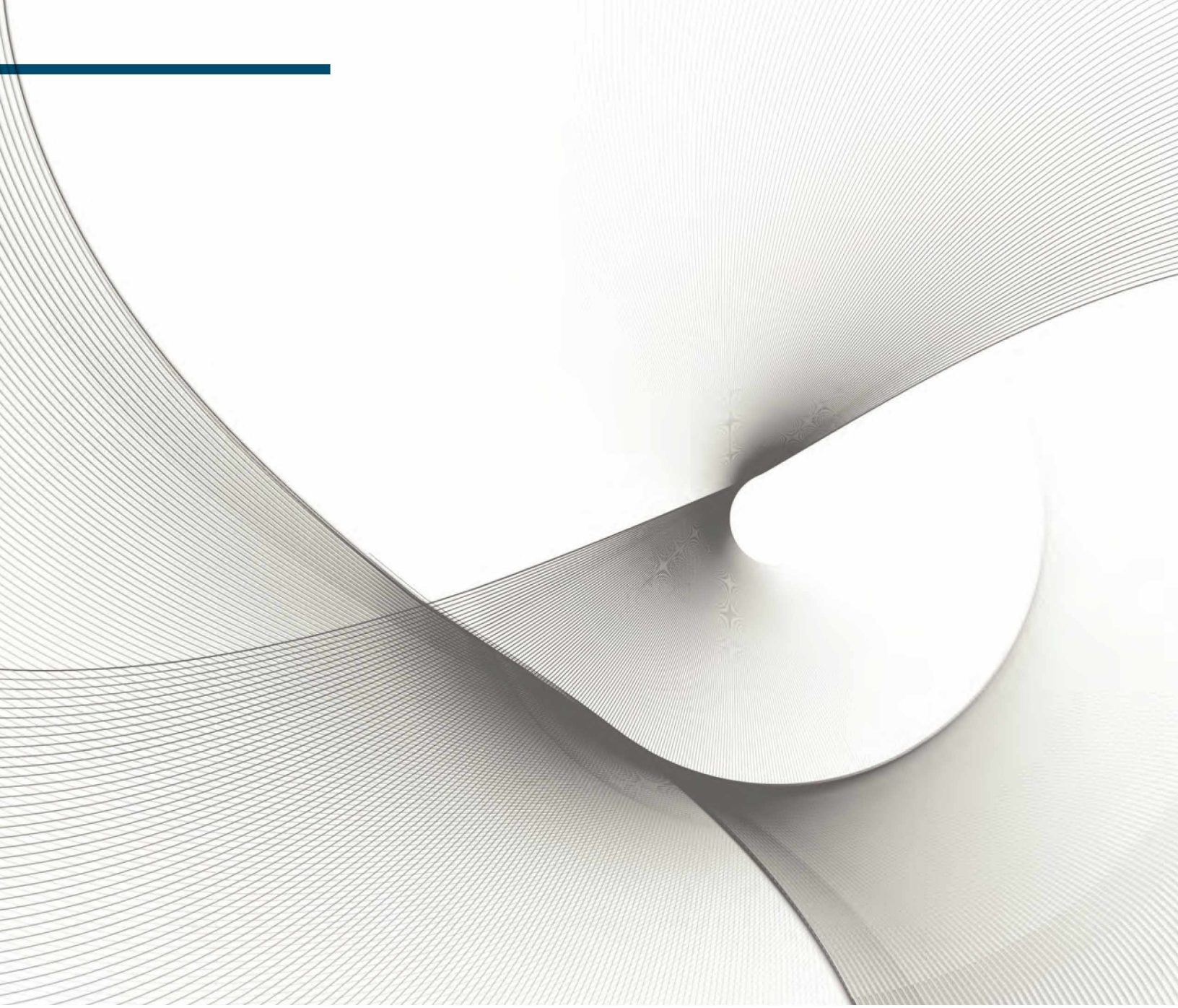

Prescription Drug Overdose:

State Health Agencies Respond

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Prescription Drug Overdose:
State Health Agencies Respond

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Executive Summary

This report presents health agency leadership perspectives from nine states on how prescription drug overdose has emerged as a national public health problem. It also shows the increasing awareness of the problem, which prevention and monitoring strategies have shown promise, and the infrastructure, technology, prevention, partnership, and leadership required to combat comprehensively and to reverse this rising trend.

Since 1999, abuse, misuse, and overdose of prescription drugs have significantly increased. Each year more than 20,000 persons in the United States die from drug overdose. Those with the highest rates are adults ages 35–44 and persons living in the South and West regions of this country. Opioid drugs, commonly prescribed to relieve pain, are the most common source of drug overdose deaths.

This increase in drug overdoses has created a considerable public health burden, and many states lack the capacity, personnel, and infrastructure to respond adequately to this emerging threat. Nonetheless, State and Territorial Health Officials (SHO) clearly recognize this problem and have demonstrated leadership in responding to and the planning for this threat.

To assess the knowledge, response, and planning regarding prescription drug misuse and overdose, in late 2007 the Association of State and Territorial Health Officials (ASTHO) and the Centers for Disease Control and Prevention (CDC) conducted interviews with SHOs and other senior leaders in nine states. This report outlines the knowledge, perceptions, partnerships, recommendations, policies, and other issues that are fundamental to understanding and responding to drug misuse. The following states are included in this report: **Arkansas, Florida, Indiana, Kentucky, Montana, North Carolina, Oklahoma, Utah, and West Virginia.**

Key Interview Findings:

- Most State Health Agencies (SHA) recognized that prescription drug overdoses were a growing issue but in some cases only recently realized its magnitude. Most agencies became aware of the overdose problem through mortality data.
- States rely heavily on measures such as interagency task forces and prescription monitoring programs to address the problem. Less common are educational and regulatory initiatives.
- States cited insufficient data, privacy and confidentiality concerns, and lack of state-based injury prevention capacity as barriers to implementing a response.
- States recognized the need to increase the visibility of the prescription drug overdose problem.
- States also identified the potential effectiveness of evidence-based guidelines for prescribers and for policy and programmatic tools. Although many states have implemented responses, their effectiveness is unclear.

Recommendations:

- SHAs should routinely track all major causes of injury. To increase public and professional awareness of the drug problem, states should emphasize its magnitude and rapid growth—the many young lives that are cut short and the mounting costs for state programs, law enforcement, Medicaid, and substance abuse treatment.
- State governments should identify a "home" for coordinating the response to the drug overdose problem. Prevention, surveillance, and response are often too fragmented across agencies and divisions of state government.
- States should build their capacity by using cost savings from reducing fraud and abuse involving prescription drugs to fund overdose prevention as part of SHA injury prevention. They should address privacy, confidentiality, and other concerns about prescription-drug monitoring programs (PDMP) by emphasizing to physicians the value of knowing which of their patients are abusing medications and the value of prosecuting unscrupulous providers.
- SHAs should rigorously evaluate the effect of prevention and control efforts on health outcomes.

The Rising Tide

Between 1999 and 2005, the annual number of unintentional drug overdose deaths in the United States more than doubled—from 11,155 to 22,448. Drug overdose became the second leading cause of unintentional injury death in the nation in 2002, just behind motor-vehicle injuries. The 35–44 age group had the largest increase.[1]

A 2006 CDC report showed that the rise in drug overdose mortality was due to increasing deaths from prescription drugs rather than from illicit drugs such as heroin and cocaine. The primary problem was a class of prescription drugs known as opioid analgesics.[2] These drugs are powerful painkillers with a potential for abuse because of their heroin-like effect. Physicians increasingly prescribed these drugs during the 1990s to treat moderate and severe pain. However, their potential for misuse was underestimated, and opioid analgesics quickly became the most popular category of abused drugs. By 2007, more teenagers used opioid analgesics recreationally than used marijuana.[3]

In 2000, publicity about prescription drug abuse focused on OxyContin®, a powerful opioid painkiller. Today, however, the most common opioid involved in drug overdose deaths has become the pill form of methadone, which is increasingly used as a painkiller because it costs twenty times less than drugs such as OxyContin®.[4] From 1997–2006, the sales of Oxycontin®, methadone, and other opioids increased substantially.[5]

Total Unintentional and Undetermined Intent Drug Overdose Deaths, 2005

Arkansas: 221

Florida: 2,003

Indiana: 526

Kentucky: 586

Montana: 71

North Carolina: 848

Oklahoma: 405

Utah: 389

*West Virginia: 169

Source: CDC WONDER

**Official 2005 drug poisoning mortality data for West Virginia is incomplete.*

This drug overdose epidemic hit some parts of the country particularly hard. More than half of the country—particularly Southern and Midwestern states—saw their drug mortality rates double. West Virginia's rate increased over 500 percent, while rates in Oklahoma, Montana, and Arkansas tripled. Increases were generally greater in more rural states.[1]

Rates of both use and misuse of opioid analgesics are highest in low-income populations that likely rely on Medicaid, so the social costs of this problem are significant. One national evaluation of insured populations found that opioid abusers had mean annual direct health care costs eight times higher than nonabusers.[6] Another study estimated that the total costs for opioid abuse was $8.6 billion in 2001 dollars. Direct healthcare costs accounted for $2.6 billion, and lost productivity totaled $4.6 billion. The costs in 2005 dollars would be $9.5 billion.[7] Given the substantial increase in drug overdose in recent years, economic costs are expected to be significantly higher in 2008.

Within the public sector, law enforcement agencies have traditionally been responsible for preventing and responding to drug abuse. SHAs have typically served supporting roles, such as providing mental health and substance abuse treatment programs. With the change to a drug abuse problem that is increasingly related to prescribed pharmaceuticals, the role of SHAs has expanded. At the same time, state drug control offices have shifted emphasis from illegal drug control to preventing prescription drug misuse.

The problem impacts SHAs in numerous ways. It affects state Medicaid and workers' compensation programs, which pay for both the prescription drugs and the medical care necessary to treat overdoses among low-income and disabled populations. The prescriptions for these drugs are written by physicians and dentists and dispensed by pharmacists, all of whom are licensed

State Health Officials and Other Interview Participants

Arkansas: Paul Halverson, DrPH, FACHE, Director and State Health Officer; Jerry Jones, Pharmacy Director; Jodianne Tritt, JD, Director of Community Support; Charles McGrew, Deputy Director and Chief Operating Officer, Arkansas Department of Health

Florida: Ana Viamonte Ros, MD, MPH, Secretary of Health and Surgeon General; Rich Weismann, Poison Control Director, Florida Department of Health; Bill Janes, Director, Florida Office of Drug Control

Indiana: Judith A. Monroe, MD, FAAFP, State Health Commissioner, Indiana State Department of Health

Kentucky: William Hacker, MD, FAAP, CPE, Commissioner of Public Health, Kentucky Cabinet for Health and Family Services

Montana: Todd Harwell, MPH, Chief, Chronic Disease Prevention and Health Promotion Bureau; Bobbi Perkins, EMT-B, Injury Prevention Program Manager; Roger Citron, RPh, Medicaid Pharmacist; Steven Helgerson, MD, MPH, State Medical Officer, Montana Department of Public Health and Human Services

North Carolina: Leah Devlin, DDS, MPH, State Health Director; Marcus Plescia, MD, Chief of Chronic Disease and Injury Section, North Carolina Division of Public Health

Oklahoma: Mike Crutcher, MD, MPH, Commissioner of Health; Shelli Stephens Stidham, Chief, Injury Prevention Service, Oklahoma State Department of Health

Utah: Bob Rolfs, MD, MPH, State Epidemiologist, Utah Department of Health

West Virginia: Chris Curtis, MPH, Acting Commissioner; Jim Kaplan, MD, Chief Medical Examiner; John Wilkinson, Director, Office of Health Facilities Licensure; Aron Hall, DVM, MSPH, CDC Epidemic Intelligence Service Officer; Danae Bixler, MD, MPH, Bureau of Public Health, West Virginia Department of Health & Human Resources

by state licensing boards, which frequently sit within SHAs. These agencies are also often the home of prescription monitoring programs, which track prescriptions for controlled substances, including opioid painkillers and sedatives. Finally, SHAs are leaders and experts in collecting relevant data about mortality, hospitalization, and emergency department visits for problems such as drug overdose.

SHAs play a growing role in addressing the rise in prescription drug overdoses through disease surveillance and data collection, education and outreach, policy development, and coalition building. As leaders of these agencies, State and Territorial Health Officials (SHOs) play a critical role in determining the scope and effectiveness of their agencies' responses to this problem.

To better understand the prescription overdose problem at the state level, CDC funded ASTHO through an existing cooperative agreement to conduct interviews with nine SHOs during the fall of 2007.

The Assessment Process

The goals of the interviews were to:

- Understand SHOs' awareness about the problem of prescription drug overdoses.
- Learn about state responses to the problem.
- Identify perceived barriers to addressing the problem.
- Identify SHOs' perceived needs to better address their state's prescription drug overdose problems.

Participants were selected from 19 states with at least 50 nonsuicidal drug overdose deaths in 2004 and overdose rates that at least doubled from 1999 to 2004. Care was taken to include geographic and social diversity among the sample in addition to including those states that had expressed an interest in participating.

SHOs from the nine states were encouraged to invite a small group of program experts, leaders from partner agencies, and others to attend the interview and to provide expertise and perspectives. Interviews were conducted by telephone in October and November 2007, and lasted for about 30 minutes. Respondents could review the transcripts for accuracy and clarity. Participants' quotes in this report are typically, but not always, verbatim.

Seven SHOs were interviewed. In addition, interviewees included state epidemiologists, state injury prevention directors, leaders of state drug control offices, and other relevant state health and substance abuse staff.

Findings

This section describes the .ndings from the SHO interviews, which are organized according to the specific study goals. Themes are presented when appropriate and illustrative quotes are used to reinforce key points.

Interview Guide

CDC and ASTHO developed a semi-structured interview guide that included a series of open-ended questions:

- Tell me what you know about prescription drug overdoses in your state.
- When did you become aware of the prescription drug overdose problem in your state? How did you become aware of this problem?
- Please describe in detail your agency's response to the prescription drug overdose problem.
- What in your opinion have been the most effective approaches to dealing with this problem in your state? How would you define success in terms of your agency's response?
- What has motivated or facilitated your agency's response to addressing the current prescription drug overdose problem?
- What barriers have reduced the effectiveness of your response?
- Historically, what has been your agency's response to prescription drug overdose problems in your state?
- Talk about what you think your agency's role should be in addressing this and future prescription drug misuse problems.

State Health Agency Awareness

When asked how they became aware of the prescription overdose problem, interviewees typically had a general sense of the overall numbers of deaths and other health outcomes associated with drugs or prescription drugs. All were aware that they had a growing problem in their states. A wide variation existed in when they became aware of the problem, ranging from the mid-1990s to 2007, the year of the interviews.

Several states indicated that data from state medical examiners were the primary source of their information. Other sources included media reports and national reports in public health literature.

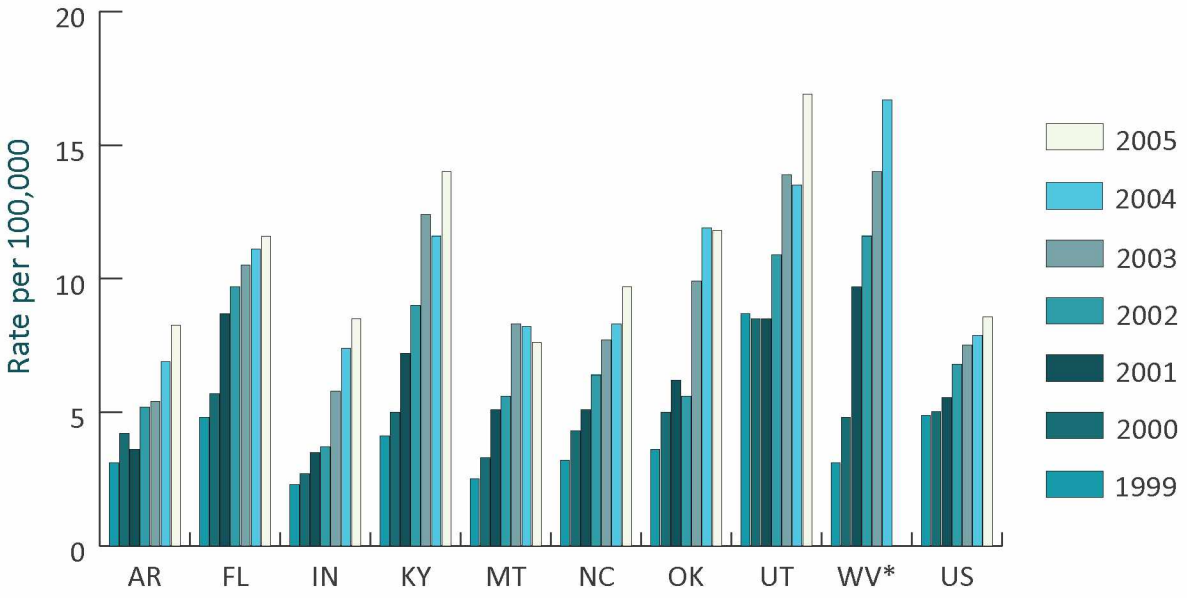
> **KENTUCKY –** William Hacker: "The prescription drug overdose problem has grown consistently over the past 10 years. We became more aware of the problem due to better data. Although no single event raised our awareness, over the years several anecdotal stories of overdoses both accidental and intentional have been shared in the media."

NORTH CAROLINA – Leah Devlin: "We lose over 700 people from unintentional overdoses each year. The big ones are methadone and OxyContin. It's a multifactorial problem."

UTAH – Bob Rolfs: "Somewhere around 2000, the medical examiners noticed a trend. Previously, there were about 30-40 deaths per year in prescription opioid use. That jumped to somewhere around 250."

WEST VIRGINIA – Jim Kaplan: "We began to see an upward trend in toxicology fatalities around 1997-1998. We began to see general trending of the methadone problem in 2002-2003."

Unintentional and undetermined intent drug poisoning mortality rates by year, selected states and the U.S., 1999-2005



** Official 2005 drug overdose mortality data for West Virginia is incomplete.*

State Health Agency Responses to the Problem

Although SHA responses to the problem varied, certain activities were frequently reported. They included state task forces, implementing state prescription drug monitoring programs (PDMPs), and linking state-managed databases.

Creating State Task Forces

In many cases, either the SHA or another state agency had convened representatives from various components of their respective governments—and in some instances members of the community. For example, Bill Janes, Director of **Florida's** Office of Drug Control, described a drug control advisory council with members from public health, law enforcement, other state agencies, the community, and the Governor's office. William Hacker noted that in 2004, **Kentucky** created the Governor's Office of Drug Control Policy within the Justice and Public Safety Cabinet to coordinate state agency efforts. Several states reported creating task forces in which members were drawn from mental health and substance abuse agencies, law enforcement, offices of drug control, pharmacy boards, coroner/medical examiners, workers' compensation, Medicaid, public employees' insurance programs, medical licensing boards, medical, dental, and pharmacist associations, and other non-governmental stakeholders. **West Virginia's** "Controlled Substance Advisory Board Workgroup" similarly convenes key statewide stakeholders to identify priorities and to develop strategies.

Some participants thought that forming a task force was a critical early step:

> **NORTH CAROLINA –** Leah Devlin: "In 2002, our Epidemiology Officer and the Secretary of the Department helped create a 25-member task force to help deal with the issue. They came up with 48 recommendations of what we should do. The task force was key. It brought together law enforcement, mental health and public health. This was the first time the issue was addressed with a collaborative approach."

Implementing State Prescription Drug Monitoring Programs

States frequently cited prescription drug monitoring programs as tools to monitor prescription sales of controlled substances, such as opioid analgesics and benzodiazepines (see inset).

Some SHAs are making extensive use of their PDMP data for surveillance and evaluation:

> **KENTUCKY –** William Hacker: "Ten years ago the Department of Public Health established an electronic reporting system, Kentucky All Schedule Prescription Electronic Reporting (KASPER) to track controlled substances dispensed within the state. KASPER is designed to provide information to physicians and pharmacists and serve as an investigative tool for law enforcement. For example, if a physician sees a patient that exhibits drug seeking behavior, he/she can access KASPER online or by phone to find out if any other provider or pharmacist has prescribed narcotics and when. The system's benefits also include that high quality care is provided to those patients who truly need prescription drugs. The KASPER program is now housed in the Cabinet's Office of Inspector General and continues to be the primary data source that guides prescription drug overdose prevention efforts of the Department of Public Health."

State Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs (PDMP), have been implemented in 26 states and nine more are in the development phase according to the U.S. Department of Justice. PDMPs create statewide databases to monitor prescriptions and to identify patients who may "doctor shop" or forge prescriptions to illegally obtain large amounts of drugs. They can also identify physicians who are prescribing especially large quantities of drugs. Most programs provide patient-specific drug information upon request of the patient's physician or pharmacist. Some state programs proactively notify physicians when their patients are seeing multiple prescribers for the same class of drugs.

The number of states with prescription monitoring programs has grown rapidly in recent years, driven in part by financial support from the Department of Justice through the Harold Rogers Program. Among the nine states included in this report, PDMPs operate in six: Indiana, Kentucky, North Carolina, Oklahoma, Utah, and West Virginia. Only Indiana and Oklahoma's PDMPs were enacted prior to 1990; the others were all enacted in 1995 or later.

FLORIDA – Ana Viamonte Ros reported, in 2007, that Broward County began to pilot a local database that could then be used statewide. Advocates hope that a pilot in such a populated county will demonstrate both the effectiveness and confidentiality of the PDMP and make future implementation possible.

WEST VIRGINIA – Danae Bixler: "Our (PDMP) data suggest that the problem is mixed: a substantial proportion of fatal cases had prescriptions for the drugs that killed them—often from multiple physicians and multiple pharmacies. In other cases, many decedents did not have prescriptions for at least one drug identified in post-mortem toxicology. This suggests that a substantial proportion of decedents are getting prescriptions directly from physicians and the others are getting drugs through diversion [to nonpatients]."

Other Data Collection and Sharing Efforts

Respondents mentioned several data collection or sharing efforts.

UTAH – The state is trying to link data from the state prescription monitoring program with the state medical examiner's and emergency department databases.

WEST VIRGINIA – John Wilkinson, reported data sharing within the Bureau for Public Health: The Office of Health Facility Licensure and Certification has shared information on participation in state narcotics treatment programs by people dying of drug overdoses with the Office of the Chief Medical Examiner.

WEST VIRGINIA – Aron Hall, CDC Epidemic Intelligence Service Officer, mentioned a recent collaborative investigation of drug overdose deaths in West Virginia. The investigation involved the CDC, West Virginia Office of Epidemiology and Health Promotion, Office of the Chief Medical Examiner, Board of Pharmacy, and statewide opiate treatment programs. Investigators from CDC abstracted data in collaboration with each of these entities to describe risk factors for fatal drug overdose and patterns of prescription drug abuse.

MONTANA – The state is currently linking medical examiner records on drug overdose deaths with Medicaid files to examine the prescribing patterns, co-morbidities, and costs associated with such deaths.

Public and Provider Education

State health departments have also taken advantage of their existing contacts with the community:

FLORIDA – Bill Janes: "There are many (statewide) coalitions and community efforts to increase awareness, but we must do a better job of reaching our families."

INDIANA – In Indiana, law enforcement maintains issue jurisdiction, but the Indiana State Department of Health has offered outreach and education to healthcare providers who prescribe drugs, and to statewide media to encourage responsible and educational reporting.

WEST VIRGINIA – The West Virginia University School of Medicine offers two CME courses entitled, "Clinical Challenges in Prescribing Controlled Drugs." The courses present provider education to help guide the judicious use of controlled drugs, balancing the needs of patients with the risks of abuse and diversion.

Regulatory or Legislative Initiatives

States have rules and laws that might affect the use of controlled prescription drugs and related overdoses.

FLORIDA – Bill Janes described an electronic prescribing initiative that passed the Florida Legislature in 2007. "While we continue to work to implement a prescription drug monitoring database, I believe e-prescribing is the system of the future. It is more timely and less expensive. The problem is most doctors do not e-prescribe and this solution is probably not achievable in the immediate future." Florida's e-prescribing legislation requires a state agency to

- Create a clearinghouse of information on electronic prescribing,
- Create a Web site to provide healthcare providers with information about the process and advantages of electronic prescribing, software availability, and state and national initiatives on electronic prescribing.
- Convene quarterly meetings of stakeholders to assess implementing e-prescribing.

In Palm Beach County, a Good Samaritan law protects citizens who help anyone who is overdosing.

MONTANA – The state requires Medicaid clients to obtain preauthorization for certain drug prescriptions. Medicaid only covers preauthorized prescriptions.

Creating Programs

States provided many examples of government programs that addressed aspects of population-based services and patient care.

ARKANSAS – The Arkansas Department of Health is working with the state coroners' association and others to get prescription opioids and other drugs out of the homes of people who have recently died at home so they do not fall into the hands of drug abusers. Arkansas also has a drug destruction program to ensure that the drugs are properly disposed of when found in homes.

KENTUCKY – The Kentucky Department of Mental Health and Mental Retardation received a grant to address substance abuse. One of its programs uses clinicians and other professionals to focus on outreach to communities with high rates of substance abuse. Initial results show promise. Data will be available next year. In addition, Kentucky created a public health program that screens all pregnant women for substance abuse.

MONTANA – The state created a case-management program within Medicaid. Clients who use multiple pharmacies and prescribers are designated to one physician and one pharmacy for all controlled substance prescriptions.

Tracking State Health Agency Actions

Most respondents acknowledged that, while awareness is growing within their agencies, the response to the problem has not matched the extent of the burden. Furthermore, states could not conduct enough formal prevention programs to permit critical assessment and evaluation. Therefore, much of what is known is anecdotal or incomplete.

INDIANA – Judith Monroe noted that Indiana State Department of Health's outreach to statewide media and providers has increased awareness and discussions about drug overdose—but unfortunately, this awareness has not translated to a decrease in mortality rates.

KENTUCKY – The state is evaluating the results of its community outreach program. Initial results show promise. Final results should be available next year. Kentucky also noted promising research on the effectiveness of substance abuse courts ordering treatment and close monitoring rather than incarceration for drug-related crimes.

Barriers to Addressing the Problem

SHOs noted many barriers to addressing the drug overdose problem. Limited awareness of the extent of the unintentional drug overdose problem was a common theme:

> **ARKANSAS –** Paul Halverson: "We have terrible statistics, but no one talks about it."

> **NORTH CAROLINA –** Leah Devlin: "I don't think people are aware of this as an issue. We've been trying to get this through for ten years."

When discussing data collection and sharing issues, particularly PDMPs, privacy and liability concerns were a common theme. Patients and their advocates are concerned that their medical information may be scrutinized without permission by persons other than healthcare providers, such as law enforcement. Healthcare providers are concerned that their medical decision will be second-guessed by law enforcement or by malpractice attorneys. However, all respondents indicated that the most stringent privacy protections are implemented at SHAs to protect patient confidentiality and to ensure that databases are used only to maintain the public's health. PDMPs are obliged to consider stakeholder privacy and confidentiality concerns. SHOs emphasized their agencies' histories of protecting sensitive health information and that SHAs have the appropriate education, policy, and technical infrastructure to be responsible data stewards.

> **FLORIDA –** Privacy concerns are common barriers that prevent implementing PDMPs. As Florida's Ana Viamonte Ros reported in 2007, Broward County began to pilot a local database that could be used statewide. Advocates hope that a pilot in such a populated county will demonstrate both the effectiveness and con.dentiality of the PDMP and facilitate future implementation.

> **NORTH CAROLINA –** Leah Devlin: "There is a huge privacy issue. It does seem very 'big brother,' where drugs are put in a database. It freaks people out."

An additional barrier regarding PDMPs was convincing pharmacists that the burden of reporting prescription information was small and justified given the importance of preventing drug misuse.

Also, respondents raised concerns that attention to this issue might cause physicians to cut back on prescribing opioid painkillers to the point where some people's pain might be undertreated.

> **UTAH –** Bob Rolfs: "We under-treat pain, but now there is a push to treat pain more. (Prescription misuse) could be an offshoot of that. But we don't necessarily want to scale back and go back to under-treating patients. We need to find the balance between treating the people who need more and preventing overuse."

With respect to mounting a response to prescription misuse, the most common obstacle cited was lack of funding both to identify the sources of the problem and to provide treatment for people with substance abuse problems. In **North Carolina**, it was noted that substance abuse treatment programs were not readily available, especially in rural areas.

The theme of lack of capacity within SHAs for injury prevention in general is also related to this issue. As Paul Halverson of **Arkansas** put it, "We have no injury capacity in this state. It's embarrassing that we, state and nationally, don't have staff to work on the number one issue for 1 to 44 year-olds—unintentional injury."

Montana staff also noted that their state did not have a well-organized injury prevention program. In other states with injury programs, participants noted that drug overdoses still had to compete for attention with other injury priorities.

Future Needs — What Should Health Agencies be Doing?

Respondents noted many potential areas where prevention efforts have been suggested, proposed, or implemented. SHOs and others laid out their priorities in addressing future issues:

> **ARKANSAS –** Paul Halverson: "What I would like is a good, efficient drug monitoring program. We have to stop doctor shopping and inappropriate prescriptions. Doctors should know whom else the patient is seeing. Building the database to prevent abuse is critical. It is not intended as a police mechanism—it is truly to enhance the public's health by being an informational tool."

FLORIDA – Ana Viamonte Ros: "We need to understand the best practices of other states and how they have overcome obstacles. We need to strengthen rules for enforcement and increase availability for health insurance and rehabilitation services. Unifying mental health and substance abuse is very important, along with the education and awareness message."

KENTUCKY – William Hacker: "We need to improve collaboration between state agencies and other partners. As linkages continue to build, partners can share their individual passions with one another to address community needs at both the macro and micro levels. This problem will not be solved in a decade, maybe several. It is necessary to keep the issue in front of both the general assembly and executive branch."

NORTH CAROLINA – Leah Devlin: "We're an aging state. As we get older we'll see more in pain. We will have to do more prevention."

UTAH – Bob Rolfs: "We need to keep this issue at a high level to continue working on things. We need to involve public education, guidelines for physicians that are evidence based, and we need to understand the problem better, including the epidemiology of it. At a micro-level, our focus has been analyzing secondary data. We need to get prospective data to get a real understanding of the issue. In the meantime, we know enough to keep going."

WEST VIRGINIA – Chris Curtis: "We need more prevention efforts. We can't do it ourselves, we need to engage all the players to work with us. Public health needs to validate the extent of the problem and work with our partners to educate and prevent. It's not only a public health issue, it's a medical care issue because these drugs are prescribed by private practitioners."

The states chosen for this assessment represent a cross-section of jurisdictions with sharp increases in prescription drug overdose deaths since 1999. ASTHO and CDC sought to include a geographic, demographic, and cultural mix of states to best capture national trends for such an emerging public health challenge. Not surprisingly, the SHO interviews yielded an impressive array of needs, priorities, challenges, and recommendations—although many common themes arose.

Collectively, SHOs and their leadership teams identi.ed these most common problems, solutions, and conclusions:

- Most states recognize prescription drug overdoses as a growing issue, although some states only recently became aware of its magnitude locally. Most states became aware of the problem through mortality data.
- States rely heavily on measures such as interagency task forces and prescription monitoring programs to address the problem. Less common are educational and regulatory initiatives.
- States cited lack of awareness of the problem, insufficient data, privacy and confidentiality concerns, and lack of state-based injury prevention capacity as barriers to implementing a response.
- States cited the need to increase the visibility of the prescription overdose problem.
- States need evidence-based guidelines for prescribers and effective policy and programmatic tools. Although many states have implemented responses, their effectiveness is unclear.

Many of these issues reach beyond the scope of this singular issue. Limited capacity within SHAs to address injury prevention impedes progress on the nation's fifth leading cause of death, while also impairing opportunities to study, prevent, and educate about drug overdose. Privacy concerns related to prescription drug monitoring programs are common among public health issues, yet lessons learned from states with active PDMPs like **Kentucky** can be used to assuage fears and to increase national adoption of such programs. Cross-agency partnerships in states like **Arkansas, Montana, West Virginia, North Carolina,** and **Florida** present models for responding to health threats that can only be overcome by using multidisciplinary approaches. Creating awareness and performing public outreach, as is the case in **Indiana**, demonstrates the crucial need and effectiveness of health marketing, promotion, and education. **Utah's** mature epidemiology capacity has helped leaders understand, appreciate, and strategically address this emerging health threat.

These multidisciplinary responses and solutions can reverse such a formidable trend. As ASTHO's interviews revealed, SHOs are increasingly aware of the growing problem of drug overdose and are developing multifaceted approaches for prevention and control. While prevention infrastructure and capacity may not match the extent of the problem, innovation is both necessary and common, as indicated in the interviews. This report is a step in identifying, promoting, and ultimately preventing the public health tragedy of prescription drug abuse and overdoses. Continuing education is needed and yields results, as **Indiana** and **West Virginia** demonstrate. Closing infrastructure gaps for injury prevention and control is fundamental, particularly in places like **Arkansas**. And investing in sound, robust surveillance like **Utah's** is a crucial step in identifying problems and targeting scarce prevention dollars.

State public health is but one necessary partner to eliminate drug overdoses; **Florida's** model partnership with drug control and **North Carolina's** task force creation showcases this clearly. Identifying a "home" for drug abuse in state government, delineating clear roles for agencies, providing adequate surveillance and prevention resources, and leaders who appreciate and promote this issue are fundamental for prevention and control. ASTHO hopes that the findings, recommendations, and observations included in this report will shine light on the preventable cause of 20,000 annual deaths. It also hopes to promote partnership and collaboration between state public health officials and its key internal and external stakeholders throughout the nation.

Recommendations

Many opportunities for policy, programmatic, legislative, or regulatory change emerged from the candid responses by SHOs and their teams. Though each state has a unique policy and bureaucratic environment, there are several strategies to address the barriers and unmet needs reported by the survey participants, all of which may be applied in other jurisdictions.

- State governments should identify a permanent home for the response to the drug overdose problem. Too often, prevention, surveillance, and response are fragmented across agencies and divisions of state government. A task force is a useful temporary response, but is probably not effective as a long-term solution.
- SHAs should routinely track all injury causes including drug overdose and track the patterns of drug prescriptions in their states using data from prescription drug monitoring programs.
- In addition to surveillance, prescription drug monitoring programs can be valuable as part of a comprehensive prevention program, but they alone cannot solve the problem. To date, none of the PDMPs in surveyed states have been able to reduce the rate of deaths from drug overdoses. PDMPs may work best when they are proactive and paired with aggressive prevention, drug treatment, and enforcement components.
- To increase public and professional awareness, states should emphasize the many young lives cut short and the mounting costs to state programs, law enforcement, substance abuse treatment, and Medicaid. Medicaid recipients are more likely to be prescribed narcotics[8] and to die from prescription drug overdoses.
- States can address their lack of capacity in this area by showing that effective prevention measures save state dollars being spent on potentially unnecessary medication, emergency department visits for drug overdoses, and prescription fraud. Cost savings from such measures are greater than those realized by preventing illicit drug misuse, because the state may itself be paying for the drugs. Some of those savings could go to the SHA to fund an overdose prevention component of a state injury program.

- States can address privacy, confidentiality and other concerns regarding monitoring medical care by emphasizing to physicians and pharmacists the benefit of knowing which of their patients are abusing medications and the value of prosecuting unscrupulous providers in their communities.
- States should seek the assistance of schools of public health, medicine, and pharmacy to evaluate the effect of policy initiatives on health outcomes. They should also use evidence-based practice guidelines such as the "Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain," developed by the Washington State Agency Medical Directors Group.[9]

References

1. Paulozzi LJ, Annest JL. Unintentional poisoning deaths—United States, 1999–2004. MMWR 2007;56:93-6.

2. Paulozzi LJ, Budnitz DS, Xi Y. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15:618-27.

3. Substance Abuse and Mental Health Services Administration. Results from the 2006 national survey on drug use and health: national findings. Rockville (MD): The Administration, Office of Applied Studies; 2007. Report No.: DHHS pub. no. SMA 07-4293.

4. Toombs JD, Kral LA. Methadone treatment for pain states. Am Fam Physician 2005;71:1353–8.

5. Department of Justice (US), Drug Enforcement Administration. ARCOS: Automation of Reports and Consolidated Orders System. [cited 2008 Mar 27]. Available at URL: www.deadiversion.usdoj.gov/arcos/index.html

6. White AG, Birnbaum HG, Mareva MN, Daher M, Vallow S, Schein J, et al. Direct costs of opioid abuse in an insured population in the United States. J Manag Care Pharm 2005;11:469–79.

7. Birnbaum HG, White AG, Reynolds JL, Greenburg PE, Zhang M, Vallow S, et al. Estimated costs of prescription opioid analgesic abuse in the U.S. in 2001;Clin J Pain 2006;22:667–76.

8. Raofi S, Schappert SM. Medication therapy in ambulatory medical care; United States, 2003–2004. Vital Health Stat 2006;13.

9. Washington State Agency Medical Directors' Group. Interagency guideline on opioid dosing for chronic non-cancer pain. [cited 2008 Mar 31]. Available at URL: www.agencymeddirectors.wa.gov.

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