A Drug Policy for the 21st Century

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American Osteopathic Academy of Addiction Medicine

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Office of National Drug Control Policy

- Component of the Executive Office of the President

- Coordinates drug-control activities and related funding across the Federal Government

- Produces the annual *National Drug Control Strategy*
National Drug Control Strategy

• The President’s science-based plan to reform drug policy:
  1) Prevent drug use before it ever begins through education
  2) Expand access to treatment for Americans struggling with addiction
  3) Reform our criminal justice system
  4) Support Americans in recovery

• Coordinated Federal effort on 112 action items

• Signature initiatives:
  – Prescription Drug Abuse
  – Prevention
  – Drugged Driving
PREVENTING DRUG USE AND SUBSTANCE USE DISORDERS
Prevention

• Each dollar invested in a proven school-based prevention program can reduce costs related to substance use by an average of $18.¹

• Effective drug prevention happens on the local level.

• Prevention must be comprehensive:
  – evidence-based interventions in multiple settings
  – tested public education campaigns
  – sound public policies

Why Prevention?
Escalation of Drug Use During the Teen Years

Source: SAMHSA, 2012 National Survey on Drug Use and Health (September 2013).
Drug-Free Communities Support Program

• Small amount of Federal funding combined with local resources and volunteer support

• Mobilize community leaders to identify and respond to the drug problems unique to their communities

• Focus on community change to prevent youth drug use
Healing those with Substance Use Disorders
Persons Aged 12 or Older Needing Treatment for Illicit Drug or Alcohol Use and Obtaining Specialty Treatment, 2013

Did Not Receive Treatment (20.2 million)  
Received Specialty Treatment (2.5 million)

89%  
11%

22.7 Million Needing Treatment* for Illicit Drug or Alcohol Use

*Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility within the past 12 months.

Source: SAMHSA, 2013 National Survey on Drug Use and Health (September 2014).
U.S. health care reforms will extend access to and parity for substance use treatment and mental health services for an estimated 62 million Americans and help integrate substance use treatment into mainstream health care.¹

Coverage for expanded Medicaid population is likely to create an increased need for substance abuse treatment services and staff.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- Medicaid Managed Care Organizations, Children’s Health Insurance Program, and Alternative Benefit (Benchmark) are required to meet the provisions within Application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.
Medication-Assisted Treatment (MAT) Formulary Options

- Medication-assisted treatment (MAT) – using an FDA-approved medicine and psychosocial treatment – is highly effective.
- Detoxification and psychosocial treatment alone without medication show high rates of relapse.
- The medicines are not interchangeable; Massachusetts ensured patient insurance coverage for full array of medicines, including:
  - Injectable naltrexone (Vivitrol);
  - Methadone; and
  - Medicines combining buprenorphine and naloxone.
MAT Constraints Mean Patients Need a Spectrum of Coverage Options

- Injectable naltrexone (Vivitrol)
  - Indicated for relapse prevention
  - Requires patient to be opioid abstinent for 7-10 days prior to first injection
  - Not a controlled substance but requires in-office injection
  - Newer medicine, so providers may not have experience with it
  - Significantly better compliance than with oral naltrexone
  - Cannot be initiated with pregnant women

- Methadone:
  - Only dispensed from Opioid Treatment Clinics
  - In some areas of the country, clinics have waiting lists or are for-profit only

- Buprenorphine and Naloxone Film:
  - Requires patient to live near a physician with a Data 2000 waiver or an Opioid Treatment Clinic that uses Buprenorphine Naloxone
  - In some areas of the country, clinics have waiting lists
  - Cash-only practices may limit access to low-income patients or Medicaid users
  - Data 2000 waiver physicians can see only 100 patients, and many are authorized for only 30.
With State Policy Teams publicizing that all forms of medication-assisted treatment (MAT) for treatment of substance use disorders need to be available as the standard of care (i.e., buprenorphine/naltrexone [Suboxone], methadone, Vivitrol).

Working with health plans and pharmacy organizations to offer adequate coverage for screening and treatment for substance use disorders, including MAT.

Working with Center for Medicare and Medicaid Services to inform states of substance use disorder health benefits that insurance policies should contain.

Inventory treatment availability and work within Affordable Care Act/state-run health marketplaces to ensure proper resourcing.
Prescription Drug Abuse in the United States (All Drugs Combined)

- 6.5 million Americans reported current non-medical use of prescription drugs in 2013.¹
- Approximately 1 in 5 people using drugs for the first time in 2013 began by using a prescription drug non-medically.²
- Of the 41,340 drug overdose deaths in 2011 in America, 22,810 involved prescription drugs.
  - 16,917 involved opioid painkillers (vs. 4,681 involving cocaine and 4,397 involving heroin)³
- $55.7 billion in costs for prescription drug abuse in 2007, including $25 billion in direct health care costs and $5.1 billion in criminal justice costs.⁴
- Studies have found that individuals abusing opioids generate, on average, annual direct health care costs 8.7 times higher than non-abusers.⁵

¹, ². Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. U.S. Department of Health and Human Services. [September 2014].
³. National Center for Health Statistics/CDC. Unpublished special tabulations of 2011 Multiple Cause of Death data (June 10, 2014).
Source of Prescription Pain Relievers

How different misusers of pain relievers get their drugs

<table>
<thead>
<tr>
<th>Methods and sources for obtaining pain relievers</th>
<th>Recent Initiates</th>
<th>Occasional Users</th>
<th>Frequent or Chronic Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bought from friend/relative, dealer, or internet</td>
<td>9%</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>Prescribed from 1 or more doctors</td>
<td>17%</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>Obtained from friend/relative for free or w/o asking</td>
<td>68%</td>
<td>66%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Drug Poisoning and Other Injury Causes of Death 1999-2012

NOTE: Suicide and homicide include deaths by drug poisoning or firearms.

Source: Centers for Disease Control and Prevention/National Center for Health Statistics. Underlying cause of death, 1999-2011 extracted from CDC WONDER Online Database on July 25, 2014. Data for 2012 were extracted from CDC WISQARS Online Database, October 17, 2014.
State Overdose Death Rates, 2011

U.S. National Rate: 13.2 per 100,000 Population

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2011 on CDC WONDER Online Database. Extracted June 20, 2014.
Recent Actions on Opioid Safety

• FDA required:
  – A risk evaluation and mitigation strategy (REMS) for extended/release long-acting (ER/LA) opioids as a class.
  – Post-marketing studies to look at addiction and overdose rates.
  – Box warning for Neonatal Abstinence Syndrome.
  – New language restricting use of ER/LA opioids to those with pain severe enough to require around-the-clock analgesia and for which alternatives are insufficient.

• FDA recommended and DEA rescheduled all hydrocodone products to Controlled Substances Act Schedule II

Non-medical Prescription Opioid Users Who Try Heroin

• Prescription opioid use is a risk factor for heroin use. Approximately 4 out of 5 of heroin users ages 12-49 used prescription opioids before heroin initiation.¹

• Among nonmedical prescription opioid users, heroin use is relatively rare; across a five year period following initiation, only 3.6% of people who used prescription opioids non-medically tried heroin.²

• Injection-drug users report tolerance motivates them to try heroin.³

• New research shows heroin effects, price, availability and ease of use motivate heroin users who formerly used prescription opioids.⁴

² Ibid
Prescription Drug Abuse Prevention Plan

• Coordinated effort across the Federal Government

• Four focus areas:

1) **Education**
2) **Prescription Drug Monitoring Programs**
3) Proper Disposal of Medication
4) Enforcement
Overdose Prevention and Education

The *National Drug Control Strategy* supports comprehensive overdose prevention efforts, to include:

- More extensive public education campaigns about overdose, including the signs of overdose, emergency interventions, information about “Good Samaritan” laws where they exist, and the importance of connecting people to substance use disorders treatment.

- Expanded training and availability of emergency interventions, such as naloxone for first responders (including campus police).

- Increased education among health care providers about informing patients using opioids (and their family members/caregivers) about potential for, signs of, and interventions in case of overdose.

- Naloxone co-prescribing.
Promising Practice: Naloxone Pharmacy Collaborative Practice Agreements

- Under collaborative practice agreements pharmacies can stock and dispense naloxone to the public for use by patient caregivers during an opioid overdose without a prescription by their primary care provider.

- State laws vary.

- Examples include:
  - Rhode Island in partnership with CVS and Walgreens
  - Washington State
Monitoring

Goals

• PDMP in every state and interoperability among states.
• Use of the system by prescribers to identify patients potentially at risk for or engaged in prescription drug misuse or at risk for medication interaction.

Main Actions

• Secured language for Department of Veterans Affairs to share prescription drug data with state PDMPs.
• Approximately 26 states can share data across state lines.
• Pilot projects with ONC and SAMHSA in Illinois, Indiana, Kansas, Michigan, Nebraska, North Dakota, Ohio, Oklahoma, Tennessee, and Washington State.
‘High Utilizers’ Declined When Prescribers Required to Consult PDMPs

- Tennessee’s PDMP Law went into effect at the start of 2013.
- Prescribers now must access the PDMP before prescribing opioids to a new patient.
- “High utilizer” defined as a person who used 5 prescribers and 5 pharmacies in a 90-day period.
- High utilizers decreased 47 percent from the fourth quarter of 2011 to the fourth quarter of 2013.

Promising Practice: Pharmacy or Provider Restriction Programs

- Programs which can limit patients based on unusual claims data to a single provider, pharmacy, or both.

- In Medicaid, lock-in period cannot be indefinite, and patients must:
  - “Have access to Medicaid programs of adequate quality.”
  - Be notified in writing.

- Only 46 states have these programs, and 16 post their eligibility criteria publicly.

- More research is needed on effectiveness for reducing overdose or the prevalence of substance use disorders.

Medicare Part D Opioid Overutilization Program

- Overlap and multiple providers is common in Medicare and related to higher hospital admissions.¹

- Medicare instituted the opioid and acetaminophen overutilization program partly in response to GAO-11-699, which found 170,000 beneficiaries receiving medicines from 5 or more prescribers.

  - Prescribers were often unaware of use of multiple prescribers despite the availability of PDMPs.
  
  - Programs are in place to monitor activity; the new program sets the expectation that Part D plans to make use of this information.

Source: ¹ Jena AB, Goldman D, Weaver L, Karaca-Mandic P. Opioid prescribing by multiple providers in Medicare: retrospective observational study of insurance claims. BMJ. 2014 Feb 19;348:g1393. doi: 10.1136/bmj.g1393. PMID: 24553363
Prescription Drug Monitoring Program/Restriction Program Questions

• What PDMP indicators or pharmacy use patterns are a red flag for prescriber, pharmacist, or pharmacy management intervention?

• When a provider notices a red flag, what clinical intervention should occur?

• What training is needed for prescribers to manage risks while maintaining duty to patients and complying with the law?

• What technological tools (e.g., electronic health records, doctor shopping algorithms, or pharmacy benefit review and restriction programs) could help advance PDMPs?
Heroin Use and Non-Medical Use of Pain Relievers in the Past Year among Persons Aged 12 or Older: 2002-2013

Source: SAMHSA, 2013 National Survey on Drug Use and Health (September 2014).
Hepatitis C Risk Reduction: Substance Use Disorder Treatment as Prevention

- No vaccine for Hepatitis C.
- The CDC reported that new Hepatitis C infections increased 44.7% between 2007 and 2011.¹
- Predominantly in white adolescents and young adults with histories of injection drug use and prior use of prescription opioids, mostly in non-urban areas.²,³
- Risk counseling alone does not change behavior.²
- Drug treatment attendance is associated with injection cessation and decreases risk.²
- Access to sterile drug prep equipment/syringes and in communities most in need is scarce.²

For More Information:

WhiteHouse.gov/ONDCP