UNIVERSITY of MARYLAND SCHOOL OF NURSING

Essentials for Policies that Support a Holistic Approach to the Opioid Epidemic

Fourth Annual Interprofessional Forum on Ethics and Religion in Health Care:
TRANSFORMING APPROACHES TO SUBSTANCE USE DISORDERS
April 8, 2017

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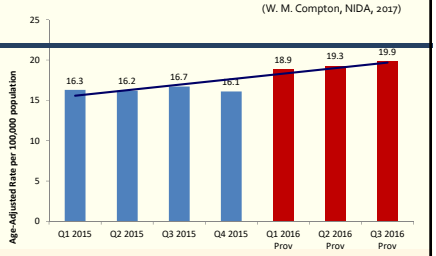
Opioid Use Disorders and Opioid Overdose Epidemic
EPIDEMIOLOGICAL TRENDS

U.S. Overdose Crisis:
52,404 Deaths in 2015
(33,091 from Prescription and Illicit Opioids)

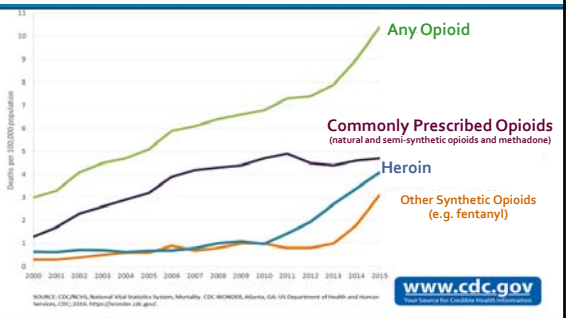
(W. M. Compton, NIDA, 2017)

And preliminary estimates suggest a 20% further increase in OD deaths in 2016….



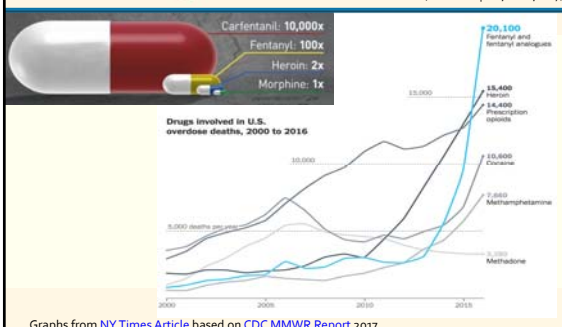
Source: DC NCHS 2017.

Overdose Deaths Primarily from Opioids: Prescription Drugs, Heroin and Synthetics (i.e. Fentanyl and similar)



2016 Fentanyl-Related Deaths Surpassed Heroin or Rx

(W. M. Compton, NIDA, 2017)

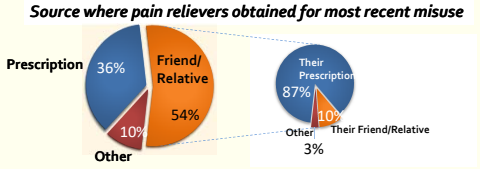


Graphs from NY Times Article based on CDC MMWR Report 2017

People Misusing Analgesics Obtain them *Directly & Indirectly* by Prescription

(W. M. Compton, NIDA, 2017)

Source where pain relievers obtained for most recent misuse



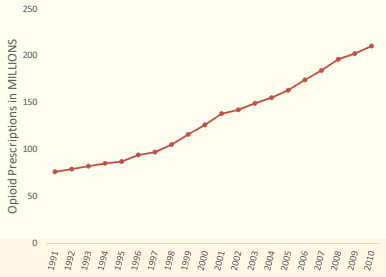
Source: Han, Compton, et al. Annals of Internal Medicine 2017;167(5):293-301

ENVIRONMENTAL AVAILABILITY:

Current Opioid Crisis Originated with Prescribing Increases

(W. M. Compton, NIDA, 2017)

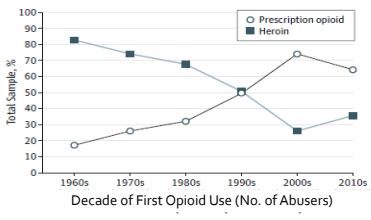
Opioid prescriptions *Tripled to MORE THAN 200 MILLION prescriptions in recent years*



Rx Opioid Misuse has been a Risk Factor for Heroin Use

(W. M. Compton, NIDA, 2017)

% Heroin Treatment Admissions that Used Heroin or Rx Opioid First



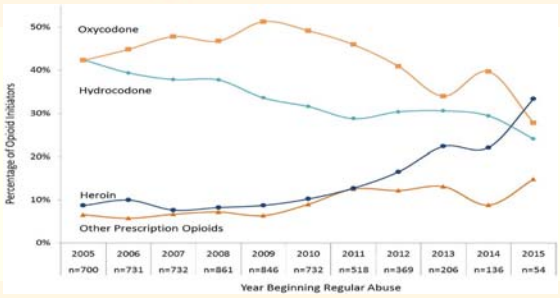
1990 – 2010
Most current heroin users **started opioid use with prescription opioids.**

Source: Cicero et al. JAMA Psychiatry. 2014;71(7):821-826.

HEROIN USE:

2010 – Now: First Opioid Likely to be Heroin

(W. M. Compton, NIDA, 2017)

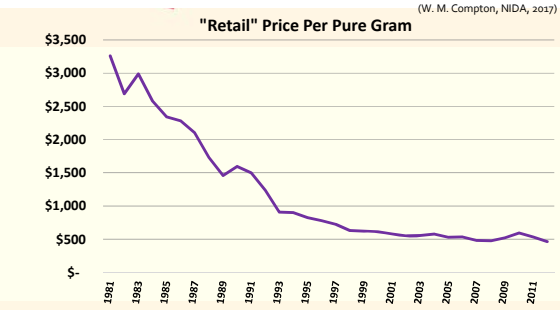


Source: Cicero T et al. Addictive Behaviors 2017;74:63-66

ECONOMICS:

Heroin Increases Due to Lower Price and Greater Availability

(W. M. Compton, NIDA, 2017)

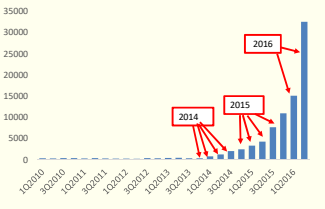


National Drug Control Strategy--Data Supplement 2014.
https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_data_supplement_2014.pdf

Retail Pharmacy Prescriptions for Naloxone Increase Markedly

(W. M. Compton, NIDA, 2017)

- **Retail prescriptions show an increase of *9520%* from the 4th quarter of 2013 to 2nd quarter 2016.**
- **Outpatient prescribing of naloxone may complement community-based distribution and first responder access.**

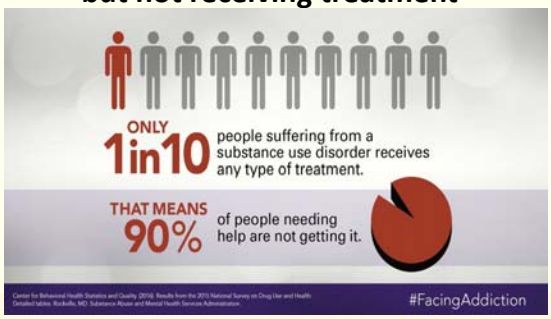


Sources: Jones CM, Lurie PG, Compton WM. Am J Public Health. 2016;106(4):689-690; IMS Health, published https://www.performance.gov/content/reduce-opioid-related-morbidity-and-mortality

Opioid Use Disorders and Opioid Overdose Epidemic

FEDERAL HEALTH SYSTEM PRIORITIES

"Treatment Gap"—Needing but not receiving treatment



White House Office of National Drug Control Policy (ONDCP) National Drug Control Strategy 2016 Priority Areas

- **Preventing drug use in communities**
- **Seeking early intervention in health care**
- **Integrating treatment for substance use disorders into health care and supporting recovery**
- Breaking the cycle of drug use, crime and incarceration
- Disrupting domestic drug trafficking and production
- Strengthening international partnerships
- Improving information systems to better address drug use and its consequences

"A substance use disorder is not a moral failing but rather a disease of the brain that can be prevented and treated"

Healthy People 2020 http://www.healthypeople.gov

- **Overarching Goals:**
  - High–quality, longer lives free of preventable disease, disability, injury and premature death;
  - Health equity, elimination of disparities;
  - Social & physical environments that promote good health for all;
  - Healthy behaviors across the lifespan.

- **Among Top 10 Leading Health Indicators/Focus Areas:**
  - Mental Health & Mental Disorders
  - Substance Abuse

http://healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020_brochure_with_LHI_508.pdf

Dept. of Health and Human Services:

3 Priority Areas for Opioid-Drug Related Overdoses and Deaths

1. Improved opioid prescribing practices
2. Expanded use and distribution of Naloxone
3. Expansion of Medication-Assisted Treatment (MAT)

DHHS: Agencies in RED = those with most influence on mental health and substance abuse services

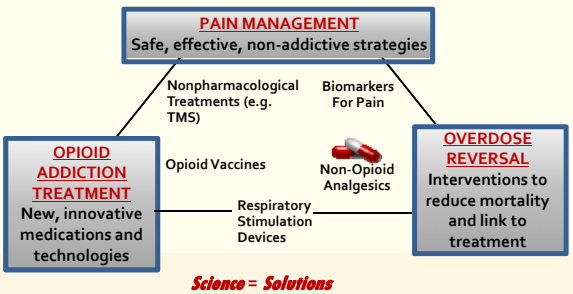
http://www.hhs.gov/about/index.html

- Administration for Children & Families (ACF)
- Administration on Aging (AoA)
- Agency for Healthcare Research & Quality (AHRQ)
- Agency for Toxic Substances & Dz. Registry (ATDSR)
- **Centers for Disease Control and Prevention (CDC)**
- **Centers for Medicare and Medicaid (CMS)**
- **Food and Drug Administration (FDA)**
- Health Resources & Services Administration (HRSA)
- Indian Health Services (IHS)
- **National Institutes of Health (NIH)**
- **Substance Abuse & Mental Health Services Administration (SAMHSA)**

NIH Opioid Research Initiative

Using Research to End the Opioid Crisis

(W. M. Compton, NIDA, 2017)



Safe Opioid Prescribing

Opioid Use Disorders and Opioid Overdose Epidemic

CHRONIC PAIN & OPIOID PRESCRIBING

Increasing Rates of Chronic Pain & Use of Opioids in U.S. Healthcare

- 35% of American adults (116 million people) in the US suffer with chronic pain
- Annual health care and other related costs estimated to be $635 billion.
- Prior to mid 1980's—cautious limited role
  - Surgery—managing perioperative pain
  - Pain management following severe injury
  - Pain relief and comfort at end of life, especially for cancer pain

J. Paul Seale, MD; AMERSA, Nov. 2017

Development of Pain Management as Subspecialty

- Anesthesiology—American Society of Regional Anesthesia and Pain was "reborn" in 1975
- 1998—American Board of Psychiatry and Neurology and American Board of Physical Medicine and Rehabilitation joined American Board of Anesthesiology in recognizing Pain Management as a subspecialty
- 2000—First joint examination was offered for certification by all 3 specialties
- Opioids became a commonly prescribed, low cost management approach to many patients with chronic pain

Archives of Physical Medicine and Rehab 2001; 82(4):564-565

J. Paul Seale, MD; AMERSA, Nov. 2017

Regulatory Pressure to Improve Pain Relief and Increase Patient Satisfaction

- 1996 President of American Pain Society advocated use of pain as "fifth vital sign"
- 1999 Veterans Administration initiated measurement and documentation of pain as 5th vital sign (P5VS)
- Expectation: pain score of 4 or higher would trigger "comprehensive pain assessment and prompt intervention"
- 2001 the Joint Commission on Accreditation of Hospital Organizations rolled out similar Pain Management Standards for non-VA settings
- Inclusion of 3 pain-related questions on HCAPS, the patient satisfaction survey used to determine hospital reimbursement rates

Mularski et al, JGIM, 2006

J. Paul Seale, MD; AMERSA, Nov. 2017

Promotion & Marketing of Opioids for Non-malignant Pain

- Purdue Pharma introduced Oxycontin in 1996
- Marketed 1996-2001 to >5,000 MDs, nurses & pharmacists at 40 national all-expense-paid pain management and speaker training conferences in CA, AZ and FL
- Targeted MDs who were highest prescribers of opioids (esp. Primary Care)
- Patient starter coupons for free 7 to 30 day supply of Oxycontin (34,000 coupons redeemed)
- Promoted aggressively for use in non-cancer pain, resulting in 10 fold increase in Rx to 6.2 million in 2002
- Reached blockbuster status by 2001 ($3 billion in sales 2001-2002)
- Total profits of >$35 billion

J. Paul Seale, MD; AMERSA, Nov. 2017

Criminal Misrepresentation of Risk of Addiction by Purdue

- Trained sales force to describe risk as "< 1%" for patients with chronic pain, based on 2 retrospective studies from 1980s
- Actual risk now know to be 8-12%, based on systematic review & data synthesis (Vowles et al, 2015)
- May 2007 3 Purdue executives pled guilty to claiming Oxycontin was less addictive and less subject to abuse & diversion than other opioids
- Paid $634 million in fines
- Marked increases in abuse, diversion, non-medical use & overdoses in early 2000's
- 2004 most frequently abused opioid in US

J. Paul Seale, MD; AMERSA, Nov. 2017

New Evidence Of Collusion By Congress, Lobbyists And Drug Distribution Industry

- Reported by 60 Minutes and Washington Post Oct. 17, 2017
- Authored by Bill Whitaker of CBS News
- Based on information provided by Joe Rannazzisi, former head of DEA's Office of Diversion Control

J. Paul Seale, MD; AMERSA, Nov. 2017

Role of Distributors (Middlemen)

- Cardinal Health, McKesson and Amerisource Bergen are Fortune 500 companies with significant money and influence
- Control distribution of 85-90% of prescription drugs in the retail U.S. market.
- Ship drugs manufactured by companies like Purdue Pharma and Johnson & Johnson to drug stores all over the country.

J. Paul Seale, MD; AMERSA, Nov. 2017

Consistent Failure to Report Suspicious Orders

- Under Controlled Substances Act distributors must report "suspicious orders" to the DEA.
- Consistently failed to report unusually large or frequent shipments
  - In Kermit, West Virginia, a town of 392 ordered 9 million hydrocodone pills over 2 years
  - Mid-sized distributor shipped more than 28 million pills to WV over 5 years, with 11 million sent to Mingo County (population 25,000)
- In 2008 DEA assessed fines of $13.2 million to McKesson and $34 million to Cardinal Health for filling hundreds of suspicious orders for millions of pills
- Total of distributors' fines >$341 million over the last seven years.

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Industry Struck Back at DEA

- Over the past decade recruited and hired at least 46 investigators, attorneys and supervisors from DEA into high-paying jobs with drug industry and law firms representing them
- Pressured top DEA lawyers to take a softer approach
- DEA bosses demanded more and more evidence
- Key leaders in DEA enforcement were reassigned to other duties
- By 2013 caseloads slowed down dramatically and success against suspicious shipments virtually stopped

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Industry Appealed to Congress

- In 2013 began working with members of Congress to create legislation that would strip the DEA of its most potent tool in fighting opioid distribution
- "Marino Bill" promoted as way to ensure that patients had access to pain medication they needed
- Spent $102 million lobbying Congress, claiming DEA was out of control

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Impact of Industry Influence on Legislation

- The "Marino Bill"
  - written by Linden Barber, ex-Director of DEA litigation and now Sr. VP with Cardinal Health
  - Introduced by Congressman Tom Marino and Congresswoman Marsha Blackburn
  - Presented to Senate in March 2016 & passed by unanimous consent by House and Senate with no objections and no recorded votes
  - Actual impact: has prevented the DEA from freezing suspicious shipments of opioids
  - No distributor shipments of narcotics have been frozen now for almost 2 years

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Pharmaceutical Ties of Nominees for Major Washington Posts

- Nomination of Senator Marino as Head of ONDCP ("Drug Czar") was announced Sept. 2, 2017 by White House
- Marino withdrew his name from consideration October 18, one day after the airing of the "60 Minutes" investigation
- Former pharma executive is now reported to be under consideration for nomination as head of Health and Human Services

J. Paul Seale, MD; AMERSA, Nov. 2017

Medication-Assisted Treatment (MAT)

- MAT includes opioid treatment programs (OTPs) and office-based opioid treatment (OBOT);
- MAT combines behavioral therapy and medications to treat substance use disorders;
- MAT for opioid addiction is subject to federal legislation, regulations, and guidelines, including DATA 2000 and federal regulation (42 CFR Part 8)

Center for Substance Abuse Treatment (CSAT)

Substance Abuse Treatment Facility Locator

- Searchable directory of drug and alcohol treatment programs that shows the location of facilities around the country;
- More than 11,000 addiction treatment programs, including:
  - Residential treatment centers,
  - Outpatient treatment programs,
  - Hospital inpatient programs,
  - Treatment programs for marijuana, cocaine, and heroin addiction,
  - Programs for adolescents, and adults.

Center for Substance Abuse Treatment (CSAT)

Buprenorphine Physician Locator

- To locate physicians authorized to prescribe office-based buprenorphine for the treatment of opioid addiction

Buprenorphine Prescribing

- **Drug Addiction Treatment Act of 2000 ("DATA 2000")**
- **The Recovery Enhancement for Addiction Treatment Act of 2015-2016 ("TREAT Act")**
- **Comprehensive Addiction Treatment Act of 2016 ("CARA 2016")**

The Drug Addiction Treatment Act of 2000 (DATA 2000)

- Designed to provide **increased access** to treatment in primary care and other office-based settings
- The Act would allow patients to receive opioid replacement treatment (ORT) their primary care provider's office, thus **decreasing the burden and shame of seeking treatment**
- However, when the law was enacted, **only physicians** who took a specialized class and request this designation could legally prescribe the medication
- Each physician was **limited to 30 patients** per practice
- Nurse practitioners/ Physician Assistants were not included

Comprehensive Addiction Recovery Act (CARA 2016): 3 Pillars

1. Supports expansion of **diversion programs** that channel individual caught in low-level drug law violation away from the criminal justice system and into evidenced based treatment instead.

2. Supports the **expansion of medication assisted treatment (MAT)** using methadone, buprenorphine and other forms of MAT. Includes those incarcerated in facilities not currently providing MAT for opioid use disorder.

3. Supports the expanded use of **naloxone** for first responders, who can quickly administer the medication and reverse the effects of the life threatening opiate overdose. The act authorizes grants which help to defray the cost.

CARA: Not funded

- Reauthorizes the funding for the National all Schedule Prescription Electronic Reporting Act for state prescription drug monitoring programs.
- Increases education to providers concerning opioid abuse, pain management and safe opioid prescribing.
- Expands use of MAT in conjunction with behavioral interventions.
- One section of the Act is dedicated to addressing care for the treatment for pregnant and postpartum women.
- The bill reauthorizes a grant program for residential opioid addiction treatment and creates a pilot program for agencies to address identified gaps in the continuum of care. This includes non-residential treatment services.

Patient Limits

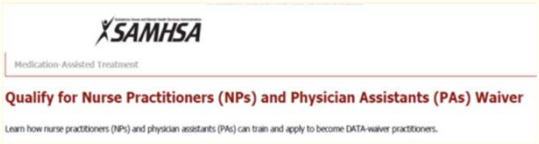
- CARA allows states to lower the patient practice limit and allows states to require practitioners to comply with additional practice setting, education or reporting requirements. States cannot lower the patient limit below 30.
- CARA raised the per patient limit that restricted the number of patients a MD can treat with buprenorphine from 100 to 275 in an effort to improve patient access to care.

Provider Requirements

- Agrees to fully participate in the **Prescription Drug Monitoring Program (PDMP)** of the State in which the qualifying practitioner is licensed.
- Must complete **24 or more hours of training** in the treatment and management of opiate-dependent patients provided by:
  - American Society of Addiction Medicine
  - American Academy of Addiction Psychiatry
  - American Medical Association
  - American Psychiatric Association
  - Or other organizations that the Secretary determines appropriate

CARA 2016: Waiver Requirements

- Waiver Notification to SAMHSA
- Submission of Training Certificate
- Special DEA Identification Number



https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers

CARA: Nurse Practitioners
(Prescriptive Authority for Advanced Practice Nurses)

- Includes a provision that expands office-based treatment-
  - Permits **Nurse Practitioners and Physician Assistants** to prescribe buprenorphine for the first time.
  - Expands prescribing privileges for 5 years until 2021.
  - NPs and PA must complete 24 hours of training to be eligible to apply for the waiver to prescribe buprenorphine.
  - If the NP resides in a state which requires MD collaboration or supervision, they must be supervised by a qualifying physician.
  - The HHS secretary has 18 months to provide guidance through updated regulations on office based opioid addiction treatment.

Nurse Practitioner/Physician Assistant Requirements:

- 1. **Licensed** under state law to prescribe schedule III, IV or V medications for pain
- 2. Completed 24 or more hours of **training** in the treatment and management of opiate-dependent patients provided by previously named groups
- 3. **Other training or experience** that will demonstrate the ability of the NP or PA to treat and manage opiate-dependence
- 4. The NP/PA practices under the **supervision** of a licensed physician who holds **an active waiver to prescribe Schedule III, IV, or V narcotic medication for opioid addiction therapy**
- **IF REQUIRED BY STATE LAW, practices in collaboration with a physician who holds an active waiver** to prescribe medication for opioid addiction treatment

American Association Nurse Practitioners (AANP)
Nurse Practitioner State Practice Environment

Full Practice: State practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing. (21 states plus DC—43%)

Reduced Practice: State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care. (17 states—33%)

Restricted Practice: State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care. (12 states—24%)

Inequality and African-American Men in Baltimore, MD

RACE, EDUCATION & POVERTY

SOCIAL DETERMINANTS OF HEALTH

http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

- **Resources** (Safe housing and local food markets)
- **Educational, economic, and job opportunities**
- **Health care services**
- **Recreational and leisure-time opportunities**
- **Transportation options**
- **Public safety**
- **Social support**
- **Social disorder**
- **Culture**
- **Language/Literacy**
- **Residential segregation**
- **Crime & Violence**
- **Social norms and attitudes**
  (Discrimination, racism, and distrust of government)
- **Socioeconomic conditions**
  (Concentrated poverty & stressful conditions that accompany it)
- **Access to mass media and emerging technologies**
  (Cell phones, Internet, and social media)

PLACE MATTERS:
THE RAT PARK EXPERIMENT (1970s)

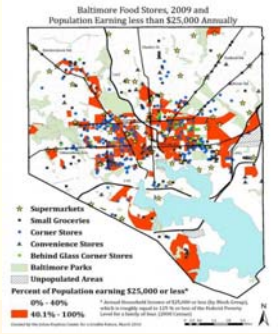
HTTPS://WWW.YOUTUBE.COM/WATCH?V=PKH8BOSLMQY

BRUCE ALEXANDER'S HYPOTHESIS : DRUGS DO NOT CAUSE ADDICTION; ADDICTION TO OPIATE DRUGS COMMONLY OBSERVED IN LABORATORY RATS EXPOSED TO IT IS **ATTRIBUTABLE TO THEIR LIVING CONDITIONS, AND NOT TO ANY ADDICTIVE PROPERTY OF THE DRUG ITSELF.**[1]

HE TOLD THE CANADIAN SENATE IN 2001 THAT PRIOR EXPERIMENTS IN WHICH LABORATORY RATS WERE KEPT ISOLATED IN CRAMPED METAL CAGES, TETHERED TO A SELF-INJECTION APPARATUS, SHOW ONLY THAT **"SEVERELY DISTRESSED ANIMALS, LIKE SEVERELY DISTRESSED PEOPLE, WILL RELIEVE THEIR DISTRESS PHARMACOLOGICALLY IF THEY CAN."**[2]

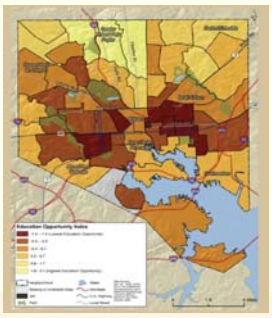
HTTPS://WWW.INTELLIHUB.COM/RAT-PARK-EXPERIMENT-SHOWS-CULTURAL-ROOTS-DRUG-ADDICTION

Baltimore City: Poverty Levels



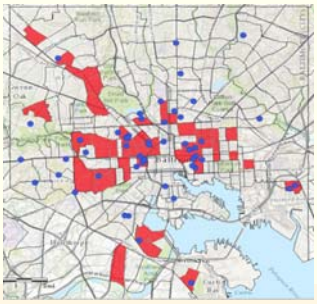
RED:
40% to 100%
of Population
Earning
</=$25,000

Baltimore City: Educational Attainment



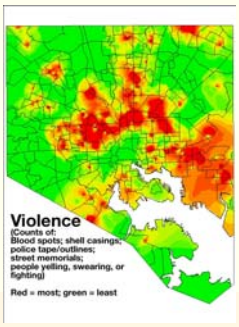
BROWN:
Lowest Education
Opportunity

Baltimore City: Resident of Public Housing



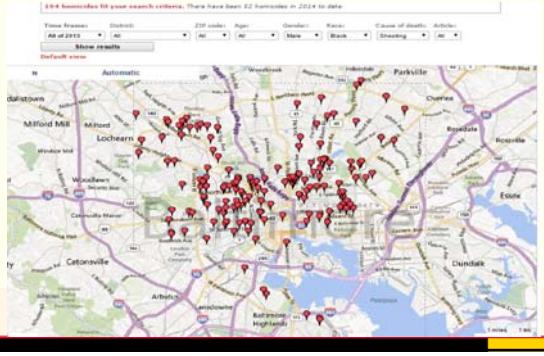
RED:
Public
Housing
Communities

Baltimore City: Violence



RED =
Most
Violence

Homicide Victims by Race:
Baltimore, 2013



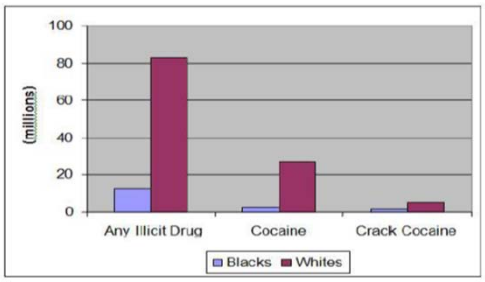
Homicide Victims by Race:
Baltimore, 2013

	BLACK	WHITE	OTHER	TOTAL
HOMICIDES, ALL CAUSES	224	9	2	235
HOMICIDES, SHOOTING, ALL GENDERS	181	7	1	189
HOMICIDES, SHOOTING, MALE	164	3	1	168

http://data.baltimoresun.com/bing-maps/homicides/

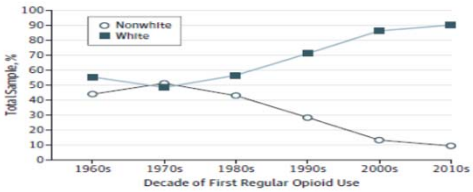
Race and Illicit Drug Use:

FIGURE 1: Lifetime Drug Use by Race, Ages 12 and Older
(Estimates for drug use by persons age twelve and older from SAMHSA)



Race and Heroin Use:

Figure 3. Racial Distribution of Respondents Expressed as Percentage of the Total Sample of Heroin Users



Data are plotted as a function of decade in which respondents initiated their opioid abuse.

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

Actual & Perceived Racism:

"May be cutting black men down before their time"

- **Black men in America**
  - **Lower life expectancy**
  - **Increased risk for almost every health problem known**
- **UCLA Minority Health Study:**
  - **Gap persists when controlling for poverty & lifestyle**
  - **Possibly related to Stress Response** (release of cortisol = "Toxic Cocktail" ↑ BP ↑ blood sugar & ↓ immune sx)
  - **Cumulative Stress Response compounds effects**

Baltimore Sun, Susan Brink (10/4/07) *Racism may affect black men's health*

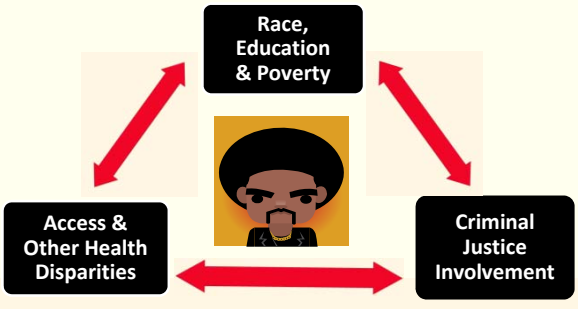
Inequality and African-American Men in Baltimore, MD

CRIMINAL JUSTICE INVOLVEMENT

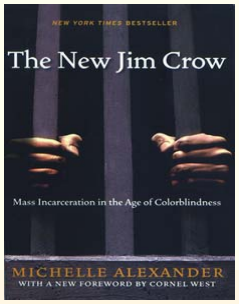
Inequality and African-American Men in Baltimore, MD

MASS INCARCERATION OF AFRICAN-AMERICAN MEN

Vicious Multi-Directional, Multi-Generational Cycle



"The New Jim Crow: Mass Incarceration in an Age of Colorblindness"



"A primary function of any ***racial caste system*** *is to define the* ***meaning of race*** *in its time.* ***Slavery*** *defined what it meant to be black (a slave), and* ***Jim Crow*** *defined what it meant to be black (a second-class citizen). Today* ***mass incarceration*** *defines the meaning of blackness in America: black people, especially* ***black men, are criminals****.* ***That is what it means to be black****."*

Racial Inequality in the U.S. Justice System

(*American Prospect*, Sophia Kerby, March 17, 2012)

- People of color disproportionately policed, incarcerated, and sentenced to death at higher rates than their white counterparts
- Racial disparities in sentencing disenfranchise millions of black men by limiting:
  - Voting rights
  - Access to employment, housing, public benefits and education

Racial Inequality in the U.S. Justice System

(*American Prospect*, Sophia Kerby, March 17, 2012)

- **People of color**: 30% of US population; 60% of imprisoned
- **Incarceration Rates:**
  - 1 in 15 African American men
  - 1 in 36 Hispanic men
  - 1 in 106 White men
- **Bureau of Justice Statistics:**
  - ***1 in 3 black men can expect to go to prison in their lifetimes***
- **Human Rights Watch:** ***African-Americans***
  - ***14% of regular drug users***
  - ***37% of those arrested for drugs (1980-2007 > 25 million adult Afr Amer)***

BALTIMORE DRUG ARREST DATA

	1980	2003
Drug Arrests as Proportion of All Arrests	9.8%	28.6%
Change in Rate of Drug Arrests per 100,000 (405% growth)	2,231	11,276
WHITE Change in Rate of Drug Arrests per 100,0000 (185% growth)	573	1,633
BLACK Change in Rate of Drug Arrests per 100,0000 (759% growth)	832	7,152
BLACK/WHITE Ratio of Drug Arrests (Change = 3.01)	1.45	4.38

Ryan King (May 2008). Disparity by Geography: The War on Drugs in America's Cities

"The Critical Link Between Health Care and Jails"

James Marks & Nicholas Turner, *Health Affairs*, March 10, 2014

- *"**Jail involved individuals** (people with a history of arrest and jail admission), **carry a heavy illness** burden, with high rates of infectious and chronic disease, mental illness, and substance abuse. Because these people tend to also be **uninsured**, **jail frequently has been their only regular source of health care**"*
- 30% of local corrections budget allocated for inmate health care costs → *"This investment is largely lost when* ***people are released back into the community, where they typically do not get treatment****"*

"The Critical Link Between Health Care and Jails"

James Marks & Nicholas Turner, *Health Affairs*, March 10, 2014

- *"People with* ***untreated substance use or mental illness*** *are at* ***heightened risk of cycling in and out of jail*** *for low-level, non-violent offenses"*
- *"The* ***expansion of Medicaid eligibility*** *under the* ***Affordable Care Act*** *is a critical opportunity* ***to bring the jail-involved population into the mainstream healthcare system****"*

CURRENT POLITICAL ENVIRONMENT

Trump May Cut the Office of National Drug Control Policy

By Paul Gaita (@bio/paul-gaita) 03/01/17

Advocates hope that Trump's vague statements about fighting opioid abuse will spare the office from proposed budget cuts.

President Donald Trump's proposed federal budget (https://www.nytimes.com/2017/02/27/us/politics/trump-budget-military.html), which seeks to increase military spending by a staggering $54 billion, also calls for severe reductions to numerous domestic programs like the Environmental Protection Agency and Internal Revenue Service, which provide essential benefits to millions of Americans.

Among the agencies that suddenly find themselves at risk is the Office of National Drug Control Policy (http://www.cbsnews.com/news/will-president-trump-slash-the-office-of-drug-policy/)(ONDCP), which oversees the government's anti-drug programs. In response to the news, letters opposing the move have been sent to Trump and the new head of Office of Management and Budget, Mick Mulvaney, from a coalition of medical and drug policy groups, as well as from the National Fraternal Order of Police.

The Washington Post

Politics

Trump taps Kushner to lead a SWAT team to fix government with business ideas

Jared Kushner Gets New Job 'Overhauling' the Federal Government

The White House Office of American Innovation, to be led by Jared Kushner, the president's son-in-law and senior adviser, will operate as its own nimble power center within the West Wing and will report directly to Trump. Viewed internally as a SWAT team of strategic consultants, the office will be staffed by former business executives and is designed to infuse fresh thinking

Report: Chris Christie Tapped by White House to Lead Opioid Commission

To address opioid crisis, Trump to give Chris Christie the helm

Christie's role would be part time and would not require him to resign as governor, NJ.com reported.

New Jersey Governor Christie will head a commission to look at ways to exercise federal funds and programs to deal with the ongoing opioid epidemic in the United States.

Christie: Putting Jared Kushner's father in prison is 'ancient history'

"Public Health Emergency"
NOT "National State of Emergency"
(SO NO NEW FUNDING)

The Washington Post

Post Politics

Trump declares the opioid crisis a public health emergency

By Jenna Johnson and John Wagner October 26

President Trump said Thursday that the opioid epidemic — which is killing more than 100 people each day — is the "worst drug crisis in American history" and said his administration is declaring it a public health emergency, pledging the nation's full resolve in overcoming it.

THE PRESIDENT'S COMMISSION
ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS

Roster of Commissioners

Governor Chris Christie, Chairman
Governor Charlie Baker
Governor Roy Cooper
Congressman Patrick J. Kennedy
Professor Bertha Madras, Ph.D.
Florida Attorney General Pam Bondi

Commission Established March 2017

Final Draft Report November 1, 2017

We are the Drug Policy Alliance.

NOVEMBER 2, 2017

BLOG POST

White House Opioid Commission Blows Teachable Moment

WIDNEY BROWN

The White House Commission on the opioid crisis released its final report on Nov.1. The report contained a range of recommendations including increasing the number of drug courts and launching a public campaign to prevent abuse of opioids and to challenge the stigma associated with its use.

While much of the focus on the Commission's final report is understandably on critiquing its recommendations, there is a larger issue at play—what is absent

"The Commission blew an opportunity to share with the public what is well-known and understood by public health and addictions experts on the frontlines of the opioid epidemic—that there are proven harm reduction and treatment interventions that will be far more effective at curbing overdose fatalities than any supply reduction or enforcement strategy."

The Washington Post

Opinions

Jeff Sessions wants a new war on drugs. It won't work.

We cannot incarcerate our way out of drug use and the opioid epidemic

By David Cole and Marc Mauer June 22

David Cole is national legal director of the American Civil Liberties Union. Marc Mauer is executive director of the Sentencing Project.

Attorney General Jeff Sessions is right to be concerned about recent increases in violent crime in some of our nation's largest cities, as well as a tragic rise in drug overdoses nationwide ["Lax drug enforcement means more violence," op-ed, June 18]. But there is little reason to believe that his response — reviving the failed "war on drugs" and imposing more mandatory minimums on nonviolent drug offenders — will do anything to solve the problem. His prescription contravenes a growing bipartisan consensus that the war on drugs has not worked. And it would exacerbate mass incarceration, the most pressing civil rights problem of the day.

Opioid Use Disorders and Opioid Overdose Epidemic

THE ACA & ACCESS TO SUD SERVICES

Historically speaking…..

- **Addiction treatment has always been segregated** from the rest of healthcare, and almost always provided in separate specialty care addiction treatment programs.
- **Financing** for addiction treatment was also separated from other healthcare coverage, **typically "carved out"** and managed separately from the larger healthcare plan.
- Many private **insurance plans have not covered** addiction treatment at all. Over 80% of addiction treatment financing has come from government sources (Block grants, VA, etc.)
- Whether public or private, coverage has always been **restricted to only the most advanced and severe form of substance use problem: addiction**. Coverage for less severe but far more common forms of substance use disorders has never been included.

Affordable Care Act - ACA

- Uninsured people with substance use disorders (SUDs): Est. 1.6 million
- Medicaid Expansion: to cover SUD treatment in alternative benefit plans
- Mental Health Parity & Addiction Equity Act of 2008:
  - Enrollees in alternative benefit plans, Medicaid managed care plans, and the Children's Health Insurance Program.
  - All state Medicaid programs must ensure that coverage and limits on the use of treatment for SUD are no more restrictive than those placed on other medical and surgical services.

(Grogran, Andrews, Abraham et al., 2016)

IOM Consensus Recommendations for Essential Health Benefits (EHB)

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity & Newborn Care
5. **Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**
6. Prescription Drugs
7. Rehabilitative and Habilitative Services
8. Laboratory Services
9. Preventive and Wellness Services & Chronic Disease Management
10. Pediatric Services, including Oral and Vision Care

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html

6 Ways "Obamacare" is Already Changing Behavioral Health Coverage

1. Pre-existing conditions are now covered.

2. Insurance plans must offer parity of mental and physical health coverage.

3. There are limits on out-of-pocket spending.

4. Insurers must cover prescription drugs.

5. More people are getting treatment.

6. The already strained system isn't keeping up.

http://www.thefiscaltimes.com/Articles/2013/11/26/6-Ways-Obamacare-Changing-Mental-Health-Coverage

Continuing Progress on the Opioid Epidemic: The Role of the ACA

Key Findings

- The share of hospitalizations for substance use or mental health disorders in which the patient was uninsured fell from 22 percent in the fourth quarter of 2013 (just before the ACA's major coverage provisions took effect) to about 14 percent by the end of 2014.
  - In states that expanded Medicaid under the ACA, the uninsured share of substance use or mental health disorder hospitalizations fell from about 20 percent in the fourth quarter of 2013 to about 5 percent by mid-2015.
- Between 2010 and 2015, the share of people foregoing mental health care due to cost has fallen by about one-third for people below 400 percent of the federal poverty level.
- The states with the highest drug overdose deaths also are projected to experience dramatic increases in their uninsured rates if the ACA were repealed:
  - The top three – West Virginia, New Hampshire, and Kentucky – would see their uninsured rates nearly or more than triple if the ACA were repealed, as would Massachusetts.

HHS Office of Assistant Secy for Planning & Evaluation, ASPE Issue Brief, 1/17/17
https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths

Repeal Obamacare and the opioid epidemic will get much worse

Updated: JANUARY 17, 2017 – 6:42 PM EST

by Antoinette Kraus , Director of the Pennsylvania Health Access Network
@ATK2003 (http://twitter.com/ATK2003)

Repealing the Affordable Care Act without a replacement plan is dangerous for the health and economic well-being of our Commonwealth. A new Harvard Medical School and New York University study (https://www.hcp.med.harvard.edu/sites/default/files/Key%20state%20SMI-OUD%20v3.pdf) shows that repealing the ACA would have tragic consequences for millions of Americans affected by mental illness and by the devastating opioid epidemic. 180,526

http://www.philly.com/philly/blogs/health-cents/Repeal-Obamacare-and-the-opioid-epidemic-will-get-much-worse.html

Substance Use and Mental Health Disorders: Impact of Potential Repeal of the ACA…..

- **Medicaid is single largest source of care for people with mental health and substance use disorders (SUDs)**
- **Approx. 29% of people with insurance coverage through Medicaid expansion have one or both disorders**
  (Buck, 2011; Dey, et al., 2016; Miller, 2013; Paradise, 2017; Toledo, 2017; Fornili, 2017)
- **Medicaid-eligible individuals with SUDs more likely to experience:**
  - Higher levels of medical & psychiatric comorbidity
  - Greater problem severity
  - Have more need for higher-complexity treatment (Bailey, 2017)
- **About 30 million more people will lose insurance coverage** (CBO, 2017)
- **Increase "Treatment Gap" by over 50%** (Frank & Glied, 2017)
- **Approx. 217,000 additional deaths over next decade** (Roberts et al, 2017)

UNIVERSITY of MARYLAND SCHOOL OF NURSING

In Closing: We are morally and ethically bound to address this drug addiction crisis, and the time is now.

- ***"We do not have a crisis of pills needing management, although pills are part of a picture we must address.***
- ***We do have a crisis of people who need care responsive to who they are and the communities where they live."***

***Stefan Kertesz, MD, MSc, Professor, Univ. of Alabama School of Medicine*

UNIVERSITY of MARYLAND SCHOOL OF NURSING

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"Knowing is not enough, we must apply. Willing is not enough, we must do." Goethe