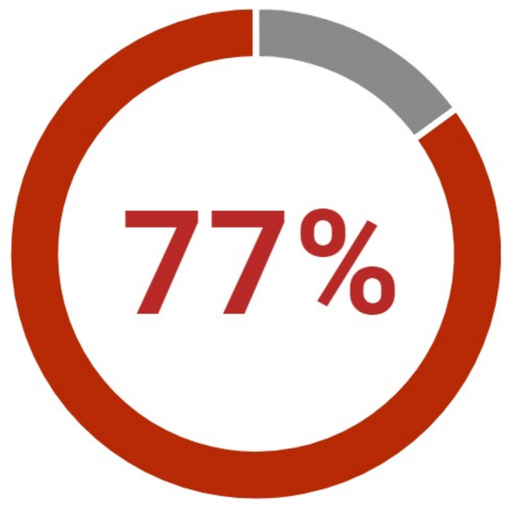
CALL TO ACTION

RECOMMENDATIONS FOR CORRECTIONAL FACILITIES

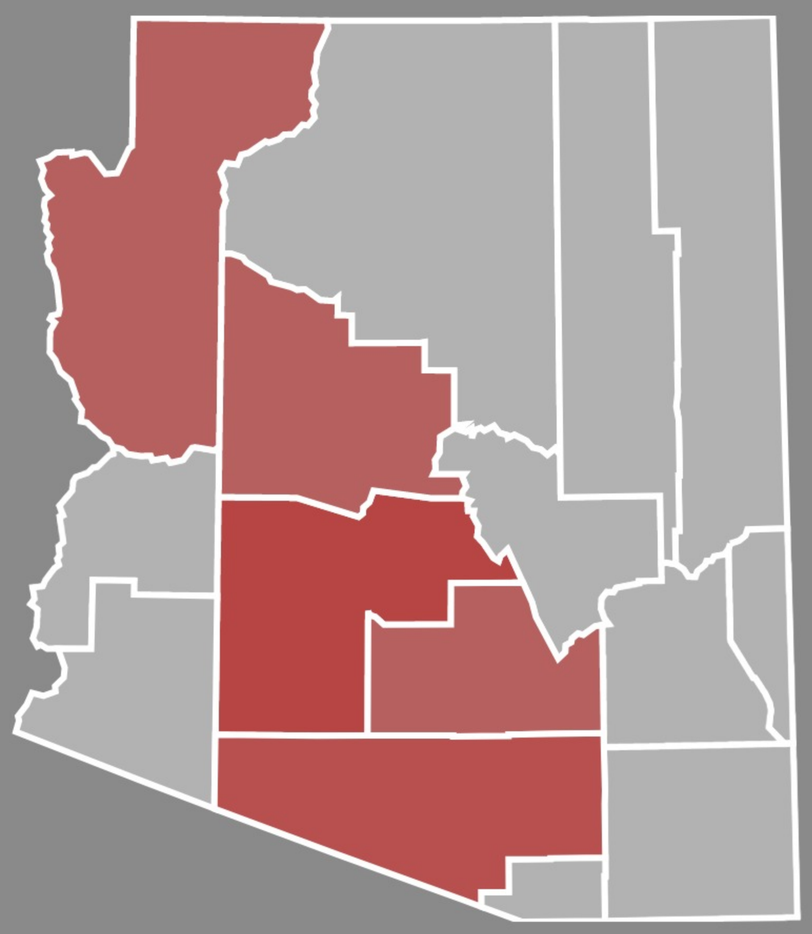
Identify high risk individuals.
Increase access to treatment.

1. Identify high risk individuals

- Studies have shown the risk of death for inmates with opioid use disorder increases during the early post release period
- Women were at an increased risk for overdose and opioid related deaths
- Screen for high risk individuals prior to release



of ADOC inmates assessed at intake have histories of substance use disorders



2. Increase access to naloxone

- Increase the number of individuals receiving **naloxone** and training on how to use it at the time of release
- Increase the number of individuals starting Vivitrol prior to release
- Trained law enforcement agencies can receive free naloxone through the ADHS naloxone voucher program at **azhealth.gov/opioid**
- Provide materials upon release on how to identify and respond to an opioid overdose

3. Increase Medication Assisted Treatment (MAT) services while incarcerated

Meet with GC4
Oct 1

Survey
Nov 1

Communicate with federal govt
Nov 1

Identify funding opportunities
Dec 1

Best practices and funding to facilities
Reb 1

A recommendation has been made to encourage the federal government to allow Medicaid to be used to provide MAT in correctional facilities

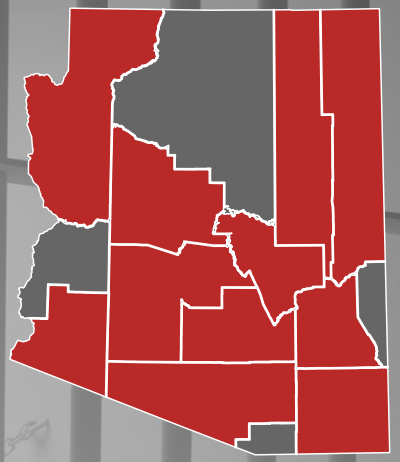
azhealth.gov/opioid

ARIZONA DEPARTMENT OF HEALTH SERVICES

Appendix G – Correctional Facility Survey Results

Opioid Response
from Arizona Jails and Prisons

ADHS sent a survey about opioid-related treatment and intervention programs to find out what programs AZ jails and prisons were already using or interested in using.



A total of 25 jails and prisons from 11 counties responded to the survey

Between 2014 and 2016, individuals who were **recently released from prison** were:

2.5 times more likely to experience **hospitalization** & **4.7** times more likely to experience **death**

from an **opioid-related event**

There are three main opioid-related treatment services and interventions that the jails and prisons are trying but only a small percentage of facilities have **implemented them**.

- **Vivitrol treatment**: 8%
- **MAT provider referral**: 12%
- **Naloxone dispensed**: 8%

Barriers to implementation

- **Cost of programs**
- **Access to training**
- **Coordination with other agencies & groups**

ARIZONA DEPARTMENT OF HEALTH SERVICES